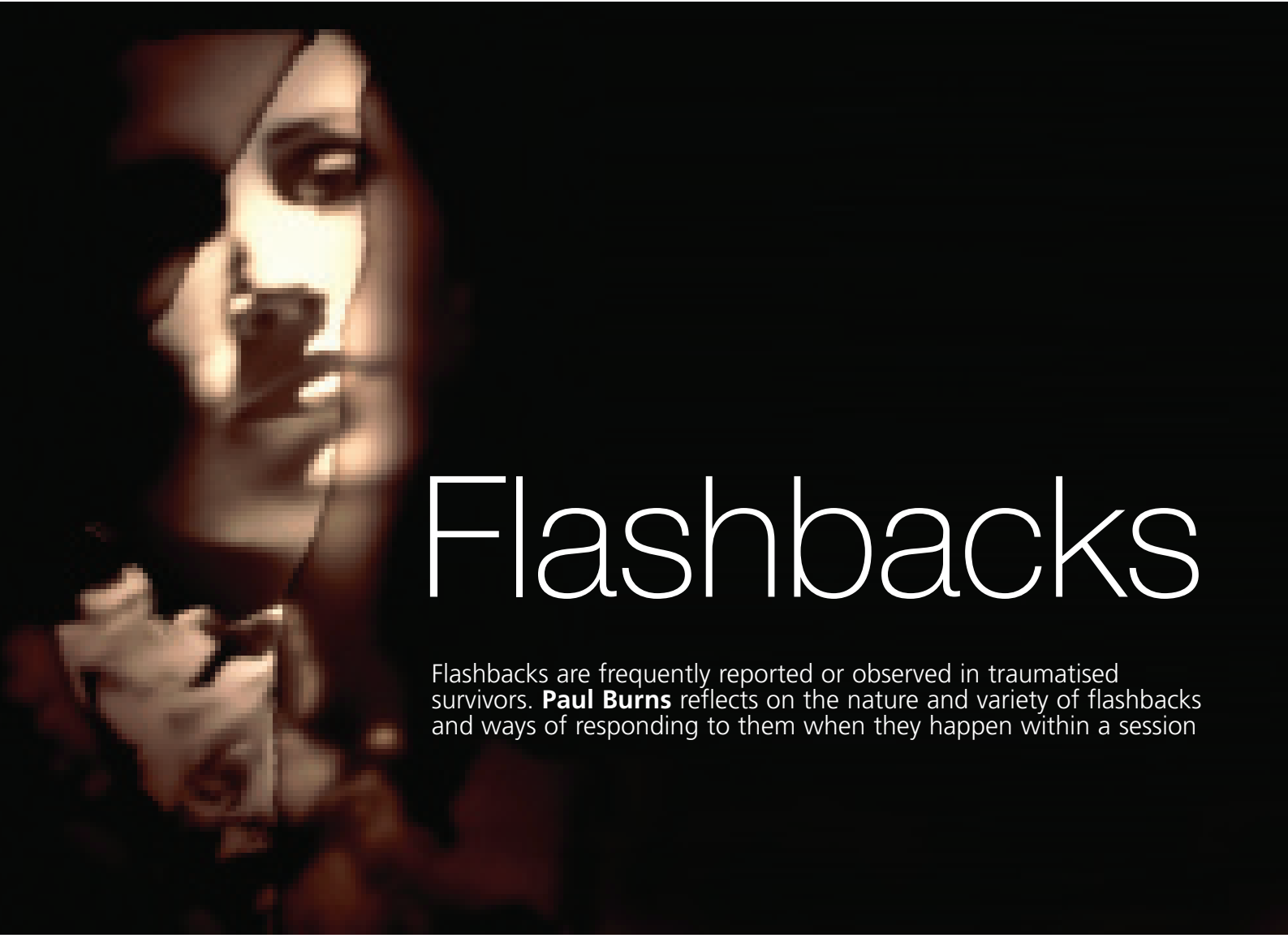

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# Flashbacks

Flashbacks are frequently reported or observed in traumatised survivors. **Paul Burns** reflects on the nature and variety of flashbacks and ways of responding to them when they happen within a session

Flashbacks are often seen as a defining feature of PTSD but they are just one form of the re-experiencing component required for this diagnosis and not the most common. Alternative components are persistent intrusive thoughts, nightmares, and mental and physiological responses to reminders of the precipitating event. In the psychological sense of the word, flashbacks are mostly associated with trauma but it may help to see them in a wider context, such as this description:

> *For general purposes flashbacks can be defined as the sudden re-experience of events that may range from pleasant to terrifying. If pleasant they are life-sustaining, and may even be induced voluntarily and consciously by the sight, sound, smell, touch, taste, and fond recollections of former times. If terrifying they are life-threatening, and are evoked involuntarily and unconsciously. They may be of either short or long duration, and will vary in their frequency of recurrence, intensity, and fragmentation.*[1]

If this classification is accepted then flashbacks are not necessarily pathological, far more common, and may be pleasant or trivial as well as horrific. It also raises the possibility that there is a continuum between everyday versions of flashbacks and their most unpleasant presentations.

In a number of rooms where there was no blackboard I have reminded a group of the sound of nails scratching such a surface. Many people reported and some could be observed shuddering at the thought of this noise, demonstrating both how even an imagined, non-threatening stimulus can invoke involuntary responses and how susceptible individuals can be to flashbacks in the wider sense of the term. With some clients concerned about flashbacks I use this example to suggest that what they have experienced is a more marked version of a common occurrence rather than a sign of 'madness'.

## The history of flashback

The term seems to have originated in the chemical industry to describe a type of explosion. By 1916 it was being used to describe time shifts in novels or films and in the 1960s as a metaphor for experiences that appeared to be linked to previous use of hallucinogens.

In 1941 Kardiner referred to 'hallucinatory reproductions of sensations on the original occasion'[2]. Flashback did not appear in DSM-III in 1980 but

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the associated phenomena were described in that issue. The term was added to a revision of DSM-III in 1987 and is included in DSM-IV under PTSD as 'dissociative flashback episodes'.

A UK study of military records found that flashbacks were far less common before the 1970s[3]. The authors suggest that this could indicate that responses to extreme events are being mediated by culture.

## Names

Flashbacks are referred to as waking nightmares, traumatic recall, reliving the trauma, and, of course, are a type of dissociation. Some clinicians have regarded flashbacks as a form of spontaneous abreaction. When clients limit what they share about reexperiencing or a professional for other reasons has limited information, other labels might be used, eg transient hallucination, panic attack, amnesia, concussion, poor concentration, and confusion.

Clients may not call their experiences 'flashbacks' but have other terms that are influenced by culture such as 'possessed', or more idiosyncratic descriptions like 'a fit of the terrors', 'weird moments' or 'losing it'.

## Nature of flashbacks

> *Compared to normal autobiographical memory, flashbacks are dominated by sensory details such as vivid visual images and may include sounds and other sensations. However, these images are typically disjointed and fragmentary. 'Reliving' of these memories is reflected in a distortion in the sense of time such that the traumatic events seem to be happening in the present rather than (as in ordinary memories) belonging in the past.'*[4]

In one study[5] people meeting PTSD criteria were asked to write about the trauma and later identified what was written while in flashback as opposed to ordinary memory. Flashback periods had more detail, particularly perceptual detail, more mentions of death, more use of the present tense, and more mention of fear, helplessness, and horror. Ordinary memory sections were characterised by more mentions of secondary emotions such as guilt and anger.

One review of flashback literature found it hard to distinguish between what had been lived through and imagined experiences[6]. This may mean that when there are no other witnesses readily available it is difficult to establish what are accurate recollections rather than distorted, invented or what might have come from the suggestions of others. The British Psychological Society has warned: 'Psychologists must be aware that the question of whether traumatic memory is processed, stored and recalled differently from normal memory is currently unresolved. Unusual, dramatic, powerful or vivid memories, and "flashback" bodily sensations cannot be relied upon as evidence of the historical truth or falsity of the recovered memories.'[7]

## Variations in flashbacks

The nature of flashbacks varies significantly and even an individual could have a range of flashback experiences. For example, re-experiencing may be more vivid when there are other stresses in an individual's life or less debilitating as recovery progresses. The aim of the following list is to reduce assumptions about what 'flashback' means for an individual.

When asking about very fearful experiences judgment and care are called for and the list is not recommended as the basis for systematic questioning. However, it may be useful to refer to the list on occasions to consider what details are missing and whether seeking these would be in the interests of the client.

**Kinds –** Does the person distinguish between different kinds of flashbacks and if so using what criteria?
**Length of the flashback –** How long was the person absorbed in the re-experiencing?
**Frequency –** How often are the flashbacks and, if there are different sorts, how frequent are these?
**Intensity –** How strong was the fear and any other emotions experienced?
**Degree of disorientation –** To what extent did the person assume she was back at the scene and time of an extreme event?
**Immediacy –** Some people report experiences where they are watching events happen to them

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rather than seeing immediately, like watching a film of oneself as opposed to being and doing at the time it was filmed.

**Physical expression –** Did the person remain still or continue with the activity he was engaged in before the flashback? Or was he physically reliving, eg protecting himself, hiding or trying to run away. How might these relate to fight, flight and freeze responses?

**Utterances –** During the flashback, what was said, mouthed or what noises were made?

**Verbalisation –** After the flashback, to what extent is it possible to describe the experience or parts of it? Eg a person may be able to re-enact a movement more easily that speak about it when they would not find it difficult to put in words actions not linked to the flashback.

**Physiological features –** What does the person report and what do others observe? Eg palpitations, dizziness, nausea, perspiration, paleness, trembling or changes in breathing.

**Stimulus –** What triggers the flashback and is the person aware of what the trigger was? Triggers may be external, such as hearing a word or sound, a physical sensation such as when a car sharply brakes, or a thought that comes to mind. Sometimes a combination of triggers is needed or may produce a more significant response.

**Precipitating factors –** Do some things make flashbacks more likely? Such factors might include temporal (eg time of day, anniversaries), people (being with or without another), substances (eg using or not using alcohol), stress level, media coverage, and not being able to follow avoidant routines.

**Links to avoidance –** To what extent and in what ways does fear of flashbacks influence avoidant behaviour?

**Control –** To what extent can the person either sense the start of a flashback and moderate its course or redirect attention once the fuller experience has started?

**Response to others –** To what extent can the person be brought out of a flashback more quickly by another's intervention? What sorts of interventions seem to work best?

**Disjointedness –** Was the flashback a series of disjointed sensations or can it, or parts, be recalled coherently? Has the sense of coherence or completeness of the narrative grown over time?

**Voluntary recall –** What recollections that are linked to the flashback can be recalled voluntarily without further triggering?

**Ability to review –** To what extent is the person able to review with another what happened during the flashback without re-triggering or overwhelming anxiety?

**Clarity –** If able to recall, did the experience involve a specific time and place, or was it less clear, or seem more generalised? Especially in survivors of multiple trauma, are elements of events entangled, perhaps adding to confusion about the sequence even when less dissociated?

**Range and focus of senses –** If able to recall, what senses seem to have been most engaged during the flashback? As well as sight, sound, smell and taste there are different kinaesthetic senses. We register some sensations through our skin and hair. Some feelings may also be sensed more deeply, such as a squeezed hand. We have proprioceptive sensors that tell us how body parts are positioned and moving. Then there are physical sensations that are often linked subjectively to emotions, eg a heavy feeling in one person's stomach might be linked to 'anxiety' and in another the same feeling means 'depression'. Finally, the vestibular system of the inner ear informs the brain about balance, motion and acceleration.

**Missing senses –** Are some senses missing and to what extent might this be understandable? Eg, if it was very dark during an extreme event vision would be limited while in an incident involving spilled ammonia it would be curious if smell did not feature.

**Time –** Was the experience of time distorted? Eg, slowed, speeded, frozen.

**Coping style –** How is the person after the immediate terror of flashback? Eg, numb or other forms of dissociation, agitated, aggressive, blaming.

**Preferred response –** After a flashback what does the person do or would prefer to do? Eg, avoid or seek company, wish to be held or avoid physical contact, be active or passive, speak or be silent, and use of substances.

**Post-feelings –** After the flashback has receded how does the person feel about herself and her

**‹ Contained within the flashbacks are unresolved elements of the trauma and part of helping to assist the reprocessing of an experience could be to discuss the nature of the flashbacks linked to it ›**

predicament and what thoughts are linked to these feelings?

**Post-meaning –** After the flashback has receded how does the person evaluate it and what concerns are there? Eg, 'I am cursed' or a fear that such an experience is a 'sign of insanity'.

## Grounding

The first time a client had a dramatic flashback as he sat opposite me I was shocked. His eyes rolled, he whimpered and cowered in his chair and appeared to be trying to protect his face. My immediate response was alarm but I tried to conceal this as more fear is the last thing that such a client needs. What is most likely to be of help is hearing a voice that sounds familiar and friendly yet authoritative. This voice keeps reminding them where and when they are and that now it is safe. Once their attention can be redirected, invite them to pay attention to stimuli within the room or that can be perceived from it.

Grounding has several meanings but in the context of responding to a flashback it refers to situational awareness and distracting techniques. These can be used both by a clinician and by the person seeking to avoid or recover from an overwhelming reexperiencing or other states such as panic attacks.

Draw the attention of the client away from what is distressing and towards what is neutral or positive. In selecting new areas of attention avoid items that might link the person back to the traumatic event. Eg, if someone has been in a motor accident don't draw attention to the sound of traffic outside.

Grounding is readily accepted or at least not objected to by people who are dissociated or panicking. But if you have discussed and demonstrated grounding before it is needed, this limits the scope for confusion and may speed up responses to it.

## Examples of redirection

■ A series of simple questions about features in the room. Eg 'What colour is the door?' 'How many chairs are in the room?' However, if people have difficulty answering questions simply direct attention.

■ Drawing attention to features in a room. Eg 'Notice the grain of the wooden bowl.'

■ Directing attention to parts of the body. Eg 'Notice how your left foot is touching the floor.' Simply drawing attention to breathing or heart may hinder as these could act as reminders of the distress but getting to breathe slower and deeper may be useful.

■ Providing information about time and place. Eg Remind of the month and year and current location. Avoid name of place where the trauma happened. Eg, for a survivor of a bombing in London, instead of London give the name of a district not associated with the terrorism.

■ Changing physiology. Eg, instruct to stand up, take steps or ask, 'What happens when you look up at the ceiling?'

■ Describing a picture that can be seen by client and telling a story about it. Eg 'In the picture is a lake. See how still it is. The pure water came from melting snow and it sustains many plants and animals. It is a safe place, just like this room.'

If you sense the client may respond, you could ask them to tell you what else she or he can see in the picture. If they are not ready to respond, resume your commentary.

## Conclusion

While not the most common reaction to an extreme event, flashbacks and beliefs about them add significantly to distress. Clients may need reassurance that these responses do not suggest other forms of mental illness.

Rather than being consistent, flashbacks vary in many ways. The list of differences above could help clinicians better understand a client's flashback experiences and to identify facets to explore further.

As with many other symptoms, it may make little sense to attempt to treat flashbacks in isolation, apart from responding to them as they happen with grounding techniques. However, contained within the flashbacks are unresolved elements of the trauma and part of helping to assist the reprocessing of an experience could be to discuss the nature of the flashbacks linked to it. ■

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