FROM: TRAUMA & RESILIENCE – A HANDBOOK MANAGING SEVERE TRAUMATIC STRESS

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A. The Brain Responds to Trauma

The body's reaction to trauma goes beyond a biological stress response. Neurobiologists have in recent decades shed more light on how the human brain reacts to severe trauma. These insights are invaluable for understanding how to manage severe traumatic stress.

Deep brain structures, the amygdala and hippocampus, take center stage in survival situations. As part of the limbic system, they guide emotion and behavior for safety and survival. This part of the brain works at an instinctual, unconscious level and responds to sensation rather than to language or conscious thought. The amygdala assesses sensory perceptions from the body for their significance, and indicates detected significance by emotions. For example, it alerts the body to danger, and sets a flight–fight response in motion when needed. In dangerous situations, the amygdala functions like an alarm system. It also stores experiences, especially dangerous ones, as memory images connected with strong emotions. These memory images coupled with strong emotions aid the body in reacting immediately and effectively to threats.

The hippocampus saves memories and factual details (when and where something happened), then categorizes and stores them in short-term memory. It also makes memories available to higher cortical brain structures that allow conscious processing. Learning from experience requires at least a functioning short-term memory. Unfortunately, high stimulation of the amygdala interferes with hippocampal functioning. A person with high amygdala stimulation has strong emotional and physical distress (arousal, somatic flashbacks), but is unable to further process an event (van der Kolk, *Psychobiology*, 2007). Once arousal is under control, the hippocampus can categorize, store, and connect information to the brain cortex for cognitive and verbal processing. This is necessary for understanding, integration, and making meaning. Several modern therapeutic and healing prayer intervention strategies support relaxation by creating physical and emotional experiences of safety and connection (grounding, imagery), which decrease amygdala arousal, making way for effective processing of emotionally charged traumatic memory.

Psychological trauma is like an emotional scar that causes the brain's appraisal system to overreact to stimuli, triggering physical stress, flashbacks (stressful images), or physical sensations as if major trauma was happening. The person may be unaware of the trigger, but notice the reaction in mind and body. In fact those who have not stored traumatic memory in higher brain structures may be unaware that a trauma-related sensation has caused alarm in their body. Those without conscious recall of parts of the trauma can be left with confusing memory gaps. Increased ability to manage arousal and traumatic stress can pave the way to restoring those gaps.

Researchers studied brain activity in people with active traumatic flashbacks when their trauma stories were read to them. There was ample activity in the right-brain hemisphere where emotional significance is evaluated. In contrast, the left-brain hemisphere, including the parts responsible for language, showed very little activity (van der Kolk, *Psychobiology*, 2007). When exposed to traumatic memories, brains can be so overstimulated that they are literally "unable to think" at a level necessary to comprehend and integrate the experience. Based on this, it is

necessary to provide tools for managing overstimulation, hyperarousal, and flashbacks in preparation for any verbal processing of a traumatic event. Connecting to a traumatized person in a gentle, respectful, calm, and if needed, firm manner is a first step toward reducing her or his state of arousal.

B. Skills for Emotional Control

Since effective processing of trauma is possible only when a person is able to manage hyperarousal and flashbacks sufficiently, skills for emotional control are essential. The following skills have been used successfully in coping with the strong emotions caused by traumatic stress.

Deep Breathing

The fight–flight response activated with trauma-related triggers releases stress hormones into the body. Anxiety makes breathing shallow and rapid; muscles of the chest move and extend upward. Shallow, rapid breaths can lead to hyperventilation or dizziness. Deep, slow diaphragmatic breathing is a quick, safe, and effective way to decrease a stress response. It is like putting on the brakes after the accelerator was pushed too far. Just a few slow, diaphragmatic breaths often settle intense arousal. Deep breathing should be practiced prior to a stressful situation. Here is one way to practice:

1. Sit comfortably in a chair, rest your feet firmly on the ground, and place your hand(s) on your stomach. (You can also practice deep breathing standing up or lying down.)
2. Breathe in, imagining air flowing into the lower part of your abdomen. Hold the air for a brief moment.
3. Slowly exhale through your mouth; you may count to eight to help slow exhalation. Pause for a moment until you need to take the next breath.
4. Take several deep breaths and notice the changes in your body. Once practiced, deep breathing can be used in any circumstance or posture.
5. As an additional help, you may think of breathing in new (God's) strength on inhalation, and letting go of tension while exhaling.

When assisting somebody in acute distress, try breathing deeply together. Crisis is not a time for detailed instructions, but a companion providing an example will lend great support.

Grounding Techniques

Grounding techniques are helpful to counteract trauma-related triggers and flashbacks. As mind and body are highjacked by memory images (flashbacks), intense emotions, and physical alarms of the amygdala, the person can return to the present moment (here and now) by grounding his or her senses in immediate safe surroundings. Grounding can work like this:

- "Notice how your feet feel touching the floor. Notice how your body feels resting on the chair. Notice any physical sensation that feels neutral or comforting."

- "Notice what you see in the here and now. (Notice some details: Which items around you are green, blue, or yellow?) Notice what you hear (details). Notice what the chair, table, clothes feel like when touched (details), and perhaps, notice what you smell. This is (day of the week, date), in (place). This is a safe place."

- In addition, consider a favorite strong scent such as cinnamon, lavender, perfume, cologne, or coffee to bring awareness back to the present moment. Some people carry a small sample of scent in their handbag or pocket and sniff it when triggered. Since the olfactory system (sense of smell) is part of the limbic system, scents with positive associations can reduce the effect of flashbacks. On the other hand, flashbacks can be triggered by scents associated with trauma, such as smoke, oil, the burning of a fire, or the scent of cologne associated with a rape. It is important to help the person select a scent with only pleasant and relaxing associations.

Imagery Techniques

Imagery techniques are used to consciously direct one's attention to relaxing, safe, and enjoyable sensations. When trauma-related sensations cause distress, redirecting the mind to pleasant sensations helps to relax and reduce the stress response. Typically, trauma survivors are relieved when they realize they do not need to suffer through flashbacks, but have tools to control, reduce, or stop them.

The following imagery techniques have been applied with good results:

1. Safe-place Imagery

   The safe-place relaxation exercise is particularly useful in overcoming traumatic stress. It fills the mind with pleasant, relaxing sensations, literally crowding out unpleasant trauma-related ones. It can reduce or stop flashbacks. The following is an instruction for safe-place imagery:

   - "Find a memory in your mind of a place that you have experienced, where you can feel completely safe, and your body is calm and relaxed. You are there by yourself. God may be present. It may take a while to find that place. Make sure you feel completely safe and relaxed there."

   - "Once you have found your safe, relaxing place, imagine entering it. Notice what you *see*. Become aware of details. Notice what you *hear*. What characteristics do the sounds have? Or, do you 'hear' silence? Notice what you *feel on your skin*. Is it warm or cold, any movement of air? Can you *touch* things around you? What do they feel like? Do you notice a pleasant *scent or smell*? What is it like?"

   - "Linger in your safe place for a while; enjoy the relaxing, pleasant sensations. Let them fill your mind until they are strong and your body feels good and relaxed."

   - "When you are ready to leave the safe place take a deep breath, open your eyes, and return to where you are now."

   The safe-place imagery needs to first be practiced when there are no flashbacks or triggers. Once this is mastered, it can be applied to stop flashbacks and trigger reactions.

2. Image-Stop-Technique
   This skill is used to control traumatic flashbacks lasting more than a short moment. Flashbacks may be stable images or a moving picture. Changing the flashback from overwhelming, horrible and inescapable image to something that can be mentally observed with some detachment from a distance achieves a greater sense of control. This reduces emotional impact.
   - "Visualize the flashback image as you would normally view images or movies at home (scrapbook, TV, computer screen)."
   - "Gently shift your awareness from the middle of the image to the edges. Imagine a picture frame, TV screen, or the edges of your computer around the image or movie."
   - "Imagine the flashback image as a picture in a scrapbook. Mentally close the scrapbook and put the date and year on the front, so you can find the image again when you are ready." Or, "If it is a flashback movie, imagine using a remote control or computer keys to change the images: press fast forward, backward, switch off the sound, change the color, or edit with a photo-shop program."

3. Imagery Rehearsal
   Imagery Rehearsal has been studied in trauma survivors who have disturbing nightmares. It was very effective after only a few focused practice sessions. The results were so impressive, they were published in the *Journal of American Medical Association* (Krakow, 2001). The Imagery Rehearsal technique assumes that intentional imagery while awake can influence the type and frequency of nightmares. Key elements of Imagery Rehearsal are:
   - Write down a disturbing nightmare (start with a less disturbing one).
   - Change the nightmare in any positive way you wish, and write down the changed dream.
   - Rehearse the changed dream in vivid imagery for ten to fifteen minutes.
   - Share the old and new dream with another person (a trusted caregiver, peer responder, counselor, or mental health professional).
   - Rehearse the new dream for five to twenty minutes daily, but never work on more than two distinct dreams each week. Start with the least distressing nightmare and gradually proceed to more distressing ones.
   - If Imagery Rehearsal unexpectedly increases emotional distress, stop and consult a mental health professional.

In less severe cases, encourage persons with nightmares simply to change the bad dream in any way they like and write down the new version. They then rehearse the altered dream daily until the nightmare is no longer bothersome.

Strategic Distraction

Simple distraction helps when intense pain, hurt, or anxiety floods in and cannot be dealt with effectively. Distraction should not become a regular habit, but has its place in managing distress. Safe activities with physical sensations are particularly suitable as they provide natural grounding in the present moment: Wrapping oneself in a blanket and enjoying a hot or cold drink, leisure reading, taking a warm shower or bath, looking at something pleasant or beautiful, or listening to calming sounds (waterfall, creek, soft music).

If one is angry or anxious, physical activity will relieve stress and generate strong, normal physical sensations. Examples include yard work, lawn-mowing, chopping wood, gardening, housecleaning, baking and cooking. Games that do not demand a lot of focus can be a welcome distraction, too. Movies can work, but need to be used with great caution as they can contain violence and trauma triggers. If social situations are a trigger, talking to a "safe" person can help inner upheaval subside.

Basic Anger Management

Anger is a common concern after trauma. If a person "goes from 0 to 100" in a fraction of a second it makes controlling anger difficult. Fortunately, most people are able to identify physical sensations that indicate when anger is rising. Examples include muscle tension, sense of heat, or higher pulse rate. Once aware of the indicators, people can remove themselves from a situation and calm down before further action. "Time out" can be as simple as leaving the room for as long as it takes to reduce anger to a manageable level. Walking away for a moment, and taking a few deep breaths can further decrease inner tension. Regular exercise often helps cut down intense, angry reactions.

Trigger Identification

Triggers are sensations that activate a person's flight-fight response. These could be any sensations associated with past trauma, such as the sight of clothes reminiscent of a robber, sounds or smells associated with a car accident, or types of touch or other sensations linked to a rape. It may take a little detective work to understand why a person is triggered by an otherwise normal situation. But, effectively "spotting" triggers is part of overcoming their effect.

The more people become aware of trauma-related triggers they react to, the easier it is to actively "take care of their flight-fight response" by using grounding skills, deep breathing, and strategic distraction. Educating recently traumatized people about triggers and common reactions equips them to "spot" triggers. This enables them to accurately interpret physical and mental arousal and react with effective use of skills. Equipped with information, handouts, and grounding strategies, they will feel more confident.

C. Avoiding Avoidance

As described earlier, when the amygdala identifies a serious threat it puts body and mind in survival mode, ready for effective fight or flight. Reactions are instinctive and physical rather than thought through. As the fight-flight reaction subsides, other brain functions such as short-term memory (hippocampus) and complex processing (executive frontal brain cortex) become available enabling deeper understanding, coherence, and decision making. While a person is in fight-flight mode, it is impossible to think in more complex terms. It is a state of uncomfortable physical arousal and a strong sense of fear and danger. This is hard to tolerate. The instinctive impulse is to spring into action to overcome or avoid the threat.

While action or avoidance is helpful in immediate danger, it is a "false alarm" when a trigger leads to a flashback. The more uncomfortable the response to trauma-associated sights, sounds, smells, and other sensations, the more likely the person is to avoid such stimuli. Someone may avoid driving for a while after a severe car accident, or may avoid driving on the road where the accident happened. If a truck was involved, then trucks could become triggers. Passing trucks could be so intolerable that driving is avoided completely. Only when people gain confidence in dealing with their distress will they gradually overcome avoidance.

Considering the pain of trigger reactions, there is good reason to avoid certain sights, sounds, physical sensations, or talking about the traumatic event as long as somebody is very distressed and easily overwhelmed. Pushing a person to talk or engage in activities that trigger traumatic memories when they do not have the necessary management tools would re-traumatize him or her without any gain. If, however, a person feels confident and equipped to cope with triggers, she or he is in a good place to talk about the trauma and take steps to overcome avoidance behaviors. The trauma will need to be faced eventually for healing to occur. Applying the wisdom of Ecclesiastes 3: There is time to avoid (distract, stabilize) traumatic memories, and there is time to face them. When a traumatized person is overwhelmed, it is time to avoid, distract, and stabilize. When a person has natural or acquired coping skills and is ready to face the trauma and related triggers, it is time to do so. Jerry Sittser attests to the necessity of facing traumatic loss in *A Grace Disguised* with a powerful metaphor:

> "The quickest way for anyone to reach the sun and the light of day is not to run west, chasing after the setting sun, but to head east, plunging into the darkness until one comes to the sunrise" (Sittser, 2004, 42).

When a person continually avoids darkness (emotional pain) the way to the sun (healing and well-being) will be protracted. Some will need to make a conscious decision to take a 180-degree turn from immediate pain relief by avoidance, and instead face what is uncomfortable in order to attain deeper long-term relief and restoration. Skills in managing traumatic stress will help a person take this step. Sittser describes his choice:

> "I discovered in that moment that I had the power to choose the direction my life would head, even if the only choice open to me, at least initially, was either to run from the loss or to face it as best I could. Since I knew that darkness was inevitable and unavoidable, I decided from that point on to walk into the darkness rather than try to outrun it, to let my experience of loss take me on a journey wherever it would lead, and to allow myself to be transformed by my suffering rather than to think I could somehow avoid it. I chose to

> turn toward the pain, however falteringly, and to yield to the loss, though I had no idea at the time what that would mean" (Sittser, 2004, 42).

Convinced of the value of facing emotional pain, counselors and other supporters may feel an urge to draw someone into talking about their trauma or loss before they are ready. It is important to wait until the person is willing to talk. The interim is best used for supporting, stabilizing, comforting, and equipping with coping methods. Once the person is ready to talk about the trauma encourage him or her to pause, breathe, or take a break whenever needed. The confidence gained by navigating in and out of traumatic memories without being overwhelmed is worth more for the healing process than a complete narrative.

Some people find it helpful to process by journaling. This is a great tool! Those prone to avoidance may need nudging to journal. They may want to first talk with another person about difficult aspects of their experience. Others may be drawn into working too hard at processing their event, not allowing sufficient time for comfort, relaxation, support, and normal activities of life. The latter group risks exhausting their limited emotional resources. They will need encouragement to slow down, take their time, and engage in normal, stabilizing, or comforting activities and then continue processing. Facing pain takes a physical toll, and needs to be offset by regenerating activities. As a physical body needs the rhythm of working and resting, so does the soul. It needs to move in an alternating rhythm of facing pain, and regenerating, or distracting.

There are many ways to avoid pain. One is to keep preoccupied with thoughts about how the situation could have been prevented. These thoughts tend to start with "if only," and can lead to self-accusation or guilt, which can then dominate the mind, leaving no room for facing pain. Another means of avoidance is to allow too much distraction (TV, play, overeating, drinking, drugs, and inappropriate relationships or sexual activities), so that pain is crowded out or numbed. For others, anger feels easier than vulnerability, but it deflects the pain. Withdrawing from all but the closest and safest friends and family may be necessary for a time, but continued withdrawal will prolong agony.

Fortunately, resilient rebound from trauma is far more common than lasting posttraumatic stress (Bonnano, 2004). Though the majority (50-60%) of the American population goes through one or more severe traumas in their lifetime, only 5-10% develop PTSD (Ozer, 2003). Among a group of missionaries working in West Africa, 85-90% had one or more severe lifetime traumas, but only about 5% developed PTSD (20% had either full PTSD or posttraumatic stress symptoms; Schaefer, 2007). This suggests that the West Africa missionaries were more resilient than the general American population. Certain types of trauma have higher rates of PTSD (physical assault, rape, and war trauma). Also, high-risk environments are a factor. Missionaries in less stable locations (high rates of poverty, crime, and civil unrest) developed PTSD more frequently. This indicates that very high levels of ongoing stress may eventually even exhaust the reserves of those with excellent coping skills. This said, a large number of traumatized persons gradually improve over three to six months from impact. Despite lingering symptoms and struggle, even more improvement can be expected during the remainder of the first year. For many, the first or second anniversary after the crisis are turning points toward improvement and return to a "new normal" way of life. Each situation and person is unique, and no judgment should be passed on people with a longer course of recovery. Only a small number will suffer long-term distress. With good support this number can be further reduced. If a person seems to

be doing well after trauma, it is good to follow up after about three months to see if recovery continues. If not, additional support by a trained counselor or professional may be needed.

D. Dissociation—Numbing and Amnesia

Dissociation is a way the brain protects the mind from unbearable distress by detaching from some aspects of the trauma. During dissociation the thalamus, a part of the midbrain, shows reduced activity. Normally, the thalamus receives sensory input from both the body and the external world. Then it connects this information with the cerebral cortex, allowing conscious processing. This thalamus–cortex interaction helps the person integrate sensory (bodily), emotional and cognitive data, process them effectively, and experience himself as coherent. Dissociation protects the mind, but at the cost of disintegrating perception, memory, and sense of self (Frewen, 2006; van der Kolk, *Dissociation*, 2007). The normal integrated conscious experience of self is disrupted when people dissociate. Though the process allows distancing, it leads to a disintegrated state of mind. When dissociation continues beyond the immediate phase after trauma, it will start to hinder effective reintegration. Flashbacks can be considered as dissociated perceptions. Other common ways dissociation is experienced are amnesia and numbing.

When dissociation occurs, some of the experience is not available. Therefore, the person cannot remember parts of the traumatic event, however hard he may try. This is amnesia, and it can be troubling and confusing. Crisis responders need to be aware that this memory gap has been established for a reason. It is part of the trauma story the person was unable to face at that time. Once the person has acquired tools to regulate distress and regains stability, her or his mind may fill in the memory gap and process it, leading to reintegration of the person's experience. If the memory gap continues and is troublesome, the person would benefit from professional counseling.

Emotional numbing occurs in another type of posttraumatic dissociation. The brain processes this type of dissociation in a very different manner. It is a state of high vigilance and increased pain tolerance (Frewen, 2006; van der Kolk, *Dissociation*, 2007). People who experience emotional numbing feel detached and not really present, as if they had "left their body;" they feel "frozen" and emotionally "shut down." This type of dissociative process called depersonalization functions like an anesthetic. Depersonalization keeps people from feeling pain when others would feel a lot. Supporters will notice these people as seeming unusually numb and calm for what is occurring (or being discussed). They appear disengaged, detached, or absent. A person talking about a horrible event in an emotionless manner may be dissociating rather than "coping." In such a state, normal coping or processing is impossible. This "shut-down" emergency state of mind avoids distress overload but does not aid reintegration. Though dissociation relieves distress in acute crisis, it is never the state of mind to process troubling events constructively.

E. Supporting People in Panic: De-escalation

After the sudden death of a loved one, assault, sexual violation, deadly disaster, or other similarly intense traumas it is not unusual for painful emotions to reach such intensity that they are impossible to control. Some people may cry uncontrollably or have a panic attack. Panicked people are agitated, pacing, crying, wailing, shouting, or hyperventilating. Their heart beats fast, their muscles are tense, they sweat; some are nauseous to the point of vomiting.

Supporting people in panic starts by remaining calm ourselves. We can control our own stress by taking a few deep diaphragmatic breaths (see *Deep Breathing* in section B), briefly praying, and focusing our mind on God's presence, help, and strength. We might pray quietly, asking God to provide comfort and safety. If we stay calm, our support and guidance can provide stability for the person in panic. The supporter's emotions directly influence the assisted one's, for better or worse.

We can help panicked people by asking them to take a few deep breaths. This works best by deep breathing together. If the person continues to hyperventilate (rapid, shallow breaths) we can offer a paper bag to hold and breathe into. This helps calm the troubling physical sensations that go along with hyperventilation. After the person is breathing slower (or into a bag), we can ask: "Which part of your body feels better now?" This turns her or his attention away from physical distress to positive sensations, and will allow further relaxation.

The following de-escalation techniques can help in difficult situations:

- Try to appear calm and self-assured, even if you do not feel that way. Consciously lower your tone of voice, speak firmly and perhaps somewhat slower.
- Always be respectful even when redirecting or setting limits. The agitated individual is very sensitive about feeling shamed and disrespected.
- Do not smile, since this can be misinterpreted as mockery or anxiety.
- Be cautious with touch (ask permission first), or do not touch at all since this can feel uncomfortable or intrusive to an agitated person.
- Allow the person physical space to pace, and do what you can to prevent physical injury.
- Do not raise your voice over a screaming person. Wait until the person takes a breath, then talk. Speak calmly at average volume.
- Speak in an authoritative, firm, but always respectful tone.
- Never argue or try to convince, since agitated persons are not in a state to be reasonable.
- Try simple steps, such as providing some water (in an unbreakable container) or a blanket, or gently directing attention to an action step.
- If possible, take the person to a place with shelter from upsetting stimuli.

F. When to Consider Medications

Emotion regulation and de-escalation skills will go a long way, but occasionally the support of medications is indicated.

Panic

If panic does not subside with support, or if it recurs intensely, a consulted physician may prescribe tranquilizers (such as alprazolam, lorazepam, clonazepam, or diazepam). These medications should only be used short-term, as they may cause dependency.

Insomnia

Agitation following a crisis can keep body and mind on alert all through the night. If insomnia lasts for several days, it leads to fatigue and decreased ability to cope. Avoiding caffeine and alcohol are important steps to improve sleep, along with relaxing and distracting activities before bedtime. If this is not sufficient, over-the-counter medications (Benadryl, Melatonin, and Valerian Root) or sleep-enhancing herbal teas are a next step. If these do not bring about six to seven hours of sleep most nights, a physician should be consulted about an appropriate sleep aid. These should generally not be taken long-term. Address the underlying cause of sleep disturbance and develop healthy sleep habits ("sleep hygiene").

Depression, Anxiety, and Posttraumatic Stress

When more severe depression, anxiety, or posttraumatic stress leads to significant difficulties functioning at home or at work, it is time to consider an antidepressant or antianxiety medication with a health care provider. In most situations an SSRI (Selective-Serotonin-Reuptake-Inhibitor) or SNRI (Serotonin-Norepinephrine-Reuptake-Inhibitor) will be prescribed. These are medications such as sertraline (Zoloft), citalopram (Celexa), escitalopram (Lexapro), fluoxetine (Prozac), paroxetine (Paxil), venlafaxine (Effexor), desvenlafaxin (Pristiq) or mirtazapine (Remeron). They improve depression, anxiety, and posttraumatic symptoms after two to four weeks of regular intake. This period is necessary for serotonin or norepinephrine levels in the brain to increase. The health care provider will consider overall mental and physical health, as well as potential side effects, in selecting the best medication.

G. Managing Suicidal Impulses

After the devastating accident in Tanzania that killed her husband and severely injured her son and herself, Ann Hamel recounts:

> "As the reality of what happened sank in I was overwhelmed. All of my life I had seen God as my heavenly Father. I willingly left the comfort and security of life in America to serve Him in Africa but I trusted Him to take care of me and my family. As I grappled with what had happened, I regretted that any of us had survived this horrible accident. Death seemed preferable to the life that I had before me. My pain was so intense that I only thought of how to escape it. I looked at the IV drip and asked our physician friend to put something in there that would end my life. I didn't want to face a future without my husband and

without God.” (Story 3)

Right after Ann realized what happened she was so overwhelmed with pain, loss, and spiritual struggle that death appeared preferable to life. She not only wished she were dead, but also considered practical steps to bring that about.

After devastating crises, suicidal thoughts can befall even the strongest and most spiritual of us. The righteous Job laments the devastating pain of his life. His distaste for life after successive disasters was grave, indeed. He wished intensely he had never been born, and cursed the day and circumstances of his birth (Job 3).

Supporters need to be aware that suicidal thoughts and urges to act on those thoughts can occur when people are overwhelmed with pain, loss, depression or anxiety. It is important to listen for indications of suicidal thinking. It needs to be our normal practice to ask people directly whether or not they feel "tired of life" or "wish they were dead." Asking will not plant dangerous ideas in someone's mind. In fact, asking the question in a caring manner provides an opportunity to talk about thoughts or urges they have been too afraid or ashamed to discuss.

Suicidal people feel trapped and helpless, either because of the situation or the intensity of their emotions. If a person voices suicidal thoughts, take safety measures immediately! Professional assistance needs to be pursued to determine the severity of risk. In the U.S.A. this is a mental health professional. If there seems to be an imminent risk of self-harm, bring the person to a local emergency room or call 9-1-1.

In the absence (or delay) of access to a professional, a trusted and mature supporter (or team) should stay with the person at all times. The presence of supporters in itself often alleviates fears and the urge to self-harm. Supporters need to make sure that any means for self-harm are inaccessible, in particular those the person may be thinking about. This includes removing potentially harmful medications, knives, guns, ropes, or other items that could be used for self-harm. Access to alcohol, which can impair self-control, should also be monitored. Normally, people in distress want both to escape the overwhelming distress through death, and also to continue living. Suicidal thoughts often frighten the person who has them. Supporters can usually connect with the part of the person that wants to live and support this inclination. In this way, supporters become allies in the fight to survive any death wish.

H. Concluding Remarks

Supporting those with severe traumatic stress can be a daunting task. In countries where health care, including mental health, is readily available, support will most often be provided by health care professionals and emergency or disaster workers. In countries where professional support is limited, peer responders, member care representatives, mission leaders or colleagues may be at the forefront providing "psychological first aid." For all of these, as well as pastors and church members with special interest in post-trauma support, understanding principles of managing traumatic stress will help in companioning people on the road to recovery, often alongside professional support.

Many cross-cultural workers in less developed countries use *Where There Is No Doctor* by David Werner (Werner, 1992) for medical first aid. This book provides information about essential health care at the grass roots level in an easy-to-understand format. Since 2003, *Where There Is No Psychiatrist* by Vikram Patel, with a similar concept became available. A similar book focused on crisis care would be a great and much needed addition.