Prevention of posttraumatic sequelae: therapeutic intervention in trauma survivors

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Traumatic experiences are very common. In the US more than half of a national representative sample had experienced life-time trauma[1]. Treatment-based studies suggest even higher rates[2,3]. It was estimated that between 1967 and 1991, an average of 17 000 000 people were affected by natural disasters each year[4]. With regard to human-caused events, scientific reports of war captivity, torture, ethnic cleansing, and genocide have increased in the last decade. Former Yugoslavia, the Middle East, and the continent of Africa are some of the areas that have triggered local and international investigations to assess the prevalence of trauma and loss and their mental health consequences.

Persons exposed to the imminent threat of violence, loss, injury, or death frequently suffer psychiatric sequelae such as posttraumatic stress disorder (PTSD)[5]. PTSD is a syndrome consisting of re-experiencing the traumatic event, avoidant behaviours, numbing, increased arousal, and anxiety. Weine and colleagues, studying a group of Bosnian refugees resettled in the US found that 65 % suffered from PTSD[6]. PTSD onset often occurs soon after the exposure, and is termed acute stress disorder (ASD)[5]. In some cases, ASD can be transient with spontaneous remission, but in many cases, it persists longer and develops into an enduring long-term disorder. PTSD is often associated with depression, substance abuse or other anxiety disorders[7]. It generates tremendous emotional suffering in the victim's psyche and wreaks havoc in every area of his/her life. As a persistent anxiety disorder, it is difficult to treat and periods of apparent recovery can be interspersed with sudden flare-ups. Its costs to society are high, as alienated, angry, withdrawn, and inwardly tormented PTSD victims are often unable to fulfill their responsibilities at home and at work. They draw heavily on rehabilitation, health, and welfare services, and often merit years of disability compensation payments. Thus, the prevention of PTSD and trauma-related comorbid disorders is a top priority.

One of the most intriguing questions, both theoretically and clinically, is whether preventive efforts should be directed at everyone who is exposed to a traumatic event or only at those who show pathological distress in the aftermath of a traumatic exposure[8].

A variety of early interventions directed at all persons exposed to trauma have been developed with the aim of preventing long-term stress residues. Many of the intervention models fall under the umbrella-term of debriefing[9], usually but not always a short group-oriented intervention, in which the traumatic experience is examined in a structured way by all exposed persons regardless of their immediate emotional response.

The likelihood that acute stress reactions will develop into long-term PTSD provided a good reason to apply early interventions for persons manifesting acute psychopathology following trauma exposure. A strategy known as frontline treatment is currently the accepted therapeutic strategy in most western armies including the USA, England, and Israel[10]. First formulated by the military psychiatrist T. W. Salmon (1919)[11], based on the experience of the British and the French armies during World War I, it has three basic principles: proximity – treatment should be administered close to the traumatic incident; immediacy – treatment must be given as close as possible to the time of the onset of the symptoms; expectancy – victims are advised that their crisis is transient, and that they are expected to return to their preexposure commitment after the intervention is finalized. Building on these principles, treatment is usually conducted close to the trauma location, meeting the casualty's physiological needs for food, drink and sleep, and aiming to prevent him or her from becoming isolated, lonely and detached. The treatment generally lasts several days,

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combines group and individual therapy and is carried out by mental health professionals.
While research findings with regard to the success of debriefing interventions have been inconclusive[8], encouraging results were reported on front-line treatment, suggesting reduction of PTSD rates in Israeli war veterans with acute stress reactions who were treated according to this procedure[12]. These findings encouraged further application and evaluation of these procedures in civilian populations[10].

In summary, despite the suffering caused by both man-made victimization and natural traumas, there has been relatively little interest in addressing the needs of survivors, especially in far away and isolated locations[13]. Although much is known about the deliberating effects of trauma exposure, its negative valence on self structures, emotional and social functioning and well being, more might be done to promote the development and application of preventive strategies and to study their effectiveness.

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