

Mental-Health Intervention for Disasters

A National Center for PTSD Fact Sheet

The aim of all disaster mental-health management should be the humane, competent, and compassionate care of all affected. The goal should be to prevent adverse health outcomes and to enhance the well-being of individuals and communities. In particular, it is vital to use all appropriate endeavors to prevent the development of chronic and disabling problems such as PTSD, depression, alcohol abuse, and relationship difficulties.

Factors that Facilitate Positive Outcomes and Prevention

There is much evidence to suggest that a number of factors help to facilitate positive outcomes and prevention (Excerpted from Disaster Mental Health Response Handbook, NSW Health, 2000). These include:

It is crucial to recognize people's strengths as well as the suffering they have experienced. While survivors' suffering must be acknowledged, and compassion and empathy conveyed to them, it is also important that those who care for them believe in and support their capacity to master this experience.

Information and education help people's understanding and should be an integral part of the support and care systems. Preparation prior to disaster, information about what has happened, education about normal responses to such events, training in what to do to help psychological recovery, information centers and ongoing information feedback to affected communities, all help people's mastery and recovery.

Sharing the experience. Many people may display a need to tell the story of their experience, to give testimony, both to externalize it and obtain emotional release, and to gain understanding and support from others. This varies enormously. It may occur spontaneously as natural groups come together after the disaster. However, there will be others who may not feel ready or who may choose not to talk about their experience. Those involved in the mental health response should be aware of these variable needs and be supportive of what the survivor wants.

Supportive networks are critical and should be retained, reinforced and rebuilt. These networks help people in the ongoing recovery process, both through the exchange of resources and practical assistance, and through to the emotional support they provide to deal with the disaster and its aftermath. Community groups may develop to facilitate support, and should be encouraged.

Possible Obstacles to Seeking Help

Several studies have pointed out that following a terrorist event such as the Oklahoma City bombing, many of those in closest proximity to the disaster do not believe they need help and will not seek out services, despite reporting significant emotional distress (Sprang, 2000).

Sprang lists several potential reasons for this:

- **Some people may feel that they are better off than those more affected and that they, therefore, should not be so upset.**
- **Some may not seek help because of pride or because they think that distress indicates weakness of some sort.**
- **Some individuals may not define services they receive as mental-health intervention, especially if such intervention is unsolicited (e.g., lectures, sermons, discussions, community rituals). Indeed, because the goal of many disaster mental-health workers is to have interventions be a seamless, integrated part of an overall disaster effort, those who receive**

- **these services may not recognize them as mental-health interventions.**
- **Many individuals are more apt to seek informal support from family and friends, which may not be sufficient to prevent long-term distress for some.**

It is critical to address this hesitance about seeking help. Nearly half of the individuals studied who were directly exposed to the Oklahoma City bomb blast had an active postdisaster psychiatric disorder, with PTSD being diagnosed in 1/3 of the respondents (North et al., 1999). Major Depression was the disorder most commonly associated with PTSD. No new cases of substance abuse were observed, which is consistent with previous findings. Symptom onset of PTSD was rather immediate, usually within one or two days, and few other cases developed after the first month.

Crisis Intervention

Generally, there are three stages of intervention, each requiring a different level of involvement:

- Emergency phase: **the immediate period after disaster strikes**
- Early postimpact phase: **any time from the day after the onset of the disaster until approximately the eighth to twelfth week**
- Restoration phase: **marked by the implementation of long-term recovery programs, generally beginning at about the eighth to twelfth week after the disaster**

Initial Mental–Health Interventions

Initial mental-health interventions are primarily pragmatic, as reflected by the following stages:

Protect:

Find ways to protect survivors from further harm and from further exposure to traumatic stimuli. If possible, create a shelter or safe haven for them, even if it is only symbolic. The fewer traumatic stimuli people see, hear, smell, taste, and feel, the better off they will be. Protect survivors from onlookers and the media.

Direct:

Kind and firm direction is needed and appreciated. Survivors may be stunned, in shock, or experiencing some degree of dissociation. When possible, direct ambulatory survivors:

- **Away from the site of destruction**
- **Away from severely injured survivors**
- **Away from continuing danger**

Connect:

The survivors you encounter at the scene have just lost connection to the world they are familiar with. A supportive, compassionate, and nonjudgmental verbal or nonverbal exchange may help them experience a reconnection to the shared societal values of altruism and goodness. However brief the exchange, or however temporary its effects, such relationships are important elements of the recovery or adjustment process. Help survivors connect:

- **With loved ones**
- **With accurate information and appropriate resources**

- **With where they will be able to receive additional support**

Triage:

The majority of trauma survivors experience normal stress reactions. However, some may require immediate crisis intervention to help them manage intense feelings of panic or grief. Signs of panic include trembling, agitation, rambling speech, and erratic behavior. Signs of intense grief may include loud wailing, rage, and catatonia. If you see these signs of panic and grief, attempt to quickly (1) establish therapeutic rapport, (2) ensure the survivor's safety, (3) acknowledge and validate the survivor's experience, and (4) offer empathy. Medication may be appropriate and necessary.

It is necessary to be aware that the needs of individual members of a community may vary greatly. The following early intervention strategies can yield positive results:

- **Provide direct services as soon as is feasible after the event, which may require temporarily bringing in outside experts. However, it is of the greatest importance that needs assessment, planning, and service delivery be done in full coordination with local providers. Outside help should at no time be imposed; respectful, coordinated interfacing with local resources, however limited these may be, is essential.**
- **Empower local care-providers to assume increasing responsibility for delivering services in their community. This can be achieved by providing in-field training from the beginning of the intervention. Encouraging local providers increases professional self-esteem and helps local resources expand quickly.**
- **Work with key community figures and leaders, local media, and governmental institutions to make them aware of the benefits of early community-based interventions.**
- **It is important to recognize that care-providers from within a community may themselves be overwhelmed and/or traumatized. Therefore, ensure that comprehensive professional support and supervision are available for them so that they may also attend to their own mental-health needs.**

Basic Principles of Emergency Care

It is helpful to remember several basic principles or objectives of emergency care.

1. Provide for basic survival needs and comfort (e.g., liquids, food, shelter, clothing).
2. Help survivors achieve restful and restorative sleep.
3. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
4. Provide non-intrusive ordinary social contact (e.g., a "sounding board," judicious uses of humor, small talk about current events, silent companionship).
5. Address immediate physical health problems or exacerbations of prior illnesses.
6. Assist in locating and verifying the personal safety of separated loved ones or friends.
7. Reconnect survivors with loved ones, friends, and other trusted people (e.g., AA sponsors,

work mentors).

8. Help survivors take practical steps to resume ordinary daily life (e.g., daily routines or rituals).
9. Help survivors take practical steps to resolve pressing immediate problems caused by the disaster (e.g., loss of a functional vehicle, inability to get relief vouchers).
10. Facilitate resumption of normal family, community, school, and work roles.
11. Provide survivors with opportunities to grieve their losses.
12. Help survivors reduce problematic tension, anxiety, or despondency to manageable levels.
13. Support survivors' local helpers through consultation and training about common stress reactions and stress management techniques.

Debriefing

There are different types of debriefing:

- **Operational debriefing is a routine and formal part of an organizational response to a disaster. Mental-health workers acknowledge it as an appropriate practice that may help survivors acquire an overall sense of meaning and a degree of closure.**
- **Psychological or stress debriefing refers to a variety of practices for which there is little supportive empirical evidence. It is strongly suggested that psychological debriefing is not an appropriate mental-health intervention.**
- **Critical Incident Stress Debriefing (CISD) is a formalized, structured method whereby a group of rescue and response workers reviews the stressful experience of a disaster. CISD was developed to assist first responders such as fire and police personnel; it was not meant for the survivors of a disaster or their relatives. CISD was never intended as a substitute for therapy. It was designed to be delivered in a group format and meant to be incorporated into a larger, multi-component crisis intervention system labeled "Critical Incident Stress Management" (CISM). CISM includes the following components: pre-crisis intervention; disaster or large-scale demobilization and informational briefings (town meetings); staff advisement; defusing; CISD; one-on-one crisis counseling or support; family crisis intervention and organizational consultation; follow-up and referral mechanisms for assessment and treatment, if necessary.**

Currently, many mental-health workers consider some form of stress debriefing the standard of care following both natural (earthquakes) and human-caused (workplace shootings, bombings) stressful events. Indeed, the National Center for PTSD's Disaster Mental Health Guidebook (which is currently being revised) contains information on how to conduct debriefings. However, recent research indicates that psychological debriefing is not always an appropriate mental-health intervention. Available evidence shows that, in some instances, it may increase traumatic stress or complicate recovery. Psychological debriefing is also inappropriate for acutely bereaved individuals. While operational debriefing is nearly always helpful (it involves clarifying events and providing education about normal responses and coping mechanisms), care must be taken before delivering more emotionally focused interventions.

A recent review of eight debriefing studies, all of which met rigorous criteria for being well-controlled, revealed no evidence that debriefing reduces the risk of PTSD, depression, or anxiety; nor were there any reductions in psychiatric symptoms across studies. Additionally, in two studies, one of which included long-term follow-up, some negative effects of CISD-type debriefings were reported relating to PTSD and other trauma-related symptoms (Rose, Bisson, & Wesely, 2001). Therefore, debriefings as currently employed may be useful for low magnitude stress exposure and symptoms or for emergency care providers. However, the best studies suggest that for individuals with more severe exposure to trauma, and for those who are experiencing more severe reactions such as PTSD, debriefing is ineffective and possibly harmful.

The question of why debriefing may produce negative results has been considered and hypotheses have been formulated. One theory connects negative outcomes with heightened arousal in the early posttrauma phase and in long-term psychopathology (Shalev, 2001; Bryant, 2000). Because verbalization of the trauma in debriefing is limited, habituation to evoked distress does not occur. The result may be an increase rather than a decrease in arousal. Any such increased distress caused by debriefing may be difficult to detect in a group setting. Thus, attempting to use debriefing to override dissociation and avoidance in the immediate post-trauma phase may be detrimental to some individuals, particularly those experiencing heightened arousal. Another consideration is that the boundary between debriefing and therapy is sometimes blurred (e.g., challenging thoughts), which may increase distress in some individuals (Bryant, 2000). Finally, those facilitating the debriefing sessions frequently are unable to adequately assess individuals in the group setting. They may erroneously conclude that a one-time intervention is sufficient to prevent further symptomatology.

Practice guidelines on debriefing formulated by the [International Society for Traumatic Stress Studies](#) conclude there is little evidence that debriefing prevents psychopathology. The guidelines do recognize that debriefing is often well received and that it may help (1) facilitate the screening of those at risk, (2) disseminate education and referral information, and (3) improve organizational morale. However, the practice guidelines specify that if debriefing is employed, it should:

- **Be conducted by experienced, well-trained practitioners**
- **Not be mandatory**
- **Utilize some clinical assessment of potential participants**
- **Be accompanied by clear and objective evaluation procedures**

The guidelines state that while it is premature to conclude that debriefing should be discontinued altogether, "more complex interventions for those individuals at highest risk may be the best way to prevent the development of PTSD following trauma."

Timing of Follow-Up Services

The timing of interventions is central to the concept of secondary prevention of PTSD and other negative consequences. Early intervention implies that services will be delivered sometime before chronicity has developed. Unfortunately, almost no research has examined the effects of differential timing of treatment. Although it has been speculated that PTSD develops by means of neurobiological changes that take place in the first few days or weeks post-trauma, most theoretical models of PTSD do not explicitly address the timing of intervention. It would be helpful to examine how timing affects prevention and treatment, specifically in relation to the

processes of symptom worsening, maintenance, and remission. Psychological models focusing on processes of therapeutic exposure, cognitive restructuring, social support, coping, rumination, "working through," and so on have largely been mute as to whether there are critical periods during which initial symptoms remit or become chronic.

As stated above, in the Oklahoma City bombing, symptom onset of PTSD was rather immediate, usually within one or two days; few other cases developed after the first month. Because all the individuals in closest proximity to the Oklahoma City bombing who reported psychiatric symptoms also had PTSD, focusing on PTSD symptoms in other traumatic situations could identify most individuals needing referral to psychiatric care. This is consistent with results from a small sample of self-referred patients following the 1993 World Trade Center bombing in New York (Difede et al, 1997). These data indicate that avoidance and numbing symptoms may efficiently identify those who may be at risk for PTSD and other disorders. Early identification may be crucial, since data from the Oklahoma City bombing suggest that, of those who were in closest proximity to the bomb blast, 9 out of 10 individuals with PTSD were still symptomatic 6 months after the disaster. This indicates that the provision of ongoing treatment is essential. In the real world of service delivery, the timing of follow-up will also depend on a variety of other factors, including readiness of the survivor, the nature of the traumatic event and its effects, and the nature of the service delivery setting.

Survivor readiness—Some survivors may not attend preventive mental-health activities or pursue a mental-health referral early in the recovery process. This may be because they are busy coping with practical problems caused by the experience (e.g., finding housing, pursuing insurance claims, or undergoing physical tests and treatment) or because they do not feel ready to face the emotions that discussing the trauma will bring up. They may not recognize the need for services due to emotional "denial" or a lack of information about the purposes and practices of psychological counseling. Survivors also may not recognize the need for services because they may expect that their emotional reactions are short-term and will pass. Moreover, they may not yet be experiencing significant impairment; some survivors will experience a delayed onset of symptoms. Mental-health practitioners should be sensitive to these possibilities. Follow-up, re-screening, and repeated referrals will help ensure that patients receive referral information when they are better able to take advantage of it.

Nature of the traumatic event—The timing of follow-up services will also be determined in part by the nature of the trauma and its effects. For traumatic events that are characterized by sudden onset and termination, services may be delivered within a few weeks after the event and may be supplemented by occasional longer-term follow-ups if they are necessary and feasible. Other traumas involve extended periods of continuing exposure to severe stressors or negative consequences (e.g., loss of housing due to disaster, or medical treatment of a serious injury). Optimally, follow-up in such cases should be delivered for much longer than is necessary for the sudden onset and termination events. When possible, follow-up services should also correspond with times when trauma-related problems may be exacerbated, such as on the anniversary of a traumatic event. For example, episodes of terrorist violence often result in criminal trials long after the violent event has ended. Because these proceedings can be stressful

reminders of the original event, follow-up services delivered in conjunction with trial activities may be helpful for survivors.

Nature of the setting—Post-trauma service delivery settings vary greatly. MVA or assault survivors may be seen in traditional medical settings; rape survivors may seek help at community-based rape crisis centers; combat soldiers may be offered "forward psychiatry" close to the scene of the trauma itself; survivors of hurricanes or floods may be gathered together at community shelters. The nature of the setting will in part determine when, and with what intensity, follow-up services may be delivered. In some environments, routine, systematic, and adequately resourced follow-up with all survivors will be feasible. The nature of the setting will also influence who (mental-health professionals, medical personnel, paraprofessionals, or others) will deliver mental-health-related follow-up.

Who Should Receive Follow-Up Services?

All survivors should be given educational information to (1) help normalize common reactions to trauma, (2) improve coping, (3) enhance self-care, (4) facilitate recognition of significant problems, and (5) increase knowledge of and access to services. Such information can be delivered in many ways, including through public media, community education activities, and written materials. More intensive follow-up services should target subgroups of survivors who are at heightened risk for chronic or severe posttrauma problems. Such targeting is warranted for two major reasons. First, resources will often be limited, making it difficult to provide all survivors with costly services. Second, immediate posttrauma distress will remit naturally for many patients (Blanchard et al. 1996), and it may not be necessary to provide mental-health services to everyone. Hypothetically, it is even possible that too much focus on mental-health issues could induce iatrogenic symptoms in some survivors. Centering survivors' attention on symptoms and problems might make them believe that they are receiving help because they have more problems than they realize.

Ideally, by systematically screening all survivors, mental-health providers will identify individuals at significant risk for continuing problems. If such screening systems are not in place, identification can be based on a number of criteria, including: a referral by a trauma responder, self-referral, a severe level of trauma exposure (e.g., exposure to death and dying), a co-occurring injury, the level of co-occurring loss, and the role of the survivor (e.g., a disaster worker responsible for body recovery).

Content of Follow-Up Activities

The variety of appropriate follow-up activities may include education, screening, referral, and treatment.

Survivor and family education—As mentioned above, educating trauma survivors and their families may help normalize common reactions to trauma, improve coping, enhance self-care, facilitate recognition of significant problems, and increase knowledge of and access to services. First, survivors and families should be reassured about common reactions to traumatic experiences and be advised regarding positive and problematic forms of coping. Information about social support and stress management is particularly important. Second, opportunities to discuss emotional concerns in individual, family, or group meetings can enable survivors to reflect on what has happened. Third, education regarding indicators that initial acute reactions are failing to resolve will be

important, as will education about signs and symptoms of PTSD, anxiety, depression, substance use disorders, and other difficulties. Finally, survivors will need information about financial, mental-health, rehabilitation, legal, and other services available to them as well as education about common obstacles to pursuing needed services.

Follow-up screening—Early identification of those at risk for negative outcomes can facilitate prevention, referral, and treatment. Mental-health providers can screen for current psychopathology and risk factors for future impairment by using brief semi-structured interviews and standardized assessment questionnaires. Screening should address past and current psychiatric and substance use problems and treatment, prior trauma exposure, pre-injury psychosocial stressors, and existing social support. Event-related risk factors should also be assessed, including exposure to death, perception of life-threat, and peri-traumatic dissociation. Acute levels of traumatic stress symptoms are especially important because they predict chronic problems. For example, more than three-quarters of MVA patients diagnosed with Acute Stress Disorder (ASD) will have chronic PTSD at 6 months posttrauma (Bryant and Harvey 2000). In follow-up appointments, it will be important to continue to screen for PTSD and other anxiety disorders, depression, alcohol and substance abuse, problems with returning to work and other productive roles, adherence to medication regimens and other appointments, and the potential for retraumatization.

Referral—A crucial goal of follow-up activities is referral, as necessary, to appropriate mental-health services. In fact, the referral to and subsequent delivery of more intensive interventions will depend upon adequately implementing the follow-up screening. Screening, whether conducted in formal or informal ways, is what identifies those who need a referral. However, embarrassment, fear of stigmatization, and cultural norms may prevent some survivors from seeking help or pursuing a referral. Those making referrals can directly address these attitudes and try to preempt the avoidance of needed services; motivational interviewing techniques (Rollnick et al., 1992) may help increase the acceptance rate of referrals.

Treatment—Research suggests that relatively brief but specialized interventions may effectively prevent PTSD in some subgroups of trauma patients. Several controlled trials have suggested that brief cognitive-behavioral treatments (i.e., 4-5 sessions), delivered within weeks of the traumatic event and comprised of education, breathing training/relaxation, imaginal and *in vivo* exposure, and cognitive restructuring, can often prevent PTSD in survivors of sexual and nonsexual assault (Foa et al., 1995). Cognitive-behavioral treatments can also prevent the occurrence of PTSD in survivors of motor vehicle and industrial accidents (Bryant et al., 1998, 1999). Brief intervention with patients hospitalized for injury has been found to reduce alcohol consumption in those with existing alcohol problems (Gentilello et al., 1995). Controlled trials of brief, early intervention services targeting other important trauma sequelae (e.g., problems returning to work, depression, family problems, trauma recidivism, and bereavement-related problems) have not yet been conducted, but it is likely that

targeted interventions will be effective in these areas for at least some survivors. Treatment of Acute Stress Disorder (ASD) is indicated for the small proportion of people at risk for developing long-term PTSD. While the field of treatment for ASD is still young, two well-designed studies offer evidence that brief treatment intervention, utilizing a combination of cognitive-behavioral techniques, may be effective in preventing PTSD in a significant percentage of subjects. In their study of a brief treatment program for recent sexual and nonsexual assault victims, all of whom met criteria for PTSD, Foa, Hearst-Ikeda, and Perry (1995) compared repeated assessments with a Brief Prevention Program (BPP) composed of four sessions of trauma education, relaxation training, imaginal exposure, *in vivo* exposure, and cognitive restructuring. Two months posttrauma, only 10% of the BPP group met criteria for PTSD, whereas 70% of the repeated assessments group met criteria for PTSD. In a study of motor vehicle and industrial accident victims who met criteria for ASD, Bryant, Harvey, Dang, Sackville, and Basten (1998) compared five sessions of nondirective supportive counseling (which provides support, education, and problem-solving skills) with a brief cognitive-behavioral treatment (which involves trauma education, progressive muscle relaxation, imaginal exposure, cognitive restructuring, and graded *in vivo* exposure to avoided situations). Immediately posttreatment, 8% in the CBT group met criteria for PTSD versus 83% in the supportive counseling group. Six months posttrauma, 17% in the CBT group met criteria for PTSD versus 67% in the supportive counseling group. One important caveat to this study is that the dropout rate was high, and the authors concluded that those with more severe symptoms may need supportive counseling prior to intensive cognitive-behavioral interventions.

In addition to targeted, brief interventions, some trauma survivors may benefit from ongoing counseling or treatment. Candidates for such treatment include survivors with a history of previous traumatization (e.g., survivors of the current trauma who have a history of childhood physical or sexual abuse) or those who have preexisting mental health problems.

Empirical Evidence Regarding Behavioral Treatments for PTSD

The trauma treatment research field is still young, and treatment research can be complicated and difficult to conduct. Because of this, comparisons of different treatments for PTSD are scarce; therefore, a lack of empirical evidence in the literature does not necessarily signify a lack of treatment efficacy. The current process by which trauma experts evaluate treatment options is to study the empirical literature and take into account clinical consensus on treatments that have proven effective in case studies or across clinical settings. The choice of a treatment modality is based on many factors, including unique client life challenges; side effects and potential negative effects; cost; length of treatment; cultural appropriateness; therapist's resources and skills; client's resources and stressors; co-morbidity of other psychiatric symptoms; the fluctuating course of PTSD; the need to foster resilience; and legal, administrative, and forensic concerns.

While there is limited empirical literature on which to base comparisons of alternative treatment methods, a number of treatment approaches have gained empirical support. Some of these treatments have shown promising results across a number of different settings and with different trauma populations. They are available within VA hospitals and merit attention when considering referral options. Listed below are some treatments that have gained empirical

support (Friedman, 2000):

Cognitive-Behavioral Therapy (CBT)

There are more published well-controlled studies on CBT (over 30) than on any other PTSD treatment. CBT treatments for PTSD include:

- **Exposure therapy, in which patients are asked to describe their traumatic experiences in detail, on a repetitive basis, in order to reduce the arousal and distress associated with their memories**
- **Cognitive therapy, which focuses on helping patients identify their trauma-related negative beliefs (e.g., guilt or distrust of others) and change them to reduce distress**
- **Stress-inoculation training, in which patients are taught skills for managing and reducing anxiety (e.g., breathing, muscular relaxation, self-talk)**

CBT treatments usually involve some combination of the above methods combined with education about PTSD and the development of a good therapist-patient relationship. Other CBT treatment methods may be added to address related problems, such as anger (anger management training, assertiveness training) or social isolation (social skills training, communication skills training).

In general, cognitive-behavioral methods have proven very effective in producing significant reductions in PTSD symptoms (generally 60-80%) in several civilian populations, especially rape survivors. However, the degree of symptom reduction is likely to be somewhat less in veterans with chronic combat-related PTSD. Nevertheless, the magnitude and permanence of treatment effects appears greater with CBT than with any other treatment.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR involves having the patient bring to mind images of the trauma while engaging in back-and-forth eye movements (or while alternating one's attention back and forth using taps or sounds). It also addresses trauma-related negative beliefs. It has been shown to be more effective than psychodynamic, relaxation, supportive, or placebo wait list therapies (where patients are put on a waiting list to receive treatment but don't actually receive it by the time they are tested). Research comparing EMDR to the more generally accepted cognitive-behavioral techniques shows significantly better results with CBT than with EMDR, particularly at three-month follow-up. CBT results also show greater sustainability. Research looking at the different components of EMDR shows that the eye movement component adds no additional treatment effect to the imagery exposure and the process of dealing with negative beliefs.

Psychodynamic Therapy

Research on the use of psychodynamic therapy is difficult to conduct because psychodynamic techniques do not focus on symptom reduction. Instead, they focus on more fluid intra- and interpersonal processes. To date, there has been only one randomized clinical trial on the efficacy of psychodynamic treatment in reducing PTSD symptoms. In this trial, 18 sessions of Brief Psychodynamic Psychotherapy were shown to effectively reduce PTSD intrusion and avoidance symptoms by approximately 40%, and improvement was sustained for 3 months. While clinicians often support the utilization of psychodynamic techniques in the treatment of trauma, particularly in the treatment of more complex trauma, much more research is needed to demonstrate the techniques' effectiveness with PTSD.

Group Therapy

While various studies have shown most group treatments to have beneficial effects with respect

to psychological distress, depression, anxiety, and social adjustment, there have been few rigorous tests of group treatments relating to PTSD symptoms. Three studies of CBT group treatments (including Cognitive Processing Therapy, Assertion Training, and Stress Inoculation Therapy) have been conducted with women traumatized by childhood or adult sexual abuse. All PTSD symptom clusters were reduced 30-60%, and improvement was sustained for six months. One CBT group treatment for combat veterans showed a 20% reduction in PTSD symptom severity. One study of psychodynamic group treatment found an 18% reduction in PTSD symptoms among women with PTSD due to childhood sexual abuse. One controlled trial of supportive group treatment for female sexual assault survivors showed a 19-30% reduction in intrusion and avoidance symptoms, which was maintained for six months.

Inpatient Treatment

There have been no satisfactory studies on inpatient treatment for PTSD and trauma-related conditions. However, clinical consensus agrees that inpatient therapy is appropriate for crisis intervention, management of complex diagnostic cases, delivery of emotionally intense therapeutic procedures, and relapse prevention.

Marital and Family Therapy

There have been no research studies done on the effectiveness of marital/family therapy in treating PTSD. However, because of trauma's unique effects on interpersonal relatedness, clinical wisdom indicates that spouses and families ought to be included in the treatment of those with PTSD. Of note, marriage counseling is typically contraindicated in cases of domestic violence, until the batterer has been successfully (individually) rehabilitated.

Social Rehabilitative Therapies

While social rehabilitative therapies (i.e., teaching social, coping, and life function skills) have been proven effective for chronic schizophrenics and other groups of persistently impaired psychiatric individuals, they have yet to be formally tested with PTSD clients.

Since these therapies appear to generalize well from clients with one mental disorder to clients with another, it is reasonable to expect that they will also work with PTSD clients. There is clinical consensus that appropriate outcomes would be improvement in self-care, family functioning, independent living, social skills, and maintenance of employment.

Hypnosis

While research on the use of hypnosis with trauma survivors indicates very little improvement in trauma symptoms, clinical consensus indicates that it can be helpful as an adjunctive rather than primary treatment, especially with dissociation and nightmares.

Creative Therapies

There is currently no controlled evidence on creative therapies (art, drama, music, body-oriented therapies). Some clinicians believe that such therapies are uniquely fitted to address specific somatic manifestations of trauma (i.e., sensory defensiveness, somatic memories, etc.). Caution is recommended in the use of somatic treatments, especially regarding the need to maintain physical safety and appropriate professional boundaries; therefore, it is important that therapists are well trained in this modality.

Maximizing Follow-Up Services

Experience indicates that relatively few survivors of many types of trauma make use of available mental-health services. This may be because survivors (1) are unaware that such services are available, (2) do not perceive a need for them, (3) lack confidence in the services' utility, or (4) have negative attitudes toward mental-health care. Therefore, those planning follow-up and outreach services for survivors must consider how best to reach trauma survivors and how to

educate them about sources of help. It is also important to think about how to market these services to the intended recipients.

In the chaos following some kinds of traumatic events (e.g., natural disaster), it is important that workers systematically obtain detailed survivor contact information to facilitate later follow-up and outreach. In addition, it is important that those providing outreach and follow-up services actively approach survivors wherever they congregate. Each contact the survivor has with the system of formal and informal services affords mental-health workers an opportunity to screen for risk and impairment and to intervene appropriately. Settings that provide opportunities for contact with survivors are diverse and include remembrance ceremonies, self-help group activities, settings where legal and financial services are delivered, and interactions with insurance companies. For survivors injured or made ill during the traumatic event, follow-up medical appointments are also opportunities for reassessment, referral, and treatment. For further information on Disaster Mental Health Interventions, please refer to the [Disaster Mental Health Services Guidebook for Clinicians and Administrators](#).

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