European Network for Psycho-Social Aftercare in Case of Disaster

Target Group Intervention Programme

Manual III

Manual for trauma-based psychoeducation for victims of disasters

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Preface

The Manual for trauma-based psychoeducation for victims of disasters (Booklet III) was developed in the course of the project „European Guideline for Target group Oriented Psychosocial Aftercare in Cases of Disaster (EUTOPA)", which is sponsored by the European Union. The main question of the project is: According to current research, what kind of crisis intervention measures have proven to decrease the risk of victims becoming mentally ill following major loss situations? In this connection, the workgroup adopts the approach that identifying survivors who are at a high risk of developing a chronic stress disorder is essential for psychosocial aftercare. Estimating the individual risk profile sets the course within the overall conception of the Target Group Intervention Programme (TGIP). TGIP describes every intervention step, from psychological primary care to indicated psychotherapy, more specifically. In our manuals (booklet I to III) we have adapted the conception to the requirement profile of international major loss situations. Booklet I focuses on a basic element of TGIP. It deals with theoretical and practical background for implementing the Cologne Risk Index, which is adapted for a checklist to measure the victims' risk-profile. This type of screening combines different survey parameters. Risk factors for developing a posttraumatic stress disorder, identifying peritraumatic dissociation and assessing the severity of symptoms. We do not imply, however, that this screening guarantees a confirmed diagnosis. Booklet II contains the modules of the Target Group Intervention Programme. In Booklet III we present trauma-based psychoeducation. Our concept is based on the opinion that process-orientation and identifying risk groups is instrumental to the implementation of a crisis intervention programme. In the past, we developed this concept for different types of situations. With the projects PLOT "Prevention of lasting psychological disorders resulting from a terrorist attack" and EUTOPA, we aim to implement this concept in the European context by using the internet. For this purpose we have established the websites www.eutopa-info.eu and www.plot-info.eu. The manual at hand (booklet III) presents trauma-based psychoeducation in form of a manual, which is suited for group-based intervention by professional helpers that counsel and/or treat disaster victims. The available at www.eutopa-info.eu/project/products complete the trauma-based psychoeducation.

Literature on Target Group Intervention Programme (TGIP)

Translations of the manual in English, French, Spanish and German are available at

www.eutopa-info.eu

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Further information about the TGIP in association with psychosocial aftercare for victims of terrorist attacks and for soldiers after foreign assignments are available at:

www.ikpp-bundeswehr.de

www.plot-info.eu

1. Introduction

Psychoeducation consists of acquiring disorder and treatment related knowledge about patients with psychiatric disorders in order to improve the chances of successful treatment. Psychoeducation is gaining increasing significance regarding prevention and treatment of stress disorders. The implications for trauma-based psychoeducation (TPE) can be derived from the concept of the progression of stress disorders (Bering, 2005). As a module of the crisis intervention programme, the Target Group Intervention Programme (TGIP), psychoeducation optimises the aftercare of victims of disasters as a risk-independent module.

This manual describes the conception and main elements of a trauma-based psychoeducation in psychosocial aftercare for victims of disasters, which can be viewed as a presentation to professional trauma-helpers on the website www.eutopa-info.eu/project/products.

2. Psychoeducation: The subject matter

Psychoeducation was developed by the American doctor Carol M. Anderson (1980) in the psychiatric context of the early 80s within the treatment of schizophrenia for characterising family intervention. Psychoeducation includes the development of disorder and treatment related knowledge concerning the patient in order to advance the success of therapy.

As psychoeducation „systematic, didactic-psychotherapeutic interventions are summarised, which are usable for informing patients and their relatives about the disorder and treatment, advancing the understanding of the disorder and responsible handling of it in order to support them in overcoming the disease" (Bäuml et al., 2003, p.3).

Additionally, psychoeducation is gaining increasing significance in the framework of prevention and treatment of emotional stress disorders. In this context, psychoeducation creates a bridge between education and counselling. The psychological effects of a potentially traumatic event are at the centre, rather than the progression of illness. Dysfunctional evaluations of trauma and its consequences lead to a high level of emotional stress (Steil & Ehlers, 2000). Therefore, it is of major importance whether a person either evaluates post-traumatic stress symptoms as part of a normal process of recovery or interprets these symptoms as a disaster.

3. Psychoeducation and Trauma: The scientific perspective

Within the scope of a study with two randomised experimental groups of victims of violence and accidents and a control group, Turpin (2005, 2007) examines the efficacy of self-help information (8-page leaflet versus extensive 31-page booklet) at three points in the measurement period. While the victims display a high subjective satisfaction regarding he written information, there are no effects on the development of PTSD as well as depression or anxiety disorders: The efficacy of providing psychoeducational information as a preventive strategy to ameliorate trauma-related symptoms is as yet unproven. However, the rating of the affected of the usefulness of e. g. self-help booklets is very high" (Turpin, 2007, p. 56). In the paediatric area, Kassam-Adams et al. (2007) developed information material in form of a leaflet and an associated workbook for parents and children being treated after severe physical injuries. Here, too, the subjective satisfaction in dealing with the material is rated as high within a randomised study with 120 parents, however, there was no influence on improved coping strategies.

Victims subjectively experience psychoeducation as helpful, but positive effects on the prevention of disorders following a trauma or improved coping strategies do not emerge.

Hobfoll et al. (2007) identified five principles of intervention in their comprehensive meta-analysis "Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention: Empirical Evidence", which on an empirical basis can be classified as guidelines for the development of intervention practices and programmes in the aftermath of disasters and mass violence: Promote Sense of Safety, Promote Sense of Calming, Promote Sense of Self- and Collective Efficacy, Promote Connectedness as well as Promote Hope. Based on these principles, the authors identified and devised recommendations. The authors highly recommend integrating psychoeducation about post–disaster reactions in public health interventions in order to promote calming. "Psychoeducation serves to normalize reactions and to help individuals see their reactions as understandable and expected. Normalizing and validating expectable and intense emotional states and promoting survivors' capacities to tolerate and regulate them are important intervention goals at all levels. Disaster survivors should avoid pathologising their inability to remain calm and free of the expectable intense emotions that are the natural consequences of such threatening and tragic events" (p. 292). Hobfoll et al. suggest psychoeducational interventions as both individual and group measures.

From a psychotraumatological view, psychoeducation could possibly also bring about a worsening of the psychotraumatic progress of trauma victims, among other things when re-traumatising effects are caused. This raises the question how a psychoeducational measure concerning trauma victims would have to be conceived and executed so that all trauma victims benefit from it and negative effects, e.g. excessive intrusions, can be counteracted.

4. Psychoeducation and trauma: The European perspective

The project EUTOPA aims to make an important step towards a European standardisation/harmonisation of the practice of care after disasters based on the state of the art instruments in the area of early intervention and screening.

The second workshop of the project EUTOPA in Amsterdam in 09/2008 was based on the "Multidisciplinary Guideline for early psychosocial interventions after disasters, terrorism and other shocking events", developed and published in 2007 by Impact, Dutch knowledge & advice centre for post-disaster psychosocial care und available at http://www.impact-kenniscentrum.nl.

Regarding psychoeducational measures in major loss situations in the period of the first six weeks after a disaster, the authors recommend the following measures.

The study group of the multidisciplinary guideline recommends that after a disaster, terrorism or other shocking event, information is offered to all those affected.

"Information should consist of:

- A calming explanation of the normal reaction to the event
- advice to speak up when help is needed
- advice to the affected to stick to daily routines and structure the days

(Impact, 2007, recommendation 11, page 15)

Based on the results of scientific research and other considerations of the workgroup (*Best Practices*), evidence based conclusions were made.

Concerning information and preventive psychoeducation **for adults,** the guideline concludes in chapter 5.1:

1. "There is little or no evidence of the value of offering general information to all those who have been affected after a shocking event. There is however a broad consensus that this is needed."
2. "There is no scientific support for the effectiveness of preventive psychoeducation, either verbal or in writing."

Concerning information and preventive psychoeducation **for children** the guideline concludes in chapter 5.2:

"There is no reason to assume that different conclusions apply for children than for adults. Of course, in the case of children it must however be looked at what information is appropriate for their specific age group and what information should be given to parents/carers. Also, pupils and their parents are entitled to information and support that is low-threshold and familiar, i.e. that takes place within their own existing social networks, such as their class, team or club. In this process, teaching professionals check whether the information provided for their own pupils is appropriate for their developmental level and what they can understand. They also help the parents in this respect. Parents and carers are given more detailed information about what possible reactions there may be and what the best way is of dealing with this. Even if this information is provided through other channels, teaching professionals (and other professionals who normally also support parents with education and care) have an important task."

As a result of the first workshop in Cologne in November 2007, the project EUTOPA

aims to improve the evidence-based practice by compiling the practical and/or scientific experiences, including psychoeducational measures, of experts and delegates. The “EUTOPA-Questionnaire”, developed and analysed by Impact, Dutch knowledge & advice centre for post-disaster psychosocial care, was distributed to the experts and delegates during the second workshop of the project in Amsterdam in 09/2008. Concerning the issue „Providing information / psychoeducation: What works?“ The recommendations of the Multidisciplinary Guideline were reviewed and discussed by 60 EU scientists, policy makers and (mental-) health care experts in the field of post-disaster psychosocial care from 24 European countries. The results were compared to the recommendations of the „Multidisciplinary Guideline for early psychosocial interventions after disasters, terrorism and other shocking events” (2007).

The following chart shows the results of the EUTOPA-Questionnaire „ Providing information/psychoeducation: What works?“

[EUTOPA participants indicated to what level they agreed with each item, and to what level each item was brought into practice in their country. For each item, the averaged responses are shown on an answering scale 1-5: 1=totally disagree/never brought into practice; 5= totally agree, always brought into practice].

Item
1. Information given to victims consists of advising them to resume their daily routine Agreement: 4,5 Practice: 3,6 Guideline says: 5
2. Information given to victims consists of explaining when they should seek further help Agreement: 4,5 Practice: 4,1 Guideline says: 5
3. Information given to victims consists of reassuring explanation of normal Reactions Agreement: 4,5 Practice: 4,0 Guideline says: 5 **4. No information is given** Agreement: 1,1 Practice: 1,7 Guideline says: 1
5. Information given to victims consists of preventive psycho-education Agreement: 3,9 Practice: 3,3 Guideline says: 1
6. Ethnic minorities must be approached as normally as possible, but at the same time in a way that is as culture-specific as is necessary. The latter consists of providing information in their mother tongue and involving key figures from ethnic minority groups Agreement: 4,9 Practice: 2,8 Guideline says: 5

(**Chart 1:** Results of the EUTOPA-Questionnaire, te Brake, 2008, unpublished paper)

The present concept of psychoeducation for victims of a disaster is geared towards the recommendations of the Dutch study group and particularly focuses on the third aspect *„Information given to victims consists of reassuring explanation of normal reactions“.* In compliance to the Multidisciplinary Guideline (2007), this manual is a contribution to implement the "Principle of Normalcy" (Fischer, 2003) as well as possibilities and limitations of self-help exemplified in psychoeducational measures after a disaster.

5. The concept of trauma-based psychoeducation

Based on the natural progression of trauma, psychoeducation for victims of disasters must consider the needs of all target groups, Recovered, Switchers and High-Risk individuals, in order to successfully prevent traumatisation. The concept and its implementation need to be appropriate for large-scale damages and follow the recommendations of the Multidisciplinary Guideline for Early Psychosocial Interventions after Disasters, Terrorism and other shocking Event (2007). The EUTOPA project's website (www.eutopa-info.eu/project/products) offers a prototype training "psychoeducation" addressed to trauma-helpers counselling and/or treating victims of disasters as a compilation of slides for downloading. An adaptation of the concept to the specific needs of victims of terrorist attacks has been developed on behalf of the Directorate-General for Justice, Freedom and Security of the European Commission within the project "Prevention of lasting psychological disorders of the victims of terrorist attacks" (PLOT), available at www.plot-info.eu (Zurek et al., 2007).

The objective of trauma-based psychoeducation is to mobilise cognitive control operations, fortify the compliance to self-help and further counselling and treatment as well as advance the individual assessment of the risk progression in those concerned. (Schedlich et al., 2003, Bering et al., 2006).

To implement the prototype training, a qualification regarding the essentials of Psychotraumatology as well as knowledge of the concept of the Target Group Intervention Programme (TGIP) are required. The latter is described in detail in booklet II "Manual for Target Group Intervention Programme in the scope of large-scale damages and disasters".

On the basis of designing trauma-based psychoeducation as an integral part of the TGIP, two aspects influence the conception of trauma-based psychoeducation for victims of a disaster: the specific situational dynamics of a disaster and the temporal progression of a potentially traumatic situation. The specific situational dynamic of a disaster influences the adaptation of TGP and in particular psychoeducation, because as a consequence of the disaster the trust in oneself and others, as well as the view of the world are centrally shaken to the core not only on an individual level

but particularly on a collective level (Fischer & Riedesser, 2003). The concept of group-based psychoeducation enables direct activation of the factor of group cohesiveness (Yalom, 1989) and in, dynamic examination, affects the shaken self- and world-conception (Fischer & Riedesser, 2003) in a trauma-compensatory way. It is also proven that lack of social support is one of the central risk factors for developing a disorder following a trauma. Therefore, a prototype training, which is suitable as a group measure as well, is presented as an example.

In the context of a dynamic examination of stress disorders, trauma-based psychoeducation must also adapt to the temporal perspective of the natural progression of trauma. (Schedlich et al., 2003, Bering, 2005, Bering et al., 2006).

Psychoeducation should be implemented after 72 hours at the earliest, when the shock phase has faded and the post-exposure phase has begun.

In this early stage, trauma-based psychoeducation must be adapted to the victims' mental health, which may be constrained due to symptoms of an acute stress reaction, independent of the risk profile (ICD-10: F43.0). The adjustment of the amount of information and the way of imparting should comply with the victims' limited acceptance capacity and ability to concentrate. As a result, information should be communicated in a brief, structured and assessable way. If possible, the presentation of psychoeducational information should be supported by pictorial material e.g. slides. Furthermore, the distribution of written information material enables the victims to recall important contents after completing psychoeducation. First and foremost, traumatic experiences are represented in a visual and sensomotoric manner and an additional visual illustration of contents embeds the information content and benefits the process of integration in the memory (Schedlich et al., 2003).

However victims of trauma can experience psychoeducation as an emotional burden. In order to minimize effects of exposure during the immediate aftermath of a disaster, information is communicated objectively. This aims at supporting of emotional distancing from the traumatic experience. Moreover, in a group there is a risk of being re-traumatised by the traumatic experiences of others in the group. Hence the exchange in a group should be restricted to general and individual measures that promote resources. „Working through" material about trauma should be avoided. In distinction from the Critical Incident Stress Debriefing (CISD), which has been developed within the scope of the Critical Incident Stress Management (CISM) (Mitchell & Everly, 1995), the project team EUTOPA assumes that working through emotional content can cause different reactions in victims.

Whereas a victim of the group of Recovery might hardly be affected and experience working through emotional material as relieving, an early re-confrontation with emotional content can have re-traumatising effects on victims of the High-Risk group.

This perception has established itself across the board (Foa & Rothbaum, 1998, Fischer, 2000, Reddemann, 2004) in phase-oriented trauma therapy and is based on the primary principle that the stabilisation phase comes before a re-confrontation. One possible complication when implementing a trauma-based psychoeducational measure is that a dissociative experience, even a flashback, may be triggered. Due to confrontation with trauma-associated stimuli, traumatised individuals may get to a state where not only recall, but also directly relive the experience. The affected people feel like being in a movie they cannot stop. Those flashbacks can be triggered by internal or external stimuli that are linked to the trauma. Even though trauma-based psychoeducation for victims of disasters is designed to keep the degree of exposure preferably small, by the use of predominantly objective and short presentation, overwhelming emotional experience of the victims cannot be ruled out. It is necessary that the professional trauma-helper implementing a psychoeducational measure for trauma-victims knows how to deal with dissociative experiences and flashbacks of victims and is able to initiate safety measures.

5.1 Material of trauma-based psychoeducation

Besides the present manual, psychoeducation for victims of disasters contains a presentation of slides for professional users that consist of advice and instructions as well as essential elements for the implementation. Trauma-based psychoeducation, which is suitable for group intervention, is provided as another collection of slides. In the appendix of this manual further written information is available as a leaflet for victims as well as for their relatives

5.2 Essential elements of trauma-based psychoeducation in the psychosocial aftercare for disaster victims

The essential modules of psychoeducation for victims of disasters can be divided into five stages:

Modules of trauma-based psychoeducation

1. Education about the current situation
2. Introduction of basis intervention
3. Explanation of specific phenomena in the victims' traumatic experience
4. Strengthening self-help
5. Limitations of self-help; other ways to get help
6. Introduction of the checklist Cologne Risk Index

Ad 1.:

Education about the current situation always represents the beginning of psychoeducation.

Information about the disaster such as course of events and extent of damage, cause and causer, number of injured and killed individuals, is reported comprehensively, possibly by an office-holder (for example police, fire brigade, government department, local health authority, city administration). As far as content is concerned, the line of standard intervention is the framework of trauma-based psychoeducation.

Ad 2.:

Within the scope of natural coping after extreme stress, the line of standard intervention is linked to the principle of normalcy (Fischer, 2003).

Line of Standard intervention: The principle of normalcy

Unfortunately, the end of a disaster does not imply the end of emotional damage. If there are physical injuries, wounds need to be medicated and may be painful for considerable time. It is necessary to rest for a while so as not to slow down the healing process. Severe physical injuries need time to heal; emotional traumatisation sometimes takes even longer to heal. Emotional wounds may be painful for a long time and require special care and time for healing. You are not the one who is crazy. Rather, the situations you experienced are "crazy". Stress reactions are a normal and basically healthy human answer to an extremely harmful experience. Almost all people react like that. Even if they are strong and resilient. There is a rational explanation for what is going on in you. Your symptoms definitely can be relieved or even completely resolved.

Ad 3.:

Explaining specific phenomena within the victims' traumatic experience is the subsequent element of trauma-based psychoeducation. Victims' feelings of guilt and shame can be reduced by distributing comprehensive information about peritraumatic dissociative experiencing that is understandable to the layperson. Psychoanalyst Horowitz (1986) described in detail how there are indications that the biphasic nature of victims' post-exposure experience approximates the internal perspective. The dynamics of traumatic reaction are determined by an alternation between phases of avoidance and denial as well as intrusion within the victim's experience. The length of the phases may vary. The attempt to ward off memories of the trauma as much as possible is a distinctive element in the phase of avoidance. Symptoms include numbness, avoidance thoughts, feelings, or actions that could arouse recollections of the traumatic experience, amnesia, diminished interest or participation in previously enjoyed activities, feeling detached or estranged from other people or a sense of a foreshortened future. In the stage of intrusion, the victims often relive the traumatic event in an uncontrollable way. They are tortured by pictures of their memories and by nightmares. Confrontation with trauma-associated stimuli leads to severe stress reactions. Trauma-based psychoeducation attempts

to approach this internal perspective by use of graphic visualisation. Visualizing psychoeducation manages to convey even complex subjects in a way that is also comprehensive to laypersons, as is illustrated in the following two slides.

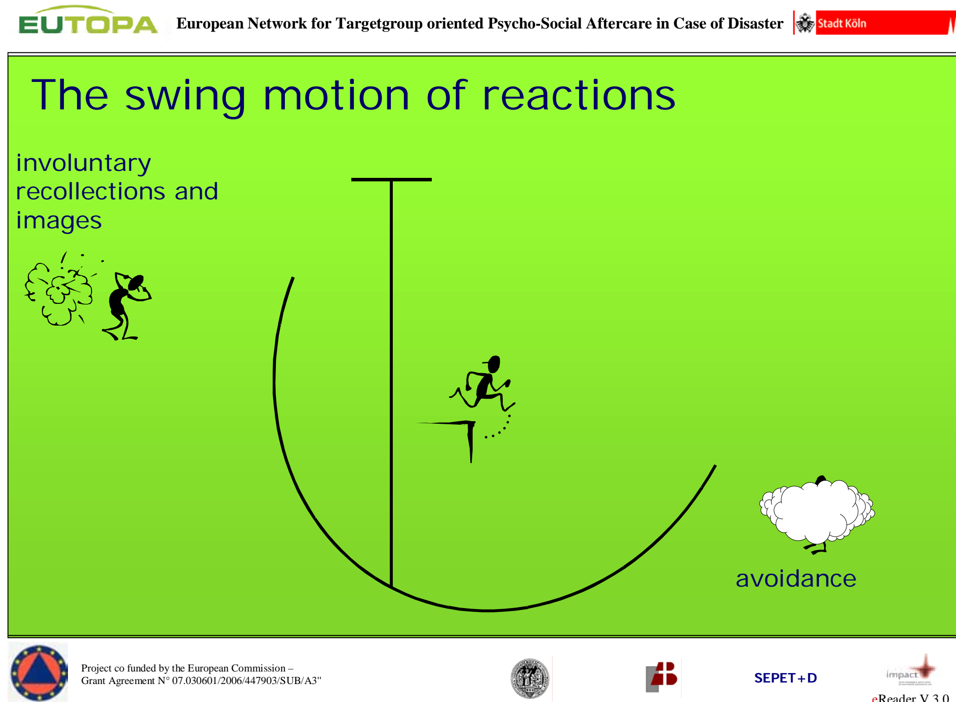

Fig. 1: The swing motion – expression of the biphasic nature during victims' post-exposure latency phase. The phase of intrusive experience is shown.

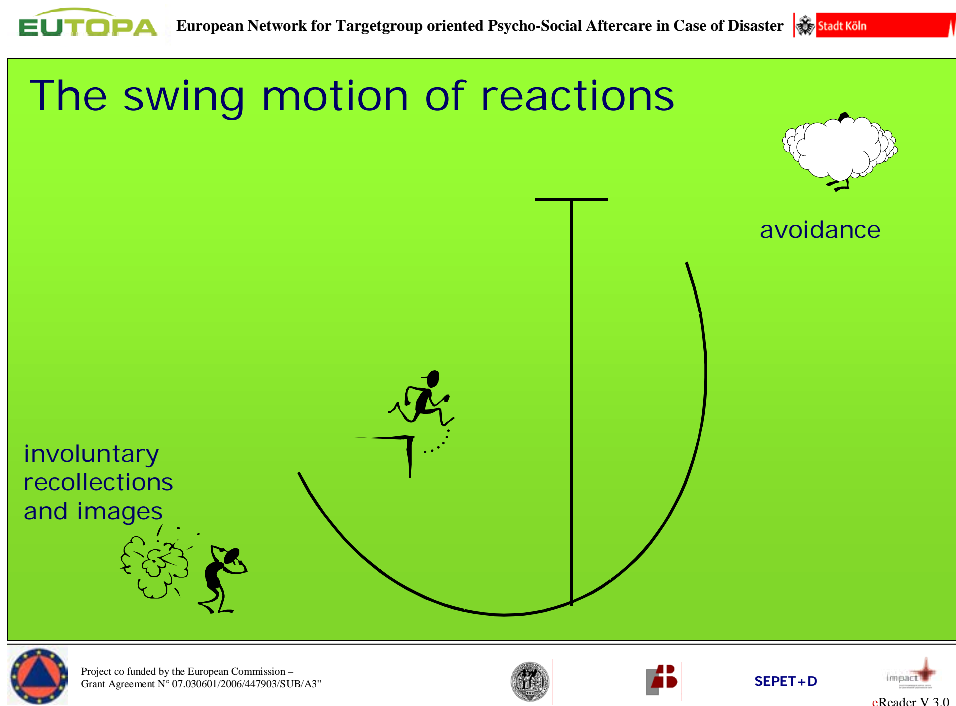

Fig. 2: The swing motion – expression of the biphasic nature during victims' post-exposure latency phase. The stage of experience within the scope of avoidance reactions is shown.

Ad 4.:

Psychoeducation focuses on the victims' ability to actively influence their healing process through self-efficacy and self-help strategies. This reduces their feelings of helplessness and incapacity that are inherent in traumatic experiences.

Ad 5.:

Thereafter the topic of discussion pertains to limitations of self-help so that maladaptive trauma-compensatory strategies can be reduced and counselling and treatment options are pointed out at an early stage.

Ad 6.:

Psychoeducation prepares a screening for a differentiated estimation of the individual risk profile with the checklist Cologne Risk Index - victims of disasters, that is described in detail in booklet I “Manual for implementing the Cologne Risk Index-Disaster in the context of major loss situations”. Further risk-specific interventions can be derived from the results of the screening.

5.3 Implementation and instructions for psychoeducation for disaster victims

5.3.1 General conditions of psychoeducation

Psychoeducation can be implemented for victims as well as for their relatives. In the early stage of exposure, psychoeducation within mixed groups is recommended. At a later stage it may be useful to differentiate between individuals being directly and indirectly affected, because the way of being affected eventually leads to different questions within the process of psychoeducation.

Within the shock phase, psychoeducational measures are not advised. The time between the disaster and implementation of psychoeducation should be at least 72 hours.

The example of psychoeducation for victims of disasters at hand can be implemented in a timeframe of up to four weeks after the incident. In the further course after four weeks, the authors consider content-related changes of basic elements necessary in order to act on the implications of the Time Course of Traumatic Stress (Fischer & Riedesser, 2003). In addition to a detailed description of the natural time course of trauma, symptoms referring to the trauma reported by the victims themselves are to be assigned aetiologically. The victims should be sensitised for a transfer into the recovery stage or into a chronic process. Possibilities and limitations of self-help are demonstrated equally. The place of the psychoeducational event should be as far away from the place of the incident as possible in order to convey efficient safety.

Psychoeducation needs adequate timing. At the same time, victims’ ability to concentrate and their power of comprehension are most likely limited after a experiencing a disaster. Psychoeducation can last 20 to 30 minutes and should not exceed 45 minutes. Empirical research still remains to be done in this regard.

5.3.2 Implementation

In the early stage of exposure, the victims' power of comprehension and their ability to concentrate are limited. Therefore, information should be communicated short, structured and accessibly. Not only verbal but also visual communication of information is beneficial.

The nature of the presentation should be clearly structured. This involves sufficient knowledge of the essentials of Psychotraumatology and the presentation itself. The focus should be on presenting briefly, structured and using comprehensible wording. Adapt your language to that of the participants. Avoid technical terms. Expressions like "stressful event" are better than "trauma". Additional visualization of the information can create an impact on the audience. Giving answers linked to the presented topics in general is advisable.

Psychoeducation should be implemented either in face-to-face contact or in a manageable group setting and in a calm atmosphere. At present, there is no empirical evidence pointing towards a single setting being better than a group setting or vice versa. In case of a major loss situation, a group setting is favourable because of time and personnel resources of the aid organisations involved. One-on-one conversations allow an adaptation of the amount and form of presentation to the victims' state of mind. In a group setting it is possible that other group members' descriptions of their traumatic experiences cause an individual victim to relive the trauma. Therefore the exchange of information within a group must be limited to general and individual resource-supporting measures. Do not urge participants to talk about their individual experiences or engage else wise in a conversation. Do not have discussions with individual participants and avoid intense conversations about personal experiences.

The traumatic situation should not be "worked through", as this could have a re-traumatising effect.

Participants displaying a tendency of wanting to talk about the event over and over should be informed about the possible additional stress factor this can cause; emphasis should be placed on the necessary capacity of finding a controlled and self-determined distance in the beginning phase. In implementing psychoeducational measures it could possibly happen that dissociative experiences culminating in flashbacks are triggered in some victims. The following passage gives helpful hints for dealing with such situations.

5.3.3 Dealing with victims' dissociative experiences and flash-backs during psychoeducation

Traumatised individuals are at risk of slipping into a state in which they not only remember, but actually relive the traumatic incident. The victims experience themselves as if they were in a movie that they are not able to stop. Such flashbacks

can be triggered by internal or external stimuli associated with the trauma. Psychoeducation is conceptualised mostly as a short and objective type of presentation that allows minimisation of the degree of stress in order to avoid flashbacks. However, it is not possible to completely prevent an overflow of emotional experiences right up to flashbacks.

If the situation occurs where a participant gets to a point where they are no longer responsive and not adequately aware of or reacting to their surroundings, the helper should try to pull the participant back into the present by using one of the following measures:

- Speak directly to the person with a raised voice and using clear words. Tell the person where they are, that they are sitting next to you and are in safety now.
- Ask what time, day, date, etc. it currently is.
- Ask apparently senseless questions like "How much is 100 minus 7"? After the person answers, continue with "How much is 93 minus 7?" etc. Questions like that irritate the person and they might actually react with anger. This reaction helps them come back to reality.
- Motivate the person to concentrate on their body and feel their feet touching the ground or their back touching the back of the chair, etc.

Following the situation, the possibly irritating method should be explained to the person in order to promote comprehension.

Avoid the following:

- Touching the person, for example on their arm, unexpectedly or without asking first.
- Dissociative persons usually do not respond to a voice that is too empathetic or quiet, nor do they react to long and complicated sentences.
- Leaving the victim in their flashback and waiting. The re-experience of traumatic event during a flashback means re-traumatisation of the victim, because on a physiological basis all sensorial and motor aspects of the trauma are being relived.
- Starting to feel panicked or guilty and expecting the victim to relieve or even explain what you may have done to cause their flashback. You can discuss this once the symptoms have subsided in an individual conversation.
- The person should not be left alone in the good intention that they need quiet now to calm down.

We regard a staff of two helpers during a psychoeducational measure as optimal in order to guarantee individual care in addition to continuous presentation in case of a problematic development.

5.3.4 The procedure of psychoeducation

Inform the participants about the procedure of the presentation, after which you will hand out leaflets about self-help.

Emphasize the voluntary participation. Victims should have the possibility of gaining distance to the traumatic event during psychoeducation (mentally or locally) in order to prevent an overflow of inner trauma related experiences.

At the end of psychoeducation, leaflets should be handed out to victims and their relatives. These leaflets contain a short guidance for self-help.
Furthermore the person implementing psychoeducation should provide information about possible regional and national help systems with addresses, websites and phone numbers.

6. Summary

Psychoeducative interventions are gaining increasing interest in the scope of secondary prevention of trauma related disorders.
We assume that the concept of the Target Group Intervention Programme (TGIP) and its risk-dependent graduation of intervention measures allows an effective and economic intervention strategy that guarantees an optimum assistance, even in case of major loss situations. Psychoeducation as a risk-independent measure of the TGIP is explained in the manual based on the Time Course Model of Traumatic Stress and is adapted to the specific situation of a disaster. Detailed instructions are given to the user who, as a professional trauma-helper, must have knowledge of the essentials of Psychotraumatology in order to operate with the aim of preventing a traumatic process and re-traumatising effects. The manual at hand presents the conception and the essential elements of a trauma based psychoeducation for the early latency phase (72 hours after the event and up to 4 weeks later). It has been developed as a group-oriented measure based on scientific findings and "best-practice" references from many European countries. In particular, victims' emotional processing of a potentially traumatic experience is unnecessary in psychoeducation. The "principle of normalcy" is the focus.

The delegates of the second EUTOPA workshop describe further questions on the subject of psychoeducation for victims of disasters in 09/2008 in their main conclusions as follows:

- „There is broad agreement with the guidelines that good quality, timely information is crucial. We need more evidence to show what really helps.
- With regard to the difference between information given in response to an event and education given in anticipation of events, how are we to identify people for whom either of these is cost effective?
- Information needs to be appropriate, adapted to specific disasters, to individual situations, and it must be appropriately timed (immediate, six weeks after, etc.).
- There is lots of good practice which can be shared as examples."

(available at: http://www.impact-kenniscentrum.nl/?pag=339&userlang=en)
In order to further verify the efficacy of trauma-based psychoeducation, the authors consider the influence of victims' risk profiles, assessed with an appropriate screening instrument like the Cologne Risk Index, essential in a study concept. We conclude that only a longitudinal design can meet the requirements of examining the right time to implement psychoeducation as well as the specific situational dynamic of the extremely stressful event and the victims' risk profile.

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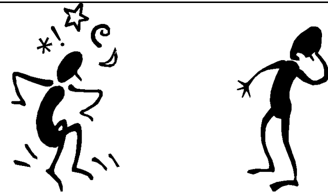
8. Appendix

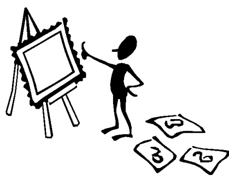
Leaflet for victims

- Guide to self-help



You are probably going to experience various **symptoms** in the coming days.

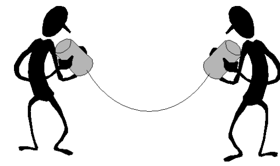
These are **normal** reactions to extremely stressful experiences.



It is important that you use any possibility to **relax** and retreat.

Allow yourself time for **recovery**!
Everyone needs individual time in order to handle an extreme emotional experience.

To talk about the experience might help, but it does not need to. Decide on the right moment and on the right conversation partner.

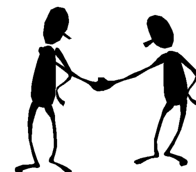


Use simple **techniques to calm yourself down**. Exercising may be an important way of overcoming stress. But not every technique for relaxation fits everybody. Distraction may be a helpful technique as well.

Use **brochures for self-help** in order to understand reactions to traumatic incidents. Read in small doses.

Activate your resources. Think about things in your life you have managed well up to now. Think about your **abilities**. Write them down.

It may be helpful making use of **professional help.** Let others clear things up to you about the consequences of traumatic experiences and possibilities of getting over them. Let others show you additional exercises for self-relaxation.



All kinds of attempts to get over the stressful experience are o.k., even extreme ones. However, **avoid** excessive drinking, avoid pills or any drugs for self-soothing.

Further information is available at www.eutopa-info.eu

Leaflet for relatives of victims

Being a relative, you are affected as well. One does not have to experience a traumatic incidence oneself to understand it. Acquire knowledge about mental trauma. This will help to understand the changes and shows your concern for the victim. First priority is the sensitive contact with each other. It is sufficient to try to understand and to show your concern to your affected relative.

Observe changes in the victim without mentioning them immediately. This may cause additional stress to the victim. Make offers to talk to them but take care of yourself, too. Even just listening to traumatic experiences may be stressful. Perhaps you experience the victim as not being the same as they were before the event, but that doesn't mean the quality of your relationship to them must change. Every relationship can benefit from the personal growth attributable to burdensome experiences.

Avoid alcohol, pills or drugs for calming yourself down.

Possibly, the victim demands more attention, seems in need of help, retreats, or tries to control everything around them. These are defence reactions that should be respected. These are normal reactions to extremely stressful experiences.
If the above behaviour continues for a length of time, communicate your observation and concern to the victim.

Share trauma-free topics, for example conversations about topics that are not related to the event or activities that are good for the victim.

Further information is available at www.eutopa-info.eu