Early intervention following traumatic events

Neil Roberts

Abstract

Our understanding of what might constitute appropriate and effective early intervention for those exposed to trauma and mass disaster has developed significantly over the past decade. This article describes potential methods of early intervention and summarizes the available evidence of their effectiveness. It is argued that there is currently little evidence to support the routine use of preventative interventions, such as psychological debriefing, prophylactic medication or multiple-session preventative psychological interventions. However, there is evidence to support the use of brief trauma-focused cognitive behavioural Intervention for individuals whose traumatic stress symptoms are not improving. There is consensus that interventions that aim to promote safety and connectedness, and address immediate physical and social needs should take priority in the acute phase after disaster. Early psychosocial intervention programmes should ideally be part of coordinated disaster-management plans, which also address these broader needs. Stepped or stratified care models provide one solution to managing limited post-trauma resources by aiming to provide education and information to all exposed individuals and identifying and prioritizing those who are most likely to benefit from further intervention.

Keywords acute stress disorder; debriefing; disaster; early intervention; prevention; PTSD

Introduction

Research suggests that the majority of us will be exposed to at least one seriously traumatic experience at some point in our lives. There is now a large body of literature to show that traumatic experience can cause significant psychological difficulties for large numbers of people, through events such as natural disasters, human-made disasters, military combat, violent crime, rape, and road traffic accidents.[1] Many of those exposed to such events neither seek nor require the help of mental health services, relying on their own natural coping skills, available social support, and community resources.[2] However, a significant proportion of people will go on to develop psychological and psychiatric problems, which can become chronic.[1] Post-traumatic stress disorder (PTSD) has received most attention in the literature, although depression, phobias, anxiety disorders, and substance and alcohol misuse problems are also common.

There is now an emerging evidence base on the efficacy of a number of psychological interventions aimed at preventing PTSD and treating early traumatic stress reactions.[3–7] Traumas and disasters present unique challenges to those attempting to decide how best to respond to such events. In response to scenes of acute distress, clinicians and service planners often feel compelled to help in whatever ways they can, and such situations do not always lend themselves well to traditional forms of evaluation. This article considers the available evidence base and consensus about key principles of early intervention, where this exists.

Neil Roberts DClinPsy is a Consultant Clinical Psychologist with Cardiff & Vale NHS Trust, UK. He has worked with the Cardiff and Vale Traumatic Stress Clinic since 1998, and recently completed two systematic reviews of early intervention following trauma. Conflicts of interest: none declared.

What is early intervention?

Early intervention can be considered to be intervention that begins within the acute phase after a traumatic event. For the purposes of this article, this will be considered to be intervention beginning up to around 3 months post-trauma.[8] Much of the psychological and psychiatric literature has focused on the evaluation of interventions targeted at preventing PTSD, and much of the remainder of this article will focus on this literature. However, it is worth noting that some authors have argued that early interventions should also focus on broader therapeutic goals such as increasing functional capacities, encouraging positive coping strategies and behaviour (e.g. use of appropriate exercise and good diet), increasing opportunities for social support, managing complicated bereavement, and addressing coping with subsequent threat.[9] These kinds of goal have not so far been the focus of early intervention trials.

Others have cautioned against the over-medicalization of psychological responses to trauma and the tendency to over-conceptualize distress in terms of PTSD.[2,10] For example, Stein and co-workers[2] argue that there are limits to the value of medicalizing trauma responses and that sometimes it is important to recognize that it is the context that the individual finds themselves in that is pathological, more than the distress that they experience (e.g. in situations of ongoing threat).

The next section describes some of the key interventions that have been used to try to prevent chronic PTSD and treat acute traumatic stress symptoms.

Psychological debriefing

For a number of years, single-session interventions such as psychological debriefing were a widely used and popular form of intervention aimed at promoting adjustment to exposure to trauma. Debriefing is an umbrella term, used to describe a number of semi-structured interventions in which a group or individual is guided through a multiple-stage process shortly after exposure to a traumatic event. Debriefing came under increasing scrutiny in the 1990s and has been the subject of several systematic reviews.[4] In their Cochrane review, Rose and colleagues[3] identified 15 individual debriefing studies, none of which demonstrated a positive effect for debriefing. Several studies have raised concerns that individual debriefing may lead to worsening symptoms in some individuals, particularly those who were initially more distressed,[4,11] although not all studies of debriefing

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have found this. More recently, a large-scale trial of group debriefing with American Peacekeepers also found no clear positive effect for debriefing.[12] The lack of evidence for the efficacy of single-session individual debriefing has led key organizations in the field to caution against its use.[7,13]

Psychological first aid

In light of the findings on psychological debriefing, 'psychological first aid' has emerged as the preferred form of immediate intervention following exposure to trauma. The term psychological first aid has been used to refer to a range of approaches that provide flexible, empathic, and informative support within the first hours and days after trauma. More recently, the term has been associated with a more formalized interventional approach that recognizes that disaster survivors experience a broad range of early reactions.[14] This modular intervention describes a number of core goals, including enhancing safety and comfort, promoting stabilization, helping survivors connect to existing social support, and providing information on adaptive coping. Psychological first aid has received widespread endorsement amongst trauma experts, although it has not so far been evaluated empirically.[10]

Multiple-session preventive interventions

A number of studies have attempted to evaluate other forms of intervention aimed at preventing PTSD. A recent Cochrane review identified 11 studies that attempted to evaluate a heterogeneous range of interventions aimed at preventing PTSD.[5,6] Most of the included studies offered intervention to all individuals exposed to an index traumatic event, and a range of different interventions was evaluated. None of the identified studies demonstrated any consistent positive effect for preventive intervention, leading the authors to conclude that multiple-session interventions aimed at all individuals exposed to a traumatic event should not be used.

Medication

A number of forms of medication have been trialled in early intervention studies, including propanolol, gabapentin, and hydrocortisone.[7] No medication has demonstrated clear preventive effects, although hydrocortisone showed trend effects in a small-scale study with septic shock victims.

Psycho-education and self-help

Information-giving is a routine procedure for most clinicians and it has been common practice in the aftermath of trauma to give those exposed information about potential negative effects and how they can access help. There has been limited research on the potential benefits of such intervention. The UK NICE guidelines on PTSD identified two studies that used a psycho-educational approach. The first found no benefits from a face-to-face educational intervention for victims of crime. The other found that a self-help information booklet was no more effective than a waiting list condition for individuals with acute PTSD.[7] Two recent studies have attempted to evaluate the effectiveness of a self-help booklet for individuals recruited after they had visited an accident and emergency department.[15,16] Neither study found any benefit for those receiving the self-help booklet, and in one study there was a trend reduction in PTSD cases in the control group relative to the intervention group.[15] The demand for information following trauma is clearly high and it would be unrealistic to think that clinicians would wish or be able to withhold this. Both studies used a booklet describing typical reactions to trauma and giving advice about coping and support. It may be that trauma survivors might benefit more from other forms of information (e.g. focus on resilience).

Interventions for those with acute traumatic stress symptoms

A number of studies have evaluated brief interventions aimed at providing treatment for those who remain symptomatic beyond the first few weeks after trauma. A recent Cochrane review identified 13 published and two unpublished treatment studies.[6] The results of meta-analysis showed clear effects in favour of trauma-focused CBT (TF-CBT) when compared with waiting list and supportive counselling for both immediate and long-term outcomes. Effects were strongest for studies where participants met full diagnosis for acute stress disorder (ASD) or acute PTSD. In most cases TF-CBT was an adapted form of imaginal exposure. The reviewers concluded that TF-CBT should be offered to all ASD and acute PTSD sufferers, and that limiting it to this group can be justified, particularly when resources are limited.

General principles in the immediate post-trauma phase

In some contexts one might anticipate that significant numbers of individuals will be exposed together to traumatic events, for example as a result of military conflict or in disaster situations. In times past, it was common to hear of mental health practitioners descending on the scene of a disaster fairly immediately after news of the disaster had broken. Whilst this kind of response is clearly well meaning, many experts in the field had significant concerns that inadequately prepared therapists were offering intervention too soon after trauma exposure, at a time when individuals were not equipped to begin to process their trauma and when other acute needs may have been more pressing. There is now a developing consensus that the immediate priorities following a trauma are to attend to the practical and social needs (such as the need for information) of the survivor before attending to trauma symptomatology.[2,9,17] Box 1 outlines a stepped model of

Hierarchy of needs model[17]

- Survival needs, e.g. escape/rescue
- Primary medical needs, e.g. first aid – resuscitation, dealing with bleeding wounds
- Physical needs, e.g. water, food, shelter, clothing
- Safety/security needs, e.g. freedom from fear
- Secondary medical needs, e.g. setting broken limbs
- Psychosocial needs, e.g. mental reactivity to the event
- Recognition needs, e.g. trying to make sense of what happened

Box 1

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