

Early Intervention Following Trauma

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Abstract

People who experience traumatic incidents usually demand the following: early organised help that has an outreach focus and help that provides them with information regarding what has happened, what they can expect for the near future and about usual reactions. They want help for their children, and they want help that lasts over time. User involvement, partnership and informational exchange more than informational transfer will be part of trauma services in the future. Unfortunately within the mental health field a "myth" that early intervention is of little benefit and actually may harm people has been established. This is in sharp contrast to the needs expressed by traumatised people. Although the new "myth" with its resulting debate may help us to critically review the responses undertaken to help people following traumatic events, there is also the danger of "throwing the baby out with the bath-water". In this presentation this "myth" will be challenged, and sensitive outreach efforts to help families facing trauma will illustrate the benefit of early intervention. However, it will be emphasised that early intervention needs to be well organised and contain more than just providing comfort and a chance to come together. The continuum of services must include immediate intervention, psycho educational intervention and more specific trauma therapy for those in need

What help do people want following trauma?

I started my career in a paediatric hospital helping families following the diagnosis of childhood cancer. Many of the parents had, at this time back in the late 1970s, gone from one doctor to another concerned about their child's symptoms often being told it was nothing. Many mothers felt they were viewed as hysterical. My mentor, the leading oncology paediatrician ingrained in me: "Always listen to the mother. She knows her child best and if she says there is something wrong, there is". For 25 years I have worked to better the situation for families who lose children, based on the feedback from the families on the kind of help they find important in the follow-up period. This "consumer based" strategy was reinforced some years ago when we conducted a country-wide assessment of parents who lost children due to suicide, accident and Sudden Infant Death (SIDS). My wife was the primary researcher and the results have been published internationally (Dyregrov, Nordanger & Dyregrov, 2003). We found that bereaved family members wanted the following: a) early help, b) outreach help, c) information about the event and potential reactions and guidance in important questions, d) possibility to meet with others who experienced the same or a similar situation, e) repeated statements about the possibility of further help as time unfolds, f) qualified and competent help, g) flexible and individually tailored help, and h) help over time and stability in helpers involved.

Based on this study we concluded that in order to secure that immediate and proper follow-up is provided in a coordinated manner, both following day-to-day trauma and crisis situations, and following major disasters, structures have to be in place to coordinate the follow-up and to secure appropriate help.

In our studies (Dyregrov, Nordanger & Dyregrov, 2000; Nordanger, Dyregrov & Dyregrov, 2003), we have found that when the following structures exist in a community, people are best cared for: a) a formalized plan of action for both immediate and long-term support, b) a coordinator for intervention activities, c) a local crisis team, d) written procedures for what needs to be done.

What people want in many ways perfectly match the hallmarks of what for years have been regarded as good crisis intervention with its principles of immediacy, proximity and expectancy, apart from the emphasis on help over time expressed by those who experience a crisis. The families' highlighting of help over time is important though, as it reflects the fact that many family members experience considerable problems over time, both individually and also in family functioning. Although the need for follow up over time is most evident following sudden death, several trauma situations (i.e., hostage situations, rape, violent robbery) lead to reactions with a prolonged time course where the needs for follow-up exceed the time frame originally believed necessary within crisis intervention.

Damned if you do, damned if you don't

Here is our dilemma in early intervention: We run the risk of sensitising people by focusing on possible reactions, we run the risk of contagion if we let them spend time together, we can be criticized for medicalising normal reactions, and we may interfere with normal recovery, when we intervene early. By not doing anything we may create secondary wounds, we may miss an opportunity to let people benefit from intervention strategies, and we may not prevent undue suffering, PTSD or other untoward consequences of potentially traumatising events. I think that emotional first aid should be part of early intervention conducted by the first response helpers who meet people in crisis or following trauma. Mental health professionals cannot and should not be used following all critical events. When to intervene must be based on a weighting of the mentioned dangers and benefits involved, and seek to minimise the chance of doing harm. My suggestion is to involve mental health professionals where there is a documented high percentage who become intensely distressed or go on to develop PTSD, complicated grief reactions of other trauma-related consequences. This will never be an exact science and based on present research the following groups should be targeted:

- Sudden deaths due to accidents, suicide, murder, and illness (untimely age)
- Violence that represent a threat to life (rape, torture, hostage situations)
- Life-threatening accidents (perceived by survivor).

In such situations a mental health intervention should be family based and involve children, and follow guidelines outlined elsewhere (Dyregrov, 2001).

Unfortunately the debriefing debate and recent advice to wait with providing help makes helpers very unsure about what to do, and as this debate has become part of the public domain, people who might benefit from help can become reluctant to seek it out. The randomised controlled studies that often are quoted are of dubious quality. However, the methodological procedure is a strong one and very much what is regarded as the gold standard in much medical research. However, while such studies are well designed to use in testing new medicine, it has its own flaws and may prove of much less value within psychology. The randomised controlled studies in the debriefing area are to me a good example of how a perfectly sound methodological procedure may test out clinically methods of low quality. Such studies are well designed to test out methods that follow a well-defined protocol, but the problem is that crisis situations demand a very flexible approach to

those who have survived, lost loved ones or provided help in the situation. It is when we use methods in an inflexible way that we run the risk of harming people. By forcing people to talk about thoughts and feelings while they as persons or a group are inclined not to do so we tamper with natural recovery. Our work should be to assist normal recovery not hinder it. A new review of the early psychological intervention area to be published in November by McNally, Bryant and Ehlers (2003), although giving too much weight to poorly designed clinical interventions in the debriefing area, is a step forward in its focus in its emphasis on doing something in the early aftermath of trauma, emphasising some of the same elements that I do within this presentation. There may be a growing consensus on early intervention issues, especially on the need to learn more. On a personal note, however, I want to say that it has been disappointing to see how many influential researchers and clinicians, known for their expertise in therapy have been spokespersons who guard against early intervention, an area where they have much less expertise.

Years ago the police called in the middle of the night and requested my presence at a local station following the shooting and killing of a man. I was quickly briefed and told that they had required the medivac helicopter because the mother of the person shot had asthma and was hyperventilating. The mother, a police officer and three more family members were present in an adjoining room. Walking into the room, I definitely felt unsure about what to do but knew that experience gives you the capacity to stay calm, quickly assess the situation, and do something. Confidence is important and it is contagious and reduces anxiety. In this particular situation the mother was hyperventilating and the policeman who held around her and patted her back did the right thing, but he quickly vanished from the situation due to the intense unpleasantness of it, as he told me later. The first thing she said was: "I am so afraid". The fear was not of another murder but a deeply felt existential fear. I continued stroking her back as the police officer had done while asking her softly into her ear how she got notified. For every answer I asked another factual question bringing her away from her emotions. Gradually as she was distracted from her deep fear, she calmed down, and we could sit down and hear how the other family members present had learned about what happened. From this we moved on to plan what should happen in the first days to come. Two days later I met with almost 15 family members, children and adults, to talk about what happened and prepare for viewing the body and stimulate open communication about an event that was difficult to deal with and to talk about.

Should we wait until problems develop?

It is being more frequently argued that one should withhold intervention following trauma, let natural healing take its course and then at a later time point screen to identify those in need of help (Brewin, Rose & Andrews, 2003). As you probably have understood I do not abide by this for all events. I do agree that we cannot intervene after every critical event that happens, but we do need to provide outreach help to everyone who experience events that are known to produce traumatic after-effects in many people, events such as those mentioned above. One of the most prominent psychiatrists in Norway publicly stated that following trauma one should not provide expert help but let the usual social support mechanisms help people, they had always been enough to help people before. I wish we could hide our heads in the sand like this, but the reality that is presented to us in clinical encounters with families is very different from this. So many families experience that while their social support system is readily available and helpful early on, many soon feel they are left alone and learn that they better not raise the subject of what they have been through if they are to hold on to their family and friends. This may reflect social changes in society,

but regardless of the cause they are real, and whether we want or not professionals play a more important role than before in people's lives. Unfortunately we are often the only persons that people can turn to over time to talk about the most important event that has happened in their or their family's life.

Following a traumatic death, verbal expression about the traumatic details surrounding the death may be less subjected to expression (censoring oneself) or, if expressed lead to social withdrawal in one's social network. Social interaction is complex and not straightforward and subtle facial expressions of emotions serve as cues that regulate social interaction. If recipients of distress expression respond negatively, the bereaved may feel misunderstood, rejected, embarrassed or betrayed (Kennedy-Moore & Watson, 2001). Emotional expression does not happen in a vacuum and the interpersonal consequences of expression cannot be easily predicted. The mixed results found for the benefit of expression can better be understood against this background. Research on social support following crises has previously shown that this is a complex area where the social network can be both harmful and helpful in their response to the crisis (Lehman, Ellard & Wortman, 1986; Range, Walston & Pollard, 1992). We who work to support and help people who experience critical events must improve our ability to guide people on how they can communicate their distress in a socially skilled manner to enhance the likelihood of receiving support.

It is obvious; however, that we need better methods to screen those in need of further help. It is promising that psychometric methods are being developed that would help us to improve screening, and funnel scarce mental health resources to those who need it the most. Brewin and co-workers (2002) have recently introduced a promising short instrument for use with adults for the early identification of PTSD, and Winston, Kassam-Adams, Garcia-Espana, Irrenbach and Cnaan (2003) have developed an instrument helpful in screening those at risk for persistent posttraumatic stress in injured children. This child instrument can easily be used during acute care and possibly could be used following other traumatic circumstances as well.

And reactions for many do last over time. Especially following traumatic death it is a myth that people recover from such events over the course of the first year. Shirley A. Murphy and her colleagues in Seattle, USA has investigated the long-term effects (over 5 years) of a violent death of a child (accident, homicide, suicide) and found that 5 years after the death 61 % of the study mothers and 62 % of the study fathers met diagnostic criteria for mental distress, and 27.7 % of the mothers and 12.5 % of the fathers met diagnostic criteria for PTSD (Murphy, Johnson & Lohan, 2002; Murphy, Johnson, We et al., 2003). These rates are two to three times higher than scores obtained from normative samples of adults in the same age range. Importantly, although their report on psychological health indicate great distress, by 3 to 4 years after the deaths parents believe that they are functioning normally even though numerous parents told the investigators that they are reminded of the deaths of their children daily. The researchers state that data suggests that the parents' points of reference shift over time and the sense of what is "normal" is lost because it has not been experienced for so long. Dyregrov and her colleagues (Dyregrov, Nordanger & Dyregrov, 2000; Dyregrov 2002) also found grave consequences of losing a child to suicide, accidental death and SIDS. As many as 34 - 52 % scored above cut-off points (> 35) on the Impact of Event Scale, 57 - 78 % above the cut-off score on the Inventory of Complicated Grief (> 25) and 31 to 65 % above cut-off points for psychological distress (GHQ > 6).

The picture that emerges from newer research is that sudden and especially violent deaths cause more stress, distress and trauma than other types of death (Kaltman & Bonanno, 2003). The need for structured interventions that can help alleviate distress and trauma is particularly important for this group of parents and their families. There is little reason to wait until problems develop; rather early contact is what they want and what we should provide.

Preventing maladaptive interpretations following trauma

Recent theoretical formulations about trauma and PTSD have emphasised the importance of the interpretation of reactions, symptoms and other people's responses following traumatic events. The influential cognitive theory of Anke Ehlers and David Clarke (2000) postulates that persistent PTSD occurs when people process the traumatic event in ways that lead to a sense of being under continuous threat. This sense of threat originates from negative appraisal of the trauma and its sequelae and disturbances in autobiographical memory. Dissociation during the event contributes to the poor contextualism and elaboration that characterize memory disturbances in people with PTSD. The role of fear and catastrophic interpretation of reactions are thus hypothesized to play an important part in the trauma cycle.

Ehlers and her colleagues have provided empirical support for this model and shown that excessive negative interpretations of traumatic events, initial PTSD symptoms, and trauma-induced changes in self are correlated with both PTSD severity and persistence in persons who have experienced different forms of trauma (Dunmore, Clarke, & Ehlers, 1999; Ehlers et al., 1998, Ehlers, Boos, & Maercker, 2000; Ehlers, Mayou, & Bryant, 1998). Others have also provided support to a cognitive model (Laposa & Alden, 2003) indicating that cognitive processes play a key role in PTSD. Recently cognitive variables such as global beliefs about life, the world and the future, and threatening interpretations of grief reactions each explained a unique proportion of variance in traumatic grief symptom severity, over and above background and loss-related variables (Boelen, van den Bout, & van den Hout, 2003).

Hindering negative interpretations of the event and its consequences should therefore be a viable strategy for preventing PTSD, other posttraumatic problems and complicated grief reactions. This is not only important for direct victims, but for helpers as well. Laposa and Alden (2003) in a study that examined the cognitive model in emergency room personnel concludes that targeting symptoms early is important as the rescue workers reporting moderate to high levels of trauma-related distress at initial assessments continued to experience it one and a half year later. As helpers usually are better trained, have more experience with, and work within supportive systems, early mental health interventions is not required for mildly upsetting events. The following example illustrates how reactions may be interpreted in a negative manner.

A 15 year old girl who was present when her father had a fatal heart attack at home was terrified at being alone in the house following the death. Her mother sought help for her some months following the death as this made it hard for the girl to lead a normal life. It turned out that she was very afraid of experiencing the presence of her father in the room and that he would place his hands on her shoulder. Her fear came from an interpretation of sensing his presence, a relatively common experience among bereaved. Due to her young age she had no experience with death and she had never heard of such experiences before. Early psychoeducational information would probably have prevented or reduced her fear.

The interpretations of emotional, behavioural, bodily and cognitive reactions and of other people's responses are very important in how people function and give meaning to traumatic events. This varies across cultures, i.e. among Khmer refugees culture-specific accounts of somatic sensations appear to play a role in the escalation of anxiety in response to somatic symptoms of anger common in those with PTSD (Hinton, Hsia, Um & Otto, 2003). It follows from Ehlers and Clarke's work that if these cognitive misinterpretations can be prevented before they get ingrained in people (and their behaviour) it would prevent PTSD. If already underway the focus is on changing maladaptive thought patterns and behaviour.

One of the other influential newer theories about trauma and PTSD is Brewin's (2001) dual attention theory. Brewin postulates two different memory systems, one called verbally accessible memory (VAM) and the other situationally accessible memory (SAM). While the first system uses the verbal mode and contains easily accessible information that can be communicated to others and integrated in one's autobiographical memory, the SAM system is containing perception based information based on the different sensory channels. Information is not verbally encoded and is harder to communicate to others and to integrate in autobiographical memory. The VAM system relies on reliable hippocampus functioning, and as this functioning may deteriorate under high levels of stress, memories of trauma may become fragmented and less time-ordered. The SAM system is less affected by levels of stress and so sensory based memories may be strong while not easy to give words. However, to be adaptively integrated in autobiographical memory, the sensory memories must be transferred to the VAM system. Flashbacks are believed to be one way of gradually allowing SAM memories into the VAM system then to be integrated in memories of past and present. Therapy is a quicker way to help this process. The question regarding early intervention is whether it is possible to speed this integration or information transfer by forcing sensory memories into words.

Four boys played hide and seek on a building site. Three of them were 11 years of age and one was 5 ½ (the brother of one of the others). The youngest boy hid under a heavy stone that started to move and before he managed to get away he was crushed to death. The head and hands of the boy were not covered by the stone and it was a horrible sight for the boys to take in. His blood was pressured into these body parts by the weight. The boys called for help and adults soon arrived to help, but the stone was so heavy that four adult men could not lift it. The local crisis team met with the families and instigated help at the school the day afterward. Two days after the death I met with the boys and most of their parents. They had had strong intrusive images since the accident and slept very poorly. Going through what happened in detail, parents could fill in on what had happened after the ambulance came and the boys had been taken away from the scene. It became clear that the boys wanted more information from the ambulance crew and we decided to arrange a meeting later for this purpose. The boys were asked specifically what they had seen, heard and touched during the accident. As the visual intrusions had been plaguing them since the event, these sensory impressions were covered in great detail, asking for how the head and hands looked. Following this the boys were given specific suggestions on what they could do to take control with these intrusive images, in the form of screen techniques. Two of the boys have been seen individually for some sessions, not for intrusive images, but for problems either dating back to before the event.

Should one have waited with early intervention until problems had become ingrained? A debriefing procedure was followed but sensitively attuned to the situation. Apart from intervening for the children, parents were advised on how they could help their other children and sessions continued over time. By this early timely, tailor-made intervention the children hopefully transferred their sensory-based memories to a verbal mode that made it easier to integrate in their autobiography. Although being able to back it with empirical data it is my experience that when one person is able to find words to express his or her sensory impressions, these words are accessible for others to use at the same time.

Unlike some other countries where professionals first meet traumatised people when they develop problems, I often meet them very close in time to their traumatic experience. Based on this experience I early came to hold a survival view of traumatic responses. They are primarily adaptive and serve to secure our survival. A sharpened intake of sensory information, coupled with access to previous experience, rapid mental processing, and numbing of emotional responses maximises the chance of survival under threat (Dyregrov, Solomon & Bassøe, 2000). This survival mode as Chemtob, Roitblat, Hamada, Carlson and Twentyman (1988) termed it do lead to an unusual experience for most people, with changes in time perception, a sense of unreality often followed by intrusive recollections and a sense of heightened danger. People also respond in ways they do not expect and are faced with decisions they never have experienced before. However, from a professional viewpoint both the immediate responses and the ensuing consequences often are easily understood, be that the questioning of one's own thoughts and responses that secure learning from events, or the increased vigilance and anxiety that secure a rapid response if a similar situation should arise. Misinterpretations of reactions, undue blaming and other untoward consequences are common and makes it important to reach out to affected individuals, families or groups. I see early intervention as important in preventing wrong interpretations of this uncommon state of experience, i.e., to counteract that people take on too much responsibility because of an altered time sense, blame themselves for not reacting enough, and continue to believe themselves to be under threat. These very early responses can be counterbalanced with timely responses be that in a group or individually.

Quality in the early intervention

If a surgical team is not particular regarding hygiene, they risk infections in patients following his surgical procedure. Throughout medicine there are procedures to secure quality. Do we apply similar standards when we tread into people's lives in the midst of a crisis? When a study of debriefing (part of the Cochrane report) uses a person on a home visit to a mother who has lost a child during pregnancy and offers one hour of intervention where a standard "debriefing" procedure is used, whereupon the helper leaves never to return for a follow-up, the potential for harm is high. No wonder researchers guard against using debriefing procedures. When a 16 year old girl who finds her boyfriend who have hanged himself meets a doctor who says "Tell me what happened" and she asks him "It is hard for me to tell, can't you ask questions?" is met with the response: "It is not the way we do it here", we have a long way to go. Those undertaking to help in such situations must know what to do and how to do it. The police officer who meets the family in their home or the grief counsellor meeting the family two days later must have a good understanding of what a critical event means to a family. And yes, there is the chance of doing harm – but so is doing nothing. And it is not easy:

A mother was called by her young adult daughter who was being attacked by her fiancée who had a psychotic breakthrough. She came to her apartment just before the police and found her daughter stabbed to death with a knife in her back. When the police entered the mother was sitting beside her daughter holding around her, knowing she was dead. The first thing she said was: This will go well will it not? She knew her daughter was dead but needed some comforting words. "Can't you see she is dead", answered the policeman. What the mother remembers as the worst is not his words, however, but the fact that he did not even get down on his knees to support her, he only stood there high above her and looked at her. It did not make it easier when some days later, while she and her husband was waiting to give their statement, two policemen that were close enough that she could touch them (as she said), discussed how much wine they should buy for their weekend party. The lack of sensitivity in the police officers has created a secondary trauma resulting in high anger in this mother, in a situation where they easily could have offered very comforting care.

How do we secure that first-line responders have the necessary skills and sensitivity to handle such situations? The medical credo says *Primum non nocere* (Galen 130-200 a.c.), do no harm. Unfortunately there is a risk of harm in everything we do and the only way we can reduce harm doing is by increasing the knowledge and skills of health professionals and others who are providing help following traumatic situations. The challenge is that unlike many medical procedures where a standard procedure can be followed, and although it would be easiest and best, it is not possible when working with human beings. When human beings interact, individual differences, and family and group dynamics demand much more flexible interventions:

Caroline is 12 years old and her mother has to undergo lung transplantation of both her lungs. I meet her because a girl in her class died of cancer and we used questionnaires to screen students in a grief group who needed more help. Her scores were very elevated and when she comes to me it is obvious that she is terrified that her mother will die. Every day when she comes home from school she expects to find her mum dead. The doctors at the hospital have put her under strong pressure to follow her mother to receive information about the medical procedures but she does not want to at all. I explain to her that it is my experience that fantasies often are worse than reality. She looks at me and says that in reality her mother can die of the transplantation but in her fantasy the worst that can happen is that she has to use a wheelchair. I have to persuade the doctors that they should let her be; she copes best with not knowing.

It is the flexibility we are able to use in our judgments that will ensure that people's individual needs are met. Quality control in providing good psychological care is not only making sure we have procedures in place, but that we are able to see the individual needs. And if you think this is difficult with individuals, it gets more complex with families or groups. How do we make sure that those who lead a debrief-group have the knowledge and skills necessary for supporting the group's resources and not leaving them feeling more helpless following our help? To paraphrase an old cartoon in *Mad* magazine, how do we secure that when the prince kisses the frog we are not left with two frogs? Here I have no solid answers, nor do I know the right questions, but what I know is that we cannot meet this complexity by simply withdrawing and say: let's do nothing.

Instead of doing less I think we need to do more. We need to get better systems in place to assist families with the upheaval in family dynamics they may face following trauma. Such situations have the potential to split the family, introduce family secrets, and create problems that last through generations. Trauma situations impact families and affect roles, rules and boundaries among family members, but so far we have dealt with this complexity largely by denying the fact and research and write about individuals. It is not only the death of a family member that lead to an upheaval in the system, but effects are evident when a father or mother are unable to sustain their children's emotional needs because of a trauma that leads to PTSD, other anxiety disorders or depression. Brown, Madan-Swain and Lambert (2003) pointed out how mothers with a child cancer survivor reported fewer PTSD symptoms when they received more social support within their family, specifically family satisfaction and communication were most consistently associated with fewer PTSD symptoms (and 25% of the mothers met clinical criteria for PTSD). In the bereavement field we have excellent descriptions of how a death in the family affect meaning construction and functioning (Nadeau, 1997), and recently some empirical studies have been published that document the importance of affect, communication and cohesion within the family (Traylor, Hayslip, Kaminski, & York, 2003). Traylor and co-workers found that families who are more aware of and able to express their emotions with one another report less intense grief over time as compared with more stoic families. Open communication were found to be a major predictor of less grief in their study, while cohesion in the family was the strongest predictor of later grief symptoms. The perception of closeness between family members (cohesion) leads to family relationships being an important source of social support. Traylor and co-workers (2003) in their implications of their study write: "When working with families in the immediate aftermath of a death, it will be particularly important for clinicians to focus on enhancing the family's sense of closeness with one another" (p.596). Let me use an example to illustrate the complexity in family relationships:

A father commits suicide by hanging. His adolescent daughter finds him hanging in the stairs to the second floor of the house while running into their house to find something she has forgotten while spending the weekend with her mother. The mother waits in the car and hears her daughter screaming from inside and runs in. The wife left the home months earlier after a married life where she has thought of leaving him for years. A grown-up daughter has been the one that the father repeatedly has told how he would commit suicide to, describing in detail the way he would do this. I meet them a few days following the death. There is intense tension in the room. The youngest blame the mother for the death, the mother blames herself and the eldest is angry at her father for what he has done. The mother has moved back in the house with a furious daughter. Apart from all the questions surrounding how to be able to enter and live in the house again and pass the place of death each day, the intrusive memories overpowering them, the practical tasks they have to undertake, there is the intense family frictions, the accusations and blaming, the pain over the loss, and the adolescent who do not want to say much. Over the first few weeks and months we have several family meetings where we openly discuss what has happened, and I address every one of the difficult family themes they have faced. Gradually they can start to interact in a more calm and friendly manner. All three need some sessions on their own. It does not make it easier that the oldest daughter never once has experienced her father giving her supporting words. He never said anything positive to her, and still she was the one he over the years told of his problems and the details of his suicide plans.

Although not all families face problems of this magnitude this is the area where we need to both understand more of the problems families face and develop strategies to assist families. I will not for a minute want somebody without experience and proper training to walk into a minefield like this. When we are to assist families and groups we need to make sure that the background and training of those who offer help is adequate, in addition to being sensitively attuned to the needs of those involved.

Another aspect that we also have to take into account is the gender differences. Not only are the chances much higher for women to develop PTSD (Kimerling, Quimette & Wolfe, 2002) but they are also more likely to report negative responses from family and friends (Andrews, Brewin & Rose, 2003). The benefits of support satisfaction and the impact of negative responses on the course of PTSD were found to be significantly greater for women than men following violent crime. Importantly, positive support appeared to hold little benefit for both genders. Andrews and co-workers conclude that concludes that their findings: "...strongly suggest that routine assessment of negative support and attempts to counter it, for example by including partners and relatives in the therapeutic process, could significantly improve PTSD outcomes, particularly for women." (p. 426).

Encourage self-reliance

It has been interesting to follow the development of new ways of understanding crisis and trauma over the last years. More emphasis has been put on salutogenic factors following in the footsteps of the model developed by Aaron Antonovsky (1979). He postulated that a person's health or disease to a large extent is determined by an individual's general attitude toward the world and his or her life. He termed this basic outlook on life "sense of coherence" and it represents the consistence, congruence and harmony in life. Other related approaches have emphasised resiliency both on the individual (Richardson & Waite, 2002) and family level (Hawley & DeHaan, 1996), how growth can be achieved through crisis and trauma (Tedeschi & Calhoun, 1995), and the importance of meaning making following trauma and loss (Neimeyer, 2001). Already back in 1996 (Dyregrov & Matthiesen, 1986) I wrote about how parents created meaning following the loss of a child and sensitively I have tried to foster such meaning making in my work with bereaved. A guiding principle for my early intervention has been the understanding of human behaviour in crisis situations as reflecting processes that seek to maximize our chances of survival. In early intervention we put emphasis on what people managed to do and focus on getting them to see how their mental mobilization helped them survive. This counteracts feelings of helplessness. When combined with teaching people self-help techniques, it serves as a strengthening of people's own resources and adds rather than subtracts from people's experience of self efficacy. An illustration will better explain this:

A few days after a mother lost one of twins to SIDS she tells her story of what happened. He had a slight cold the day before his death and slept more than usual. She took his temperature before putting him to sleep in the evening and it was normal. She gave him nose spray to alleviate his distress in breathing. Next morning the other twin, a girl, wakes up first and that almost never happens. Her intuition senses there is something wrong. She reaches over and feels the back of them both and they are warm. She relaxes a bit and take the crying girl to her own bed and then puts both hands around the boy to lift him up and discovers that his back is stiff and she immediately turns him around and sees the colour of his mouth and his slightly skewed face and knows he is dead. Thoughts race through her mind. Her 5 year old boy is asleep in her bed and she manages not to scream out loud although she swears softly.

She immediately takes the twin into the living room and dials the emergency line. While waiting for the ambulance she is intensely concerned that her 5-year-old boy shall wake up and take this horror in. She can see directly over to where the local ambulance station is and it takes “forever” before they come. They are very thoughtful and it is not before they have left with the boy and family members living close by have come to assist her (baby-sit while she goes to the hospital), that she enters her outside terrace and let the tears come. She then informs the now awake 5 years old and his first response is: “He does not need his bed anymore. We can take it apart”. In our conversation she says that she is perplexed that she cannot at all remember that she brought the living twin into the living room but she must have done so, since she was there when the ambulance officers arrived.

For this mother the early intervention is very much about acknowledging what she was able to do, explain the altered sense of time, tell her how she was able to postpone emotional reactions to do what is needed, explain the narrowing of attentional focus, and how memory functions under severe stress. Also she, as so many others, fear that she is going crazy because of the intensity and strangeness of different thoughts and emotions that have followed in the first few days after the loss. Providing her with information and a reference frame for understanding all this instantly alleviates her tension and fear. She can then get information about what a 5 year old understands of death and a first map of the terrain she is walking into. This early following the loss what is provided of information must be adjusted to her ability to take in information. As she was on the brink of splitting up with her partner (who at the last minute decided not to come with her to the session), this also becomes part of the first meeting.

Early intervention, individual differences and flexibility

In the studies of individual debriefing that constitute the basis of the Cochrane report, a model of short usually one-hour interventions following a standard format has been used, and although very favourably received by the “consumers” not shown to have reliable positive effects on subjective health measures. This should not come as a surprise, as early interventions need to be tailor-made to the individuals, families or groups that we reach out to. From my background of working with families who lose a member it is obvious that individualising what you do is extremely important to be of help to a family. Indeed, in addition to the principles of immediacy, proximity and use of expectancy, I stress flexibility as a forth principle to good crisis intervention. Flexibility in what you do, where you do it, when you do it, who you include and how long or short you intervene. With the complexity of the human mind there is little reason to believe that one procedure will fit all. I recently worked with a mother whose adult daughter was murdered following years of substance abuse and working on the street as a prostitute. Hearing her describe the lack of flexibility in the systems she met when she struggled to get help for her daughter was heartbreaking. She described a system where the daughter did not fit in, an inflexible system that demanded a structure from the clients that was impossible to follow for this client group to live up to. It reminded me to some extent of working following the discothèque fire disaster in Göteborg where 63 children were killed and around 300 survived. Many survivors found that the traditional psychiatric services were of little help to them in the beginning. The system with its focus on proper assessment before moving on to therapy was not able to be flexible to meet the group of traumatised adolescents. However, when fire personnel arranged summer camps where they met groups of adolescents canoeing or over the bonfire at night this

created an atmosphere where it was okay to talk. With the variety of human responses it is important that we can adjust our services to the people we meet.

Timing our responses to the type of event and the people hit by that event is another important aspect of early intervention. It is complex because there are so many factors entering into our decisions about how we should help. Among the factors we have to take into account when mounting our interventions are:

- Magnitude of the event: Mass-scale situations, disaster, terrorism or war versus one-person event
- Duration of event: Single-event trauma versus cumulative trauma, exposure time
- Type of event: Accident, violence, death, other loss
- Type of exposure: survivor of direct life-threat, bystander, family member, helper, etc.,
- Place of exposure: home, work, street
- Immediate reactions and recovery environment
- Cause: human or natural
- Resources available to help
- Personality, personal history, cultural background, training, resources and social network
- Expressed need for assistance

Use of groups following trauma and loss

The wish to meet others in the same situation testifies to the need to use groups in this work. What purpose do groups serve in the early intervention following traumatic events? Without entering the minefield of the debriefing debate, where I have offered my view elsewhere (Dyregrov, 1998) group approaches capture on the possibilities for using the collective for normalizing reactions when a number of people have experienced the same situation. It is especially helpful for assisting people develop to develop a complete picture of what happened, expanding on the often-narrow focus each person has had on his or her survival. The participants also learn from others and expand on the coping methods available, and at the same time a group approach allow us to reach many people at a time when resources are taxed. However, some people have a history of mental disorders and trauma in their childhood and may more easily be invaded by other people's stories because of a weak self-definition and hypersensitivity for stimuli that trigger their own trauma memories, some cope best without having to get all information about an event, some readily "take over" other people's pain and problems in addition to their own, and some are not ready to enter into a group before some time has elapsed. For those of us who work with bereaved, we know that family members first have to face the new situation within their own family, and may need not only weeks but sometimes months before they benefit from entering grief groups.

Geron, Ginzburg and Solomon (2003) in a recent study of group support for bereaved found that only one motive for joining a grief group corresponded with the perceived contribution of the group and that was the desire for relations with others in the same situation. This may also be an important factor in other group interventions following trauma as well. This desire for relations with others may reflect participant's sense of commitment and obligation in a group. At the last conference I attended here in Australia, Watchorn (2000) reported that those who actively participated in debriefing groups benefited more than those who did not, another indication that commitment is important in group participation. Following

major events that involve groups of bereaved and survivors there is a unique possibility to reach out to many and utilize the collective possibilities in the situation.

I have illustrated this in articles about the intervention for bereaved (Dyregrov & Straume, 2003; unfortunately in Norwegian) and survivors (Dyregrov & Gjestad, 2003) following a maritime disaster. However, as I have written elsewhere (Dyregrov, 1997; 1999; 2002), this demands group leaders that are skilled in what they do.

Where do we go from here?

I think we are at a crossroad in this field. We have advanced much more in the field of trauma therapy in later years than what we have done in the area of early intervention. This reflects that therapists and researchers know this terrain, this is their home turf. The sharpened senses of people who are in the midst of their trauma or crisis, opened to take in the situation in order to be able to respond quickly make them critical of the helpers they meet. The policeman that did not get down on his knees to support the mother of the murdered young woman is immediately experienced as cold and unfeeling. Yet it is not withdrawal from assisting people need when they look into the abyss, they need for us to develop more knowledge on how we can best support them, they need us to assure better quality control of procedures and helpers that work in this sensitive period immediately following events. The pendulum had swung from too many persons without proper training rushing in to do all kinds of more or less helpful interventions calling them debriefing, to the other side where everyone is now on the bandwagon stating that we should wait with intervention. The debate that has been going on almost over a decade has had one fruitful effect – we will be more quality concerned in what we offer. The debriefing debate has led to a more differentiated and flexible view of early intervention without the notion of one appropriate way to proceed

We must not give up, but work hard to be able to better help to those who need it. Not only must we be able to help them early as they request, but our help must be available over time. We will never run out of challenges, but we may run out of energy.

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