Early responses/interventions in the aftermath of traumatic events

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Overview

- Why offer early intervention? Predictors of PTSD
- What is being provided and what is the evidence?
  - Social support
  - Debriefing
  - Experimental Research: ‘Tetris’
  - Watchful waiting
  - Psychological First Aid
  - Trauma Risk Management – TRiM
  - MIND Blue Light programme
- Early Interventions with Trauma-Focussed Therapies
- Grenfell trauma pathways
Why offer early intervention?

- Preventing post-incident psychological change is far from easy (Cochrane review, Rose et al., 2003)
Why offer early intervention? Predictors of PTSD (Brewin et al., 2000)

- Gender (female)
- Younger age
- Low SES
- Lack of education
- Low intelligence
- Race (minority status)
- Psychiatric history
- Childhood abuse

- Other previous trauma
- Other adverse childhood
- Family psychiatric history
- Trauma severity
- Lack of social support
- Life stress

“The three factors relating to events during and after the trauma (i.e., greater trauma severity, lack of social support, and more subsequent life stress) convey the strongest risk of PTSD”
Why offer early intervention? Predictors of PTSD (Ozer et al., 2003)

- Prior trauma
- Prior adjustment
- Family history of psychopathology
- Perceived life threat
- Perceived support
- Peritraumatic emotions
- Peritraumatic dissociation – the strongest predictor

“Although this meta-analysis and the results of Brewin et al. (2000) provide evidence for statistically significant predictive relationships between multiple characteristics of individuals and their experiences and PTSD symptoms, the specific processes by which these factors may serve to influence the development of PTSD remain largely unexamined.”
Ozer et al. (2003): Why is peritraumatic dissociation the strongest predictor?

“With respect to peritraumatic dissociation, emotional and psychophysiological arousal, and the underlying brain activities in the HPA axis and the limbic system, it may well be that some variables operate in a contingent fashion—heightened arousal is a necessary but not sufficient condition for the experience of peritraumatic dissociation, so that not all those who experience heightened arousal go on to experience peritraumatic dissociation. The mechanism by which peritraumatic dissociation occurs may be influenced not only by arousal, but also by temperament, prior experience, and other genetic or environmental factors, including factors at the level of plasticity and learning in individual neurons (Malenka, 2000). Our examination of the literature has been able to offer only tentative glimpses into explanatory mechanisms.”
“Our analyses indicated that the strength of the relationship between social support and PTSD symptoms and diagnosis differed according to the length of time that had elapsed since the trauma. Social support served as a stronger predictor in studies where the event had occurred more than 3 years prior than it was for studies with less time elapsed. This result tends to lend some credence to the idea that social support may function as a kind of secondary prevention that is seen more clearly when symptoms are most clearly symptoms of PTSD rather than common, shorter-term reactions following traumatic exposure.

Alternatively, these findings may also suggest that the effects of social support are cumulative over time and thus may be seen most strongly in studies that assessed PTSD symptoms after several years had elapsed since the index trauma.”

- “We found that in most studies, the emphasis was on emotional support. This suggests that the kinds of phenomena for which individuals are receiving support likely have more to do with the psychological processing of the meaning of the event or the management of the psychological distress and pain experienced during intrusive memories or nightmares, rather than with needs such as financial assistance, mobilization of the criminal justice system, or restoration of lost possessions.

- Further investigation into whether this conjecture can be empirically supported would be of interest, and could also produce knowledge that could inform intervention to help ameliorate the impact of exposure to traumatic stressors.”
“Lack of social support in the aftermath of trauma is associated with greater risk of chronic PTSD (Brewin et al, 2000; Ozer et al, 2003). The experience of a traumatic event often has a negative impact on survivors’ ability to trust other people and engage in close relationships, in particular if the event involved intentional harm by others. Sufferers may feel alienated from others and withdraw from previously significant relationships. This may contribute to the maintenance of the problem, and interfere with a trusting relationship with health professionals (e.g. Ehlers et al, 2000).”
Social Support: Some Questions

- What is good social support?
  - Emotional, psychological, communities?
  - Is it different if provided by organisations?

- What happens when our friends and family are also traumatised?
  - PTSD in itself can have a profound effect on carers, especially if not understanding the nature of PTSD
  - Impact on children?

- What are the mechanisms related to ongoing threat, avoidance, and the traumatic attributions of self-blame, shame and guilt?
  - Do they inhibit us accessing social support?

- How do these influence psychological responses, including those other than PTSD?

- Should early interventions focus on increasing social support and what is the role of psychoeducation?
What makes PTSD worse?

- If the traumatic events:
  - Are sudden and unexpected;
  - Go on for a long time;
  - You are trapped and can’t get away;
  - Are man-made;
  - Cause many deaths;
  - Cause mutilation and loss of limbs;
  - Involve children
Debriefing

  - Enforced single incident debriefing with individuals found to be at least of no use or at worst harmful (Rose et al., 2004) due to sensitising people further or inhibiting them using natural support networks (van Emmerick, et al., 2002), but reported equivocal results if it can be useful as part of a wider group programme.

- NICE (2005) stated:
  - “The provision of psychological debriefing as a community support and cohesion strategy (British Psychological Society, 2002) rather than a treatment intervention to prevent PTSD is beyond the scope of this guidance.”

- Current debriefing models?
Approximately 2800 people killed

3-5 days later: 44% endorsed PTSD symptoms (n=560 by telephone)

5-8 weeks: 7.5% in Manhattan population

1-2 months: 11.2% New York metropolitan area; national estimated prevalence 4.3%; no clinically significant difference in psychological distress

3-6 months: Manhattan residents 1 or more symptoms of distress: loss of family, friends, job, displacement, female gender predictors of distress

7 months: 14% Pentagon attack survivors PTSD: more women, increased use of alcohol and those with more intense emotional reactions, dissociation and lower perceived safety more at risk

Use of self-blame and social support as coping strategies positively associated with PTSD, whereas acceptance was negatively associated

10% reported increased mental health usage; 5.3% less?

WTC Medical Working Group (2008): 7 years later continuing mental health needs
7/7 London Bombings

- 56 people killed, 7775 injured

Brewin et al. (2010): 2 year Trauma Response Programme with proactive ‘screen and treat’ approach

- 596 of 910 people screened with TSQ; most common diagnosis PTSD often co-morbid (41%); 217 received treatment
  - >80% TF-CBT; others EMDR, average 11.9 sessions; 86% improved and 66.4% clinically significant change (N.B. more than NICE recommendations)

- 61% at 7 months reported they ‘viewed the world differently’ (Rubin et al., 2007)

- 101 followed up and maintained improvement, but many did not access via GP – poor recognition (Ehlers et al., 2009), unmet need and dissatisfaction with GPs (Brewin et al., 2009)

- Psychological treatment can nevertheless reduce PTSD
Norwegian Terror Attack in Olso and Utoya Island (Thoresen et al., 2013)

- Social support barriers and perceived social support
  - Barriers were highly associated with PTSD and psychological distress (n=285 survivors) at 13/14 months

- Conceptual distinction between ‘received’ and ‘perceived’ support
  - Negative support such as ‘feeling let down’ may predict mental health problems more than a lack of support
  - Less likely to access support with perception others are ‘tired of hearing, others have their own problems, friendships over-burdened, can’t understand their suffering’

- 15 year follow up of Estonia ferry disaster with 852 losses (Arnberg et al., 2013): individuals refrained from using social support as they felt they ‘had to move on or did not want them to think they were too caught up; others were too distressed, or could genuinely not understand them"
Holmes (cited 2017): Behavioural intervention of playing Tetris in A&E following an RTA building on experimental research:

“71 motor vehicle accident victims, of whom half received the intervention (recalled the trauma briefly and then played Tetris) while waiting in the hospital emergency department, and half performed another task, all doing so within six hours of the accident. Results showed that the researchers’ hypothesis was right: those who had played Tetris had fewer intrusive memories of the trauma in total over the week immediately following the accident than the controls. The researchers also found that the intrusive memories diminished more quickly.”

James et al., 2016: Experimental studies using a visuospatial task, ‘Tetris’ to reduce the development of traumatic memories prior to watching a traumatic film had no effect
Watchful Waiting (NICE, 2005)

- “A significant number of people presenting with acute reactions or established PTSD can be expected to recover within a relatively short space of time (Rothbaum et al, 1992; Bryant, 2003). The rate of remission is higher for those with milder symptoms. For such people some element of brief education, support and advice in the context of their presentation followed by watchful waiting may be most appropriate, with the individual either encouraged to return for further assessment or offered a specific appointment time if there is sufficient concern on the part of the general practitioner or the primary care team member.

- 2.6.4.1 Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual sufferers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month.

- In their immediate post-incident care of survivors and offer practical, social and emotional support to those involved.”
Psychological First Aid

- Advice re: eliciting social support and reducing avoidance re: challenging worries of talking and being involved in community activities

- How to give social support to others:
  - respect, time, listening, recovery;
  - and what interferes with this: rushing, giving own experience, saying they were 'lucky', acting as if they were 'weak', giving advice without listening.
  - Encouraging eliciting other support when it's not enough
  - Psychoeducation re: cognitive, emotional, social, physiological, negative and positive reactions
  - What does and doesn't help for all ages
TRiM (Greenberg, 2008)

- Originally operationalised with the Royal Marines in response to the identification of psychological injury related to stigma:
  - ‘a premature end to military career, or sign of weakness’

- Rolled out to other Armed Forces, and now Police Forces, Fire and Rescue Services, Ambulance Services, BBC Journalists
  - “TRiM is a proactive, post traumatic peer group delivered management strategy that aims to keep employees of hierarchical organizations functioning after traumatic events, to provide support and education to those who require it and to identify those with difficulties that require more specialist input.”
TRiM practitioners are trained and selected volunteers.

Training involves: psychological aspects of incident site management, how to plan for personnel's psychological needs after an event, how to conduct a semi-structured risk assessment interview and how to conduct basic psycho educational briefings. Personnel are also taught how and when to liaise with managers and medical/welfare staff.

“A TRiM assessment supports you. It is a personal, purely voluntarily attended, peer to peer, non-clinical discussion. A TRiM assessment aims to identify if you are normalising events, or alternatively if you are displaying signs of potentially needing additional support. A TRiM assessment is completed with you by a TRiM practitioner. The assessment will support your recovery and allow you to understand that your reactions are natural and normal. The TRiM practitioner will also assist you in signposting you to any further support.”

(Hampshire Fire and Rescue Service)

The assessment is +3-7 days post exposure to traumatic incidents and again 28 days later.
“Prior to its implementation, the British military conducted a randomized controlled trial of Trauma Risk Management against standard care in 12 warships; 6 were randomized to use Trauma Risk Management after collecting baseline measurements. Follow up after 12–18 months found no significant change in psychological health or stigma scores in either group; however, the studied vessels only encountered low numbers of critical incidents. Additionally, measurements of organizational functioning were modestly better in the Trauma Risk Management ships.” (Greenberg, et al., 2010)
MIND ‘Blue Light’ Programme

- Launched March 2015 with further funding in June 2017
  - Programme for employees
  - Managing Mental Health in the emergency services training
  - Infoline and information booklets on managing mental wellbeing, building resilience and where to go for support (order via website)
  - Webinar films
  - Blue Light Champions
  - Support for search and rescue teams
Early Interventions with Trauma-Focused Therapies

- The majority of RCTs focus on the outcomes of therapies rather than the optimum timing

- How do we assess whether people receiving earlier interventions would have recovered naturally or developed worse and more chronic symptoms?
Conclusions

- The UK screen and treat programmes following Manchester, Grenfell, London Bridge, Finsbury Park, Parsons Green, offer opportunities in improving our understanding.
- How can we maximise these?
- What should we be looking at?
- How do we work out the best practice?
- Social support versus trauma-focused psychological intervention: are they distinct?