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Sharing Session Resource Book

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Since 2003, the Council had been launching a series of good practice sharing with the aims of facilitating improvement in service quality, promoting a sharing culture and encouraging exchange of practice wisdoms in our social service sector.

In this year, our Specialized Committee has chosen the theme “Trauma Intervention” as the key theme of our good practice sharing in December 2007. Social workers in different services might need to handle various types of trauma cases. In order to facilitate sharing of practical experience and wisdom, a sharing session was organized with speakers from various background and services.

There were 4 parts in the Sharing, including Introduction of Trauma Psychology, experience in handling Extra Marital Affairs Cases, Bereavement Counseling and Unwed Teen Pregnancy. The sharing content is documented for the sector’s reference and for further service development in handling relevant cases.

Specialized Committee on Family and Community Service 2007-2008

Helping People with Posttraumatic Stress in the Community

Caritas Medical Centre

Professor Kitty K.Y. Wu

The psychological impacts of trauma include both fight and flight biopsychological responses that may be distressing in the short-term but are essential for survival; and long-term distressing and dysfunctional responses which could compromise the health of the individual. While resilience, which indicates rebounding of functions to pre-trauma level after a transient period of distress, constitutes the experience of the majority, some survivors of trauma may experience mental distress that requires professional support.

1. Who are affected?

People who could be psychologically affected by a traumatic event do not only include the so called “direct” victims who have direct experience of the traumatic event whether or not s/he is injured or not in the incident. Family members of these direct victims and witnesses of the traumatic event could also become “indirect” victims shouldering the burden of the psychological impact of the event. Emergency personnel including policemen, fire-fighters, health care workers, volunteers, and media workers who were exposed to the aftermath of the traumatic event could also become “hidden” victims. This is because the psychological impact of vicarious traumatisation could often be overlooked for these individuals as they expect themselves and are expected by others to provide help and support and may not be prepared to be the receiver of help themselves. Having an awareness of these different possible types of victims who could experience negative psychological impact from traumatic event is essential for acknowledging the potential needs and provision of necessary support and resources in the community after the occurrence of a traumatic event.

2. What are the outcomes?

Extreme, unstable and distressing psychological responses which include fear, shock, sadness, guilt, anger, irritability, grief, flashbacks, insomnia etc. are common human experiences immediately after a traumatic experience. Though mobilization of resources and support like company of others who could offer practical help and empathy are usually required and beneficial during this acute phase, these distressing responses are not regarded as pathological or abnormal. Instead, these temporary responses could be regarded as normal human responses in reaction to an abnormal and traumatic situation. As long as these responses are consistent with the context of the reality, they could often serve as a signal of crying for help and enhance the mobilization of resources for the individual. Nevertheless, if these psychological responses became prolonged or too distressing, the mental health of the individual may be compromised. According to the Diagnostic and Statistical Manual of Mental Disorder, 4th edition (American Psychiatric Association, 1994), the prevalence rate of Acute Stress Disorder for individuals exposed to trauma ranges from 14-33%. The lifetime prevalence rate of Posttraumatic Stress Disorder (PTSD) in community-based studies is approximately 8% for the adult population. However, PTSD is not the only possible aversive outcome of traumatic incident and disaster. According to World Mental Health Survey 2000 data, the prevalence of mild or moderate mental disorders including depression, anxiety and PTSD after disaster is 20% (World Health Organization, 2005).

3. How social workers can help?

As social workers working in the frontline of the community play an essential role for provision of support and bridging of professional mental health services for victims of different kinds of traumas including family violence, crime, and disaster, it is essential to equip ourselves with knowledge and skills to conduct effective screening and provision of appropriate support for survivors of traumatic incident. According to international guidelines, services should be provided to the affected based on their needs and clinical evidence. A number of the suggestions highlighted in these guidelines are pivotal and should be familiarized by frontline workers (NICE:

National Institute for Health and Clinical Excellence, 2005; WHO: World Health Organization, 2005). Some of the important points are discussed in the following.

4. Differentiating needs

First, a common misconception highlighted by WHO is that PTSD is the main or most important mental disorder to be focused after a disaster. In fact, PTSD is only one of the common mental disorders among other mood and anxiety disorders that could be resulted from experiencing a disaster. In addition, the low level of help-seeking behaviour for PTSD symptoms in many non-western cultures suggests that PTSD is not the focus of many disaster survivors and there is a concern that agencies are over-emphasizing PTSD and are creating narrowly defined services that do not serve people with other mental problems. For majority of disaster survivors who experienced temporary and non-dysfunctional traumatic responses, it is essential not to mistaken them as having mental disorder. Psychological first aid from community level workers to ensure the provision of safety, empathy and practical support are usually sufficient. For disaster survivors who experienced persisting and dysfunctional traumatic responses, referral to specialist mental health care would be required (World Health Organization, 2005).

5. Single-session debriefing should not be routinely offered

Local service providers and frontline workers should also observe and not to ignore the recommendations regarding the use of single-session debriefing for people affected by traumatic incident and disaster. According to existing evidence, single-session debriefing that focus on the traumatic incident should not be routinely given immediately after the disaster due to the lack of evidence supporting its efficacy and the documentation of harmful effects in some studies. In addition, for survivors who experience mild symptoms of less than four weeks after the trauma, watchful waiting, as a way of managing the difficulties, should be considered. A follow-up contact should be arranged within one month (NICE, 2005; Rose, Bisson, & Wessely, 2002). Perhaps, it is justified to summarize the recommendations based on existing evidence that it is essential to provide practical support, empathy, and assistance for mobilization of social resources for people affected by traumatic incident to ensure

their safety and facilitation of natural recovery. Single-session debriefing that focus on the traumatic incident may affect the process of natural recovery and should not be provided unless there are exceptional justifications or adaptation in the procedures so that possible harmful effects could be minimized. On the other hand, watchful waiting does not mean that nothing could be done. Besides provision of practical support with a safe and supportive environment, provision of information like health tips, self-care, and contacts for further mental health service may enhance a sense of mastery. The utilization of self-report screening measures by frontline mental health workers could also be considered as a less intrusive procedure of watchful waiting (Wu & Leung, in preparation).

6. Empowering clients with knowledge

Frontline workers are encouraged to empower the public and clients with research evidence that facilitate adaptive coping as well as early identification and intervention for those who are at-risk for prolonged distress (Wu, 2007). Research findings confirming that majority of survivors would have resilience and recover after the acute phase of the traumatic event can be used for educational purpose at the acute phase after trauma as it helps frontline workers to normalize acute but transient distress experienced by the majority of people after a traumatic experience, and educate them on the probability and help-seeking procedures for prolonged distress. The risk factors identified in this research can also guide frontline workers in early identification of the at-risk survivors and to provide early treatment and psychosocial support. Research findings on prevalence and risk factors of posttraumatic stress reactions can also become valuable information for clients helping them to have an increased sense of mastery and facilitating effective self-care particularly for those who are at-risk for prolonged distress. Research findings can also be utilised in explaining the rationale of treatment procedures to encourage early help seeking behaviour. Frontline workers can also utilise local findings in educating the clients to enhance acceptance and recognition of existing evidence (Cheng, Wong et al. 2004; Ho, Kwong-Lo, & Mak, 2005; Wu, Chan, & Ma, 2005a; Wu, Chan, & Ma, 2005b; Wu & Cheung, 2006). In terms of format and tools of information provision, besides using pamphlets and audio-visual aids, the availability of frontline worker for verbal

discussion with immediate clarification for victims after a major traumatic is suggested.

7. Encouragement for adaptive behaviour

Encouraging and helping people affected by traumatic event to mobilize support from their natural sources (i.e., family, relatives and friends) and continued engagement in adaptive behaviour as early as the situation allows would usually facilitate natural recovery. When hospitalization is required, the aim is to facilitate the individual to reintegrate back to the community as early as possible. Thus, prolonged hospitalization which may take the individual away from his/her natural environment of support or encourage maladaptive avoidance behaviour should be avoided.

8. Continuing education for workers

Frontline workers are encouraged to make use of local platform and training opportunity provided by different professional bodies for updating knowledge and skills. The Asian Society for Traumatic Stress Studies (AsianSTSS) which was set up in Hong Kong in 2005 is among one of these organisations that provides a platform for different disciplines to exchange knowledge and experience in trauma psychology. Resources including useful websites, downloadable educational pamphlets, and calendar of local and overseas training activities are available in the website of AsianSTSS: http://www.asianstss.org.

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Extra Marital Affairs Counseling

Caritas-HK – Extra Marital Affairs Counselling Service

Ms Anna S.K. Yuen

1. Introduction

This article aims at a brief introduction of Extra-martial Affairs (EMA) counselling service provided by Caritas-HK --Project on EMA. Possible traumatic impacts of extra-marital affected on different parties would be described. The intervention framework by EMA which is based on a holistic approach and users' participation model would also be shared. The part for assessment and intervention framework for EMA crisis cases would be focused on female non-participating parties(FNPP) as they constitute the majority group for seeking professional help.

2. Background of the Caritas EMA counselling service

Extra-marital affair has been a taboo for many individuals and families in a Chinese society. The Caritas EMA Hotline Service has pioneered to operate since 1995. The EMA Hotline Service is the pioneer 24-hours information hotline and it provides professional telephone counselling service for parties affected by the extra-marital affairs in the local context. According to our EMA hotline statistics, until the end of 2006, the Service received a total of 215,562 calls. On average, it receives about 1,000 new EMA hotline calls monthly. Reviewing the profile of the hotline callers, majority of the callers who seek professional help were female non-participating parties. The median range of callers and their spouses was 36-45 years old. Apart from night time professional counselling service, the Service also connects service-users with community resources for further follow-up service such as casework, group work etc. The intervention framework for the Caritas EMA Project pursues for a remedial-preventive-advocacy model for which each level of intervention is interwoven and collaborative with different target groups of service users. The intervention strategy is also directed towards a users' participation and empowerment based. (Please refer to

table below).

Intervention Strategy

	Target Groups	Modes of intervention
Treatment & Rebuilding	Different parties affected by EMA trauma ✧ NPP, PP, TP, Children affected by parents' affairs/marital conflicts	✧ Individual/marital counselling ✧ Therapeutic Groups ✧ Mutual Help groups & supportive network ✧ Time-out service (Caritas Family Crisis Support Centre since 2002)
Early Identification & Prevention	✧ Couples, Children & youth ✧ Professionals ✧ local citizens ✧ Community & neighbourhood leaders, mass media, etc.	✧ Community Education & Media Work ✧ Hotline counselling service: - EMA Hotline (2537 7247) - Children Hotline (2522 2929) ✧ EMA Homepage (www.ema.caritas.org.hk) ✧ Community campaigns & promotional programmes with users' participation
Research & Advocacy	✧ Government Personnels & Politicians ✧ Practice-based researches & Publications	✧ Focus group & empowerment network of ex-users ✧ Professionals from other disciplines

3. Common emotional responses and traumatic impacts on different parties affected by extra-marital affairs

Extra-Marital affairs is often regarded as a marital infidelity issue in a monogamous society and it is still a prevailing social phenomenon in Hong Kong. The nature of affairs cases is getting complex and perplexing as the affairs development can involve multi-parties but not just a simply triangular relationship. In recent years, the discovery of extra-marital affairs crisis are often complicated by other family and social problems such as gambling and debt problems, chronic mental illness of family members, prolonged financial stress resulted from unemployment, cross-border marriages, etc. Hence, marital conflicts resulting from EMA crises are more complex. In a recent study by Hong Kong Tuen Mun Hospital, husband with extra-marital affairs (EMA) also constitutes one of the risk factors leading to family violence.(Tsui, Chan, So and Kam, 2006).

It is no doubt that an extra-marital affairs discovery is a crisis for parties who are involved as it is a threat for an intimate couple relationship or a potential threat for a romantic relationship development. For the participating parties (PP), they might feel the implicit tension and chronic stress in balancing the spousal system and the romance and love system with the third party when the infidelity issue is kept in high secrecy. For some and non-participating parties (NPP), stress is accumulated from the suspicious stage and tension of couple relationship escalated during the discovery stage. For the third parties (TP) who are often portrayed as intruders of others' marriage and integrity of the family system, they are highly sensitive for the social stigma in the current socio-cultural context. Nevertheless, in reality, the traumatic impacts upon the revelation of marital infidelity are perceived differently by different individuals and families in different socio-political cultures.

Some common emotional and behavioural responses for different parties upon the EMA discovery crisis are highlighted as follows:

a) Male participating parties	✧ Confused ✧ Denial ✧ Easily get agitated ✧ Guilt ✧ Avoiding attitude towards spouse ✧ Loss of face ✧ Passive-aggressive behaviours in relating with the spouse ✧ Decision-making struggles ✧ Depression ✧ Suicidal threats and attempts
b) Female non-participating parties	✧ Shock ✧ Anxiety & fear of losing the spouse ✧ Anger at the spouse's betrayal ✧ Confused ✧ Denial ✧ Depression ✧ Feeling sad and hurt ✧ Fear of losing the marriage & family integrity ✧ Jealousy ✧ Loss of face ✧ Suicidal ideation & attempts ✧ Repeated and overwhelming thoughts of the EMA evidence-finding process ✧ Ambivalence in the decision-making ✧ Decrease in self-esteem and self-confidence
c) Female third parties	✧ Anxiety ✧ Ambivalence and struggles and decision-making ✧ Confused ✧ Depression ✧ Irritability ✧ Jealousy ✧ Guilt

	✧ Revenging ideas and attempt ✧ Feel hurt and painful for sudden/unprepared separation and loss for the romance ✧ Suicidal threats and attempts
d) Children affected by parents' affairs	✧ Children are keen observers in the family system: If they are emotionally disturbed by parents' marital conflicts as a result of the EMA crisis, presenting alarms for adults attention and early professional assessment & intervention are usually their acting-out behaviours. For instance, sudden drop in academic performance, social withdrawal, regressive behaviourss etc.

4. Some commonly asked questions for assessment and intervention for EMA crisis cases:

It is not uncommon to see that people with EMA crises are often confused and ambivalent. Marital conflicts are often intensified during the discovery stage. Hence, pacing with clients in facing the EMA crisis positively is significant.

With reference to a female non-participating party case, here are some questions for assessment and intervention at the crisis stage:

- *When* the EMA discovery happened? (eg. Last week/Last month/Last year)
- *Where* did the EMA discovery reveal client ? (eg. at home, at detective's office, on the street etc.)
- How did the EMA reveal to client? (eg.MPP's self-disclosure of the affairs, FNPP's checkout for evidence, etc.?)
- *How much* did client know the affairs? (Assess for the intensity & toxicity of the evidence-finding and evidence keeping process)
- *How long/duration* for the affairs lasted as disclosed to FNPP?
- What is/are significant impacts on client's physical health status which required immediate medical attention? (Eg. FNPP has got sexually transmitted disease which triggered off the disclosure of husband's affairs)

- *What is/are* client's feelings towards the incident? (eg. Anger, Confused, Shock, Fear & anxiety are common for FNPP)Any suicidal thoughts & /attempts/self-harming attempts?*What is/are* MPP's attidtude/feelings/behaviours towards FNPP during and after the EMA discovery?
- How far are the impacts of the EMA discovery affect the individual's daily functioning, significant others, interpersonal relationships and other aspects of his/her life?
- Wh*at is* the degree of anxiety/shock/acceptance of the EMA reality?
- Any pre-sessional progress? *What has the* client done to cope with EMA crisis before coming for counselling (seeking relatives and social network support, any suicidal attempt, intensified marital conflicts and/or open discussion with spouse etc.?)
- Set priority of counselling goals with client if there are more than one.

From our clinical experience in EMA Project, some FNPPs who are facing husband's EMA trauma feel isolated and alone in experiencing the pain and struggles for the EMA trauma, hence to engage the FNPP to join the therapeutic and supportive groups are resourceful for them. It not only strengthens the resiliency capacities of an individual family affected by EMA, it also strengthens the social cohesiveness of people as a group to encounter the adversities in the marriage road. It also cultivates a positive and supporting attitude in facing the marital discord as a result of EMA. Moreover, it facilitates the 'Self-help, Mutual-help' atmosphere in the community as a whole.

5. Some Keys to minimize traumatic impacts of EMA crisis

- Life and Death issue on Top priority
- Rapport and Pacing with client in *decreasing the emotional intensity and detoxification process* of the 'traumatic' episodes of the EMA crisis
- Stop violence and intense marital conflicts before putting couples for joint session
- Engage client's cooperation for other professional support such as psychiatric assessment, clinical psychological service, time-out service etc.
- No hurry for decision-making
- Explore and validate client's own strengths/experience, supportive network before coming for professional help; and equip with other community resources
- Instilling hope and positive attitude in handling the adversity situation with client

- Be ready for providing prompt crisis intervention during and even after the critical stage of EMA crisis
- Take care of worker's own mental health state and equip with team members' support and community resources
- Beware of worker's own value dilemma and beliefs about love, marriage, EMA and divorce issues

This article has not covered the trauma that a MPP, a TP and the children that affected by parents' EMA crisis, yet as social work professionals, we have to prepare ourselves for the challenges ahead in working with these target groups whenever and wherever settings they turn up for professional help.

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When Trauma meets Bereavement: The Recollection of Practice Wisdom

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Trauma and bereavement often intrude into a person's life jointly. The daily functioning of bereaved persons is highly affected by the dual effects of these two experiences. Thus, it is not uncommon for them to approach social workers for support and services. This paper is an attempt to delineate the practice wisdom in supporting clients who are facing trauma and bereavement. Starting from the definition of trauma and bereavement, it is hoped to introduce the essences in the two types of experiences. Practice experiences will then be outlined in three different scenarios of trauma meets bereavement. In the conclusion, reminders for practitioners in preparing oneself will be highlight.

1. What is Trauma?

The word trauma is stemmed from the Greek word for wound (Rando, 1993, p.568). It also stands for "damage or defeat". The present layman definition of trauma, as defined by dictionary, is

"1. Any physical damage to the body caused by violence or accident or fracture etc.
2. An emotional wound or shock often having long-lasting effects"

(Webster on-line dictionary, n.d.)

Thus, it is a term that is used by different disciplines. In medical definition, trauma refers to a serious or critical physical injury or bodily wound. There is a medical specialties in traumatology (Medicine Net, 2005, September 25). On the other hand, it is a term used by psychologists or social workers in describing the turmoil brought by great threat in life.

The word trauma attracted more attention in research in the field of psychiatry and psychology since the inclusion of the new diagnosis of posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association (APA, 1980)). At that time, trauma was defined as a significant stressor that would stir up major symptoms of distress in most people. The definition was amended in the revised version of DSM-III, the DSM-III-R, adding an extra specification of "outside the range of normal experience" to the original definition (APA, 1987). When APA published the DSM-IV in 1994, the range of trauma was further expanded. Trauma is defined by two components: the nature of and responses to the event. Both components are necessary and sufficient condition.

Criterion A1: A direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

Criterion A2: The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behaviour) (APA, 1994, p.424).

In this expanded definition, death becomes a more significant component of trauma. Besides, victims of trauma are also expanded from those who directly expose to the threat to those who are learning about the sudden death of their significant others. Thus, this definition increases the interface of the concept of trauma with bereavement.

The discussion above is on the English definition. As for the Chinese definition, the commonly used term for trauma is chuang shang (創傷), literally composes of two components: "Creation" (創) and "Wound or Harm" (傷) (Chan, Chow, & Ho, 2005). The components might imply the dual nature in the Chinese views towards trauma: it

does wound and harm the affected persons, but at the same time, opens up opportunities for creation of new domains in their lives.

2. What is Bereavement?

As defined by dictionary, bereavement is

"State of sorrow over the death or departure of a loved one."

(Webster on-line dictionary, n.d.)

As for scholars in the field of death and dying, they have differentiated bereavement with other similar concepts: grief and mourning. Bereavement refers to "the objective situation of having lost someone significant" with grief as the emotions reactions and mourning as the social expression of bereavement respectively (Stroebe, Hansson, Stroebem & Schut, 2001, p.6).

Sorrow or sadness are the commonly recognized emotions in facing the death of the loved one, and the Chinese term for bereavement counseling is sometimes referred as bei shang fu dao (悲傷輔導) (Chow & Chan, 2006). Anger, fear, anxiety, numbness and guilt are other emotions that they may experience. When studying the interface of bereavement with trauma, it can bring up extra attention of overlooked emotional reactions in bereavement.

3. When Trauma meets Bereavement

Trauma and bereavement can meet in three different scenarios differentiated by the temporal order. Trauma can be the antecedent, comorbidity, or consequence of bereavement.

3.1 *The First Scenario: When trauma is the antecedent of bereavement*

Among the three scenarios of the interfacing of trauma and bereavement, it is more commonly referred to the bereavement experiences of the traumatic death of the loved one (Clements, DeRanieri, Vigil, & Benasutti, 2004; Kaltman & Bonnano, 2003). Deaths resulted from disasters, accidents,

murders, suicides, or war are considered as traumatic death. Asides from the cause of death, situational factors like multiple deaths around the same moment and the bereaved being the survivor of the same death threat can also be the conditions of traumatic death.

Case Example:

"I think I am in a dream. This morning, I still had breakfast with him. He said that he would be back for dinner tonight… And now, you told me that he is dead... I think he will be back when I wake up! "

(bereaved girl friend of a deceased traffic accident victim)

The reaction towards the bereavement of a traumatic death can be a compound reaction to both the trauma itself and the bereavement of sudden death. Rando (1993) consider traumatic death as a risk factor of bereavement, and a source of complication in mourning. She highlighted that bereaved persons facing the traumatic death can have "post-traumatic stress reactions, stress response syndrome, anxiety, helplessness and powerlessness, survivor guilt, personality disturbances and a violated assumptive world." (Rando, 1993, p.570). More specifically, she borrowed the Lifton's framework (Lifton 1976, 1979 as cited in Rando, 1993) in describing the reactions of trauma survivors and applied to bereaved persons of traumatic death. Five characteristic themes are highlighted:

i. ***Death Imprint***

It is the obsessive intrusion of flashbacks of images or revisiting of feelings of threat. It is similar to the description of symptoms of re-experience in the PTSD diagnosis.

ii. ***Death Guilt***

Death guilt is the guilt and self-blame of the bereaved persons of being unable to save the life of the loved one. Sometimes the guilt is not grounded with reasons, and merely caused by the fact that they are still surviving. Questions like "Why did I survive while he died?", or "Why

did I survive while letting him die" are typical responses of those with survival guilt.

iii. ***Psychic Numbing***

Psychic numbing, just as physical numbing immediately after the physical trauma, is a defense mechanism in protecting the victim from being overwhelmed by the huge wave of emotions. It is not uncommon for the bereaved persons of traumatic death reported to have a blank mind (個腦一片空白) or have a sense of being in a dream. The psychic numbing might also extend to physical numbing, that they don't feel hungry or thirty, or can't listen to any message.

iv. ***Conflicts over nurturing and contagion***

After experiencing trauma, the bereaved persons are facing struggles. On one hand, they feel weak and vulnerable, and would like to receive help and nurture. On the other hand, they worry that the sudden loss is contagious and will be happened in other relationship, thus preferred not to depend on others. They might also feel guilty of being nurtured when survival guilt is presented. The feelings of being weak and fragile also make them uncomfortable, and might convert to anger and rage at their surface.

v. ***Formulation of meaning***

Trauma appears to be absurd to the survivors. Meaning making process then becomes a central task of grieving (Neimeyer, 2000). Meaning making can be of different levels. It can be sense-making, life lessons learnt, or assimilation of the loss into the existing meaning system they have (Neimeyer, 2001).

vi. ***Intervention Strategies***

As suggested by Rando (1993), bereaved persons of traumatic death usually have their post-traumatic symptoms overriding their other

grieving reactions. Rando described " …the [post-traumatic] symptomatology is like a blanket covering the mourning and first requires full scale intervention for post-traumatic stress in order to get to the mounring underneath." (Rando, 1993, P.587).

She has proposed seven important domains for intervention:

- Therapeutic relationship
- Normalizing information
- Denial and numbing reactions
- Intrusive and repetitive reactions
- Recall of the trauma
- Anxiety associated with traumatic memories
- Reintegration, rebuilding and reconnecting (Rando, 1993, P. 590 - 609)

Besides the above seven main themes for intervention, six reminders as practice wisdom are generated from my clinical experiences in working with bereaved persons of traumatic deaths in Hong Kong.

i. ***Providing tangible care***: As suggested by Rando, trauma symptomatology overlays the mourning in most of the traumatic bereavement situation. For the trauma survivor, the most important issue is about survival. Helping them to have a secure and safe environment is prominent in the first stage of working with the traumatic bereaved persons. Most of the time, it can be achieved through the provision of tangible care.

ii. ***Working with resistance***: The process of engaged bereaved persons of traumatic deaths is often grueling. The resistance might be related to their numbness or avoidance towards the recalling of the trauma. It can also be related to overall decrease in trust towards other in facing their vulnerability. The fear of attachment or fear for anticipated eventual abandonment also becomes barrier in relationship building. Thus the worker has to be patient and watch out for workable moments.

iii. ***Working with guilt***: As suggested by Lifton, death guilt is one of the prominent features in the process. Workers have to be sensibly handling the expressed guilt without pre-mature dispute of guilt. Finding meaningful way to work with the guilt, for example, compensational act, exploration of lessons from the guilt, or writing apologetic letter to the deceased can be some ways. More importantly, worker has to facilitate the bereaved persons to find their own comfortable way to work with their guilt.

iv. ***Working with flashbacks***: Flashbacks can be a disturbing symptom for some bereaved persons. They might have sense of loss of control. Practical tips of working with flashbacks, like guided imagery, or NLP techniques can be helpful.

v. ***Working with meaning***: Robert Neimeyer (2000, 2001, 2002) is one of the leaders in promoting meaning making in the wake of loss or trauma. He proposed many useful strategies in facilitating the meaning making process for bereaved or traumatized persons. The strategies include loss characterization, past/future self-letter, life imprints, poetic explorations, metaphoric stories, laddering techniques, collective remembering and videography.

vi. ***Working according to the clients' pace and wish***: Though there are many possible strategies in working the bereaved persons of traumatic deaths, there is no "one-size fits all" solution. The reactions, pace and style of individual bereaved persons can be varied in a great range. Thus, we have to be sensitive to the preference and pace of the client in trying out possible intervention.

3.2 *The Second Scenario: When trauma is the comorbidity of bereavement*

Bereavement of non-traumatic (that is not sudden nor violent) deaths, and even long-expected ones such as from chronic illness can also be perceived as traumatic by some bereaved persons. The response to this types of

bereavement caused by non-traumatic deaths can still share similar responses to traumatic experiences. This is the scenario when trauma is the comorbidity of bereavement.

Case Example:

"Though the doctor forewarned us that my husband would die soon, I never get prepared. To me, his death is still a sudden death. That's why I was so crazy around the death bed..."

(bereaved wife of patient with Ca Lung)

In my clinical experiences in working with bereaved persons of natural death, it is not uncommon to have similar comment as above. Besides, they reported heightened anxiety when hearing the telephone rings (after they received the bad news via telephone). Re-experiencing the final hours of a natural and expected death in the ward, dreams about the deceased, and intrusive thoughts about the deceased were frequently reported too. Besides, there was also a common avoidance to go to the hospital where their loved one died, or the place they had been to before for fearing of outbreak of intense emotions (怕觸景傷情). These reactions are similar to reactions towards trauma.

In a broad sense, when trauma is defined as a wound, or more specifically a psychological wound, bereavement -- the loss of a beloved one -- can be a psychological wound or trauma. Thus bereavement and trauma resemble each other.

In this scenarios, five reminders are generated:

i. ***Assessing traumatic responses in non-traumatic death***: Workers have to be sensitive to the possible traumatic responses of the bereaved persons when facing non-traumatic death. The bereaved person of chronic patient who died after a short-term temporary improvement (迴光返照) are more prone to have traumatic responses as the psychological preparation for the impending death was weakened after the temporary improvement.

ii. ***Acceptance of numbness at early phase***: If bereavement is perceived as a trauma by the bereaved person, he is likely to have numbness as the first reaction. Intensive counseling at this early phase with this group of clients can be futile, as the recipients are numb. Probably, some pre-verbal skills like physical touch, a comforting facial expression or offering a warm cup of tea is more valuable in this stage.

iii. ***Acceptance of helplessness at early phase***: It is natural for a worker to have the desire to help. Working with bereaved persons who have traumatic responses might have a general sense of helplessness, which might be echoing reactions with the experiences the clients. The sense of helplessness in worker might induce a sense of discomfort that pushes for further action. As worker, we have to be sensitive to this dynamic, and differentiate whether the extra work done is for the benefit of the clients or for the comfort of oneself. Probably, with good clinical supervision, the reflection can be facilitated with more feedbacks.

iv. ***Acceptance of abnormalcy***: Death of love one is an ab-normal (or atypical) daily experience thus it is normal to have abnormal reactions. The bereaved persons might be very sensitive to the judgement of others on their reactions. Sharing reactions of other bereaved persons and normalizing their reactions can help the bereaved persons.

v. ***Prevention is better than cure***: Most of the time, the perceived suddenness of the death is rooted in the unwillingness to face the death openly and genuinely before it comes. When death comes, there are lots of unfinished businesses that add strain to the bereaved persons. Workers, who are caring for the family at pre-death phase, can support the family at this level.

3.3 *The Third Scenario: When trauma is the consequences of bereavement*

Another easily overlooked scenario of interface between trauma and bereavement is trauma as the consequences of bereavement. After the death

happens, the bereaved family members have to gone through series of procedures which are unfamiliar to them (Chow, 2006). Some of these procedures are considered to be traumatic to them.

Case example:

"Knowing about his death is not traumatic to me, but viewing his body is..."

(bereaved adult son of patient with Ca Stomach)

In Hong Kong, there are a series of procedures needed to be worked on by the bereaved persons after the death of the loved one. They are

- Breaking of bad news
- Traumatic reactions of other bereaved family members
- Viewing the death moment
- Viewing the dead body
- Identifying the body
- Police Investigation
- Reporter's interview
- Funeral rituals
- Going to the showroom of funeral home
- Court hearing

As the social workers caring for bereaved persons, we should equip ourselves with the knowledge about these procedures and provide information to the bereaved persons in advance of the procedures. The preparedness for the procedures can reduce the traumatic impact on them. Besides, being there can be a good gift to the person as well. In addition, one of the role of social workers is advocator. We can identify possible improvement for these procedures that can help to reduce the impact as trauma too.

4. New Developments in Trauma Studies: The role of neurology

There is a growing attention of the neuro-biological consequences of trauma. Kimble and Kaufman (2004) has extensively reviewed this topic. They have identified four

neurological systems that are perceived to be related to the clinical patterns of post-traumatic disorder (PTSD). They included: the locus coeruleus, the hippocampus, the anygdala, and the thalamus. Though the findings of different research are not yet conclusive, the identification of the potential role of neurology reminds us as social workers the importance of interdisciplinary approach in caring for those who are having post-traumatic symptoms. Besides, acceptance towards the reported symptoms of memories, or intrusive images of the bereaved persons should be higher with the understanding of the potential biological root of traumatic reactions. Yet, as shared by Kimble and Kaufman (2004), the suggestion of biological root is not promoting a pessimistic view of psychological intervention. They acknowledge the balance between nature and nurture in the development of PTSD. On one hand, trauma can affect the brain; but at the same time, intervention can produce neurobiological changes. There is still a prominent role for social workers to work with trauma victims.

5. The Overlooked Victim: The Social Worker

The care for the traumatized or bereaved persons often involves the retelling of trauma or bereavement experiences. The social worker is exposed vicariously to the trauma and can be considered as one of the victims. McCann and Pearlman (1990) introduced the term vicarious traumatization to describe the effects of working with trauma victims on workers. Pearlman and Mac Ian (1995) further elaborated "…vicarious traumatization as the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae." (Pearlman & Mac Ian, 1995, p.558). They proposed multi-dimensional effects that include sensory, emotional, and psychological reactions as well as changed views towards self, others and the world. The effect is also considered to be cumulative across time and relationship with clients. There is another similar concept -- Compassionate Fatigue -- that describes as the decrease in empathetic capacity due to weariness in bearing the suffering of the clients (Figley, 1995). These are all proposing the potential job-related stress for workers who care for trauma victims.

Sabin-Farrell and Turpin (2003) have done an extensive review on studies of vicarious traumatization. They conclude that evidence is inconsistent and the studies are having methodological issues. Some of their studies are based on personal experience sharing. Though the evidence is unclear at the moment, workers who care for traumatized persons should be more sensitive to one's own needs. Probably, the continuous availability of good supervision for both reflective and informative support can help. Worker should also cultivate preferred self-care strategies to nurture oneself. Since worker is one of the important therapeutic factors in the care for trauma victims, caring for workers can indirectly improved the quality of care to the trauma victims.

6. Conclusion

Trauma is a wound. In facing the loss of his love one through death, there is a psychological wound for the bereaved person. Just like nurses who offer wound care for patients with physical wounds, social workers offer psychological wound care, aiming to reduce the complications of further infections. There is no magic cure for the wounds, and healing takes time. Though the wound is healed, there might be marks left. Similarly for the psychological wound, the mark of remembering the loss of his loved one usually does not fade. What we can do is to facilitate the client to live with the wound, to learn from the wound and treasure the relationship he has had with his loved one. This journey is both an art and science.

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Unwed Teen Pregnancy

Mother's Choice

Ms Suvan S.W. Law

1. The Reason Behind – Crisis Pregnancy

Mother's Choice Pregnant Girls' Services has been providing services in helping single women, their partners and families facing crisis pregnancy in Hong Kong since 1987. This presentation is aimed to share the frontline experience in working with clients facing crisis pregnancy and the follow-up works after the clients made their decisions.

Nowadays, most of the youths are still in lack of sexuality knowledge but believing some myths (wrong information) about different methods of "contraception" that were heard or acquired from their peers or/and through internet. Their increased openness in sexual attitude and having sexual intercourses without considering the consequences of facing Crisis Pregnancy.

According to the Report of Youth Sexuality Study 2006 published by Family Planning Association concerning the youth's sexual knowledge attitude & behavior toward sex, more F.3 to F.7 students accepted "Pre-marital Sex" & "Cohabitation". The percentage of students who had dating experience had also significantly increased among both boys and girls. Besides, more students had experienced sexual intercourse

and many of them had their first sexual intercourse when they were below age 15. But one of the most striking data was that the majority of youth aged 18-27 who had sexual intercourse in the past six months had not sought contraceptive advice.

2. Services provided by Mother's Choice

When a girl or woman discovers the unplanned / crisis pregnancy, she can first contact Mother's Choice Pregnant Girls' Services through our hotline at 2868 2022. Our counselors and social workers will provide emotional support and information given. Through the hotline counseling, she will know about the choices she will have in facing crisis pregnancy, the information as well as procedures to assess the resources she needs. Our staff will also collect some basic information so to understand the client's current situation for initial assessment. An intake interview will be arranged if she needs further in-depth counseling or need someone to discuss her upcoming baby plan for better preparation.

Any woman facing crisis pregnancy will have to make a very difficult decision – whether she will continue the pregnancy and give birth to her baby or terminate the pregnancy. If she decides to deliver the baby, she also will have to think about if she would take care of the baby her own or relinquish her parental right through adoption. She will also consider if she needs accommodation, whether staying home or in Mother's Choice hostel for pregnant girls during her gestation. The social worker will provide follow up and referral services after her delivery or termination of pregnancy. Counseling and follow up services will be provided no matter what the client's final decision will be.

3. Common Reactions when facing Crisis Pregnancy

There are some common reactions after confirming a crisis pregnancy:
"I can't let my parents know, they'll kill me."
"I can't support myself to be a mother, I want to finish my schooling."

"My boyfriend will not take up the responsibility, she will break up with me if I don't have an abortion."
"I am not ready to be a mother, it was an accident!"
"I have no choices!"

Emotions and reactions towards crisis pregnancy differ from person to person. According to our working experience, many clients may experience the following emotions.

- Shocked, Frightened
- Frustrated, doesn't know what to do
- Angry with self and others
- Feeling helpless, lost and alone
- Seeks help, but still feels worried
- Has strong sense of shame which weakens their analytical ability
- Baby plans are easily affected by significant others.

4. Three Choices when facing Crisis Pregnancy

When facing crisis pregnancy, the pregnant woman has 3 choices to choose including parenting, abortion and adoption. Each choice will bring its consequences. The social worker has the responsibility to inform the clients about the pros and cons of all choices in order to ensure the final decision is an informed and right choice.

It is a very difficult decision for the client to make especially for those who noticed their pregnancy at their late term gestation. The followings are the influential factors to the clients' decision making process.

- Religious beliefs or personal feelings of morality
- Family support system
- Partner, friends and social network
- Financial condition
- Level of education/ employment
- Physical/ mental/ emotional health
- Personal goal & future plan

Studies had shown that the more the client feel in control of the decision, the more support the client have from others, and the more informed the client is about the details of the choice and possible consequences; the less the client feel pressured, and the less the client feel uncertainty or ambivalence, will help them to make a better decision when facing crisis pregnancy.

Therefore, as a social worker, we shouldn't make the decision for the client but respect theirs after they were well informed. The social worker's understanding of the impacts, the pros and cons of 3 choices toward the client as well as the available resources of the client or/and in the community, so the client will be able to make a well-informed decision.

The 3 Choices –

i. **Parenting -** a lifelong commitment that probably needs help and support. The single woman who chooses parenting will experience changes and challenges not only physical and psychological changes, but also the role & lifestyle change after becoming a mother. In order to prepare the client to be a parent, an assessment is needed on the birth mother's maturity, reliability, readiness, availability, social and financial support, baby caring skills and assessable resources in the community to support the client to take up the role as a mother.

ii. **Abortion –** an operation to terminate the pregnancy. The client should be informed about the related ordinance of having a legal abortion in Hong Kong, the methods of abortion and its possible physical and psychological impacts towards her, so she would make a well-informed decision.

In Hong Kong, a safe and legal abortion can be performed within the first 24 weeks of pregnancy. According to Section 47 of the Offences Against the Person Ordinance, termination of pregnancy requires two registered medical practitioners to agree and sign with the following reasons:

- Risk to the life of the pregnant woman or injury to her physical or mental health may be greater than if her pregnancy was terminated.

- There is a substantial risk that if the child is born, he/she may suffer from severe physical/mental disabilities.
- A termination of pregnancy must be performed in recognized private, public government hospitals or an operating theatre of The Family Planning Association of Hong Kong, and by registered doctors.

A post-abortive woman may experience the following physical and psychological complications.

Physical complications

- Excessive bleeding
- Perforation of the uterus
- Cervical injury and scarring
- Drug allergies and complications with anesthetic

Psychological complications

- Guilt
- Avoidance behaviors including avoidance of children or pregnant women and withdrawal from relationships
- Psychological “numbing”
- Re-experiencing events related to the abortion, e.g. Flashbacks; recurrent and intrusive thoughts about the abortion, nightmares
- Anxiety over fertility and childbearing issues
- Interruption or disruption of the bonding with present and/or future children
- Suicidal thoughts or acts, self-destructive tendencies
- Anniversary reactions, such as Mother’s Day, date of abortion, the baby’s due date.

iii. **Adoption –** is the legal act of permanently placing a child with the parents other than the birth parents. It aims to offer the baby an opportunity to have a stable and secure family life. The birth parent(s) relinquish the parental rights and responsibilities of that child which will be transferred to the adoptive

parents. The baby will then be adopted by adoptive parents who have met the criteria set by the Social Welfare Department on age, educational level, financial status, living environment, marital status and relationship, so to ensure the couple has the commitment to take care of the adoptive child.

Birthparents who choose to make an adoption plan for their baby will experience the separation with their baby and may

- Have a sense of loss on their child's birthday, Mother's Day, etc.
- Be filled with unresolved grief and guilt.
- Often wonder what their child is like and whether he/she thinks about them.

We encourage the client to prepare a letter, gift and photos for the baby after they decide placing the baby for adoption. They can express their reasons and struggles in making an adoption decision. They can also state their love and expectation towards the baby in the letter. The preparation of a gift and photos for the baby is to express their love, so the baby will have something to remember his/her birth parents.

A woman who experience the lost and grief after having an abortion or separating with the baby through adoption find it difficult to grief her lost baby (through abortion or adoption) openly. Emotional disturbance may take her a period of time to go through. Counseling services provided to those who had an abortion or placed the baby for adoption is suggested.

5. Post Abortion Counseling

Factors preventing a woman from mourning the loss of her aborted child

- No evidence that a baby ever existed.
- No formal leave-taking or ritual for the mother, such as a funeral.
- No or insufficient support because usually few people are told about the abortion.
- Not given permission to grieve openly.
- Carries the guilt of ending her baby's life- can't forgive herself.
- Experience rejection and judgment to talk about it.

- No resources to help.
- Wasn't informed about the impacts after abortion.

The Purpose of Post Abortion Counseling is to provide a safe place for clients, so:

- To share the pain and emotions of past abortion experience (s)
- To deal with the grief issues associated with the abortion
- To experience acceptance
- To learn new skills in coping with ongoing reminders.

The Healing Journey

i. Remembering the Pain (Process the emotions)

- They might have been denying and repressing the painful emotions connected with the abortion experience for months or years.

- Provide an environment in which the woman can talk and share about the experience.

ii. Identifying and Releasing the Anger

- They might have a serious resistance to verbalizing their anger, help them to understand that those hidden anger might turn to unresolved trauma

- Encourage the client to stop denying the pain and anger.

iii. Grieving the Loss

- The bonding process between the mother and child begins very soon. But the need to grieve the loss of an aborted child is almost being ignored.

- Help client to grief by naming the baby, writing out her feelings for her child, writing letter to the child, and even having a quiet, private memorial service & etc.

- Help client to experience and go through the process of grief, i.e. denial, anger, bargaining, depression, guilt / shame, and acceptance.

iv. Learning new ways to deal with the ongoing reminders

- Affirm them for their perseverance, courage and honesty.

- Encourage ongoing support, care and growth. Remind them that healing is a process.
- Develop skills or tools for the future.

6. Post Adoption Follow Up

As mentioned before, a woman who had relinquished her child for adoption may experience:

- Grief
  - the emotional response to loss
  - Feelings of sadness, hopelessness, depression, numbness, anger and even guilt.
- In some serious cases: depression, emotional disturbances, withdrawal from society, psychosomatic illnesses and low self-esteem. Some may even find having difficulty in forming healthy relationships.

Factors preventing a woman from mourning the loss of her adopted child

- The pregnancy and relinquishment were most often kept secret, preventing any open acknowledgment of the loss.
- The grief was not socially supported and could not verbalize her grief. She had to suppress and deny her pain.

<u>The Goal of a Grief Resolution Process</u> is to re-establish the client's emotional equilibrium.

Since the grief the clients experiencing is not openly acknowledged, socially accepted or publicly mourned, the relationship with the baby is not recognized, the grief they have is more difficult to resolve. 4 aspects of dealing with normal bereavement in Worden's Model, including accept the reality of the loss, experience the pain of grief, adjust to the environment from which the lost person is missing, and withdraw emotional energy and reinvest it in another relationship, these 4 tasks seemed to be too difficult for the clients to complete.

Robinson (2000) thinks that the grief of relinquishing mothers is more complicated and deep, the following is suggested to resolve their grief.

i. Acknowledge and validate the loss

- To help the client acknowledge and validate the loss in order to address her grief. The client can try to retrieve any and all documentation, from the relinquishment paper to the original birth certificate, if available. Also, letters and photos from the time of the pregnancy and relinquishment might be helpful.

ii. Experience and express the pain of grief

- To help the client express the pain of losing her child. Through creating rituals and memorials, e.g. writing letters, articles, poems, having a ceremonial burial & etc. Many birth mothers find solace after validate their grief and "let it go" through those rituals.

iii. Find support and understanding

- What they are experiencing is different from a normal bereavement since the child was never existed in their life before. Therefore, being understood and accepted will help the client to resolve the grief. Participating in a support self-help group is suggested to support them validate the pain and loss through mutual understanding.

7. Helping the client – DOs & DON'Ts

The followings are the Dos and Don'ts on helping the clients who are struggling with the decision they had made after a crisis pregnancy.

<u>DOs:</u>

- ENCOURAGE them to talk and share
- LISTEN patiently
- REASSURE them we all make mistakes
- REASSURE their feelings are normal

- ALLOW them to vent their anger toward others. REMIND them that it is a sign of deeper hurt
- ALLOW them to regret their choice –we all LEARN from mistakes

DON'Ts

- SHUT THEM OFF by changing the subject
- CONDEMN them for making bad choice
- DENY that they lost a child
- Encourage them to BLAME OTHERS or PUSH them to forgive others
- INSIST they did the "right thing" or the "best thing" at the time
- LEAVE them without encouraging them over and over again

8. Conclusion

In Hong Kong, there are very few studies on the impact of decision making towards the women after facing crisis pregnancy. We can only learn from our frontline experience and take reference from the literatures and studies conducted by other western countries. In Chinese community, abortion and adoption seemed to be a taboo as it is difficult for women who had an abortion or made an adoption decision to speak or share their experiences or feelings and have to hide it as secrets. It also hinders those women to seek help from professionals that may further worsen the problems. We believe our increasing awareness and understanding on the impact of crisis pregnancy will help us to walk with our clients to overcome the difficulties more effectively. We still have a lot to learn, but our understanding, compassion and hope are utmost important to the clients who in face of crisis pregnancy.

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The Hong Kong Council of Social Service
Service Development (Family & Community)
Good Practice Sharing 2007-2008

"Seminar on Trauma Intervention"

Date: December 6, 2007 (Thursday)

Time: 2:15 p.m. to 5:30 p.m.

Venue: Auditorium, 1/F, Duke of Windsor Social Service Building, 15 Hennessy Road, Wanchai

Moderator: Mr Peter Ho (Member of Network on Integrated Family Service Center, Executive Director of Hong Kong Catholic Marriage Advisory Council)

Programme

Time	Topic
2:15	Registration
2:30	Trauma Psychology • Psychological impact of trauma • Issue of concern in handling trauma case **Professor Kitty K. Y. Wu** Clinical Psychology Department, Caritas Medical Centre
3:15	Extra Marital Affairs Counseling • Emotional response for people experiencing EMA • How to minimize traumatic experience in family **Ms. Anna S. K. Yuen** Project on Extra-Marital Affairs, Caritas – Hong Kong
3:45	Break
4:00	Bereavement Counseling • Healing the bereaved persons of traumatic death • Helping family to face the changes and challenges in life **Dr. Amy Y. M. Chow** Department of Social Work and Social Administration, The University of Hong Kong
4:30	Unwed Teen Pregnancy • Impact of crisis pregnancy toward girls and their family • Post-abortion counseling • Post - adoption follow up **Ms. Suvan S. W. Law**, Mother's Choice
5:00	Open Discussion

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