Early intervention for acute psychological trauma

Stephen Rayner

> We have now reached the point where counsellors swarming about any major disaster have begun to outnumber even the lawyers, and where distressingly similar questions about motive and intent have become difficult to dispel.[1]

ALTHOUGH THE COMMENT ABOVE is clearly a cynical view of psychological interventions in the aftermath of potentially traumatic events, it implies that clinicians involved in trauma management may not have, or cannot articulate, clear clinical goals — or even state simply why they are involved and what they are doing in the aftermath of potentially traumatic events. The result might not only be the type of image problem implied by Gist and Woodall, but may include interventions being undertaken or resources prioritised for other than sound clinical reasons.

It is essential that clinicians begin with a clear set of aims and outcomes from which to base and guide their practice. Hence, my aim in this article is to state clear and simple clinical aims and outcomes for early intervention in the management of psychological trauma that are consistent with best practice guidelines.

Acute psychological trauma

Events that are associated with psychological trauma (potentially traumatic events) usually involve people having experienced, witnessed, or been confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. People's reactions could be considered "traumatic" if their reactions include intense fear, helplessness or horror, and if they develop clinically significant impairment in social, occupational or other important areas of functioning that last more than a few weeks.[2] The incidents would typically be unexpected and, in context, would be considered significant enough to be associated with significant distress in most people.[3]

Mental health problems and disorders that arise in the aftermath to exposure to psychological trauma have three main features. Firstly, the onset of problems or disorders is clearly linked to a significant and identifiable event (and presumably problems and disorder would not have developed without exposure to the event). Secondly, the problems must cause significant impairment in functionality. Thirdly, they share characteristic symptoms, which can include elevated physical and emotional reactivity to reminders of the event, attempts to avoid exposure to reminders, symptoms of depression and anxiety, and possible dissociation.

Identified acute trauma-related disorders include Acute Stress Reaction (ASR), Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder – Acute (PTSD-Acute). Although

Abstract

- The aim of early intervention for psychological trauma is to prevent the progression from Acute Stress Reaction to Acute Stress Disorder and Post Traumatic Stress Disorder – Acute, for people with no premorbid or comorbid condition.
- Early intervention strategies commence after the occurrence of a traumatic event, but do not stand alone; rather, they should fit in with prevention and longer care strategies in the overall management of psychological trauma.
- Early intervention for psychological trauma involves three types of interventions:
  - Indicated prevention strategies, aimed at "at-risk" individuals who are identified as having minimal signs and symptoms (such as exposure to traumatic events) that could foreshadow or warn of possible Post Traumatic Stress Disorder;
  - Case identification interventions, which involve screening for and indicating Acute Stress Disorder using a range of strategies such as self-identification, identification by primary health personnel, structured screening programs and clinical assessments; and
  - Early treatment, using valid programs for Acute Stress Disorder or Post Traumatic Stress Disorder – Acute.
- Although all three intervention types are important in the management of acute stress, case identification and early treatment are of higher priority than indicated prevention strategies in the aftermath of psychological trauma.

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ASR is recognised only in the International classification of diseases, 10th revision (ICD-10)[3] and ASD only in the *Diagnostic and statistical manual of mental disorders, 4th edition* (DSM-IV),[2] PTSD is recognised in both classification systems. All three disorders include fairly similar, characteristic, trauma-related symptoms (although dissociation is more central in ASD than in the others), with the main difference being the onset and duration of symptoms. For ASR, symptoms develop within minutes of a traumatic event and last up to hours or days; for ASD, symptoms begin after a traumatic event and last from 2 days up to 1 month; and for PTSD-Acute, symptoms must last for at least 1–3 months after the incident. There is certainly scope for diagnosis to evolve from one disorder to another, over time. Beyond the 3-month duration of PTSD-Acute is PTSD-Chronic. This suggests a clear continuation of a possible single condition (although does not account for all PTSD conditions, such as delayed-onset PTSD, for which there is no clear antecedent other than exposure to a traumatic event). Although ASR is identified as a diagnosable disorder in ICD-10, it could more appropriately be considered a normal response to psychological trauma (as it remits naturally within hours or days), whereas ASD and PTSD-Acute are more abnormal responses. Even though not a traumatic-type reaction, Adjustment Disorder could also be considered a probable diagnosis in the aftermath of significantly stressful events (where there is uncertainty as to whether an event was considered potentially traumatic).

Early intervention strategies

It is essential to examine accepted principles of mental health early interventions that can be adapted to psychological trauma. The Australian Government Department of Health and Ageing (DHA) defines early intervention as:

> … timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of patients suffering from a first episode of disorder.[4]

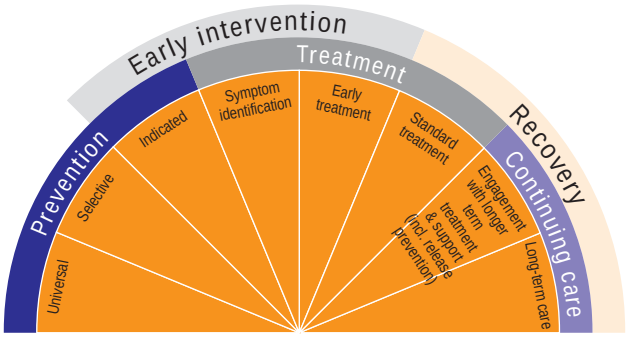
Early intervention overlaps between prevention and treatment (Box) and is part of a continuum of care, not a "stand-alone" approach. Interventions should be complementary, with the view of the DHA being that:

> … only a balance of interventions across the entire spectrum can meet the diverse needs of population groups and thus impact on incidence, prevalence, morbidity, mortality, and other factors associated with mental health problems and mental illness.[4]

As such, the DHA's spectrum of mental health intervention is a useful model to guide mental health interventions related to psychological trauma.

Early intervention aims to prevent emerging signs and symptoms for people developing or experiencing a first episode of mental disorder from progressing into diagnosable disorders, and reduces the need for recovery interventions.

The position of early intervention in the management of mental health problems



Early intervention aims to reduce the effect of the disorder in both its duration and the damage it may cause to a person's life.[5] Therefore, the aim of post-trauma early mental health intervention could be considered to prevent the progression of ASR to ASD or PTSD-Acute, for people with no premorbid or comorbid condition. Following the template of the DHA, early intervention should include three broad strategies: Indicated prevention, Case identification, and Early treatment.

Indicated prevention

Indicated prevention strategies are aimed at "at-risk" individuals who are identified as having minimal signs and symptoms that could foreshadow or warn of a developing mental illness. For psychological trauma, interventions should be considered when some of the diagnostic criteria for ASR or ASD are appearing, usually in the hours and days following exposure to traumatic events, and should aim to prevent the progression of ASR to ASD, or the development of ASD. Exposure to traumatic events alone could be regarded as enough to trigger indicated prevention strategies, as exposure alone can satisfy one of the diagnostic criteria for ASR or ASD.

Common indicated prevention strategies include "psychological first aid", psychoeducation, reinforcement of coping and resilience, maximising social support and cohesion, and cognitive, emotional and behaviour strategies to mitigate symptoms. Also included may be strategies to increase therapeutic alliance, maximise engagement with therapy if required, advocate for mental health treatment, provide education to destigmatise, maximise assistance-seeking, create a positive expectation of recovery, and aid self-recognition of symptoms and appropriate self-referral.

Case identification

Case identification in early intervention aims to recognise signs and symptoms of emerging disorders, even when the

signs and symptoms are fewer, of shorter duration, or less intensive and disruptive than necessary for full diagnosis.[5] Case identification is an essential part of early mental health intervention. A diagnosis of ASD or clinical symptoms of ASD without specific dissociation symptoms are recognised by the United States National Center for Post Traumatic Stress Disorder as accurate predictors of subsequent PTSD.[6] Therefore, identification of ASD or sub-threshold ASD should be the target in early intervention for psychological trauma.

A range of case identification strategies should be used to maximise effectiveness. These could include effective health promotion and education (including self-scoring screening tools) to help people exposed to psychological trauma self-assess and make informed decisions about their own mental health care, including help-seeking or referral to medical personnel. Medical personnel, with their proximity, core role in overall health management, and acceptance by people, have a significant role in the early intervention and management of psychological trauma. Primary care medical personnel should be familiar with symptoms of post-trauma reactions and how to screen for indications of disorder. Screening can involve guided questioning to elicit indicators of disorder. In particular, primary medical personnel should be vigilant to ongoing heightened arousal which does not settle, ongoing disturbed or abnormal behaviour, and ongoing cognitive impairment, such as dissociation or memory problems, as precursors to PTSD or ongoing trauma-related psychological injuries.[7]

Formal mental health screening can be used in the aftermath of potentially traumatic events to supplement self-assessment and assessment by medical personnel, especially in organisations, groups, or where people may be reluctant or hesitant to self-refer. Screening can use instruments validated for psychological trauma, such as the Acute Stress Disorder Scale or the Posttraumatic Checklist – Civilian version (PCL-C). Although the PCL-C is designed as a measure of PTSD rather than ASD, there is great similarity between PTSD and sub-threshold ASD, and there are benefits in using the same instrument over the course of time. To reduce false-positive indicators of disorder and to not potentially "medicalise" normal and transient reactions to trauma, formal screening should not be undertaken in the first 2 weeks following a potentially traumatic event. Further, there is evidence that ASD assessed 2–4 weeks after an incident is a valid predictor of consequent PTSD.[8]

Assessment by a mental health professional would be the ultimate aim of case identification, with the intention to diagnose and to determine appropriate treatment or management options (if required). In making assessments, clinicians should consider symptom severity and duration, the degree of impairment in functionality, the motivation of the person, any ongoing or history of stressors or comorbidity, the person's premorbid personality and functionality, the person's resilience and coping mechanisms, social supports and attitudes of their peers to their dysfunction, the person's possible prognosis, and whether the response is considered understandable or reasonable given the circumstances. To support a clinical assessment, a structured clinical interview, such as the Acute Stress Disorder Interview (ASDI)[8] can be used. The ASDI has been validated against DSM-IV criteria for ASD and appears to meet standard criteria for internal consistency, test–retest reliability, and construct validity.

Early treatment

Early treatment for ASD and sub-threshold ASD aims to prevent the development of PTSD-Acute and to restore functionality. First-line treatment for ASD or PTSD-Acute is generally psychotherapy. The basic criteria for use of psychotherapeutic treatments for acute trauma are that they are evidence-based and appropriate. Standardised Cognitive Behavioural Therapy (CBT) strategies for ASD are available.[8,9] They show promise in ameliorating ASD and preventing the subsequent development of PTSD,[10-12] and should be considered as first-line options. CBT approaches to ASD typically include psychoeducation about trauma responses, training in anxiety management techniques, cognitive restructuring, planned exposure to trauma cues (imaginal and in vivo), and relapse prevention, provided over four to five sessions and conducted from about 2–12 weeks after the event. The primary aim of early treatment is to alleviate symptoms of physiological arousal, improve sleep, and facilitate cognitive and emotional processing of trauma-related information.

Medication should also be considered, although care should be emphasised, as there appears to be no medication that effectively targets ASD or PTSD-Acute symptoms. The primary aims would be for symptom relief for acute arousal reduction, to aid sleep while to manage symptoms of anxiety and depression.

Prioritising strategies

Although the DHA identifies these three early intervention strategies without any priority or weighting, the International Society for Traumatic Stress Studies argues that indicated prevention strategies that might appeal to the provider should not be prioritised over the more clinically important case identification and early treatment strategies.[13] Most people exposed to potentially traumatic events will not develop PTSD with or without intervention, while those with ASD are at real risk of developing PTSD.

If all intervention options are available, use them all. However, if there are limits or restrictions on what can be done, it is essential to identify and treat the minority of people who have a disorder, an emerging disorder, or who are most at risk of developing a disorder (ie, do case identification and early treatment), rather than intervene (through indicated prevention alone) with the majority of people without disorder and without expected complications in their recovery. To target

indicated prevention resources at the majority who may not need them, at the expense of targeting those who need clinical support the most, is prioritising interventions for non-clinical reasons, and is likely to reinforce the cynical opinion of early intervention described in the opening quote.

Competing interests

None identified.

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