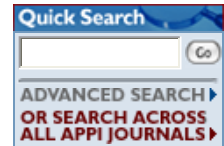


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Treatment in Psychiatry

Early Psychosocial Intervention Following Traumatic Events

**Jonathan I. Bisson, D.M., F.R.C.Psych.,
Mark Brayne, M.A.,
Frank M. Ochberg, M.D. and
George S. Everly Jr., Ph.D.**

Bill, a 35-year-old journalist working for a local radio station, was sent to report from the scene of a bomb attack that resulted in several fatalities. What he witnessed at the scene distressed him greatly. Immediately afterward, he began repeatedly to reexperience what had happened, leading him to avoid either discussing or thinking about it. He continued to work, but he lost interest in things around him. He became withdrawn, irritable, and hypervigilant.

These symptoms rapidly diminished over the first few weeks, but then 1 month after the attack they began to increase again for no apparent reason. What is the differential diagnosis? How should Bill's symptoms be managed?

Nature of the Problem

Although psychological reactions are common after traumatic events, there is some confusion about how best to respond to them. Some clinicians have argued that early psychological interventions after traumatic events are an important aspect of a comprehensive continuum of care (1), while others have argued that an early application of formal psychological interventions to anyone involved has no useful role in posttrauma response and that good social support is the key to the prevention of later mental health difficulties (2). A number of factors have led this confusion, including the paucity of generalizable research data directly relevant to mental health intervention in the wake of different types of traumatic events; the limited personal experience of many clinicians in working with major traumatic events; and the conflicting messages that have emanated from the field.

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Prevalence of Psychological Reactions

Epidemiological studies suggest that the majority of individuals involved in traumatic events will not develop a problematic psychological response (3). The so-called normal response is highly variable. Some individuals will develop a marked initial reaction that resolves over a few weeks, while others will have little or no initial reaction and will not develop any difficulties (4). However, a minority will develop mental health difficulties that require psychological or pharmacological intervention.

Posttraumatic stress disorder (PTSD) is the most widely recognized posttraumatic psychiatric disorder, but it is not the only one. Depression, anxiety disorders, substance misuse, and adjustment disorders are also common (5). These, along with nonpsychiatric issues that cause distress (e.g., finances, housing, lack of information, and relationship breakdown), should be considered in addition to PTSD in patients with posttraumatic mental health problems. It has been estimated that PTSD occurs in around 14% of those exposed to traumatic events (5). Rates tend to be higher among individuals more directly exposed to traumatic events, but recent well-designed research suggests lower rates of problematic reactions than many imagined, highlighting a marked human resilience in the wake of traumatic events. For example, among residents of New York City living south of 110th Street after the terrorist attacks of Sept. 11, 2001, the prevalence of probable PTSD fell from 7.5% at 1 month to 1.6% at 4 months and 0.6% at 6 months (3).

Diagnosis

Determining whether an individual is experiencing a problematic response or a reaction that will spontaneously resolve after a traumatic event can be difficult. The trajectory of the response over the first month is helpful in determining the probable course of the symptoms. If the initial distress is steadily diminishing, the symptoms will often be self-limiting. If reactions are persisting, increasing, or particularly problematic, a comprehensive mental health assessment is required to determine the individual's needs, with attention being paid to the presentation, background, mental state examination, risk assessment, social factors including support network, and information from other sources including relatives.

Diagnoses should be made according to diagnostic criteria, such as those of DSM-IV. The temptation to diagnose PTSD purely on the basis of what the patient has experienced must be avoided. The diagnoses mentioned above, along with acute stress disorder, are probably those most commonly encountered, but other difficulties, including acute psychotic reactions, may occur.

Management

There is no evidence to support a policy of formal therapeutic intervention for everyone after a traumatic event. The emergence of "group critical incident stress debriefing" and its many variants during the 1980s was not accompanied by systematic research to determine its effectiveness (6). Several randomized controlled trials of debriefing, largely in its nongroup application, have since been conducted, and they form the basis of several widely cited systematic reviews (7, 8) that recommend against the use of individual, single-session interventions for everyone involved in a traumatic event. Critics of the conclusions drawn from these reviews argue that the trials examined were methodologically flawed, were adaptations of group critical incident stress debriefing for individual use, and involved applications of the technique to populations different from that for which it was originally designed (emergency service personnel). Several nonrandomized but controlled studies have concluded that various forms of debriefing had positive effects (e.g.,

references 9, 10), but these are countered by similarly designed studies that found neutral (e.g., 11) or negative (e.g., 12) results.

Perhaps the most valid scientific concern about the current evidence base on debriefing is that of overgeneralization of the results. The studies included in most reviews of randomized controlled trials focused largely on individuals with physical injuries. Great caution must be exercised when considering the implications of these results for other populations; they should inform practice rather than determine it for other populations. Given the absence of evidence for single-session interventions for individuals and the suggestion that such interventions may cause harm for some people, careful evaluation of their use in other groups is required.

There is not likely to be total agreement on how the current evidence base should be interpreted. Indeed, the term "debriefing," although poorly defined to the point of having lost any valuable denotative quality (13), has come to symbolize (inappropriately) virtually all early psychological intervention. It now serves as something of a lightning rod for the debate on early psychological intervention. There does, however, appear to be a consensus that ignoring the early posttrauma period altogether would be misguided.

Recent practice recommendations have included relatively noninterventionist approaches through to the routine provision of alternative early intervention approaches. Any intervention should be based on and tailored to the individual's needs. For most, the first step would be to provide practical, pragmatic support in a sympathetic manner, to complement the input of friends and family that is likely to provide the mainstay of psychosocial support (8, 14). For others, specific help will be required, for example, with financial issues. Some will require evidence-based treatment for a specific psychiatric disorder or a combination of social and psychological input.

More formalized initial interventions, such as psychological first aid, may be thought of as a compassionate and supportive presence designed to reduce acute distress and facilitate access to continued care, if indicated (15). However, the efficacy and effectiveness of psychological first aid and other early interventions that use a phase-sensitive, multicomponent intervention format (e.g., 16, 17) need further evaluation.

In reality the situation is much healthier than many assume. Randomized controlled trials have now produced positive results for multiple-session trauma-focused cognitive behavior therapy for survivors with acute stress disorder within a month of the trauma (18), those with distressing traumatic stress symptoms 1 month after the trauma (19), and those with acute PTSD between 1 and 3 months after the trauma (20). These results led the authors of the 2005 U.K. National Institute for Health and Clinical Excellence guidelines to recommend that trauma-focused cognitive behavior therapy be made available to all individuals with acute PTSD between 1 and 3 months after a traumatic event (8).

Summary and Recommendations

On the basis of the available evidence, we believe it appropriate to make the following recommendations regarding response to trauma:

1. Shortly after a traumatic event, it is important that those affected be provided, in an empathic manner, with practical, pragmatic psychological support. Individuals should be provided with information about possible reactions they might have; what they can do to help themselves (coping strategies); how they can access support from those around them (particularly family and

community); and how, where, and when to access further help if necessary.

2. It is important that provisions be made for individuals to obtain the appropriate early support after a traumatic event. However, any early intervention approach should be based on an accurate and current assessment of need.
3. Individuals who experience continued symptoms a month or more after a traumatic event can benefit from psychological intervention. If an individual's reaction is extreme, formal intervention can be beneficial when applied earlier.
4. We encourage exploration of a psychological first aid approach that takes explicit account of people's natural resilience, built on what might be termed psychological triage and proper stepped or stratified care. People cope with stress in differing ways, and no formal intervention should be mandated for all exposed to trauma. Use of trauma support should be voluntary, other than in cases where event-related impairment is a threat to an individual's own safety or the safety of others.

In the case presented, despite Bill's significant initial distress, there was no indication for an early formal intervention. Bill's symptoms were likely (but not guaranteed) to gradually reduce over the first month without becoming problematic. Bill's employer was aware of the increased risk of psychological trauma in journalists, had arranged for all staff to receive awareness training in a group format, and had introduced a peer support system that consisted of the potential for individual and small-group discussion sessions (17). Within a few days after the incident, a peer supporter met with Bill, and they discussed what had happened. The peer supporter noted Bill's level of distress, reminded him of the common reactions following traumatic events, and arranged to meet him again 4 weeks later. They also discussed mobilizing Bill's usual forms of coping (e.g., exercise) and relaxation (e.g., listening to music); avoiding potentially problematic coping responses, such as heavy consumption of alcohol; and accessing support from those around him, particularly his family and community. The peer supporter also provided information on how, where, and when to access further help if necessary. Sources of further help included management at work, the peer support scheme, and Bill's primary care physician. Bill's line manager also met with him and offered to support him in any way she could. Bill did not want to discuss the bombing incident with his manager, but he felt encouraged that she had asked after him and was aware that he may be experiencing a psychological reaction.

Because Bill's early symptoms had begun to improve after a few weeks, he did not feel any need to seek any further help. When his symptoms began to worsen a month after the bombing, he was concerned that he might be developing a problematic response requiring more help. His boss recognized a change in his work and suggested that he see the peer supporter for the planned 4-week follow-up meeting, and he did so. After his second meeting with the peer supporter, he became aware that he may require more formal assistance. Through his company's employee assistance program, he was put in touch with a clinician 6 weeks after the traumatic event. The clinician performed a full assessment, taking a detailed history of Bill's background, what had happened, and his responses to the event, paying attention to other symptoms, such as depression, anxiety, and substance use, in addition to symptoms of PTSD. The assessment also included a risk assessment and details of Bill's social situation and support system. The clinician concluded that Bill was suffering from acute PTSD and that his primary need was treatment for it. Bill described some depressive features, but these were felt to be secondary to the PTSD and therefore likely to diminish with effective PTSD treatment (8).

Bill was treated with 10 sessions of trauma-focused cognitive behavior therapy. His clinician

considered a period of watchful waiting (8) in which Bill would be asked to keep a diary of his symptoms, as one study found that 17% of individuals who met the criteria for PTSD no longer met criteria after doing this (20). In Bill's case, given the significant increase in symptom severity, the clinician believed that formal psychological treatment should be started without delay. The clinician discussed with Bill the planned treatment and the theory behind trauma-focused cognitive behavior therapy. Once a therapeutic relationship was established, the trauma itself was discussed in great detail, and Bill was required to listen to tapes of the sessions as homework. He gradually habituated to the fear associated with his traumatic experience, and he was also helped to challenge some of his distorted cognitions, such as "I should have done more to help prevent people from dying rather than making my broadcast."

By session 7, Bill had improved sufficiently to be able to visit the scene of the attack with his therapist. This helped Bill reappraise what had happened and generate a less distressing memory of the actual scene. At the end of therapy, Bill reported very few traumatic stress symptoms, no longer felt depressed, and was returning to his former activities. People around him also commented on the improvement in his mental state. He and his therapist agreed to meet again 1 month and 3 months later to determine whether his improvement was maintained.

Footnotes

Received Feb. 16, 2007; accepted Feb. 22, 2007. From the Department of Psychological Medicine, Cardiff University, Cardiff, Wales; the Dart Centre (Europe) for Journalism and Trauma, London; the Dart Foundation, Okemos, Mich.; and the Johns Hopkins School of Medicine, Baltimore. Address correspondence and reprint requests to Dr. Bisson, Cardiff University, Monmouth House, University Hospital of Wales, Heath Park, Cardiff CF14 4XW, Wales, UK; bissonji{at}cardiff.ac.uk (e-mail).

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