



Information Gathering after Trauma: Considerations for Human Rights Work, Peacebuilding, and Interviewing

Laurie Leitch

The collection of information from victims of human cruelty, as well as survivors of natural disasters, can provide essential information for use in promoting justice, enhancing peacebuilding, and developing preventive programs. Victims and interviewers often believe that telling the story of what has happened will not only provide needed evidence, but also represents the beginning of healing. Today neuroscience can contribute positively to the way that traumatic-events evidence is collected. The way that someone's story is told has a powerful impact on whether the interview or debriefing process will be re-traumatizing to the victim (or survivor) or will be a step toward healing and will promote or reduce the likelihood of secondary traumatization for the interviewer. The trauma resiliency model for collecting evidence seeks to manage high arousal, contribute to the healing and resiliency of survivors, and reduce potential secondary traumatization and burnout by interviewers.

WHEN TRAUMATIC EVENTS OCCUR, the documentation of what happened from the point of view of survivors can provide valuable information for use by truth and reconciliation commissions, courts, the media, social service workers, and peacebuilders. Services for survivors often include debriefings in groups in which each person is able to 'tell the story' of what happened. Individuals can begin to feel understood, 'seen', and supported when they know that their experience has been witnessed. This can create a sense of solidarity with others who have also experienced the same or a similar event. There is, however, an underbelly to the process of being witnessed and giving evidence—the potential for re-traumatization of the survivor and secondary traumatization of the interviewer or debriefing group members.

Current knowledge of the ways the human nervous system responds to trauma, and how it responds when hearing about the trauma of another person, offers the potential of reshaping interviewing and debriefing processes in ways that promote healing rather than reinforce nervous system dysregulation and re-traumatization. The

Laurie Leitch is a co-founder and co-director of the Trauma Resource Institute in Santa Fe, New Mexico.

trauma resiliency model (TRM) is a skills-based intervention program that uses a manual based on the biology, rather than the psychology, of traumatic response.¹ The approach draws on neuroscience research, including neuroimaging studies,² that shows how trauma affects cortical and subcortical processing of information, and as a treatment modality, the resolution of post-traumatic stress activation through the completion of thwarted fight and flight responses and skills of self-regulation.³ TRM offers concrete guidance to individuals who collect evidence by interviewing survivors as well as to those whose role it is to initiate a process of healing from traumatic events that includes telling the story of what happened.

EFFECTS OF DISASTERS AND LARGE-SCALE TRAUMATIC EVENTS

V. J. Carr and his colleagues describe two sets of psychological consequences— threat effects (those occurring in the immediate aftermath) and disruption effects (those extending weeks, months, and sometimes years beyond the disaster)—that arise from experiencing a disaster, but can also characterize other catastrophic or large-scale traumatic events, such as tribal and ethnic violence and terrorism.⁴ Disruption effects include constant exposure to debris and damage to infrastructure, disillusionment with governmental agencies, living in resettlement housing and camps, displacement, fear of the next hurricane, flood, or fire season and so on, property and job loss, fragmentation of families, financial stress, tensions with and danger from opposing political, ethnic, and tribal groups, and an array of emotional symptoms associated with each effect. The study by Carr and others highlights the fact that many traumatic events are not circumscribed events with a defined endpoint.

When left untreated, traumatic stress reactions have been found to lead to long-term negative mental health effects.⁵ Further, symptoms from a traumatic event can still be present after many years and may not spontaneously remit.⁶ Levels of symptoms found early in the post-disaster period have been found to be strong predictors of later symptoms.⁷

1. E. Miller-Karas and L. Leitch, *Training Resiliency Model Training Manual—Level 1* (Santa Fe, Trauma Resource Institute, 2007).

2. R. A. Lanius et al., 'A review of neuroimaging studies of hyperarousal and dissociation in PTSD: Heterogeneity of response to symptom provocation', *Journal of Psychiatric Research*, 12 (2004), 33–39.

3. P. Levine, 'The body as healer: A revisioning of trauma and anxiety' in M. Sheets-Johnstone (ed.), *Trauma Healing Articles* (Niwot, Colorado, Foundation for Human Enrichment, 1996), 1–22.

4. V. J. Carr et al., 'Psychosocial sequelae of the 1989 Newcastle earthquake: II. Exposure and morbidity profiles during the first two years post-disaster', *Psychological Medicine*, 1997, 167–78.

5. G. H. Bower and H. Sivers, 'Cognitive impact of traumatic events', *Development and Psychopathology*, 10 (1998), 625–53. K. T. Brady, et al., 'Comorbidity of psychiatric disorders and posttraumatic disorder', *Journal of Clinical Psychiatry*, 61, suppl. 17 (2000), 22–32. R. Mayou, R. Bryant, and A. Ehlers, 'Prediction of psychological outcomes one year after a motor vehicle accident', *American Journal of Psychiatry*, 158 (2001), 1231–1238.

6. R. Kessler et al., 'Posttraumatic stress disorder in the national comorbidity survey', *Archives of General Psychiatry*, 52 (1995), 1048–1060.

7. F. Norris, '50,000 disaster victims speak: An empirical review of the empirical literature, 1981–2000', White River Junction, Vermont, National Center for PTSD and the Center for Mental Health Services, 2001.

The Body and Trauma

There is growing and substantial evidence that in addition to psychological trauma, survivors of trauma also suffer significant and often debilitating physical or somatic symptoms resulting from their experience. Thus, traumatic stress causes both mental health problems and a variety of serious somatic symptoms, including loss of bowel and bladder control;⁸ shaking, trembling, and increased heart rate;⁹ myofascial pain;¹⁰ diabetes;¹¹ heart disease;¹² and a continuum of stress-related diseases.¹³

The trauma field is now seeing the arrival of body-focused interventions, such as TRM, in which the primary emphasis is on traumatic symptoms as patterns of dysregulation in the nervous system rather than on cognitions and emotions. Research using neuroimaging finds that even under a relatively mild emotional challenge, negative emotion significantly affects many components of cognitive functioning.¹⁴ Biologically based models focus on brain stem survival responses and dysregulation in the autonomic nervous system (ANS) rather than on neo-cortical cognition. These models have benefited from advances in neuroimaging techniques that show autonomic nervous system arousal patterns following traumatic events.¹⁵

Patterns of dysregulation increase the risk of physical and psychological illnesses, such as immune system disorders, depression, anxiety, and cognitive impairment.¹⁶ Studies like those above highlight the importance of interventions that use knowledge of nervous system responses to trauma and trauma processing and that target regulation of the ANS. Their findings also highlight the value of monitoring arousal patterns during interviewing and debriefing and using patterns of questioning that help maintain nervous system balance.

8. Z. Solomon, N. Laor, and A. C. McFarlane, 'Acute posttraumatic reactions in soldiers and civilians' in B. A. van der Kolk, A. C. McFarlane, and L. Weisaeth (eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (New York, Guilford, 1996), 102–114.

9. J. A. Bernat, H. M. Ronfeldt, and K. S. Calhoun, 'Arias I: Prevalence of traumatic events and peritraumatic predictors of posttraumatic stress symptoms in a nonclinical sampling of college students', *Journal of Traumatic Stress*, 11 (1998), 645–65. A. Y. Shalev et al., 'A prospective study of heart rate response following trauma and the subsequent development of posttraumatic stress disorder', *Archives of General Psychiatry*, 55 (1998), 553–59.

10. R. Scaer, *The Traumatic Spectrum: Hidden Wounds and Human Resiliency* (New York, W. W. Norton & Company, 2006).

11. S. Golden, J. Williams, and D. Ford, 'Depressive symptoms and the risk of type 2 diabetes: The atherosclerosis risk in communities study', *Diabetes Care*, 27 (2004), 429–35.

12. D. Musselman and C. Nemeroff, 'Depression really does hurt: Stress, depression and cardiovascular disease', *Progressive Brain Research*, 122 (2000), 43–59.

13. B. L. Green, M. C. Grace, and G. C. Glesser, 'Identifying survivors at risk: Long term impairment following the Beverly Hills Supper Club fire', *Journal of Consulting and Clinical Psychology*, 53 (1985), 672–78; Scaer, *The Traumatic Spectrum*.

14. L. Mujica-Parodi, T. Greenberg, and J. Kilpatrick, 'A multi-modal study of cognitive processing under negative emotional arousal', Cognitive Science Society, 2004, www.cogsci.northwestern.edu/cogsci2004/papers/papers416.pdf.

15. Lanius et al., 'A review of neuroimaging studies of hyperarousal and dissociation in PTSD'.

16. M. R. Gunnar and D. M. Vasquez, 'Low cortisol and flattening of expected daytime rhythm: Potential indices of risk in human development', *Development and Psychopathology*, 13 (2001), 515–38. B. McEwen, 'Protective and damaging effects of stress mediators', *New England Journal of Medicine*, 338 (1998), 171–79. R. M. Sapolsky, *Why Zebras Don't Get Ulcers: An Updated Guide to Stress, Stress-Related Diseases and Coping* (New York, W. H. Freeman, 1994).

Secondary Traumatic Stress

In Rwanda in 2006, a woman being trained in TRM told of having lived with a sharp pain across the top of her head that she described as feeling like a slash from a machete.¹⁷ She had been checked by physicians and had been told that there was nothing physically wrong with her. Although the woman had not been wounded with a machete during the 1994 Rwandan genocide, in which hundreds of thousands died or witnessed people being attacked, she had heard clients describe their terror as the genocide unfolded, their own wounds, and what they had seen happen to others. Her sensory experience of a slash on her head was, most likely, the result of secondary traumatization that had not lessened over the years.

Social service providers, human rights workers, and other professionals are often thought to be immune from the typical traumatic responses that 'ordinary people' experience.¹⁸ Even when an individual has not directly experienced a trauma, listening to the after-effects of the events as described by those directly affected can result in what is commonly referred to as vicarious traumatization, or secondary traumatic stress (STS).¹⁹ It can also in some instances result in traumatic stress²⁰ and the development of post-traumatic stress disorder (PTSD).²¹

B. E. Bride's study of STS symptoms in 282 social workers found that 25 percent of the sample reported the following STS symptoms on a scale of occasionally to very often: intrusive thoughts about clients, avoidance of clients, diminished activity level, emotional numbing, foreshortened future, irritability, and difficulty concentrating.²² A study by A. Luce, J. Firth-Cozens, S. Midgley, and C. Burges found that individuals who experience a trauma as a civilian and as a professional have higher levels of symptomatology than those that experience the traumatic event solely as one or the other.²³ The traumatic stress reactions that often follow a catastrophic event can hinder the ability of local responders to function at pre-event levels among their constituencies.²⁴ Secondary traumatization can also impair the willingness and ability to fully connect with clients and can lead to high levels of staff turnover due to burnout.

17. L. Leitch, 'Somatic experiencing treatment with tsunami survivors in Thailand: Broadening the scope of inquiry', *Traumatology*, 13:3 (2007), 11–20.

18. M. Bamber, 'Providing support for emergency staff', *Nursing Times*, 90:22 (1994), 32–33.

19. D. T. Blair and V. A. Ramones, 'Understanding VT', *Journal of Psychosocial Nursing and Mental Health Services*, 34 (1996), 24–30. L. Schauben and P. Frazier, 'Vicarious trauma: The effects on female counselors of working with sexual violence victims', *Psychology of Women Quarterly*, 19 (1995), 49–64. C. R. Figley, 'Compassion fatigue: Toward a new understanding of the costs of caring' in B. H. Stamm (ed.), *Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators*, 2d edn (Lutherville, Maryland, Sidran Press, 1999), 3–28. L. Sexton, 'Vicarious traumatization of counselors and effects on their workplaces', *British Journal of Guidance and Counseling*, 27 (1999), 393–403.

20. M. Lerner, 'In the aftermath of the tsunami: Addressing emergent psychological needs', *American Academy of Experts in Traumatic Stress*, 2005, 1–4, www.aeets.org/column1.htm.

21. R. Zimering et al., 'Posttraumatic stress disorder in disaster relief workers following direct and indirect trauma exposure to Ground Zero', *Journal of Traumatic Stress*, 19:4 (2006), 553–57.

22. B. E. Bride, 'Prevalence of secondary traumatic stress among social workers', *Social Work*, 52:1 (2007), 63–70.

23. A. Luce et al., 'After the Omagh bomb: Posttraumatic stress disorder in health service staff', *Journal of Traumatic Stress*, 15:1 (2002), 27–30.

24. L. Leitch, 'Caring for the caregivers: Somatic experiencing treatment with social service workers following Hurricanes Katrina/Rita', *Journal of Social Work*, 54:1 (2009), 9–18.

During her training in Rwanda, the worker described above volunteered to do a demonstration with me. Using TRM skills, which are focused on releasing stored traumatic energy and resetting the ANS, she was able to shift her awareness between the pain across the top of her head and places in her body that felt no pain or even felt positive (calm or relaxed). After about twenty minutes of this shifting of attention between the pain and no-pain, she described sensations of warmth on the top of her head and down her face. The pain had disappeared completely. I continued to check with her about the pain over the several days of the training; it had not returned. TRM skills can also be used by training and treatment teams for self-care. Their use helps stabilize the nervous system and maintain the resiliency of a team, whose members can then better respond to the needs of trainees and survivors.

THE STORY AND WAYS TO TELL IT: THE TRAUMA RESILIENCY MODEL

Neuroscience has shown that when the nervous system is overwhelmed, it becomes dysregulated, which can cause a cascade of physical and psychological symptoms. Nervous system dysregulation can occur when an experience is perceived as frightening or life-threatening. It can also occur and be reinforced when someone is asked to tell the story of what happened or when listening to the stories being told. The question therefore is What can be done to minimize being overwhelmed while at the same time collecting necessary information or helping a survivor feel heard and understood? The answer lies in the way the story is told.

A core skill of TRM is called titration. The term comes from chemistry: when making a chemical compound, instead of adding the entirety of one chemical to another, the chemical is added in titrated (small) increments, with the researcher watching the reaction after each titration in order to modulate reactivity. Peter A. Levine adapted the concept to his biological model of intervention.²⁵ Among TRM skills are Levine's, including titration, as well as others. Working with small increments of traumatic material (titration) is a key element of TRM's intervention program, as is the development of somatic resources. Such resources are protective, helping make individuals sturdy and adaptable. Inside the body, resources are places of less negative or of neutral or positive sensation. In other words, resource sensations are places of nervous system organization in the body, in contrast to places of nervous system disorganization (such as pain, agitation, and numbness). Used together, the skills of titration and resourcing reduce the likelihood of escalation of arousal, flooding, or re-traumatization and help develop a sense of mastery and self-management over intense somatic states.

Using TRM's model, the story of an event is collected in ways that titrate the traumatic aspects of it and emphasize the survival or mastery parts of the story (resource). A survivor is usually either reluctant or unwilling to tell the story or ready to tell it in its entirety in one breath. Guidance is required of the interviewer. The goals of the interview or debriefing dictate the choicepoints and actions of the interviewer. Certainly the foremost goal is to do no harm (and ideally to do some good). Another goal is to collect the necessary information or to be a witness to the experience of the survivor.

25. P. Levine, *Waking the Tiger* (Berkeley, California, North Atlantic Press, 1997). P. Levine, 'Somatic experiencing: Resilience, regulation, and self', unpublished paper, 2005.

Where in the story should one start? How many details need to be told in one titration? How does one handle strong emotions or high levels of arousal? How does one know when someone is in a state of high arousal? Sometimes survivors go into a frozen state, in which they may look calm on the outside but are actually in a high state of activation internally. Both hypo- and hyperarousal are indicators of dysregulation and nervous system activation.

The TRM model develops resources first, before delving into traumatic material. This is done in the sequencing of questions. For example, rather than beginning with ‘Tell me what happened to you’, one would start with a titrated request along the lines of the following:

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

Requests such as these are considered resourcing questions. They orient the survivor toward aspects of the experience that are of lesser trauma. They remind the individual that they have lived or survived or are managing in the face of all their challenges.

TRM is biologically focused. The goal is to help the nervous system return to balance. TRM treatment helps the survivor learn how to track the sensations associated with resourcing. One would say to the survivor, ‘And as you tell me about that moment when you realized it was over, what do you notice inside right now?’ Sensations are the language of the nervous system, and so the skill of sensory tracking is a part of TRM treatment sessions.

During treatment, if the survivor is not asked to track the sensations associated with the resource, but only to *talk* about the resource, the intervention becomes merely a cognitive intervention. The intervention should, however, be on a sensory level. In interviews without a treatment component—that is, those focused on information gathering—the interviewer monitors the survivor’s nervous system arousal by observing such things as posture, gestures, rate of breathing, changes in skin coloration, and muscle tension patterns. As the arousal level is observed to increase—an indicator of the sympathetic branch of the ANS being activated or of the nervous system going into freeze—the interviewer shifts to questions focused on mastery, self-management, competency, or social engagement. Resourcing questions access the parasympathetic branch of the ANS and help create calm or nervous system balance.

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

I worked with a man who had removed the bodies of more than twenty co-workers, friends, and others from the rubble. His wife had also died in the quake. This was a situation in which saying ‘Tell me about the moment when you knew you had survived’ seemed inappropriate. So many had died that being a survivor was often

something about which people felt guilty. Instead I asked, ‘Tell me who else survived’. The man pulled out his cellphone and showed me a photo of his young son. That was where we began the story. I asked him to tell me about his son and what they do together. I asked several questions along this line in order to intensify the resource sensations. Our brain is programmed for survival and is programmed to attend first and foremost to anything perceived as being threatening to survival. The TRM skill of resource intensification helps override a single-point focus on traumatic material and uncomfortable emotions and sensations in the body and encourages balance by accessing the parasympathetic.

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

Managing arousal levels when the trauma story is being told is done by titrating the traumatic details of the story. This is accomplished by shifting between questions about resources (and the corresponding sensations associated with a description of resources) and questions about the details of the traumatic event. Using the skills of titration and resourcing increases the likelihood of allowing trauma data to be collected without causing more trauma. The survivor stays in the resilient zone, or at least is helped to return to that zone if he or she becomes hypo- or hyperaroused. In debriefing groups, the facilitator can help group members titrate between traumatic details and resources in such a way that models, and even restores, the normal rhythm of the ANS (to a balance between the sympathetic and parasympathetic branches). The process of telling the story or providing the data needed in investigations then becomes an experience of self-regulation and healing.

CONCLUSION

The way a story is told and the way trauma data is collected is extremely important in situations where telling the story of trauma is deemed helpful for the healing of an individual or is needed as part of information gathering, such as involving treatment intakes or a human rights or legal process. Biological models of traumatic response, such as TRM, that place primary importance on nervous system regulation and dysregulation, have much to offer survivors as well as interviewers and responders. Regardless of the treatment and healing modality being used—whether ritual, storytelling, debriefing, legal testimony, or intake interviews—and regardless of the culture, the goal is to do no harm. Understanding the relationship between the sympathetic and parasympathetic branches of the autonomic nervous system and ways of monitoring arousal levels (including signs of hypo- and hyperarousal) promotes interview and intervention techniques that stabilize rather than contribute to dysregulation and

distress. In addition, when a survivor is helped to report information from within the resilient zone, the accuracy of the information provided is likely to be considerably better than it would be otherwise.

The human nervous system reacts in the same way in its response to threat and fear regardless of culture, country, or ethnic group. The meaning that symptoms of dysregulation and distress might have can vary widely across cultures, but the symptoms themselves are the same. TRM's biologically based training and treatment are appropriate for use across cultures.²⁶ Biologically based interventions have much to contribute in the many arenas that focus on survivors of large-scale trauma. Benevolent and gentle, yet efficient, methods of interviewing and treatment that enhance hope and resiliency are the very least that survivors and those who respond to them deserve.

26. Leitch, 'Somatic experiencing treatment with tsunami survivors in Thailand'. L. Leitch, 'The truth is not simple', *Psychotherapy Networker*, November/December 2008. L. Leitch and E. Miller-Karas, 'Biologically-based mental health intervention in post-earthquake China: Trauma resiliency model', accepted for review, *International Journal of Emergency Mental Health*, December 2009).