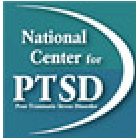

NATIONAL CENTER FOR PTSD
FactSheet

Treating Survivors in the Acute Aftermath of Traumatic Events

Excerpted with permission, from a chapter written by Arieh Y. Shalev, M.D., Department of Psychiatry, Hadassah University Hospital, Jerusalem to appear in R. Yehuda (Ed.), *Treating Trauma Survivors with PTSD: Bridging the Gap Between Intervention Research and Practice.* Washington, DC: American Psychiatric Press.

Summary

Treatment of survivors in the acute aftermath of traumatic events is complex. Survivor's concrete needs may be very urgent, secondary stressors may still be operating, expressions of distress are volatile and highly reactive to external realities, and symptoms expressed may not reflect psychopathology. Normal healing processes are already operating, and significant assistance is provided by natural supporters and healers (e.g., relatives, community leaders) and should not be interfered with. Professional helpers are often enduring significant stress themselves and do not operate in their usual environment. A treatment model, which favors knowledge of pathogenic processes over symptom recognition, is described.

Introduction

'Therapy' during the acute phase may be distinctive in the following ways:

* A *conceptual re-framing* is needed: at this phase one may still be handling the trauma, rather than treating a post-traumatic condition. Psychological rescue (or first aid) may be the proper term for some interventions.

- Along with symptoms, current sources of stress should be in the forefront of the clinical evaluation. Relocation, separation, or continuous threat (such as during political repression) are powerful modulators of behavior. Help at this stage may consist of mitigating the effect of concurrent stressors.
- The mental and physical conditions that follow traumatic events are extremely complex, unstable, and rapidly changing. Perception of the event may vary from one individual to the other, individuals may be suggestible and unusually reactive: they may be very responsive to the emotional tone of helpers, but also reactive to real or fantasized realities, such as rumors.
- Expressions of distress are often appropriate at this stage, and one should be very careful not to classify them as 'symptoms' in the sense of being indicative of a mental disorder. The appropriateness and the 'productiveness' of the early response are more important indicators of disorder than the intensity of the response.

- During rescue efforts, professionals and nonprofessionals may have similar roles (e.g., soothing, comforting, orienting, reassuring etc.). Nonprofessionals are available in larger numbers and include the survivor's natural supporters (e.g., relatives, peers) and other community members (nurses, volunteers, disaster area managers). These supporters may also be overwhelmed and distressed, and mental health professionals' roles may be to support and guide the supporters.
- Professionals may be induced to share another person's grief as part of the healing process. The degree to which they can do this may have important effects on their efficacy as helpers and on their own well being.

Who should be treated by mental health specialists?

This dilemma has been approached in two systematic ways: The first was to provide specialized treatment to those identified as being ill (e.g., soldiers who ceased to function during combat because of stress responses). The second consisted of covering all those exposed by providing some kind of professional intervention, recently in the form of debriefing. This chapter proposes to help making such decisions by pointing to the following ideas:

- The dichotomous choice between treatment and no-treatment should be replaced by the notion of 'depth of treatment'.
- The early and urgent needs of all should be addressed (yet, not necessarily by psychological interventions).
- Trauma survivors should be considered at risk for developing traumatic stress disorders.
- Specific risk factors should be evaluated, for each case on the basis of the existing literature.
- The survivors' progress towards recovery should be followed and clinical decisions made on the basis of observations over time (instead of symptoms at any particular point in time).
- Treatment should be provided in a context of continuity of care.

The nature of traumatic events

DSM IV definition sets an entry criterion for considering an event to be traumatic in the context of making a diagnosis of PTSD-that is, an event that is life-threatening and in which one responds with a specific subjective response. However, it is not a good-enough definition of a traumatic event in that it is nonspecific and does not address the mechanisms of mental traumatization.

Extreme events may traumatize people in many different ways.

Concrete elements of traumatic events that increase the risk for PTSD include:

- Threat to one's life or body integrity.
- Severe physical harm or injury.
- Intentional injury or harm.
- Exposure to the grotesque.
- Witnessing or learning of violence to loved ones.
- Causing death or severe harm to another.

The severity of traumatic events is related to them being intense, inescapable, uncontrollable, and unexpected.

Traumatic events can also be defined as those exceeding the person's coping resources or breaking his or her protective defenses.

Traumatizing elements of events can include:

Fear and threat.

Stress theory proposes that specific innate or acquired mechanisms control human responses to threat. Learning theory predicts that psychobiological responses to extreme threats will be reexperienced because associations are learned between the threatening event and cues present at the time of trauma. Further, through conditioned learning, avoidance of trauma reminders increases. The intensity of the threat, its perception by the individual, and the immediate bio-psychological response are important predictors of subsequent psychopathology. The degree of perceived control over events and over one's reaction is an important modulator of the effect of stress on the brain. Physiological stress (e.g., bleeding or dehydration) may further influence response to a stressor.

Actual or symbolic loss.

Real and symbolic damage in the form of injury, separation or death of significant others, loss of property, destruction of social networks etc., result in feelings of loss and damage to esteem and identity. Loss and subsequent mental processing may be central to the development of PTSD. Suffering a loss not experienced by those around you can result in feelings of extreme alienation from others. E.g., after finding a close friend mortally wounded, an Israeli army officer described feeling "totally cut off from others. I was completely alone, detached from my own soldiers who suddenly became total strangers to me."

Exposure to grotesque and disfigured human bodies.

Emotional or physical pain of others, dehumanization, degradation, humiliation. Exposure to the grotesque, extreme agony of others, human cruelty, dehumanization, degradation, and humiliation can shatter reassuring assumptions and damage defenses or coping mechanisms.

Forced relocation.

Separation from and/or lack of information about loved ones. The cutting of comforting social ties can result in loneliness and social isolation.

Damaging appraisals of survivor's behavior or response.

A stable narrative of the traumatic events and of one's own responses is formed and consolidated during the short period that follows trauma and shapes how the event will be remembered. Memories of a traumatic event can be influenced by social appraisals of behaviors during or following the event (e.g., shameful, virtuous, dishonorable, heroic, cowardly, etc.). Extreme social labels are often counter-productive because they make it harder for survivors to process the complexities and ambiguity of their own experience.

Phases of coping with traumatic stress

Responses in the days that follow trauma are characterized by being under stress, use of extreme defenses, (such as over control of emotions or dissociation), and a focus on physical and emotional survival.

A later period of reappraisal and reevaluation has the main psychological task of assimilation of events and their consequences. This period is characterized by intrusive recollections of the traumatic event.

Both periods can be physically and psychologically demanding.

Coping styles vary from action prone to reflective and analytical, from emotionally expressive to reticent. Clinically, response style is not as ultimately important as the degree to which coping efforts are successful as defined by the survivor's ability to:

- Continue task-oriented activity
- Regulate emotion
- Sustain positive self value
- Maintain and enjoy rewarding interpersonal contacts

Symptoms expressed following trauma

Initial symptoms are varied, complex, and unstable. They can include exhaustion, stupefaction, sadness, anxiety, agitation, numbness, dissociation, disorientation, confusion, depression, physical arousal, and blunted affect.

Some responses are ‘normal' in the sense of affecting most survivors, being socially acceptable, psychologically effective, and self-limited.

Indicators of effective coping include: a low degree of distress (though this should not be confused with numbing or blunted affect); intrusive recollections that lead a survivor to recruit sympathy and help; upon repetition, the trauma narrative becomes richer, includes other elements, and takes on a reflective tone (e.g., "When I think about it now, I could have done worse."); nightmares change from mere repetition of the event to more remote renditions.

Indicators of more pathological responses include: continuous distress without periods of relative calm or rest; severe dissociation symptoms that continue following a return to safety; intense intrusive recollections that are fearfully avoided, experienced as a torment, or seriously interfere with sleep; extreme social withdrawal; the inability to think about rather than just emotionally experience the trauma.

Assessment and evaluation

Need to clarify what elements were traumatizing for the individual rather than imposing own assumptions or theory. Domains to assess and evaluate include:

Exposure to traumatizing elements includes death of loved ones, injury, relocation, loss of property, social network, previously held beliefs, cognitive schemata, identity, honor, peace of mind, sense of continuity with previous life (e.g., "I'm not the same person any more.").

- Individual prior risk factors for traumatization: Including prior psychological disorder, prior trauma exposure
- Presence of secondary physiological stressors: Includes effects of injuries, pain, internal bleeding, dehydration, medical procedures
- Presence of secondary psychological stressors: Includes police interrogation, media attention, prolonged relocation, continued separation and estrangement from family and friends, bewilderment, disorientation, uncertainty about safety of self and significant others, missing family members, continued lack of control over what is happening.

  Questions to assess secondary psychological stressors include: Is the survivor secure and out of danger? Does he or she have enough control of what is happening? Are there major uncertainties in the present? Are negative events (or news) still expected?

  Does the survivor have clear enough information about self and significant others? Has adequate human attention and warmth been given to the survivor? Has trust been established between survivors and helpers? Can the current conditions humiliate or dishonor the survivors?

- Evolution of symptoms over time: This includes the quality, intensity, and development of early responses. Assess content and structure of trauma narrative as it evolves (including concrete descriptions, subjective appraisals, emotional responses)

without pointing out inconsistencies or making interpretations. Notice whether narrative becomes richer, includes more elements, takes on a reflective tone.

- Coping efficacy: degree to which symptoms are tolerated by survivor or interfere with functioning: Can the survivor continue task-oriented activity? How well organized, goal directed, and effective is such activity? Is the survivor overwhelmed by strong emotions most of the time? Can emotions be modulated when such modulation is required? Is the survivor inappropriately blaming himself or herself? Does the survivor generalize such accusations to his or her personality or self? How isolated, alienated, or withdrawn is the survivor? Does he seek the company of others or avoid it?
- Availability of healing resources: Includes access to social support, nature of societal response.

Interventions

General principles

- Help providers must be tolerant of symptomatic behavior, strong emotions.
- Help providers must respect the survivor's ability to self-regulate and monitor his or her environment.
- Help providers must break the wall of mental isolation that can follow trauma exposure and must maintain continuity of care so that survivors do not begin to feel betrayed and re-isolate.
- Help providers must provide care that is tailored to the needs, capacities, and desires of survivors.
- The survivor must be able to properly utilize and enjoy what is offered. Stress responses may reduce such capacity.

Generic goals of early interventions

- To reduce psychobiological distress and the effects of secondary stressors.
- To treat specific symptoms when they interfere with normal healing processes.
- To assist the normal healing process by supporting the survivor and helpers, by seeing that such helpers are available, that families are evacuated together, etc.
- To follow progress by continued assessment of global coping efficacy.

Interventions in the different phases of the acute response

Peri-traumatic period

- Protect from further exposure to stress, contain the immediate physiological and psychological responses, and increase controllability of the event and of subsequent rescue efforts.
- Be aware of and responsive to survivor's comfort and dignity (e.g., by covering his or her body, avoiding intrusive looks of others and of the media).
- Reorient survivor within the rescuing environment, identify self and role.
- Continuously inform survivors about steps to be taken (e.g., evacuation to a hospital), medication given (e.g., morphine), and other information.
- Provide genuine information (including admitting lack of information) but avoid breaking bad news if possible.
- Maintain human contact with survivors throughout rescue efforts.
- Bring in natural helpers (e.g., relatives, friends) and support them with advice and information.
- If survivors have difficulty expressing their experience verbally, use other bodily and emotional channels are open for communication. E.g., comforting touch (with respect for gender and social boundaries), physical comforts (warmth, hot showers, clean clothes), favorite music, foods, books, movies.
- Whenever possible, reconnect or evacuate survivors with their family and friends.

Addressing Early Responses

Early post-trauma interventions should aim to facilitate psychological recovery and disable progressive sensitization.

- Encourage survivors to verbalize and share their individual story with others: While telling the story is stressful and rarely without strong emotion, it also creates an emotional bond that reduces the survivor's isolation.
- Expect oscillation between periods of extreme anguish and relative rest.
- Encourage grieving for losses and re-adaptation (new learning about self /others).
- Encourage survivors to express painful emotions (verbally, through art, music).
- Attempt to interrupt continuous distress.
- Encourage survivors to be with others.
- Encourage increased thinking about the trauma (rather just experiencing).
- Allow for specific recovery styles to develop in individuals and families (one may talk and another may be silent).
- Assess the strengths and the weakness of the survivor's immediate supporters.
- Explain meaning of symptoms and recovery process to survivors and their helpers.

Treating Emergent or Unremitting Symptoms Upon Return to Normal Activities

- Survivors may become more symptomatic as they prepare to leave the hospital.
- Phobic responses, major depression, and acute PTSD may become evident because they start to interfere with normal tasks.
- If there are new or unremitting symptoms 4 or more weeks after return to a safe environment, survivor may require professional care.

Specific techniques

Crisis interventions and stress management

- These interventions attempt to stop the vicious circle of catastrophic appraisal and extreme distress, address survivors' perception that their reaction is abnormal or that they have totally lost their inner strength, move subjects from a stage of disarray to a stage of effective coping.
- Excessive distress is thought to impair effective problem solving, and coping.
- Steps of crisis interventions include 1. Appraising with the individual what specific elements in a given situation create intolerable distress. 2. Recognizing, legitimizing, and challenging the perceived totality of the situation. 3. Addressing efforts already made to solve the salient problem. 4. Assessing other ways of problem-solving, other resources, alternative plans of action (such as effective help-seeking, postponing efforts to find a solution, and focusing on alternative goals).

Treatment of combat stress reaction (CSR) within the military

- CSR has had dual goals of treating combat soldiers and reducing manpower loss due to psychological reactions.
- PIE model (proximity, immediacy, and expectations) focused on treating CSR casualties as near as possible to the frontline, as soon as possible, and with an expectation of recovery and return to duty.
- Effectiveness of PIE approach has not been confirmed by studies of CSR, and there is some evidence that it is not effective in preventing PTSD.
- Best approach may be to allow a natural selection process by which those who recover within the time allocated to staying in a frontline facility may go back to their previous role, while those with persistent reactions are evacuated to the rear.

Brief cognitive interventions

4 and 5 session Cognitive Behavioral Therapy (CBT) interventions administered weeks after trauma have been found to reduce rates of PTSD in samples of sexual assault, nonsexual assault, and accident victims.

Debriefing

- Semi-structured individual and group interventions are designed to alleviate initial distress and prevent the development of mental disorders following exposure to traumatic events through reviewing the facts, sharing emotions, validating individual experiences, learning coping skills, evaluating current symptoms, and preparing for future experience.
- Controlled studies of debriefing interventions have shown that most survivors perceived debriefing sessions as beneficial and satisfying and that the interventions significantly reduced concurrent distress and enhanced group cohesion.
- But in controlled studies of 4 different types of trauma survivors, one-session interventions were not effective in preventing PTSD and, in 2 of 4 studies, had negative long-term effects.
- The effects of debriefings in the context of continuous care have not been studied.

Pharmacological interventions

- Short-term administration of anxiolytics (i.e., benzodiazepines for 5 nights) to recent (between one and three weeks) trauma survivors was found to improve sleep and PTSD symptoms, but prolonged treatment by high potency benzodiazepines in recent trauma survivors (2 to 18 days following trauma) was associated with higher incidence of PTSD at six months.
- Pharmacological agents that interfere with learning (e.g., benzodiazepines) may prevent post-trauma adaptation. This argues against administering such drugs continuously to trauma survivors.
- Therefore, the use of sedatives in recent trauma survivors should have specific target (e.g., sleep, control of panic attacks) and should be time-limited.
- No studies have been conducted on effects of antidepressants in acute trauma victims.
- Other classes of drugs may prove useful, but no studies have yet been completed.

Effects on helpers

- Rescuers and helpers are also at risk for developing stress responses.
- Warning signs of burnout include excessive exposure, inability to disengage from work, irritability, inability to relax, difficulties communicating with others.
- Effects on rescuers can be reduced by: monitoring exposure to trauma, ordering and enforcing breaks and resting periods, providing relief replacement workers.
- Professional and lay helpers who help by listening to trauma survivors' distress and trauma stories need adequate preparation, support, and opportunities to ventilate and share their emotions.

Conclusions

There are multiple reasons why early interventions can be ineffective:

- PTSD has a complex etiology.
- The relative contribution of early and short interventions is necessarily small.
- Early responses to trauma are changeable and a mixture of normal and abnormal behavior.
- It is difficult to identify which persons are at risk for continued problems.
- It is difficult to conduct interventions in early aftermath of disastrous events.

What have been found to be effective are multiple sessions of CBT provided weeks (not days) following the trauma. However, in many cases, if the client cannot tolerate CBT, supportive counseling is in order until the client can tolerate the intensity of some aspects of brief CBT.

Effective treatment should be administered during the early posttraumatic period to symptomatic survivors.

Immediate contact can provide the survivor with an open door (or address) for continuous or later treatment and the ability to identify oneself as being in need of treatment.

Stages of early responses to traumatic events should follow this general framework:

1. Provide concrete help, food, warmth, and shelter.

2. Once out of concrete danger, soothe and reduce states of extreme emotion and increase controllability.

3. Assist survivors in the painful and repetitive re-appraisal of the trauma.

4. Treat specific syndromes such as acute stress disorder, depression, and other anxiety disorders.