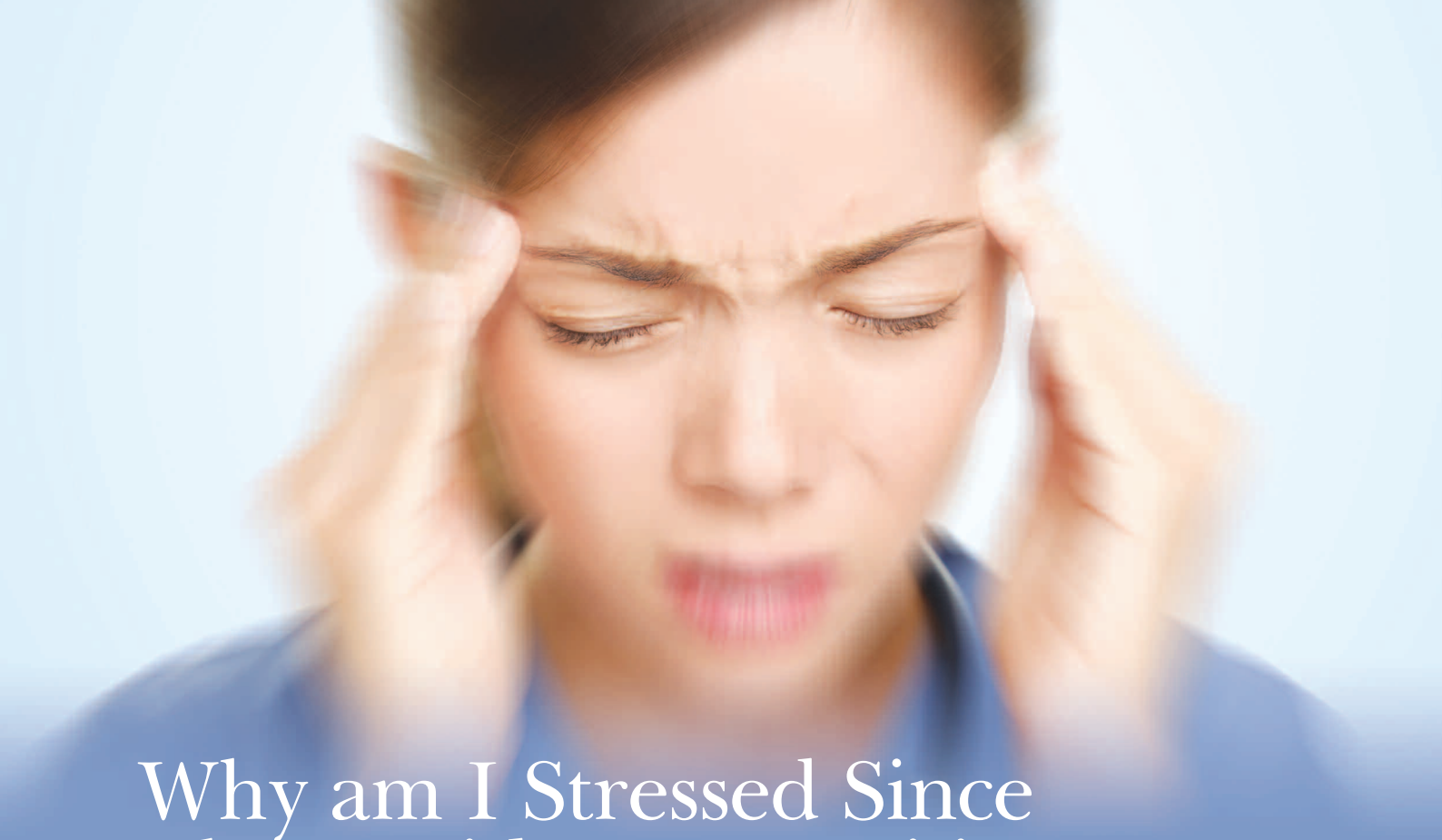

Why am I Stressed Since That Accident? Cognitive Model of Trauma Including Perceived Injustice

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Stress is a common reaction to traumatic events such as traffic, work and medical accidents. Recovery varies between individuals. It has been suggested that traumatic stress becomes persistent when individuals develop a sense or belief of serious current and ongoing threat, as a result of:

1. Excessively negative thoughts about the index trauma and its after effects. The trauma is not seen as time-limited or sensation-limited. Individuals over-generalise from the traumatic event and see a range of normal everyday activities as more dangerous than they really are. They magnify the chance of further catastrophic events occurring. Some examples of this (Ehlers and Clark, 2000) are shown in Table 1 opposite.

Table 1:

What is appraised?	Negative appraisal
Fact that trauma happened	*"Nowhere is safe"* *"The next disaster will strike soon"*
Irritability, anger outbursts	*"My personality has changed changed for the worse"* *"My marriage will break up"* *"I can't trust myself with my own children"*
Emotional numbing	*"I'm dead inside"* *"I'll never be able to relate to people again"*
Flashbacks, intrusive recollections and nightmares	*"I'm going mad"* *"I'll never get over this"*

These illogical appraisals keep the stress going by directly producing anxiety, depression and anger and by encouraging individuals to do things which enhance stress. For example, suppressing thoughts about what happened can make the thought more likely to come to mind. This may, unwittingly, be reinforced by family and friends who avoid bringing the subject of the incident up in conversation.

2. Trauma memory may be difficult to recall *intentionally* – it is fragmented and disorganised. Alongside this, there can be a high frequency of *involuntarily* triggered intrusive memories involving painful re-experiencing, often visual.
It is thought that this is due to the way the trauma is 'encoded' for memory, by poor recall in content and in time (i.e. no context in time, hence the perception of current threat, even 1 – 2 years post accident).
In addition, recall is biased by selective retrieval e.g. the claimant only recalls unfriendly responses of carers at the time of the accident, and doesn't recall those that helped.
In general, the organisation of their autobiographical memory is disturbed, leading to disorientation and upsetting feelings.

Changing these negative appraisals and memories are hampered or prevented by strategies (Ehlers and Clark (2000)) such as:
1. Behavioural: trying to prevent nightmares by going to bed late/getting up early, safety behaviours (e.g avoiding driving); avoiding friends (to avoid accident-related conversations).
2. Cognitive: Thought suppression, avoidance of accident reminders, not making plans for the future, rumination about the trauma and its consequence. Dissociation, an extremely disturbing experience, when reminders of the trauma interfere with recovery, due to derealisation, depersonalisation and emotional numbing can also occur.

Both behavioural and cognitive strategies used to control stress are likely to be influenced by prior experiences and beliefs. A number of unusual experiences can be explained by the above strategies and mechanisms namely, delayed onset of stress symptoms, anniversary reactions, feeling 'frozen in time', sensation of impending doom, lack of benefit from talking about the trauma accurately.

The above explanation gives a framework to help explain the puzzling complexity and phenomena seen with some claimants and helps to provide a framework for treatment.

Specific components of distressing thinking and feeling: - Anger, the overlooked injury
In addition to experiencing anxiety and depression after a traumatic event, one very common undiagnosed or unrecognised symptom is anger, because the individual rightly or wrongly perceive that they have been, treated badly (e.g. by their employer), are not getting better, are being poorly assessed by doctors or lawyers or misunderstood by family members (Leckart, 2011). This tends to be trivialized, or ignored partly perhaps due to it not being explicitly recognised as a DSM V or ICD 10 disorder. The closest options available in DSM V include - Intermittent Explosive Disorder (312.34) or Adjustment Disorder Unspecified (309.9).

Perceptions of injustice may not simply be 'understandable' non-significant reactions to experiencing a non-fault debilitating injury (Sullivan et al 2014). Research and clinical experience indicate that perceived injustice, after an injury, can impede successful recovery from that injury and associated pain, and can trigger a number of social, psychological and physiological changes which compromise recovery.

Incorporating cognitive understanding into robust opinions
We have previously cited a number of medico-legal postulates (Koch, 2015) which operationalise explicitly the importance of robust opinions. These reflect the need to comprehensively assess diagnosis, causation and attribution (Koch Postulate I) and this includes any factors which could affect a specific index event reaction (Koch Postulate VII). The recognition of illogical cognitive appraisal including perceived

injustice is crucial to the above two postulates. The forgoing discussion has been crystallised into an additional postulate, namely:
Experts should consider whether the level of anger and frustration experienced by a claimant meets the criterion for a recognised psychological disorder or is a normal, time-limited reaction, aided by conclusion of litigiation. (Koch Postulate XVII).

Treatment Implications
Providing effective therapy requires a careful assessment of which aspects of thinking and behaviour are causing difficulties and preventing a natural resolution of trauma-related stress.

Putting trauma into the past requires clearer trauma memory, re-appraising the trauma and its consequences (e.g. sense of threat currently) and altering dysfunctional behavioural and cognitive strategies that prevent or impair accurate, realistic memory. A wide range of CBT- based interventions help to achieve this including 'in vivo' exposure, by the individual with support from family, friends or therapists.

Given the research indicating that perceived injustice and anger are predictors of ongoing disability, interventions that give modified perceived injustice are likely to be associated with reduction in chronic pain, as well as depression and anxiety (Elbers et al (2015)).

Conclusion
Clearer understanding of cognitive, emotional and behavioural aspects of trauma experience help the lawyer and the expert arrive at a more robust opinion of diagnosis, causation and prognosis and also aid the therapist in focusing on interventions which are beneficial and accelerate recovery.

Reference:
Ehlers A and Clark DM (2000) A cognitive Model of PTSD. Behaviour Research and Therapy 38, 319 – 345

Elbers NA, Collie A and Akkermans A J (2015) Does blame impede health recovery after transport accidents. Psychological Injury and Law 8, 82 – 87

Koch HCH (2015) Robust opinions need robust reasoning: 15 medico-legal postulates. Solicitors Journal. Feature. 06.05.2015

Leckart B (2011) Anger: an overlooked injury. WETS Psychology newsletter. October 1, 33

Sullivan MJL, Yakobov E, Scott W and Tait R (2014) Perceived Injustice and Adverse recovery outcomes. Psychological Injury and Law 7, 325 – 334

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