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Introduction

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Traumatic life events are unpredictable, uncontrollable, and devastating. Suddenly, persons or groups are exposed to unimaginable suffering and threats to themselves or others, resulting in terror, panic, frailty, and vulnerability. Traumatic events violate core tacit beliefs and assumptions that otherwise promote safety, stability, well-being, purposefulness, and personal and collective agency. Unfortunately, trauma is not rare and as a result represents a major public health problem. Population estimates in the United States vary, as do methods and definitions of trauma across epidemiological studies, but approximately 5 of every 10 individuals will be exposed to a major, severe life stressor or trauma at some point in their lives (Breslau et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). At the time of the event, and for a varying period of time afterward, trauma eviscerates normal functioning and consumes consciousness, physiology, and coping resources.

While the prevalence of trauma across the lifespan suggests that it is part of the human condition, on average, people are remarkably resilient and adept at recovering over time. The risk of long-term, untoward mental health problems implicated by exposure to trauma is surprisingly low. Although time does not heal all wounds, most individuals will heal psychologically, socially, and morally with the passage of time. Though the majority of people exposed to trauma are initially overwrought, epidemiological studies show that between

8% and 9% are at risk for chronic mental health problems stemming from all forms of trauma (Breslau et al., 1998; Kessler et al., 1995). Those who experience chronic posttraumatic symptoms and problems pose a major international mental health challenge. The chronic psychological and social difficulties that stem from trauma are pernicious, disabling, and resistant to change (e.g., Kessler et al., 1995; Kulka et al., 1990).

For many, psychological recovery and adjustment from trauma are not linear, static processes but, rather, unfolding lifelong challenges. In the aftermath of trauma and traumatic bereavement, clinicians and public health officials need to be concerned with how long a person suffers acutely and how much time passes before a relatively normal routine is reestablished (the rate of recovery) and the risk for enduring functional impairment and specific chronic mental health problems that may require professional intervention (e.g., posttraumatic stress disorder [PTSD]; American Psychological Association, 1994), as well as symptom flare-ups after periods of effective functioning (e.g., Bryant & Harvey, 2002; Harvey & Bryant, 2002). Yet, for some, after an initial period of disruption, trauma can lead to personal growth, more effective coping with minor life hassles, as well as a greater sense of connection with loved ones (Frazier, Conlon, & Glaser, 2001; Tedeschi, 1999; Williams & Yule, 1993). A variety of complex, interrelated (and yet to be researched) factors moderate the rate and form of recovery from trauma across the lifespan. The psychological and psychiatric effects of a given trauma depend on temperament, psychological and physiological individual differences, developmental period, culture, gender, and social context (e.g., Breslau et al.; 1998; Kessler et al., 1995; Shalev, 1999; True et al., 1993). Characteristics of the traumatic event are also important predictors of outcome—severe, malicious, and grotesque traumas as well as traumatic bereavement are associated with much greater risk for posttraumatic adjustment problems than for other forms of trauma (e.g., Breslau et al., 1998; Kessler et al., 1995; Kulka et al., 1990).

In the mix of causal factors that create or attenuate risk for lasting problems from exposure to trauma is the quality of the recovery environment (e.g., how friends, family members, coworkers, and the community at large respond; e.g., Bolton et al., 2003; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Ullman, 1997) and the professional care provided to people immediately and soon after trauma, otherwise referred to as *early intervention*. This book is devoted to the public health, clinical, and research issues relevant to early intervention for trauma and traumatic loss.

Unfortunately, people suffer through most traumatic experiences in anonymous isolation because of the nature of the event (e.g., incest), the stigma attached (e.g., sexual assault), the social context (e.g., punitive significant others), or some combination of these factors. In all too many cases, no

one is around to assist in recovery, and care is never provided. For example, most sexual assaults are unreported; victims receive neither medical attention nor mental health intervention (Rennison, 2002). When trauma and traumatic loss are associated with a public emergency or become public for any number of reasons, a wide variety of professionals may intervene with people immediately or soon following the experience. Most early responders on the scene of an incident are emergency services personnel or medical care professionals (police officers, emergency medical technicians, emergency room staff, assistant district attorneys, firefighters, Red Cross personnel, etc.) whose priority is ensuring physical safety, securing basic needs (shelter, water, food, etc.), or gathering evidence to process a crime, not attending to victims' emotional needs or current mental health. Some *first* or *early responders* may be called on to assist in a time of disaster and tragedy simply because they happened to be there or because of professional training of some kind. Other individuals who assist people soon after tragedy have a formal mental health role providing immediate emotional support, screening, and triage for severity of psychological response and risk for chronic difficulties and assisting individuals in planning for the days, weeks, and months of recovery and reemergence into daily routines. Some of these specialists have advanced training in acute trauma and its care, some have advanced degrees in the allied health professions (e.g., social work, psychology, psychiatry, and nursing), and others do not have specialized training per se.

As would be expected, there is great variability in training background, role, philosophy, approach to emergency services, and mental health background in personnel who work with trauma survivors at various points in the response chain. However, in the aftermath of trauma, all professionals, regardless of the services they provide or the context in which they provide it, are part of a collective invested, in one way or another, in facilitating recovery. Arguably, from a mental health perspective, one of the guiding assumptions shared by all professionals stems from implicit theories of crisis intervention and grief counseling: If a trauma or loss is not resolved in a healthy manner, the experience can create lasting psychological and social problems (e.g., Roberts, 1991). This may be true. Initially, victims of trauma and traumatic loss experience tremendous emotional shock and upheaval. Unexpectedly, their routines, their sense of fairness and goodness, and their expectations about how things work and how they should be treated or how human beings should be treated have been shattered and disrupted tragically, which could taint their life course in completely unanticipated and disorienting ways. There is no doubt that trauma and traumatic loss are implicated as causes of chronic and severe mental health problems, such as PTSD (e.g., Kessler et al., 1995). Furthermore, early mental health interventions could prove to be an important

tool to prevent problems implicated by exposure to trauma (see Litz, Gray, Bryant, & Adler, 2002). In addition, because individuals' decisions about seeking care in the weeks and months after trauma may be influenced by the way they were treated and the things they learned immediately after the trauma occurred, it is important for all professionals in the response chain to appreciate how they might be constructive and not inadvertently destructive. In the early intervention for trauma and traumatic loss arena, there is consensus about why early intervention is important, but more questions remain with respect to how, when, and with whom interventions should take place.

This disturbing state of affairs is due to a variety of factors. First, there is a dearth of naturalistic, prospective studies of the course of posttraumatic recovery, especially the course of adjustment to mass violence and traumatic loss. Although research has illustrated convincingly that, following trauma, after a period of intense distress, approximately 90% of individuals recover effectively without professional intervention, many questions remain (e.g., Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). For example, it is unclear how resilient people naturally cope with severe trauma and whether resilience is lifelong or phasic (e.g., a period of adjustment could be followed by a period of severe impairment).

Second, there is much conjecture about what puts people at risk for chronic PTSD, but there are few well-designed, empirical studies. Furthermore, there are no cogent conceptual frameworks to draw from when considering practical screening programs for early trauma intervention. At present, studies have examined correlates of chronic PTSD (e.g., Harvey & Bryant, 1999), but there are very few focused investigations of specific risk mechanisms. If risk mechanisms could be identified, secondary prevention programs could be designed to address the factors that place people at risk for chronic PTSD.

Third, although there is good evidence to support the use of multisession, therapist-intensive, cognitive-behavioral interventions in the secondary prevention of PTSD (e.g., Bryant, Sackville, Dang, Moulds, & Guthrie, 1999), the necessary and sufficient elements for successful prevention remain unstudied. In the context of traumas that affect large numbers of individuals (e.g., mass violence) and in medical care contexts where well-trained professionals may be scarce, evaluating efficient methods of delivering the key elements of early interventions is crucial.

Fourth, there is scant descriptive, epidemiological, or clinical research on the unique psychosocial needs and outcomes of individuals who suffer traumatic loss or those who suffer the dual burden of losing a loved one through trauma while experiencing their own acute trauma (e.g., Raphael, Dobson, & Minkov, 2001). Although there are some promising uncontrolled trials (e.g.,

Shear et al. 2001; Sireling, Cohen, & Marks, 1988), there are no randomized controlled trials of early interventions for traumatic bereavement.

However, when disaster, trauma, and traumatic loss strike individuals and communities, professionals of goodwill with various background and so-called trauma specialists are on the scene to assist victims as early as possible. For example, the tragic mass violence on 9-11-01 and the loss incurred created an assumed huge demand for brief early intervention and other mental health services, and a strong desire for professionals, many of whom also suffered pain and sorrow on that terrible day, to help in some way during a time of great tragedy and suffering. Large sums of money were devoted to meeting the acute mental health aftermath of 9-11. For example, the Federal Emergency Management Agency awarded $132 million for "crisis counseling" in New York City, which was the largest grant in the agency's history, nearly the total amount awarded for emergency mental health in disasters since 1974. Yet, there was uncertainty in many circles about how to use the vast resources—the question that arose was, "What best practices are recommended based on scientific evidence?" The disquieting answer to this question is that there is little valid research from which to draw practical recommendations.

The field of early mental health intervention for trauma was at a crossroads and approaching a paradigm shift well before 9-11. The early intervention field is dominated by non-evidence-based practices, poorly defined and anachronistic notions about recovery from trauma and risk for trauma-linked disorders, and an apparent unresponsiveness to scientific inquiry. It is perfectly understandable for professionals to attempt to help people cope with the immediate and enduring aftermath of personal and collective tragedy. It is also understandable that special disaster and victims' assistance organizations such as the Red Cross routinely provide early counseling and grief intervention services to affected individuals. Communities and governmental agencies are intensely motivated to take care of those affected by trauma and traumatic loss, often funding and mandating early intervention for people in their charge. For example, personnel in all five boroughs in the New York City Police Department were provided formal psychological debriefing after the 9-11 terrorist attack. Added to this mix are entrepreneurs and organizations that routinely offer early interventions such as *critical incident stress debriefing* (Mitchell & Everly, 1996), even though there is insufficient evidence to support its efficacy (e.g., Litz et al., 2002; Rose, Brewin, Andrews, & Kirk, 1999). Because of this lack of sufficient scientific evidence, the community of mental health professionals and consumers of services (e.g., government officials, private agencies, school boards, and hospitals) need to be considerably more cautious about the type of acute care recommended on the scene of a trauma or in various contexts soon afterward (e.g., the workplace). Offering or requiring services with-

out evidence for their efficacy could, in the best case, waste much time and resources, and in the worst case thwart natural recovery. It is not acceptable that early interventions for trauma be based exclusively on the understandable human need to help people who appear to be suffering or out of the motivation to promote organizational or corporate goals. A model of care needs to be articulated such that, in the absence of evidence-based screening and intervention strategies, victims should be assisted in the least intrusive manner possible and in a way that respects their natural resourcefulness.

As it turns out, the crisis counseling doctrine that healthy recovery from trauma and traumatic loss reduces risk for chronic problems is mostly true, but professional intervention in most instances is not needed to make this happen (Litz et al., 2002). In addition, there are myriad ways that individuals process and recover from trauma and loss, and initial suffering or the lack of overt strong emotional upheaval does not imply that anything is wrong (e.g., Wortman & Silver, 1989). Some people do not share their emotional experience of loss and trauma, as a personal preference, not necessarily as a result of denial or avoidance. In fact, recovery from trauma and loss can be hampered by poorly timed and overly intrusive demands for emotional expression and sharing (e.g., Stroebe, Stroebe, Schut, Zech, & van den Bout, 2002).

Nevertheless, the crisis counseling approach assumes that something needs to be "done to" *any* survivor of trauma. The approach taken is that soon after trauma, all victims need some kind of education, guidance, support, or emotional outlet, assuming that people cannot find these things in their natural environment. In addition, crisis counseling assumes that some kind of brief intervention soon after trauma can have lasting impact in the course of adjustment to trauma. However, there is no evidence to support this view, and there are several well-designed research trials that suggest that, at best, early brief interventions are inert with respect to affecting the course of coping with the psychological aftermath of trauma (e.g., Bisson, Jenkins, Alexander, & Bannister, 1997).

Old assumptions about early interventions are being challenged from a variety of fronts. Because it is unclear how best to serve the immediate and acute needs of trauma sufferers and there is little agreement how best to facilitate recovery from trauma, a reckoning of where we are and where we need to go is required. As there is little research on early interventions to prevent chronic posttraumatic difficulties, it is critical to set forth a research agenda for the future. It is also important to glean important lessons learned from past practical field experience in early intervention—there have been, and continue to be, well-meaning efforts to assist individuals following trauma and traumatic loss. Future research must examine the necessary and sufficient ingredients (and the unique meaningful clinical and functional outcome indicators) of

effective mental health first-aid care and formal secondary prevention of chronic psychopathology.

The goal of this book is to comprehensively address the conceptual, empirical, and applied issues pertaining to early intervention for trauma and traumatic loss. The intent is to clarify the available evidence supporting various types of interventions, and when an evidentiary base does not exist, to use researchers with extensive clinical experience to generate conceptual frameworks that will guide future studies in an area that desperately needs empirical research. Another goal is to cover the issues and content areas essential to an understanding of early intervention, focus on clarifying empirical and methodological issues, and set forth a research agenda for the next phase of early intervention research. We anticipate that the information in this volume will be useful to various care providers and professionals in all disciplines and organizations that are concerned with how best to help people adapt to trauma, as well as decision makers and consumer groups. Additional intended audiences include graduate students and postdoctoral trainees in the allied health professions interested in evaluating the state of the art in empirical research on early intervention, in service of conducting further research (e.g., public health, clinical social work, psychiatry, and clinical psychology).

TYPES OF TRAUMA AND TRAUMATIC LOSS COVERED IN THIS BOOK

Although we do not address early intervention for all possible types or categories of trauma in this book (war zones, natural disasters, technological disasters, etc.), we do not systematically limit the scope and type of trauma discussed. The principals discussed in this volume are applicable to most traumatic events, large or small, experienced at any age, in isolation or shared by all of humanity. On the other hand, different types of traumatic events are distinguished by unique exigencies in the immediate environment and the acute recovery context. In addition, the degree of public awareness and civic or legal involvement, the number of victims, the extent of the devastation, the breadth of the shared experience, and the resources available are among the many factors that determine the extent to which early intervention is possible or feasible. Thus, this book will not entail recommendations for various specific logistical "how-tos" germane to all possible traumatic contexts (which would be nearly an impossible task). Our goal is to explicate the state of the empirical literature and recommend evidence-based early intervention strategies as well as to set forth an extensive agenda for future research. Clinicians and clinical researchers will need to mold these principles and empirical methods into tasks and agendas applicable to various unique traumatic contexts. We are confident that this is possible.

ORGANIZATION OF THIS BOOK

The book has three parts. The first part, "Predictors and Course of Acute Stress Disorder, Posttraumatic Stress Disorder, and Traumatic Grief," provides a depiction of the psychological demands of trauma and traumatic loss, the course of acute adaptation and recovery, and what research has shown places individuals at risk for chronic posttraumatic difficulties, including acute stress disorder, PTSD, and traumatic grief. First, in Chapter 2, Bryant describes the clinical course, epidemiology, and the assessment and treatment of acute stress disorder, which is ostensibly PTSD in the first month after exposure to trauma. The presence of acute stress disorder (ASD) is a powerful predictor of those who will go on to develop chronic psychosocial disturbance stemming from exposure to trauma. Bryant argues that early intervention should be provided exclusively to individuals with ASD soon after a traumatic event so that scarce secondary prevention resources can be devoted to those most at risk for chronic PTSD and least likely to get better on their own. In the next chapter, King and colleagues review research that has explored personal, traumatic event, and social factors that promote or impede effective recovery from trauma, so-called resilience and risk factors, respectively. One of the most important new lines of research on trauma and PTSD will be the identification of specific temperamental, personality, psychological, physiological, and social mechanisms or processes that impede recovery from trauma. Once these factors can be reliably assessed in logistically feasible ways in the acute aftermath of trauma, their mitigation will prove effective as a secondary prevention strategy. King, Vogt, and King (in Chapter 3) also provide a conceptual framework to advance empirical research on risk and resilience factors. In the last chapter in this part, Chapter 4, Gray, Prigerson, and Litz discuss conceptual and definitional issues in traumatic grief. When people lose intimates unexpectedly, and from malicious acts of violence in particular, they are at risk for complicated or chronic grief-related problems and mental health disturbances (Raphael & Martinek, 1997). In this bereavement context, recovery demands and mental health outcomes are represented by a synergy of psychological trauma and grief. The study of loss by traumatic means, and, in particular, the psychological and psychiatric sequelae implicated by loss due to malicious violence, is relatively new. At present, there is no single paradigmatic approach but, rather, several competing theories conceptualizing the causes of chronic grief implicated by bereavement by traumatic loss. Nevertheless, research has shown that loss by traumatic means can lead to chronic grief, which can be horrifically functionally impairing.

The next part, "Empirical Research on Early Interventions for Trauma and Traumatic Loss," summarizes the state of the art in research on early inter-

vention for trauma and traumatic loss across the lifespan (in very young children, older children, and adults). In each chapter, the authors describe existing research and explicate a set of empirical questions for future research as well as propose methods of study. In Chapter 5, Litz and Gray critically review the history and current state of early intervention for trauma, distinguish psychological first aid from the methods and goals of formal secondary prevention interventions, and make a set of recommendations for research and practice. In Chapter 6, Van Horn and Lieberman describe research on early intervention for trauma and traumatic loss in the most vulnerable of individuals: infants, toddlers, and preschoolers. Early physical and sexual abuse and, in particular, a combination of brutality, neglect, and sexual abuse or incest can have a profoundly devastating impact on emotional and intellectual development, the quality of adult attachments, self-care, self-esteem, a variety of psychopathologies, and substance abuse (e.g., Cohen, Brown, & Smaile, 2001; Dube et al., 2001; MacMillan et al., 2001). Unfortunately, there is little research on secondary prevention interventions for traumatized children, which is extraordinary given the societal problem of child neglect and abuse. Van Horn and Lieberman also describe their treatment approach, which systematically incorporates parents to promote and restore trust and healing. In Chapter 7, Cohen describes the best way to target trauma in school-age children and adolescents. The reader needs only to recall the terrible tragedy of Columbine to appreciate the important work of Cohen and others. Fortunately, such mass violence episodes are statistically rare. However, assaults among school-age children as well as suicide and motor vehicle accidents are not rare. For example, in 2001, 17.4% of students in the United States carried a weapon to school and 6.6% of students reported missing at least 1 day of school in approximately 30 days because they felt unsafe at school or on their way to or from school (Centers for Disease Control and Prevention, 2001). In Chapter 8, Raphael and Wooding discuss ways of conceptualizing and treating traumatic loss in adults. Although loss by traumatic means (e.g., homicide, mass violence, and suicide) is considered in the diagnostic nosology as a psychological trauma that can result in PTSD, the PTSD construct fails to capture the unique psychological and social burden of traumatic bereavement. Raphael and Wooding also discuss the psychological, social, and psychiatric sequelae of loss by traumatic means and discuss the unique early intervention needs of individuals bereaved in such tragic circumstances. Finally, in Chapter 9, Gray, Litz, and Olson discuss various ways early intervention can be studied in scientifically sound ways. There are a host of practical barriers and ethical considerations unique to the early posttraumatic context that creates hurdles and roadblocks to research efforts. Nevertheless, empirically sound and internally valid early intervention investigations can, and have been, conducted.

The last part, "Special Topics," has a series of chapters germane to early intervention. First, in Chapter 10, Neria, Suh, and Marshall summarize the lessons learned from providing mental health care after the 9-11 attack on the World Trade Center in New York City and describe a series of steps taken to respond to this enormous tragedy. Next, in Chapter 11, Rauch and Foa discuss the unique psychological and interpersonal challenges women face in the immediate aftermath of sexual violence and describe their research on secondary prevention of PTSD using cognitive-behavioral therapy. Third, in Chapter 12, Eriksson, Foy, and Larson discuss ways of intervening with a population of individuals affected chiefly by bearing witness to the trauma of others, such as emergency services personnel and relief organization workers. Fourth, in Chapter 13, Zatzick and Wagner address an underresearched but important topic—the enduring psychological burden created from physical trauma—and address ways of assisting individuals before they leave the hospital to prevent chronic PTSD. Fifth, Blanchard, Hickling, Kuhn, and Broderick, in Chapter 14, discuss their research on early mental health intervention for motor vehicle accident survivors. In the United States, motor vehicle accidents account for over 3 million injuries a year and are among the most common traumatic events (Blanchard & Hickling, 1997). Finally, in Chapter 15, Castro, Engel, and Adler, all of whom are clinicians and researchers in the U.S. military, address empirical and practical issues in early intervention for soldiers in the field of battle and when they return from war. The demands, stressors, and conflicts of participation in war can be traumatizing, spiritually and morally devastating, and transformative in potentially damaging ways, the impact of which can be manifest across the lifespan. The U.S. military has learned many important lessons about training and intervening early so as to reduce the mental health impact of combat. The U.S. military is also the largest user of psychological debriefing as an early intervention, in part because "after-action" debriefing has a long history in the military culture. The book ends with some concluding and summarizing remarks.

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