

Early Psychological Intervention

mize emotional processing of horrific events, as in exposure therapy,⁵ but rather to respond to the acute need that arises in many to share their experience, while at the same time respecting those who do not wish to discuss what happened. (p. 128)

Foa (2001) suggested that in the immediate aftermath of trauma, people should follow their natural inclination with regard to how much and to whom they talk, and that professionals should listen actively and supportively, but not probe for details and emotional responses or push for more information than survivors are comfortable providing.

The bottom line is that in the immediate aftermath of trauma, professionals should take their lead from the survivors and provide the help they want, rather than tell survivors how they will get better. As Raphael and Dobson (2001) pointed out, "There has been a failure in many formats of acute post-trauma intervention to develop and utilize a systematic, scientifically based, and clinically appropriate framework of assessing need" (p. 153). Given present knowledge, it is impossible in the immediate aftermath to tell which survivors will later need psychological treatment.

It remains to be tested empirically whether psychological first aid is effective in promoting recovery from posttraumatic stress. As the debate about psychological debriefing has shown, plausible ideas about what interventions make sense in the aftermath of trauma do not necessarily mean that these interventions will promote recovery from posttraumatic stress. Raphael and Dobson (2001) arrived at a similar conclusion, noting that although psychological first-aid interventions "are intended to be generic and supportive, they have not been subjected to research and evaluation, so that the usefulness and validity of their application needs to be established. Their general supportive nature and nonactive intervention suggest that they are unlikely to do harm" (p. 143).

It is interesting that the consensus opinion appears to be returning to views that prevailed in military circles 50 years ago. During World War II, American officers held group debriefing following combat, and the process was conceptualized as a review and reconstruction of the event in which the perspectives of all participants were validated nonjudgmentally (for a review, see Shalev, 2000). Advice, interpretation, or other direc-

tive interventions were not provided. History has turned full circle in that trauma counselors are again recognizing that approaches that are supportive and noninterventionist may be optimal in the immediate aftermath of trauma. It appears that the focus is shifting from directly encouraging people to review and disclose their experiences (reflected in CISM) to providing support and a forum for people to discuss their reactions if they are so inclined.

IDENTIFICATION OF INDIVIDUALS AT RISK FOR CHRONIC PTSD

As we discussed earlier, the majority of people exposed to trauma will experience transient stress reactions that remit within 3 months of the traumatic event. If mental health resources are allocated to those who will experience a chronic mental disorder, an important goal for mental health professionals in the acute posttrauma phase is to identify individuals who will develop a chronic disorder. That is, there is a need to identify people who will subsequently develop a chronic disorder because this subset of trauma survivors, unlike those who experience a transient stress reaction, will require treatment. This identification procedure has been termed the "triage" (Raphael et al., 1996) or "screen and treat" approach (Brewin, 2001).

There are important reasons for screening trauma survivors before providing an intervention. First, one has to bear in mind that traumatic events can trigger not only PTSD, but also a range of other disorders, such as psychosis. Second, the purpose of screening is to identify those survivors who are unlikely to recover on their own and therefore in need of treatment. Prospective longitudinal research has identified predictors that can be used for this task. Current research indicates that the single most important indicator for the risk of chronic PTSD is the severity of PTSD symptoms. Although symptom severity in the initial days after a trauma is not a good indicator of PTSD risk (Shalev, 1992), from about 1 to 2 weeks after the event onward, the number of symptoms, their severity, or both predict chronic PTSD (Harvey & Bryant, 1998b; Koren et al., 1999; Murray et al., 2002; Shalev et al., 1997). Brewin (2001) recommended carefully monitoring symptoms in the aftermath of the event, preferably with validated screening instruments. He recommended intervention only when symptoms fail to subside naturally by about 4 to 6 weeks posttrauma. Schnyder and Moergeli (in press) emphasized that a single screening may be insufficient because a certain number of people will have a delayed onset of chronic PTSD symptoms.

Practitioners need economical instruments for screening large populations of survivors to identify those at risk for chronic PTSD. Brewin et al. (2002) have developed a promising screening questionnaire. It identifies PTSD by any combination of six reexperiencing or hyperarousal symptoms and has excellent agreement with clinician diagnoses of PTSD. Although this instrument shows promise for screening for chronic

5. Exposure therapy for PTSD is a behavioral treatment that helps the person confront trauma memories and reminders of the event that evoke intense emotional or physical responses. It involves emotional and detailed recounting of the traumatic memories in the temporal order in which the event (or events) unfolded. The recounting includes the person's thoughts and feelings. Recounting is done either by visualizing the event in one's imagination and talking about what one visualizes (imaginal exposure) or by writing a detailed account of the traumatic event. The recounting is usually repeated until it no longer evokes high levels of distress. In addition to imaginal reliving, exposure often entails an *in vivo* (real-life) component in which patients enter situations or engage in activities associated with the trauma until the stress diminishes. For example, a survivor of a motor vehicle accident may practice driving his or her car past the scene of the accident until distress associated with the memories of the accident subsides.

PTSD, there is a need for validated screening instruments that can be used with individuals recently exposed to trauma, so that those who will subsequently develop chronic PTSD can be identified; prospective longitudinal studies are warranted to develop these instruments.

Another indicator relevant to early identification of people who will develop chronic PTSD is depression. In one study, survivors who had major depression in addition to PTSD at 1 month after the event showed greater decreases in their ability to function at work and with friends and family and had a greater chance of having PTSD at 4 months than did those who had PTSD without depression (e.g., Shalev, Freedman, et al., 1998).

The ways people try to cope with trauma are also relevant. One possible indicator of need for early treatment is rumination (e.g., going over and over in one's mind questions like "Why did the trauma happen to me?" "How could I have prevented this from happening?" "What if I had done X?" and "What would my life be like if this had never happened?"). Taking rumination into consideration, in addition to severity of initial symptoms, improves predictions of who will get chronic PTSD (Ehlers et al., 1998; Murray et al., 2002). Similarly, excessive precautions, such as sleeping only with a knife near one's bed and with the lights on (Dunmore et al., 2001), and excessive avoidance, such as not leaving one's house (Bryant & Harvey, 1998), are associated with risk for persistent PTSD.

The way trauma survivors interpret the initial posttrauma symptoms, such as reexperiencing, numbness, and irritability, predicts the persistence of symptoms independently of symptom severity (Dunmore et al., 2001; Ehlers et al., 1998). Survivors who interpret these symptoms as signs that they might be going crazy, about to lose control, or permanently changed for the worse are at greater risk for chronic symptoms and in greater need of treatment than are those who interpret their symptoms as a normal part of recovery. Sadly, many trauma survivors endure long-lasting physical consequences, such as chronic pain, visible scars, or loss of limbs. These survivors have a greater chance of having chronic PTSD and thus a greater need for help than those who are unhurt or who recover well from their physical injuries (Blanchard et al., 1997; Ehlers et al., 1998).

Thus, although research has not confirmed optimal criteria for establishing an individual's need for early treatment, the results from prospective longitudinal studies have suggested indicators that may aid detection of individuals unlikely to recover without treatment. Future research may show that a particular combination of measures is better in predicting low chance of recovery than is symptom severity alone. For example, Halligan, Michael, Ehlers, and Clark (2003) conducted a prospective longitudinal study of assault survivors and found that a combination of assault severity and cognitive measures predicted 71% of the variance of PTSD symptom severity at 6 months after the trauma, whereas initial symptom severity predicted 55% of the variance. From a practical point of view, the

severity of the early posttrauma symptoms from about 1 to 2 weeks after the trauma onward is currently the most straightforward indicator of need for treatment. (Note that this assumes that the trauma survivor is safe when the symptoms are assessed).

EARLY TREATMENT OF SURVIVORS WITH CLINICAL SYMPTOMS OF POSTTRAUMATIC STRESS

CBT Starting in the First Month After Trauma

Unlike debriefing, psychological treatments for PTSD symptoms in the initial weeks and months after trauma were mainly adapted from CBT programs for PTSD (e.g., Foa & Meadows, 1997; Foa & Rothbaum, 1998). Much as in the case of psychological debriefing, early attempts to apply CBT techniques in the first few weeks following rape failed to demonstrate efficacy (Frank et al., 1988; Veronen & Kilpatrick, 1983). Although the patients receiving CBT showed substantial improvement in psychological symptoms, the studies did not establish that these changes were greater than those occurring with natural recovery. Furthermore, these studies had methodological problems that made their interpretation difficult. However, more recent studies, including several RCTs, suggest that CBT may be effective in treating PTSD symptoms and thus speeding up recovery in people recently exposed to trauma, and some of the studies have shown that early CBT treatments reduce the risk of long-term PTSD (see reviews by Ehlers & Clark, 2003; Litz et al., 2002). In contrast to the studies of debriefing, the CBT studies have focused on individual treatment.

Using a CBT approach, Foa, Hearst-Ikeda, and Perry (1995) treated 10 female victims of rape or aggravated assault, most within several weeks after the trauma. All met symptomatic, but not duration, criteria for PTSD. The intervention comprised four weekly 2-hr sessions that included treatment elements that have figured prominently in subsequent RCTs: education about trauma symptoms, detailed reliving of the traumatic event in memory, real-life exposure to avoided situations associated with the assault, cognitive restructuring designed to modify maladaptive beliefs, and training in relaxation and breathing skills. Ten other assault victims received only repeated assessments. Unfortunately, victims were not randomly assigned to the treatment versus assessment-only conditions.

The treatment Foa et al. (1995) provided proceeded as follows. During the first session, the therapist educated the patient about typical acute responses to trauma, and assembled a list of objectively safe situations and activities that the patient had been avoiding since the assault. During the second session, the therapist furnished a rationale for exposure therapy, emphasizing that many symptoms continue to occur because the patient has not adequately processed the trauma. After teaching the patient deep muscle relaxation and controlled breathing skills, the