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Anger

Anger is a natural feeling that everyone experiences and can take the form of mild irritation or severe and uncontrollable – causing the sufferer to be irrational and/or violent.

Anger management is a form of counselling to help you cope with any angry feelings you may have that affect your health, work, social behaviour or personal relationships.

The Mental Health Foundation discovered during a survey that 28% of adults worry about their anger level and 32% knows someone who suffers from anger.

Physical Symptoms

Anger releases stress hormones such as cortisol and adrenaline, which increases your heart rate, blood pressure, temperature and breathing. This is known as the "fight or flight" response. This release of chemicals aids you in focusing on the threat and reacting quickly, however you may regret some of your actions later.

Excessive release of stress hormones can cause illness.

A person's reaction to anger depends on their family history, culture and stress levels and can be shown by:

- sarcasm
- swearing
- shouting
- name-calling
- bullying
- physical violence including breaking and throwing things
- inward violence against themselves

Anger Management

Anger can be detrimental to your health and your relationships, so it is important to handle it in a healthy way:

- recognising your angry and how it is triggered
- taking time to cool down
- reducing your general stress levels in life

Anger can lead to domestic violence and addiction to drugs, alcohol and gambling if not treated.

Phoenix Counselling, St George's Natural Therapy Centre, Alexandra House, 17 St George's Road, Truro TR1 3JD
Tel: (01872) 272 800 Mob: 0756 180 1709 maria@phoenixcounsellingcornwall.co.uk

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Treatment

Self-help guides can be useful to help you identify triggers and in-so-doing can help you recognise them at the time. They can also teach you how then to regain control over your anger. Talking therapies such as anger management groups (provided by the NHS) and counselling/psychotherapy can also be useful. CBT is usually used for anger management.

Anxiety

Anxiety is a very broad term insofar as it can be in relation to a particular situation or with no cause to pinpoint. General Anxiety Disorder (GAD), affecting 1 in 20 people (usually those in their 20's) is the constant feeling of doom with no real attributing cause. GAD is slow to develop and sufferers may not experience all the symptoms associated with it.

Psychological Symptoms:

- Irritability
- lack of concentration
- impatient
- restless
- social withdrawal
- worry
- tensions
- inability to "switch-off"
- feeling of dread

Physical Symptoms:

- dizziness
- drowsiness and tiredness
- pins and needles
- irregular heartbeat (palpitations)
- muscle aches and tension
- dry mouth
- excessive sweating
- shortness of breath
- stomach ache/churning
- nausea
- diarrhoea
- headache
- excessive thirst
- frequent urinating
- painful or missed periods
- difficulty falling or staying asleep (insomnia)

You may also find it stressful going to work and may take days off sick. Unlike Social Anxiety or phobias, you might not know what triggers your anxiety which can intensify your symptoms.

Anxiety is a natural response to danger and is linked to the "fight or flight response" whereby adrenaline is released into the body preparing you to fight or run. It is also related to other disorders such as OCD and phobias.

Cause

Anxiety can be caused by a major stressful incident or no apparent reason. It is thought that the chemical imbalance of two neurotransmitters called serotonin and noradrenaline can significantly impact on mood, increasing the likelihood of developing anxiety-related conditions.

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Needless to say, the cause of anxiety is thought to be a complex one, such as:

- your body's biological processes
- genetics (the genes you inherit from your parents)
- your environment
- your life experience

There are two main forms of treatments for anxiety:

- psychological therapy
- medication

Psychological treatment

Cognitive Behavioural Therapy (CBT) is known to be very effective when treating anxiety.

Medication

Your GP can prescribe different types of medication to treat anxiety based on what is best for you. Your GP will discuss your options with you in detail prior to commencing the treatment.

Long-term medication includes:

- selective serotonin reuptake inhibitors (SSRIs), such as sertraline or paroxetine
- venlafaxine
- pregabalin

Short-term medication includes:

- antihistamines
- benzodiazepines
- buspirone

Selective serotonin reuptake inhibitors (SSRIs)

Selective serotonin reuptake inhibitors (SSRIs) are antidepressant that increases the level of serotonin in your brain. They can take several weeks to be effective.

Common side effects include:

- nausea
- low sex drive
- blurred vision
- diarrhoea or constipation
- dizziness
- dry mouth
- loss of appetite
- sweating
- feeling agitated
- insomnia

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When starting this type of medication, you should visit your GP after 2, 4, 6 and 12 weeks to assess its effectiveness.

Serotonin and Noradrenaline Reuptake Inhibitors (SNRI)

This type of medicine increases the amount of serotonin and noradrenaline in your brain.

Common side effects may include:

- nausea
- headache
- drowsiness
- dizziness
- dry mouth
- constipation
- indigestion
- insomnia
- sweating

If you are prescribed this medicine, your blood pressure will be monitored regularly.

Anti-Convulsants

If SSRIs and SNRIs are ineffective, you may be prescribed a drug used for epilepsy as it has been found to be beneficial in treating anxiety.

Common side effects include:

- drowsiness
- dizziness
- headaches

Antihistamines

Although usually used to treat allergic reactions, antihistamines have also been found to benefit the treatment of anxiety for the short-term by relaxing you.

Common side effects include:

- dizziness
- blurred vision
- headache
- dry mouth

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Benzodiazepines

Benzodiazepines are a sedative that is only prescribed for short-term severe episodes of anxiety because of the potential to become addicted to them.

Common side effects include:

- confusion
- loss of balance
- memory loss
- drowsiness and light-headedness

Depression

Depression is a serious illness and is very different from feeling unhappy, miserable or fed up for a short period of time. It is an intense feeling of sadness that can last for a considerable length of time and can interfere with daily life significantly with both psychological and social symptoms affecting each person differently.

1 in 4 sufferers are likely to be women and 1 in 10 are likely to be men, however men are more likely to commit suicide which may suggest they are less likely to seek help; and 4% of children between the ages of 5 and 16 are also likely to be affected by depression. Those with family history of depression are more likely to suffer from it themselves.

Psychological Symptoms:

- continuous low mood or sadness
- feelings of hopelessness and helplessness
- low self-esteem
- tearfulness
- feelings of guilt
- feeling irritable and intolerant of others
- lack of motivation and little interest in things
- difficulty making decisions
- lack of enjoyment
- suicidal thoughts or thoughts of harming yourself
- feeling anxious or worried
- reduced sex drive

Physical Symptoms:

- slowed movement or speech
- change in appetite or weight (usually decreased, but sometimes increased)
- constipation
- unexplained aches and pains
- lack of energy or lack of interest in sex
- changes to the menstrual cycle
- disturbed sleep patterns (for example, problems going to sleep or waking in the early hours of the morning)

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Social Symptoms:

- not doing well at work
- taking part in fewer social activities/avoiding contact with friends
- reduced hobbies and interests
- difficulties in home and family life

Doctors' Description:

Mild depression has some impact on your daily life.
Moderate depression has a significant impact on your daily life.
Severe depression makes the activities of daily life nearly impossible. A small proportion of people with severe depression may have psychotic symptoms

Grief

Whilst grief and depression share very similar symptoms, grief is a natural and healthy response to loss, whereas depression is an illness. However, it can be difficult to distinguish between the two. Those experiencing grief will have a tendency to fluctuate between emotions and stages of grief:

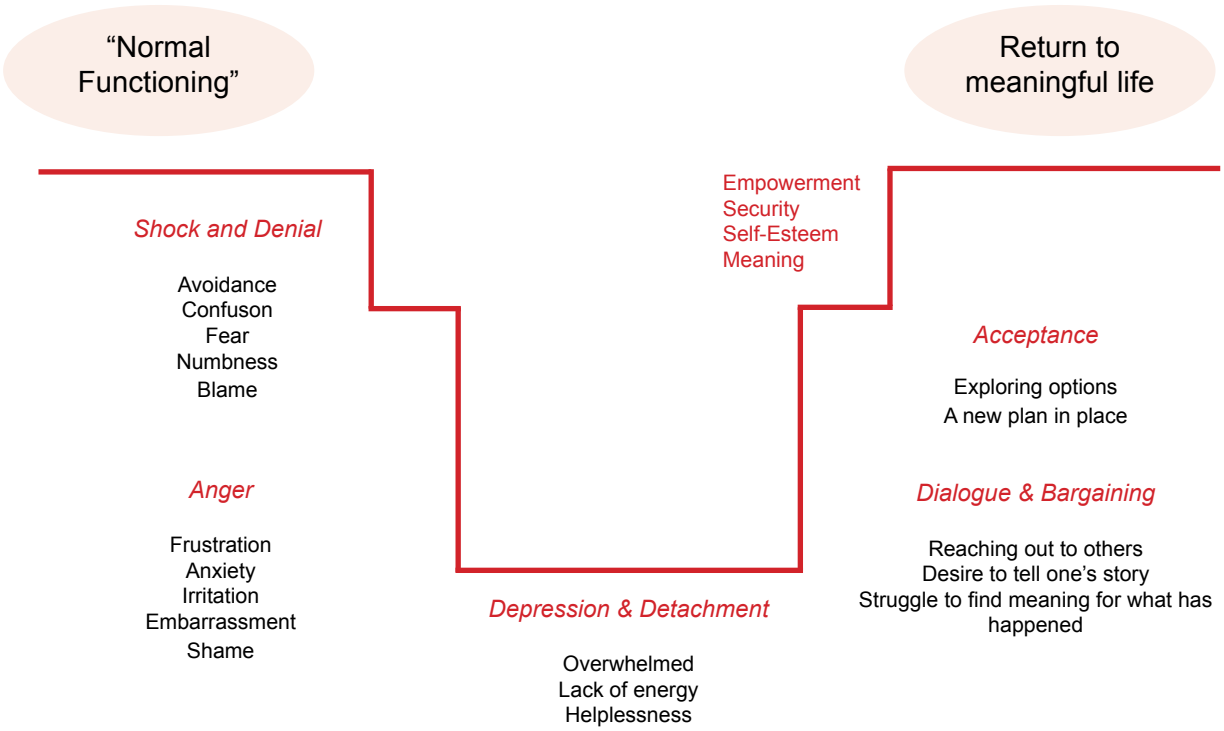

Fig. 2: Kubler-Ross 5 Stages of Grief

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Other Types of Depression

Postnatal Depression – Depression develops following childbirth – treated in a similar way to other forms of depression (talking therapies and anti-depressants).
Bipolar/Manic Depression – Periods of very low mood (depression) or very high mood (mania). Mania can exhibit harmful behaviour such as unprotected sex with multiple partners, excessive gambling or dangerous driving.
Seasonal Affective Disorder (SAD) / Winter Depression – Depression related to seasons (usually winter).

Cause

Depression is very real and is not a sign of failure or weakness. It can be debilitating and needs to be treated. It can be caused by a single or string of stressful events such as:

- Illness;
- Bereavement;
- Economic crisis;
- Child birth;
- Social isolation;
- Family history/genetics;
- Particular personality traits, such as low self-esteem;
- Substance abuse

Treatment

Treatment tends to involve a combination of medication and therapy and is based on the type of depression you have.

Mild depression

Self-help groups and guidance along with low intensity talking therapy and exercise whilst being monitored by your GP are usually recommended for mild depression as it may subside within a couple of weeks. Antidepressants are not usually recommended at this point. However, it may be prescribed for chronic mild depression (present for at least two years) called dysthymia, which is more common in those over 55 years old and can be difficult to treat.

Moderate depression

If you have mild depression that has not subsided or moderate depression, talking therapies can help. Your GP may also prescribe an antidepressant.

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Severe depression

Talking therapies such as CBT or psychotherapy has shown to be beneficial alongside an antidepressant prescribed by your GP.

Eating Disorders

Eating disorders relate to abnormal attitudes towards food, causing changes in eating habits and behaviour with an excessive focus on weight and shape, resulting in unhealthy eating habits. It can affect a person's physical and psychological health as well as impacting on their social interaction.

Common Eating Disorders

Anorexia Nervosa – weight control through starvation and excessive exercise (affecting 1 in 250 women and 1 in 2,000 men usually developing around the age of 16 or 17);
Bulimia – weight control through binging and deliberate purging or use of laxatives (affects 5 times as many people as Anorexia and 90% are female developing at the age of 18 or 19);
Binge Eating – a compulsion to over eat (affecting men and women equally usually developing around the age of 30 to 40. There are currently no statistics for this).

This is not an exhaustive list and other atypical eating disorders and subtypes exist.

Cause

- Biological or predisposing characteristics
- family history of eating disorders, depression or substance misuse
- criticism of eating habits, body shape or weight
- obsession with being slim, particularly if under pressure from society or for a job (e.g. ballet dancers, models or athletes)
- certain characteristics e.g. obsessive personality, anxiety disorder, low self-esteem or being a perfectionist
- particular experiences e.g. abuse or the death of a loved one
- difficult personal relationships
- stressful situations

Treatment:

- monitoring of physical condition by medical professional as well as:
- Cognitive Behavioural Therapy (CBT) – changing the thoughts to change the behaviour;
- Interpersonal Psychotherapy - counselling focusing on relationship-based issues;
- Dietary Counselling - counselling helping healthy diet maintenance;
- Psychodynamic Therapy: counselling focusing on how past experiences have affected the person in the present.

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If left untreated, eating disorders can be fatal.

OCD

Obsessive compulsive disorder (OCD) is a chronic (long-term) mental health condition that is usually associated with obsessive thoughts and compulsive behaviour.

Obsessions and compulsions

Obsession is a persistently reoccurring, unpleasant and unwanted thought, image or urge that causes anxiety. Compulsion is a compelling and repetitive behaviour or mental act carried out in an attempt to counteract or undo the obsession e.g. scrubbing your hands with a wire brush and bleach following emptying the bin in the thought to protect against disease.

Some common obsessions that affect people with OCD include:

- fear of causing harm to yourself or others through a deliberate action even though this type of behaviour disgusts you;
- fear of causing harm to yourself or to others through a mistake or accident – e.g. leaving the cooker on, leading to repeatedly checking the kitchen appliances;
- fear of contamination by disease, infection or other unpleasant substance;
- a need for symmetry or orderliness – e.g. having all labels on tins facing the same way;
- fear of committing an act against your religious beliefs.

Some common types of compulsive behaviour that affect people with OCD include:

- Cleaning;
- Handwashing;
- Checking – e.g. doors are locked, gas is off;
- Counting;
- Ordering and arranging;
- Hoarding;
- Asking for reassurance;
- Needing to confess;
- Repeating words silently;
- Prolonged thoughts about the same subject;
- ‘Neutralising’ thoughts (to counter the obsessional thoughts or images)

It is believed that 3/100 adults and 5/100 children/adolescents suffer from OCD, making it the most common of mental health disorders. Sufferers tend to experience symptoms at an early age and it affects people on a sliding scale of mild to severe.

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Symptoms

Although OCD is as individual as a person, there tends to be a common pattern of thought and behaviour with four main steps:

Obsession – overwhelming and constant obsessive fear or concern, e.g. you will become ill from germs
Anxiety – the obsession causes intense anxiety and distress.
Compulsion – you then adopt a pattern of compulsive behaviour to reduce your anxiety and distress, such as checking that all your windows and doors are locked at least three times before leaving your house.
Temporary relief – a pattern of compulsive behaviour is adopted to temporarily relieve the anxiety. The inevitable return of the anxiety causes the cycle to continue.

Causes

The exact causes are unknown, however it is believed that there may be genetic factors such as:

- Family history;
- Genes;
- Brain abnormalities (neurotransmitters);
- Infection such as streptococcal bacteria;
- Tics;
- Tourette's Syndrome;
- Life events where other predisposing factors are present

It is important that family and friends do not 'play along' with the sufferer's obsessions because this can make things worse and may discourage the person from seeking help. Confronting the sufferer and encouraging them to seek help is the best way to support them.

Diagnosis

The initial screening consists of a questionnaire. If you are diagnosed with OCD the severity to which you are suffering will be assessed by checking how your obsessions and compulsions impact on your day-to-day life.

OCD is classified into three levels of severity:

mild functional impairment – obsessive thinking and compulsive behaviour occupy less than one hour of your day
moderate functional impairment – obsessive thinking and compulsive behaviour occupy one to three hours of your day
severe functional impairment – obsessive thinking and compulsive behaviour occupy more than three hours of your day

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Treatment

Without treatment OCD can get worse and sufferers may never recover completely. However, treatment has shown to reduce or completely eliminate the symptoms. CBT is effective with OCD and may be coupled with antidepressants.

Medication

Similar variations of behavioural and medication treatment, as shown under anxiety and depression are used for the varying levels of functional impairment. For example:

Mild functional impairment

OCD which causes mild functional impairment is usually treated using a short course of CBT.

Moderate functional impairment

OCD which causes moderate functional impairment is usually treated using an Intensive course of CBT, or antidepressants known as SSRIs.

Severe functional impairment

OCD which causes severe functional impairment is usually treated using an Intensive course of CBT, or antidepressants known as SSRIs.

An experienced child OCD healthcare professional is required for minors.

Exposure and response prevention

Exposure and response prevention (ERP) is a treatment that involves you working collaboratively with the therapist to identify and rate a number of situations that cause you anxiety. You will then gradually be exposed to each situation without carrying out the anxiety relieving compulsion as you feel you can cope with them, starting with the lowest anxiety level.

This method has shown to reduce anxiety within just 1-2 hours. This needs to be repeated 2-3 times a day and each time the anxiety level should reduce.

OCD Action and OCD-UK are both national charities for OCD that can provide information about support groups in your area.

Surgery

Surgery is the last resort and should only be considered if all other forms of treatment have been tried accurately but unsuccessfully. For example, the sufferer has:

- received at least two full trials of different SSRIs or clomipramine, at recommended doses;
- had treatment for refractory OCD (OCD that does not respond to treatment) with the addition of antipsychotic medication or the recommended higher doses of SSRIs or mood stabilisers;
- received unsuccessful CBT treatments both in a clinic and at home, as well as having been treated by the National Service for OCD (see next page):

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National Service for Refractory OCD

In 2005 the National Institute for Health and Clinical Excellence (NICE) published guidance that the Department of Health was to commission a centre to treat people with severe, long-term refractory OCD. Since April 2007, the Department of Health has funded the National Service for Refractory OCD to fulfill this aim.

You can only be considered for help from the National Service if all other attempts to treat severe levels of OCD have been unsuccessful. Only the very few who don't respond to the National Service treatment can be considered for neurosurgery.

Ablation neurosurgery

A neurosurgeon specialising in the nervous system in the brain will use an electric current or a pulse of radiation to burn away a small part of the limbic system (the structure in the brain responsible for emotions, memory and behaviour. During controlled clinical trials, it was found that half of the 478 people treated in this way felt they had improved, but 15% felt no change or a worsening of the condition. Memory loss and mental confusion can be a serious and irreversible side effect of this treatment.

Trauma / Post Traumatic Stress Disorder

Trauma is defined, in psychiatric terms, as "an event outside normal human experience" and can affect both the mental and physical wellbeing. It can be a one-time event, such as natural disasters, assault and terrorist attack, but can also be due to prolonged/repeated events such as sexual abuse, war and hostage situations and so on. Up to 30% of those who have experienced trauma will suffer from PTSD. It affects approximately 5% of men and 10% of women at some point during their life and can occur at any age. 40% of sufferers develop the condition after someone close to them suddenly dies.

PTSD was first known as shell shock or battle fatigue syndrome, following the First World War. It was developed into the term post-traumatic stress disorder after the Vietnam War. It was officially recognised as a mental health condition in 1980 in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which was developed by the American Psychiatric Association.

Trauma Types

Trauma develops in stages, depending on the length of time the person has been suffering.

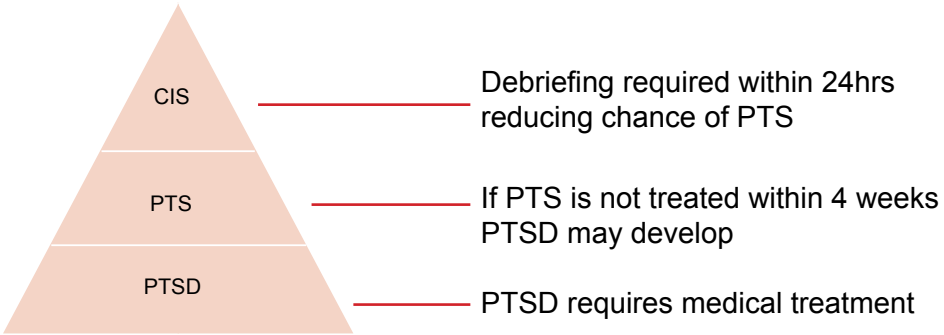

Fig 3. Trauma Diagram

Phoenix Counselling, St George's Natural Therapy Centre, Alexandra House, 17 St George's Road, Truro TR1 3JD
Tel: (01872) 272 800 Mob: 0756 180 1709 maria@phoenixcounsellingcornwall.co.uk

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Critical Incident

This can either be a positive or negative event which has a significant impact on the person's life, by raising questions regarding big parts of their personal make-up, such as morals, values and beliefs. A critical incident is something that makes a person stop and take stock of an aspect of their life, or life in its entirety. It is a milestone, a learning curve, a pinnacle in their life.

Critical Incident Technique (CIT)

This is a set of criterion used to define critical incidents, normally collated from assessing a story of something important, which happened to the person. Future coping strategies are then reflected on against the critical incident.

There is no set definition of a "Critical Incident" because it varies for each person, in each individual situation (a normal reaction to an abnormal situation). However, the blanket criteria is that it has a "sufficient impact to overwhelm the usual coping skills of an individual or group." (American Academy of Experts in Traumatic Stress http://www.aaets.org/article74.htm .)

These criteria are as follows:

- An event outside of normal human experience – an unusual event;
- A problematic or challenging situation overcome;
- Critical, conflicting, hostile or aggressive situations;
- Significant medical procedure/situation;
- An incident which made the person feel helpless;
- An incident which caused severe, but temporary, disruption or overwhelming of the person's function.

Critical Incident Stress (CIS):

This immediately follows the event, and must be addressed quickly in order to stop it from developing into Post Traumatic Stress.

Horowitz (1976) identified eight common symptoms of CIS:

- Grief/Sadness;
- Guilt regarding angry/destructive impulses;
- Fear of personal destructiveness;
- Guilt for surviving;
- Fear of identification with victims;
- Shame for feeling helpless and empty;
- Fear of repeated event;
- Intense anger directed to the source of the trauma.

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There are two types of Critical Incident Stress intervention.

These are:

Defusing Level 1 – This is done the day of the event, and in time before the person has been to sleep. It works with normalisation of feelings toward the event, and addresses immediate needs in relation to the event.
Debriefing Level 2 – This is talking therapy/support and is carried out within 72 hours of the event. This progresses from 'Defusing', and allows the person to talk about the event, and what effect it has had on them. It also addresses the person's needs as a result of the event, and provides them with information on the help available to them including potential coping mechanisms.

Post Traumatic Stress (PTS):

This is the mental and physical reaction to the event, following on from the initial shock, which can develop some days or even months later. There are no guarantees that PTS will lead to PTSD as it could pass in time, and likewise that early intervention of a critical incident will stop or reduce the development of PTS. This is all dependent upon the person's predisposing factors.

Symptoms of PTS resulting from a critical incident are the body's natural reaction to intense fear and distress, and they are as follows:

- Flashbacks;
- Sleep disturbances;
- Numbness of responses;
- Concentration disruption;
- Avoidance;
- Absentmindedness;
- Behavioural changes.

Post-Traumatic Stress Disorder:

If PTS is not dealt with within 4 weeks of the event then it can develop into a disorder with increased severity of symptoms with the potential onset of anxiety and depression, which negatively affects the sufferer's conduction of life.

PTSD can only be treated by medical intervention. However, it is difficult to diagnose, and sufferers can live with it for years with either no diagnosis or the incorrect diagnosis (being diagnosed with possibly anxiety and/or depression beforehand).

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According to the DSM IV the duration of the symptoms are critical. Duration is specified by the following terms:

Acute – less than 3 months;
Chronic – more than 3 months;
Delayed Onset – Symptoms begin at least 6 months from the critical event.

Adult Characteristics of PTSD:

Affective State

The sufferer will experience overwhelming feelings of anger, fear and shame; OR disassociation with feelings (numb – unable to connect feelings and events).

Cognitive Patterns

- Betraying – exceeding insecure feelings created by anxiety disorders;
- Guilt regarding actions and one's own survival;
- Associated extreme anxiety and detachment used as a coping mechanism;
- Being unable to recall the event; OR being unable to think of anything else;
- Ruminating about who is to blame for the event causing on going suffering.

Critical Functions

The person may be unable to reality test or judge and may have an inaccurate memory of the event.

- Somatic States
- Mood and sleep disturbances;
- Self-medication;
- Unremitting 'fight or flight' response.

Relationship Patterns

Relationships with others are likely to be disrupted. They may feel lack of trust towards others, or may feel nothing at all.

Child and Adolescent Characteristics of PTSD

If a trauma occurs prior to maturity it can hinder development and their reaction toward traumatic events. This is known as:

Anhedonia – The inability to experience pleasure
Alexithymia - The inability to ascertain own feelings.
Affective State - Intense anxiety, panic, fear, obsessively preoccupied and nightmares.

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Cognitive States:

Being unable to recall the event; OR being unable to think of anything else;
Ruminating causing on going suffering;
Creating fantasies or re-enacting the event in play.

Somatic States:

Unremitting 'fight or flight' response;
Anxiety;
Sleep disturbances.

Relationship Patterns

Relationships with others are likely to be disrupted. They may be distant; OR clingy depending on the trauma and who was involved.

Symptoms:

Persistent re-experience of the event –

- Frequently re-occurring images in the person's mind – flashbacks (children may show this through repetitive play);
- Nightmares (children may not be able to identify content);
- Persistent 'fight or flight' response;
- Intense negative distress and reaction to symbolic cues (e.g. someone grabbing a rape victims arm may remind them of the rape causing hysteria/panic);

Persistent avoidance of associated stimuli –

- Conscious avoidance of topic of event (avoid talking about it);
- Conscious avoidance of associated activities (being trapped in a fire in a bowling alley and avoiding bowling after that);
- Diminished participation in activities (e.g. a socialite not wanting to socialise);
- Detachment from others including feelings (e.g. unable to feel love for partner);
- Foreboding feeling of shortened future.

Persistent acute arousal following the event –

- Numbness of emotions;
- Hyper-vigilance and startle response;
- Sleep and concentration disruptions;
- Anxiety/depression/aggression/guilt/grief.

Further descriptions can be seen under "Trauma Types".

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Diagnosis

The DSM IV (The Diagnostic and Statistical Manual of Mental Health Disorders) defines trauma as:

"direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behaviour) (Criterion A2). (p. 463)".

Furthermore, those supporting a trauma victim can experience what is known as 'Secondary Traumatisation'. This is where the supporter is traumatised, to some degree, by the intensity of the suffering and distress experienced by the 'victim'.
Diagnosing post-traumatic stress disorder (PTSD) can be difficult for two main reasons:
The sufferer might not want to talk about the traumatic event;
The sufferer may not seek help for months or years after the symptoms begin.

Cause

Pre-Disposing Factors

Pre-disposing factors are described as "risk factors" which are present in the biology and/or psychology of the person prior to the trauma.

Biological Theory

The Amygdala is the part of the limbic system which controls expression of emotion (e.g. fear, emotion memory and autonomic functions – bowel movements, blinking and the 'fight or flight'/startle response). The Amygdala identifies danger and triggers our automatic response to this perceived danger which is called the 'startle response' for self-preservation. One of the symptoms of PTSD is persistent startle response, which means that the Amydala continues to release the chemicals inducing the 'fight or flight' response – effectively causing the person to be stuck in this automatic response. Studies show this can actually cause physical damage to the brain.

Stress causes the brain to release chemicals such as nor epinephrine and epinephrine, which becomes hyperactive when frequently and enduringly triggered by flashbacks and other intrusive symptoms of PTS.

Phoenix Counselling, St George's Natural Therapy Centre, Alexandra House, 17 St George's Road, Truro TR1 3JD
Tel: (01872) 272 800 Mob: 0756 180 1709 maria@phoenixcounsellingcornwall.co.uk

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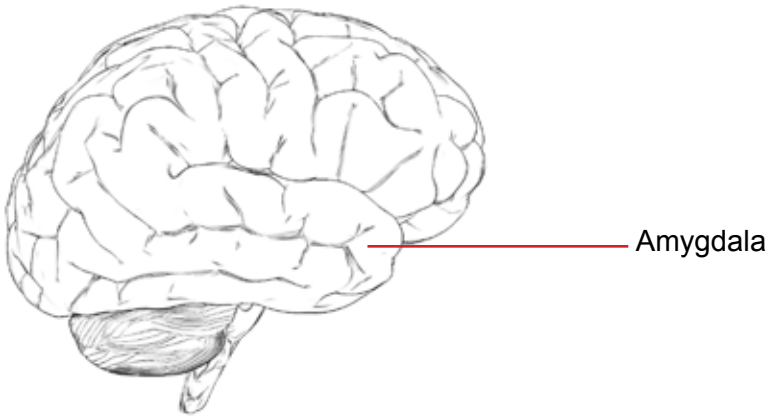

Fig. 4: Dr Ellen Weber: Amygdala Diagram

The feeling of numbness and memory disturbances could be caused by the release of endorphins and encephalins reacting to those intrusive experiences of the aftermath of trauma, such as triggers.

Reduction of serotonin levels in the brain may lead to mood disturbances as serotonin balancers are used for the treatment of depression.

Psychological Theory

These “risk factors” include previous trauma, alcohol or other substance abuse, a predisposing mental health condition, the type and the severity of the traumatic event, and the lack of adequate and competent support following the trauma. However, PTSD can develop with or without the presence of pre-disposing factors.

Risk Factor Categories:

Pre-Trauma: The psychological history prior to trauma –

- Borderline Personality Disorder (sufferer has often been subjected to physical and/or sexual abuse, neglect, hostile conflict, and parental loss or separation in the past);
- Dependant Personality Disorder (sufferer often has low self esteem, fear of separation, and the excessive need to be cared for by others);
- Low self esteem;
- Previous trauma;
- Poor coping skills;
- Pessimism and introversion;
- Genetics and family history of anxiety disorders;
- Stress related to home, school, work or social life;
- Alcohol and drug abuse.

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Peri-Trauma: The severity, duration, proximity to either direct or witnessed, and type of trauma -

- Combat;
- Kidnapping;
- Natural Disasters ;
- Catastrophic Accident e.g. train crash;
- Violent Physical Assault;
- Violent Sexual Assault;
- Witnessed traumatic events;
- Unexpectedly seeing a corpse or body parts;
- Children who are neglected or abused;
- People diagnosed with life threatening illness or major medical procedures;
- Emergency services staff;
- Sudden and violent death of a relative;
- The type of trauma also dictates the severity of the effect, such as gang rape (something 'done to' another) or flood (something that happened where the person was) may affect people differently. For example, some rape victims may feel they 'brought it on themselves' because their skirt was short, or they were drunk etc.

Post-Trauma: Severity, intensity and duration of PTSD; and the support given to that person plays a part here. For example, secondary victimisation can be caused by someone who is attempting to help the victim but may suggest blame on the victim. PTSD can worsen with isolation caused by poor or absent treatment whether by neglect or avoidance.

High-Risk Theory: This theory states that drug and alcohol problems are present prior to PTSD. The user may be more likely to be in situations where they will experience traumatic events.

Self-Medication Theory: This theory states that PTSD sufferers use substances to reduce the symptoms e.g. alcohol for hyperarousal.

Susceptibility Theory: This theory states that those with substance use problems are more susceptible to trauma as a direct result of the substance misuse.

Shared Vulnerability Theory: This theory states that some people may have a genetic vulnerability to PTSD and substance misuse.

Treatment

Seven Phases of CIS Debriefing

Debriefing can be carried out by a therapist or a person experienced and trained in CIS, PTS and PTSD using the following format, and is referred to as the Seven Phases of Critical Incident Stress Debriefing:

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Introduction – The facilitator introduces themselves (including how they are qualified to carry out the debrief), the group, the purpose and procedure of the meeting, the boundaries and the confidentially (in accordance with the organisations breeches of confidentiality requirements, whilst working in accordance with the Ethical Framework). Introductions are not timed – they are as long as they need to be. Unlike psychotherapy a contract is not made with the group. It is also important to note here that the attendees should be informed that they are likely to feel worse before they improve.

Fact Phase – Each group member explains what happened prior to the event, and where they were psychologically. They then describe their role and their own and others' participation in the event, including a summary of their perception of the event (if too much information is given the group is at risk of secondary trauma). Describing what they heard, saw and smelt (this can lead to smell as a trigger for reoccurring thoughts linked to the event) gives life to the event, and helps everyone tap into the feelings it caused.

Thought Phase – Each group member gives their first thought on the event (e.g. "I thought it was just going to be a normal call out"). It is also useful for them to give their own rationalisation of their actions, as this helps them to make sense of what happened.

Feeling Phase – The group describe their feelings to the event, how they feel now and if they have experienced this before (this gives an understanding to what they are experiencing, their coping mechanisms – positive or negative). This is not done in turn – people participate as and when they feel ready to do so because forcing it is not beneficial to either group or individual. As in psychotherapy, it is important to validate the person's experiences (this also works towards normalisation of feelings). The 'Feeling Phase' is linked with the 'Fact Phase' – how did they feel to those items described in the previous phase?

Reaction Phase – Each group member describes what they have experienced with their thoughts, feelings and physical experiences etc. since the event. For example, anxiety, nausea or headaches; shell-shock can be a physical response to being under persistent gunfire in war. Later this could also be avoidance of triggers, not talking about the event or sleeping with your clothes and shoes on so you are always ready to react if it happens again (e.g. due to fire).

Strategy Phase – Normalisation of reactions to traumatic events (everyone's reaction to an abnormal event is normal because so many factors are involved to elicit them. E.g. trauma history, resilience, type of trauma, extent of involvement etc.). Sharing of coping strategies and discussions of how these strategies can be used to deal with situations in the future. Positive coping strategies would be to take care of both body and mind with healthy living; and express your feelings and seek support from those close to you (family/friends) as this will reduce isolations and fixation of the event because it isn't being repressed; going easy on yourself – the event will affect you in some way so allow yourself to experience it and let it go (Mindfulness). Learn about PTSD and ask for help if you need it.

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Re-entry Phase – This is the conclusion of the debriefing process, a summary of all of the above. It is the question and answer time to gain clarification on the points raised. This is also the point where follow-up sessions can be discussed, and advice on further help available. In psychotherapy this phase would relate to bringing the therapeutic relationship to an ethical close. It gives insight and awareness about what has happened as a result if the trauma, and what they can do now. Useful coping styles can be given as a handout, including information on gaining further help if required later on.

Watchful Waiting

Watchful waiting is a therapy plan usually used for mild PTSD symptoms or symptoms that have been present for less than 4 weeks. Following up appointments will be made to assess the symptoms.

Psychotherapy

The National Institute for Clinical Excellence (NICE) recommends that psychotherapy is used for the treatment of PTSD prior to the use of medication. However, the sufferer may also be referred to a psychologist, community psychiatric nurse or psychiatrist depending on the extent and duration of the symptoms.

Cognitive Behavioural Therapy (CBT)

CBT can help with the use of techniques such as:

- Mindfulness (grounding, meditation, breathing techniques).
- Confronting the trauma (paced by the client, trigger identification, graduated exposure to the triggers, trauma, event location or repeating the trauma)
- Use of challenge of unhelpful thinking and reality testing

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR has shown to reduce the distress caused by PTSD by helping the brain process the flashbacks experienced as a result of a traumatic event. This is done by making several sets of side-to-side eye movements while recalling the traumatic incident.

Children and Adolescence

NICE guidelines recommends that older children with severe PTSD symptoms should be treated by trauma-focused CBT within a month of the traumatic event.
3 months after the traumatic event, it is recommended that the child receives the following treatment plan:
Trauma-focused CBT suitable to the child's age and circumstances;
8 to 12 trauma-focused sessions especially designed for children and young people who have chronic PTSD following a traumatic event;
The therapy should be no less than weekly and carried out by the same person;

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Where it is appropriate to do so, the child and their family should been involved in the treatment plan;
Medication
NICE guidelines recommend the use of paroxetine, which belongs to a group of medicines known as SSRIs (see under “Anxiety”), or the antidepressant mirtazapine. Amitriptyline or phenelzine may also be prescribed.

Medication should only be used in the following circumstances:

- The sufferer declines trauma-focused therapy;
- Trauma-focused therapy would cause further trauma;
- Trauma-focused therapy was ineffective for the sufferer;
- Severe depression or hypersensitivity, which significantly affects the person’s ability to benefit from therapy alone.

Side effects of Paroxetine

Common side effects:

- nerve problems that may cause symptoms such as orofacial dystonias (muscle spasms around the face and mouth),
- withdrawal syndrome (dependence on the medication),
- yawning,
- raised cholesterol.

Less common side effects:

- arrhythmias (irregular heart beats),
- temporary changes in blood pressure,
- confusion,
- urinary incontinence (the unintentional passing of urine).

Rarer side effects:

- panic attacks, and
- depersonalisation (you experience an unreal or altered state, or you feel that your mind is separate from your body.

Very rare side effect:

- peripheral oedema (fluid around your legs and ankles),
- acute glaucoma (a severe but short-lived eye condition that affects vision),
- hepatic disorders, such as hepatitis (liver inflammation), or
- priapism (in men): a long-lasting, often painful, erection of the penis.

Please note: You should always seek advice from your doctor before taking any medication.

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