Vicarious traumatization of the emergency personnel working to support refugees and asylum seekers in Italy

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Europe is facing a special flow of refugees in recent times, that are escaping from war, violence, terrorism, political persecution and poverty

STATISTICS

132,000 persons arriving by sea (Jan-Sept 2015)

10,000 unaccompained children arrived by sea (Jan-Sept 2015)

16,000 persons arriving by sea in Sept 2015

38,700 asylum applications up to July 2015 (including from sea and other arrivals)

(UNHCR, Sept 2015)

THE IMPACT OF TRAUMATIC EVENTS

- Mental health of refugees is generally acknowledged to be influenced both by traumatic and current stressors (e.g., Miller & Rasmussen, 2010)
- Refugees are at high risk of experiencing traumatic events before, during, and after their flight (Silove, Tarn, Bowles, & Reid, 1991)
- In addition to traumatic stressors, current stressors both in the country of refuge and the country of origin impact the mental health of both adults and children (Fazel et al., 2011; Steel et al., 2009)
- Then, we are talking about complex, repeated, prolonged, of different types, serious traumatic situations, almost always interpersonal, caused by man.

Evidence demonstrates that acute stress responses after a disaster are universal, whereas the person's culture determines the way these responses are manifest (National Institute of Mental Health [NIMH], 2014).

- Because of the accumulation of traumatic and current stress faced by refugees, treatment for traumatized refugees has long consisted of supportive, unstructured, multimodal interventions, with no central focus on processing of traumatic memories and with limited effectiveness (e.g., Boehnlein et al., 2004; Carlsson, Mortensen, & Kastrup, 2005)

- They argue that a predominant treatment focus on trauma and PTSD may not fully meet refugees' needs for various reasons (survivors of war and persecution tend to prioritize practical concerns and trauma focused therapy may therefore not be their first priority to them

WHAT WE KNOW

- The accumulation of stressors not only leaves refugees at higher risk of developing mental health problems than general populations (Bronstein & Montgomery, 2011; Fazel et al., 2005), economic migrants (Lindert, Von Ehrenstein, Priebe, Mielck, & Brähler, 2009), and compatriots who have stayed in their countries of origin (Porter & Haslam, 2001), but may also complicate their psychosocial recovery

- As indicated by the Adaptive Information Processing model of trauma, therefore, untreated trauma and other adverse life experiences have profound individual and interpersonal effects (Shapiro, 1995, 2001, 2014). Research has revealed serious and lasting consequences across the life span not only in mental but also physical health

- As indicated in the article by Carriere (2014), the detrimental effects of untreated trauma have grave societal implications.
- Although more research is needed, these findings indicate that the availability of timely and effective trauma treatment may assist in bringing about reconciliation, peaceful coexistence, and the potential for nonviolent development.
- This further underscores the need to increase efforts to provide mental health services that address the debilitating effects of trauma through expanded care opportunities, comprehensive collaborative efforts, and supporting research (Carierre, 2014).

WHO (2013) - focus of psychological interventions in the acute phase of trauma

(a) supply relief and concern to reduce hypervigilance states (create a safe environment)

(b) provide secure information to all those involved; prevent the onset of future debilitating psychopathologies such as post-traumatic stress disorder (PTSD; APA, 2013) in order to assist victims toward alleviating symptoms to take control of their lives as soon as possible.

HOW WE CAN DO IT
-EMDR-

- EMDR is evidence based and indicated by the WHO guidelines as advanced psychological treatment for extreme stress and trauma

- the intervention with EMDR is short, focused, it can be done in groups (in order to optimize the time), it is very simple to do with an interpreter (as opposed to other psychological methods)

- EMDR can be used in the acute phase but it can also be applied in the various stages of "this people on the march" (hot spots: centers of first acceptance, secondary reception centers)

HOW WE CAN DO IT
-EMDR-

EMDR is treatment of choice for trauma and trauma related disorders. EMDR clinicians working with refugees recognize that trauma can be effectively and efficiently treated, it is important, therefore, to bringing healing to those in need. No one should be left behind, effective mental health treatment should be available to all in need, EMDR can be easily implemented, is brief and trauma centered.

We can use EMDR

* with refugees
* **with emergency personnel**

VICTIM TIPOLOGY (Taylor, Frazer 1981)

- Primary victims: people who have had maximal exposure to the impact of the event
- Secondary victims: relatives or loved ones of the primary victims (either deceased or survivors)
- **Tertiary victims: rescue and recovery personnel**
- Quarternary victims: the community involved in the disaster
- Quinternary victims: people who, due to premorbid characteristicts, as a result may developed short-term or long- term pathological behavior
- Sesternary victims: people who, but for chance, could have been a primary victim or feel to be indirectly involved

SUPPORT EMERGENCY PERSONNEL

- Why?
- To whom it is addressed?
- Where action is taken?
- In which cases do we intervene?
- When do we intervene?
- How do we intervene?

WHY
EMPATHEIA
to feel inside

Empathy comes from a sort of physical imitation of the suffering of others which then evokes the same feelings of the imitator (baby / mother; spouses; helping professions)

Titchener

Mirror neurons are a group of brain cells that can make us react in mirror image to the actions and intentions of our similars. These neurons put us in the position to imitate in our body and in our mind the emotion, the feeling or the act that are happening

G. Rizzollatti

VICARIOUS TRAUMATIZATION

People who work in daily contact with acute suffering, despite they tend to develop a high tolerance threshold to traumatic events, can manifest psychopathological disorders in the short or long term as a result of **vicarious traumatization**

The term states that emergency personnel during a work situation can live a trauma, too

Not for direct exposure, but for the contact with traumatized people

Emergency personnel can live a traumatic experience in a secondary or indirect way because of the relationship with the victim

PROTECT THE EMERGENCY PERSONNEL

(Law 81/2008: consolidated law on safety at work)

- Prevent BURN OUT
- Not develop pathological consequences as a result of vicarious traumatization
- Protect consumers

IN WHICH CASES DO WE INTERVENE?

- Situations at risk of burn-out among emergency personnel or where there is already a high level of burnout

- Situations that are critical events for the team and the single person

BURN OUT

30s: Burn Out as the inability of an athlete, after some success, to obtain additional results and / or maintain those acquired

Maslach 1975: Burn Out as a stressor process related to helping professions. The operator experiences a loss of interest towards those people he should help (patients, clients, users, customers, etc.).

Helping professions at risk: doctors, psychologists, nurses, teachers, assistants, etc. In the last years other categories of workers who have frequent contact with the public have been included: lawyers, restaurant owners, politicians, managers, receptionist, etc.

BURN OUT

- Exhaustion: inability to relax and recover, feeling exhausted, lack of energy
- Cynicism: cold and detached attitude towards work and the people he meets at work. The emotional involvement at work is minimized or completely absent; loss of ideals/values
- Inefficiency: feeling of inadequacy, loss of confidence in their abilities and in themselves

MAJOR CRITICAL EVENTS FOR THE EMERGENCY PERSONNEL

- events involving children
- events with a lot of victims
- severe injuries, body mutilations or deformations
- failure of the intervention after considerable efforts
- excessive media interest
- the need to make hard choices or not adequate to their operational role
- the need to make important decisions in a short time
- death or serious injuries during service

FACTORS AFFECTING THE EXTENT OF THE EMOTIONAL RESPONSE

- Level of involvement
- Level of control
- Level of threat or loss
- Level of absurdity
- Level of notice
- Proximity: physical - psychological
- Level of stress in their lives
- Nature and degree of social support after the event
- Support of colleagues and friends
- Family support and possibility to communicate

WHEN DO WE INTERVENE?

- Before a critical event occurs, in "peacetime"
- Immediately after a critical event (from a few hours to a few weeks after the event)
- In the medium and long term

HOW DO WE INTERVENE?

* *Before a critical event occurs*

Needs analysis, evaluation of the level of Burn Out, sensitization, information and training, group/individual interventions to promote the operator and the team well-being

* *Immediately after a critical event*

Intervention varies according to the level of trauma resolution: Critical Incident Stress Debriefing, EMDR, normalization of the different reactions

* *In the medium and long term*

Trauma-focused psychotherapy, group or individual

CISM - Critical Incident Stress Management

- A systematic program for the alleviation of stress reactions after a critical incident
- CISM directly addresses current circumstances, not personal situations
- CISM is part of a group of interventions applied for groups at high risk (Ex: rescue teams, soldiers, etc.)

CISM:
it is based on different interventions according to the time from the critical event and to the phases of normalization of the post-traumatic stress reactions

- Sensitization / Training (before the critical incident)
- Demobilization (immediately after rescue intervention)
- Defusing (8-12 hours after)
- Debriefing (from 24-72 hours to weeks after the event)
- Individual/Family support
- send to Network
- Individual sessions/EMDR

DEBRIEFING

When: debriefing should not be made less than 24 hours after the critical event. It is often conducted later, depending on the circumstances, how long the event lasts, investigating matters, level of traumatization, community reactions and logistics considerations

By whom: Mental health professionals, psychologists and / or psychotherapists trained in CISM

To whom: Homogeneous groups of victims. Similar level of exposure to the event, losses suffered. Vittime of I-II-III-VI type. Minimum: 3 participants, maximum: 20 (?)

DEBRIEFING

Where: if possible in a closed room, with no interruptions (telephone or physical), chairs arranged in a circle (conductor and co-conductor seated opposite to each other), drinks and food at the end of meeting.

How: it is important to be faithful to the Protocol to be able to obtain a “U pattern"

Why: to normalize emotional reactions, break the isolation, help identify personal resources and coping strategies, increase group cohesion and optimize the social support, do an initial screening of those most at risk for future psychopathological diseases

EMDR - Eye Movement Desensitization and Reprocessing

- EMDR: desensitization (reduction of the disturb) and cognitive restructuring (increasing of positive perceptions)

- 1987 Francine Shapiro: desensitizing effects of eye movements repeated on unpleasant thoughts

EMDR: guidelines

- American Psychological Association: efficacy for PTSD
- ISTSS: revision of controlled studies with statistical significance on different groups
- Veterans Health Affairs e Ministry of Defense U.S.A.
- American Psychiatric Association
- National Institute for Clinical Excellence (NICE)
- WHO

EMDR

The processing system is innate, the disorder occurs when this system of self-healing crashes. By accessing the traumatic memory and / or the source of discomfort the system is reactivated and then reaches the adaptive resolution. During the sessions we notice a change in the cognitive structure, in the behavior, emotions and sensations, and consequently the personal conviction on its value and the level of self-esteem change.

RESILIENCE

- Individual ability to cope in a positive manner to a traumatic event, to reorganize his live continuing his normal development and feeling reinforced after the event
- Maintain flexibility and balance as we face stressful circumstances and traumatic events
- It implies that there are behaviors, thoughts and actions that can be learned or developed.