Emergency Intervention for Acute Traumatic Stress

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Victims of trauma who have been injured or psychologically overwhelmed often present for emergency services. In these circumstances emergency mental health clinicians are called on to treat not only the victim, but also the victim's family and friends. This column focuses on the emergency treatment of the patient and his or her family and friends following a single acute trauma. It does not address the complexities of treating multiply traumatized patients.

Normal coping responses

Responses to stress result from complex interactions between the nature of the stressor, the person's ability to cope, and the availability of social support. According to Lazarus (1), coping is a threat-appraisal process that comprises three distinct components—primary appraisal, or perceiving the threat; secondary appraisal, or bringing to mind a potential response to the threat; and coping, or executing a response. Coping may be problem focused, attempting to change the relationship between the person and the environment, or emotion focused, aimed at reducing emotional distress. The inability to cope with a stressful event typically results in feelings of helplessness and emotional distress.

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Horowitz (2) described the early response to stressful events as alternating between denial and intrusive thoughts leading to the eventual integration of the trauma into a person's life. He considers intrusive thoughts following trauma to be nearly universal and part of a normal process of reappraisal of the threatening experience. If emotional processing is not successful, intrusive thoughts and subsequent avoidance persist. Treatment aims at assisting patients with reframing their cognitive appraisal so they no longer feel helpless or frightened and with facilitating and supporting emotional processing until the traumatic event is integrated into enduring schemas about self and others.

Three faces of posttraumatic distress

When faced with life threats people respond with "survival-mode" functioning, characterized by the activation of specialized cognitive-affective mechanisms organized as flight, fight, or freeze behaviors (3). In addition, needs for social support are increased. Survival-mode functioning is adaptive in the context of a threat. However, once the threat has passed, continued functioning in a survival mode is maladaptive.

We propose that the clinical presentation of a traumatized patient is due to the persistence of the patient's primary survival response. High levels of anxiety and avoidance are associated with flight responses; increased anger and aggression represent the persistent mobilization of a fight response; and dissociative symptoms, emotional numbing, or depersonalization reflect freeze responses (3).

Patients with anger and anxiety readily attract attention and therefore often receive treatment interventions in the emergency room. In contrast, patients with dissociative or numbing reactions are quiet and withdrawn. Although they may not elicit mental health intervention, these patients are at high risk for developing posttraumatic stress disorder (PTSD) (4,5), and special vigilance to their needs is required.

Emergency intervention

An important aspect of acute intervention is to help the patient recognize that the danger has passed and to understand that many of the current symptoms reflect the persistence of survival responses that are no longer necessary. We propose a five-step acute intervention to assist survivors of traumatic stress: restore psychological safety, provide information, correct misattributions, restore and support effective coping, and ensure social support. This intervention aims at facilitating cognitive and emotional processing of the traumatic event and at improving coping.

Restore psychological safety. Because self-protection is the underlying motive that maintains the survival mode and its behavioral and cognitive concomitants (3), the first step is to help the patient recognize that the danger has passed and that he or she is now safe. It is useful to affirm for the patient that it is "over, you are safe now." Physical comforting from family and friends may help calm the patient. The patient who remains highly aroused or anxious may benefit from short-term treatment with benzodiazepines to reduce the sense of persistent fear and thus permit engagement in cognitive and emotional processing and improve coping.

Provide information. Attending to the patient's urgent needs for accurate

information about his or her medical condition, the status of others, and details of the event decreases immediate tension and may be important in long-term adjustment (6,7). Because trauma often results in an idiosyncratic understanding of the events, factual information can correct misperceptions and provide a cognitive map for understanding what happened.

Correct misattributions. Survivors of traumatic events frequently think of themselves and of the event in catastrophic terms. ("I've lost everything," or "It's all my fault.") The patient may suffer from feelings of guilt for real or perceived errors that caused the trauma. Helping the patient recognize the catastrophic nature of such beliefs, correct cognitive errors, and explore the experience more realistically decreases anxiety, guilt, and anger.

Restore and support effective coping. Talking realistically about the trauma and emotional responses supports coping. Psychoeducation for the patient and the patient's family and friends about normative responses to trauma can help restore the patient's sense of psychological competence and can allay fears about being "crazy" or "out of control."

The patient's friends and family need to understand that their support is an essential component of the patient's ability to cope and recover. They should be helped to develop strategies to provide necessary social support. Statements by family and friends validating typical trauma responses may decrease the patient's shame or fears and allow the patient to accept support. Potential problems with arousal, irritability, sleep, memory and recall, intrusive thoughts, nightmares, avoidance, and numbing (8) and the possible need for further treatment should be discussed. The patient should be encouraged to be an active participant in his or her medical and mental health care and to help the clinician in assessing his or her coping skills and access to community resources.

Ensure social support. In addition to the support from family and friends, referrals to appropriate community agencies, self-help groups, and outpatient mental health treatment are needed to ensure ongoing social support. Referrals should include assistance with concrete needs such as shelter, protection, and food.

Dissociative responses

Patients who dissociate have difficulty engaging in treatment due to impairments in concentration and attention. Grounding strategies, such as having the patient walk about the room and touch items, and maintaining eye contact with the patient help to reinforce that he or she is out of danger in the hospital and may help with reintegration. Once the patient is able to recognize that he or she is safe and no longer relies on dissociation, other responses such as anxiety or anger may appear. The clinician should then proceed with the five-step intervention while continuing to assess for dissociation, using grounding strategies, as needed.

Intensive treatment

The emergency mental health clinician must make decisions about whether inpatient or outpatient care is appropriate. These decisions are complex, involving multiple factors such as patient safety, patient dangerousness, severity of illness, availability of support systems, and the patient's ability to cope. The patient's ability to cope should be a key factor in determining the level of care (9).

The decision about the appropriate level of care warrants careful consideration of the response of both the patient and the patient's family and friends to the acute interventions. Patients who remain in survival-mode functioning and who are unable to summon effective coping skills require intensive interventions in a crisis unit or inpatient facility. Patients who respond to acute interventions may be discharged to outpatient care and social support. However, if the patient's family and friends or other community systems are unable to provide effective ongoing support, the patient may need a stabilization period in a crisis unit or hospital. Traumatized patients who remain dissociated, have amnesia, or experience fugue states warrant more intensive intervention in a protected environment.

Conclusions

The structured strategy for supportive psychotherapy for the acutely traumatized patient described in this paper is based on a heuristic model of human responses to threat. This approach aims to restore psychological safety through supporting normal processes of reappraisal and thereby reducing avoidance, which is an important factor in the persistence of PTSD (10). Providing information about the event and about normative human responses to overwhelming stress, as well as ensuring access to social supports, helps the patient move from a position of fear and helplessness to a state of psychological competence and coping. ♦

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