Part A
The Evolution and Development of Workplace Trauma Support
The Evolution of Models of Early Intervention for Adults: From Inspired Help Giving toward Evidence-based Pragmatism

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First of All: Do No Harm

Edward Munch’s painting *The Scream* enjoys iconic status throughout the Western world. It is not difficult to explain why. With consummate skill this Norwegian expressionist artist created a visual image that literally screams silently at us. The face depicted exerts a pull on those who stand before it. We feel engaged by an image of suffering and at the same time repelled by a depiction of danger and threat. Something awful has happened, human suffering is on display, and a powerful impulse to help dominates while something else warns us of inherent dangers. Through such dynamic and primitive processes, this image becomes a vehicle for evoking an unfolding of profound and yet simple interactions between viewers and images. Notably, all happens without a need for words.

All this powerfully demonstrates our capacity for engagement and attachment to suffering in the early aftermath of trauma. Such considerations alerts us to a possibility that for all their positive aspects, impulses to act may in fact be driven more by helpers’ self-interests or organizational imperatives within caring professions. Of the many lessons learned during the last 30 years none, is more important than the recognition that urgency of action carries a risk that outcomes may not necessarily be conducive to favorable outcomes for survivors. The legacy of early intervention would have conferred enduring credit on modern psychotraumatology had proponents and advocates of various acute care models reminded themselves not only of the need to act but also to take account of the traps and pitfalls of engaging such primitive processes. As it stands, the legacy is somewhat equivocal and aspects of current practice remain controversial.

Cautious, reflective, and evidence-based approaches may be less thrilling for helpers in the short-term aftermath of trauma but may facilitate improved survivor coping and
adjustment over the intermediate and longer term. Surely, the defining criterion for instigating early intervention should be a professional and humanitarian aspiration to act in accordance with evidence that is conducive to best possible survivor outcomes. Far too often the impulse to act has been a pretext for questionable initiatives, ill-considered practices, unsubstantiated claims, and short-lasting whims.

The Primitive Dynamics of Early Intervention

Exposure to expressions of distress in others by crying, audible calls for help, photos, television footage, and so on can evoke our keen attention and interest. An aspect of the dynamic interactive processes engaged by suffering is that continued or repetitive exposures become intolerable. Signals of suffering therefore typically and compellingly prompt action to help. Such impulses are immediate and can be difficult to resist, especially if sufferers are relatives, friends, or those with whom we identify.

While modern history teaches us that such altruism and compulsion to care are shaped by circumstance and are by no means universal, it is reasonable to argue that humans are “hard-wired” to attune and respond to others who are in distress, all with the purpose of ending that which is intolerable. By the same token we hope others will be sensitive to our own suffering.

In the case of caring professionals, a core standard of good practice is to step forward into the fray of distress and needs at times of crises. To do otherwise would generally amount to a failure of duty-of-care obligations. Therefore, when statutory or voluntary services are confronted with challenges of delivering early intervention for trauma survivors, the pattern of response has often been powerfully driven by impulses to act immediately. Thus it came to be that actions taken were often urgent and impulsive in the presumed service of survival with dignity.

Standards of practice have far too often been a function of the primitive and reflexive reactions in which they are rooted. Cognitive elaborations, meticulous planning, and careful consideration of survivors’ needs have been lower order priorities.

Impulsive imperatives have tended to rule over more cerebral pursuits such as acting after careful reflection about actual needs, formulating testable theories about evoked responses to trauma, being explicit about the etiology of evoked responses and the consequent models that could inform early intervention practices, and so on. Had this occurred, a gain might have been that actions taken would have been reasoned and rationalized so their impact might have been monitored through rigorous investigations of critical components of effective help as well as their relationship to outcomes.

Models, Methods, Techniques, and Theories

This chapter reviews models of early intervention for adult trauma survivors. Examples chosen trace changes in practice that have occurred over time and place models in their contemporaneous historical setting. No attempt is made to debate, argue, or win the case for use of particular techniques or how to render advice about overcoming practical challenges of delivering acute post-trauma services. Giving detailed consideration to
merits and limitations of each model is an enormous undertaking also beyond this chapter’s scope, and anyway is covered elsewhere in this handbook. Examples chosen for review highlight key themes or constructs that underpin ways of thinking about early interventions, their objectives as well as their aims.

The importance of models for the broad perspectives offered by this book is that they occupy positions between extremes of pure theory on the one hand and action-oriented pragmatism on the other. In their own particular way, models are a potential force for reconciliation and integration of opposites. They offer a prospect of engendering greater tolerance of pluralism in practice while also staking out a claim for which objectives and aims of early intervention are realistic and realizable.

The method of the chapter is to present an historical overview to illustrate the diverse bases from which various perspectives on early intervention have evolved. It will stake out a position that clarifies the foundations of many middle positions between opposites. These models are not necessarily reconcilable in all or even any of their constituent elements and presumptions. The review describes a diverse range of models of early intervention but will not endeavor to extricate putative elements that comprise a “pure” approach. Instead, the emphasis is to illustrate how different models are largely a product of concurrent historical developments and prevailing notions of professional or political correctness.

None of the models considered can claim a monopoly on veracity or effectiveness. Such an aspiration is but a search for a holy grail of omnipotence. Instead, what emerges from the review is that each model defines an idiosyncratic, time-specific perspective on the predicament of trauma survivors. From each are derived different formulations of the purposes of early interventions, outcomes to be achieved, and criteria for monitoring change attributable to help, advice, and support given in the early aftermath of major events.

**Remembering, Forgetting, and Reminders: Emergent Models and Historical Context**

To understand the trajectory of evolving models of early intervention through history, it is essential to consider the broader socio-political and military contexts in which they arose. Very clear illustrations of how models and historical context mirror one another emerge from a review of early intervention practices adopted by military services at times of war and peace (Weisaeth, 2003). Shepard (2000) has also pointed out that the process of mapping historical trends, and linking these to models adopted for the types and extent of psychological care, reveals recurrent cycles of acting, accumulating experience, refining practices, learning from survivors, and then dismissing it all by forgetting.

Repetitive, oscillating phases of bringing back past practices and then forgetting accumulated experience occur in conjunction with shifts from denial of psychosocial care needs to transient phases of exaggerated emphasis on troops requiring urgent help. In the former stages, presumptions underpinning models of early intervention are of soldiers being passively dependent on access to treatments delivered by professional experts in whose power is uniquely invested a capacity to deliver resolution of evoked
reactions. In subsequent transformative phases, a sense starts to prevail that a more moderate perspective fits observations and accumulated experience. A dispassionate weighing up of experience and practice-based evidence invariably recognizes the healing powers of survivors’ own strengths and resourcefulness as well as help delivered through psychosocial support networks.

Whenever evoked reactions are appropriately addressed through early interventions complemented by longer term follow-up care, it is as if assumptions take hold to the effect that a problem has been permanently resolved or eliminated. At their evolutionary zenith, models of acute trauma care fall victim to their own success. Early intervention is duly dismissed as redundant and forgotten.

The consequent amnesia and denial persist until circumstances change. A new war may kick-start the cycle again. This engenders the extraordinary spectacle of product champions vying for the “most privileged position” as if their proposals are new, refreshing, and original. Truth told, they are none of what is claimed. Advocates are but actors who replay scenes with many historical precedents. Even at this juncture in time, and probably in years to come, we do well to remind ourselves that models of early intervention have their roots in precedents and traditions that extend into the distant past. Little is new, and claims to be genuinely innovative are illusory.

So it comes to be that models of early intervention transform and transmute in response to changing political, medical, psychological, social, and military circumstances. Other pragmatic considerations, especially those that derive from fluctuating moral and ethical priorities at times of war and peace, exert additional influence. In this sense emergent models and practices to which they give rise are products of the times and circumstances in which they are formulated.

Also crucial for the process of reinventing models of early intervention are prevailing etiological considerations that account for clinical conditions putatively evoked by trauma. Survivor responses are rarely simple, resulting in a wide variety of postulated etiologies of questionable veracity (McFarlane, 2003). In consequence, constructions of combat stress reactions (CSR) that have prevailed through time are many and varied. Even to this day, model building takes place on the shifting sands of diagnostic controversies about acute stress disorder, acute and chronic post-traumatic stress disorder, and other trauma-related reactions. It is not by any means only a matter of academic interest that the DSM-IV (American Psychiatric Association [APA], 1994) and ICD-10 (World Health Organization [WHO], 1994) respectively construe these as anxiety disorders and adjustment disorders. Consistent with formulation, the former promotes fear reduction models of early intervention, whereas the latter places emphasis on practical help and support to improve the quality of survivors’ recovery environment or day-to-day coping. Through the 1980s and to the present, more flexible etiological perspectives have engendered altogether different coexistent models of early intervention apposite a range of survivor populations within the military, emergency services, or civilian settings.

As illustrated by the stages of forgetting and remembering, each phase in the dynamic cycles of transition is underpinned by different models of early intervention. Whether the general model in vogue is of denial and not wanting to know (a no-need model) or one that gives heed to compelling impulses to promptly mobilize intensive care for large numbers of survivors (an acute-dependency model) or a more reflective,
evidence-based approach (a learning-from-survivor model), each position emerges through selective perceptions of lessons learned from accrued experience. As for the selective bias that operates in these evaluations of evidence, a crucial intervening consideration is that of prevailing psychosocial and military-political imperatives.

Model Building from Modest Beginnings

Awareness of personal, psychological, medical, peer, and social factors in the genesis of CSR reactions stretches back at least to Grecian times. In fourth century BCE, Herodotus and Socrates spoke of soldiers’ intensely felt conflict between the imperatives to fight in order to win battles and understandable inclinations to flee to preserve life (Herodotus, 1998, book 7, para. 230, book 9, para. 71). The model they discussed was based on conflict resolution and consideration of how to resolve soldiers’ personal dilemmas. While survival and comfort may have exerted a pull in one direction, soldiers would also be warned about dire humiliations suffered through public derision, abuse, and disgrace heaped upon troops who withdraw from battle. In contrast, victorious soldiers as well as those killed in battle would be honored and commemorated through elaborate rituals sometimes involving whole nations. Thus, this model recognized remedial influences exerted by the very same individuals, groups, or communities in whose service soldiers had risked their lives.

The position of mercenaries has always been an interesting one in that their contractual arrangements differ from those of serving personnel drawn from a particular society. Militias, societies, or nations served by mercenaries owe nothing beyond an agreed fee. Inspiration to loyal service has historically been mediated through the mercenary privilege of looting and pillage after victorious battle. But those who were injured had to fend for themselves without mercy. Those killed were buried in anonymous mass graves. For surviving mercenaries there is, to this day, no model of early intervention other than survival through self-care and moving on to further military assignments for new paymasters. More by default than planning, the model by which surviving mercenaries adjusted to acute battle reactions is still to find distractions and live by high-risk strategies likely to retraumatize.

In 1678 the German doctor Johannes Hofer described a condition or state of nostalgia in soldiers characterized by a psychological reaction of longing for the past. Historically it is interesting to note that the military context that gave rise to this new diagnosis was a determination to curtail negative influences exerted by some soldiers upon the morale and operational readiness of front-line units. Typically, those given the new diagnosis were soldiers who had the greatest battle exposure and had been most affected by their experiences. It is interesting to note that although the model of early intervention for this condition was never made explicit, the imperative was to deliver acute services that removed obstacles to combat efficiency. Nostalgia is the predecessor of multitudes of terms since used to describe CSR.

Mass mobilization of citizens for military service became standard practice during the late eighteenth century at about the time of the French Revolution. A new ideology of citizenship engendered a new perspective on disasters and atrocities. The emergent model was based on a view that adverse incidents were rooted in social injustice.
Survivor needs should therefore, at least in principle, be addressed through measures rooted in recognition of a community’s collective responsibility to help those affected. During this pivotal phase of history, a social welfare model of early intervention found a natural place within a context of citizen empowerment and the democratic election of accountable public servants.

During the American Civil War (1861–1865), soldiers reported syndromes of responses now recognized as psychosomatic reactions associated with feelings of extreme fear and panic. Drawing upon the then-emergent science of medicine, symptoms were interpreted as indicative of cardiovascular disorder. So it came to be that palpitations, cardiac pain, rapid pulse, and respiratory problems were attributed to overstimulation of special nerve centers at the base of the heart. Battlefield observations defined syndromes of reactions variously labeled “irritable heart,” “soldiers’ heart,” and “Da Costa’s syndrome” (Da Costa, 1871; Myers, 1870). In keeping with principles of medicine as practiced at the time, early intervention involved drug treatments to eliminate symptoms of underlying physical or organic pathology.

Hand in hand with increased dependence on medical model treatments for psychological and psychosomatic reactions came demands for specialist medical services at or near front lines. These developments mediated a radical shift in the premises used to develop models of trauma aftercare. As psychosocial perspectives waned, an era of medical-model domination became ascendant. In some quarters this persists to the present and offers simple treatment prescriptions. Disappointingly, these models ignore previously recognized remedial effects of peer support, self-help, and social support. In some respects, this pure medical model set back the cause of securing effective acute help for soldiers with CSR.

An elaboration of the medical model of early intervention occurred at the beginning of the twentieth century when the Russian Army made its first attempts to provide CSR treatments at or very near front lines. This innovation had become a practical necessity spearheaded by problems associated with very long evacuation lines. Although not derived from a recognition of clinical need, a serendipitous merger occurred between strategic imperatives and soldiers’ welfare. While still rooted in orthodox medical models of early intervention, military authorities incorporated considerations of military culture and operational imperatives to pioneer some of the now widely accepted principles of forward psychiatry.

When World War I (WWI) erupted, there was scant recognition of the importance of emotions in the etiology CSR then labeled “shell shock” (Myers, 1915). This was consistent with the medical model applied at the time which perpetrated the orthodoxy of constructing suffering as impaired physical health. Remarkably, its etiology failed to take account of the horrors, trauma, and losses associated with high-fatality trench warfare. To have done otherwise would have transformed a seductively simple CSR model into one that was inconveniently complex. Such denials of the obvious mirrored high level of media censorship about what was going on in battle zones paired with a general refusal to know the intolerable. No wonder the war poets met with disbelief and accusations of being unpatriotic.

From July to December 1916, more than 16,000 cases of shell shock were recorded among British battle casualties. Eventually this condition proved to be the third most frequent cause for discharge from the British Army in WWI. At such magnitudes the
numbers of affected soldiers must have stretched services beyond their reasonable limits. In part this indicates significant limitations in any model of acute care that disregards emotions and psychosocial processes. But also, it suggests that some horrors and traumas have devastating psychological and health consequences that cannot be addressed by early intervention alone. In such instances, acute care might do well to limit its aspirations to not aggravate personal crises or do more damage.

Further impetus for model change arose from observations of troops at or near front lines. Some soldiers appeared to be particularly vulnerable to CSR. Shell shock also proved highly contagious within particular combat units. That the extent of symptom formation proved to be independent of the degree of exposure to explosions and physical shock was not readily reconcilable with the prevailing model of acute disorder. Notwithstanding such findings, models of early intervention continued to draw heavily on physical causes and reliance on physical treatments for symptom elimination. Remedies were sought by evacuating operationally compromised troops away from the trenches to hospitals for acute treatment followed by medical discharge, demobilization on health grounds, and dispatch home.

Clinical research conducted in nonmilitary settings at about this time generated evidence that eventually prompted a revision of models for early intervention for troops and, for the first time, civilians as well. Particularly notable are Hesnard’s (1914) studies of emotional changes in survivors of explosions. In time these helped foster a better understanding of CSR among front-line troops but did not significantly change acute service provision.

Away from the relentless pressures of acute treatment, Myers (1915) concluded the “shell shock” diagnosis was clinically unhelpful. His view was shared by others who in 1917 renamed the condition “effort syndrome” (Merskey, 1991). This represented, at least conceptually, a long overdue shift of emphasis away from physical causes as determinants of early intervention models. Rest and relaxation started to be recognized as core components in effective care. Later studies of English, French, and German soldiers concluded that at least 80% of “shell shock” cases had an emotional etiology (Weisaeth, 2003).

Myers (1940) also played an important role in rejecting presumed connections between various acute trauma-related syndromes and “organic molecular commotion in the brain.” He did so by drawing attention to close similarities between soldiers’ presentations and those of civilian patients diagnosed with hysteria. The latter condition was known to have a psychological etiology. It can be seen that as social circumstances started to change with public opinion being better informed about the horrors of war, so a view of etiology took hold in which turbulent emotions and conflicts were greater recognition. Consequently, new early intervention models were required. All the same, organic etiologies enjoyed continued favor within European military services even after their presumed physical basis had proven to be largely incorrect.

A wind of change, which still blows, is revealed in the formative influences of Salmon (1917). He took the view that “war neurosis” arose in soldiers caught in a dilemma of dynamic tensions. Resonant with views held in ancient Greece, conflicts arose from tensions between combat situations perceived as intolerable and the reassurances conferred by a more bearable neurotic condition. Salmon pointed out
that although acute intervention models involving evacuation or discharge secured survival, they also removed soldiers from peer support in established groups with common objectives and goal. Emergent social network models of early intervention shifted the focus of care toward practical help, guidance, and support provided at or near front lines. For those requiring intensive health care, backup was available in advanced neurological hospitals some miles from front lines or at base hospitals. This model of care is a core aspect of Salmon’s principles of forward psychiatry. Novelty of approach is discernible in the notion that effective early intervention could be achieved through peer and professional support, reassurance, and rest paired with an explicit expectation that traumatized soldiers would return to their front-line units (Myers, 1940; War Office Committee, 1922). Occupational therapy was introduced for the first time (Brock, 1918) along with a growing acceptance that troops take an active role in their own recovery as well as that of their peers.

Use of this model within advanced posts of the French Army’s medical service neuropsychiatric department as early as 1916 is reported to have achieved a return to front line duties in up to 90% of psychiatric casualties. Interestingly, the outcome criterion was resumed fighting which accommodated the operational imperative of maintaining battle capability.

Greater recognition of psychological processes in the etiology of traumatic stress reactions contributed to a focus on conflicts and dilemmas within individual soldiers rather than traumatic stresses inherent in combat. From this arose a personal conflict resolution model of early intervention. It stipulated that the manner in which soldiers resolved seemingly irreconcilable aspects of their predicament was a function of their personalities. If outcomes of soldiers’ attempts to resolve their conflicts were unhelpful for the war effort or in some ways deemed misguided by those in authority, the cause of dysfunction was presumed to be individual weakness (Eder, 1916; Shepard, 2000).

Within this model, CSR was construed as arising from a failure of personal will. As such it had moved from being medical to moralist and judgmental, which in turn inspired interventions involving disciplinary measures such as brutal administrations of painful electric shock (Moran, 1945). Other cruel techniques were used with the explicit aim of inflicting suffering to change the balance of conflicted considerations that made soldiers incapable of fighting. Early intervention followed principles similar to those used by officers faced with insubordination. Refusal to follow orders to return to the battlefield would engender ever more painful punishments until compliance was achieved. Thus the shift to psychosocial models of early intervention created a climate of care in which trauma survivors were not only held personally responsible for their disabling state but also considered to be the cause of their personal failures to benefit from acute clinical interventions (Weisaeth, 2003).

**Models of Early Intervention during World War II**

Lessons learned about early intervention had largely been forgotten or set aside by 1939. Once again, ill-considered interventions such as evacuation from battle line positions became common practice. Consequently, benefits to affected soldiers were compromised and military forces suffered severe losses of manpower (Ahrenfeldt, 1958;
Stouffer et al., 1949). The notion of CSR casualties being to blame for their condition retained considerable currency within military medical services during this period and has persisted in some quarters to the recent past (Jones, 1994).

Etiological formulations of traumatic stress responses during the initial stages of WWII tended to assume personal weakness in the face of conflicts involving fear of death or being maimed, on the one hand, and loyalty to fellow soldiers, on the other. This perspective had its roots in WWI models sustained by a misinterpretation of published evidence and accumulated experience. One line of investigation had shown that nervous disposition, lack of experience, higher age, and being a reservist increase risks of developing CSR. While some of the worst excesses of WWI-era models were not replicated, moralist and judgmental models engendered clinical approaches involving dismissive judgments of sufferers as malingerers, hysterics, or simulators not deserving of any compassion. A more dispassionate interpretation of this same evidence led others to advocate preventive selection, preventive measures, and better officer leadership training to reduce casualty rates. Early intervention in the form of prevention came into its own during WWII thus making space for psycho-educational models of practice. As the war progressed, preventive measures became better coordinated through the selection of personnel, better training for active military service, teaching officers about group cohesion, developing good leadership practices, and taking care to strengthen motivation and improve morale (Arenfeldt, 1958).

A significant etiological shift occurred about this time. Evoked reactions culminating in CSRs were linked to exhaustion rather than debilitating psychic conflicts. By implication, the core problem addressed by early intervention became tiredness for which a natural remedy is rest in secure settings. The emergent model incorporated principles of brevity and immediacy of early interventions. Focus on psychological reactions occupied centrality of clinical concerns with an expectancy to rejoin their combat units. This care was provided acutely in close proximity to front lines and was characterized by simplicity of approach (the BICEPS model of early intervention for treating soldiers: brevity, immediacy, centrality, expediency, and proximity; Freeman, Moore, & Freeman, 2009).

Reviews of wartime studies gauging return rates to front-line service showed success in up to 70% of cases referred for CSR. In conjunction with these psychosocial models, other healthcare professionals took an active role in trauma care (Shepard, 2000). With the successes of this approach, an optimistic view took hold that traumatic stress reaction were typically temporary and transitory psychological states.

WWII was instrumental in promoting models of early intervention that increasingly recognized social and environmental influences in both the genesis and resolution reactions evoked by trauma or critical incidents. In the process of so doing, better informed and more humane links were drawn between similarities in the presentations of troops with CSR and civilian patients diagnosed with neurotic conditions not necessarily associated with overwhelming experience. This was so for psychosomatic disorders and conversion syndromes irrespective of patient group. In this way, some early intervention strategies and subsequent ongoing care for functional disorders remained rooted in the notion of resolving personal conflicts whether experienced in battle or not. Eissler (1986) claimed this approach was effective with positive prognoses.
Models of Early Intervention for More Recent Wars

With the onset of the Korean War (1950–1953), CSR management failed to take account of experiences accrued during earlier conflicts. On this occasion the situation was promptly remedied in order to maintain troop numbers and front-line operational readiness. This was achieved using a BICEPS rest model with stricter-than-normal Salmon principles. In consequence, evacuation rates were as low as 35 per 1000 soldiers in active duty (Glass, 1954).

By the late 1950s accrued expertise had again been thrown to the wind as US military involvement in Vietnam increased. At its start, spurious CSR statistics and low evacuation rates were used to claim excellent morale. But the manner in which this war was conducted differed from that of previous and subsequent conflicts. With its painful progress and many sobering setbacks came a recognition of both the scope and limitations of early intervention as a function of particular circumstances prevailing during military campaigns.

US strategic and operational weakness was created by failures to screen and select troops about to be dispatched overseas. Combat readiness was further compromised by mobilizing troops for 12-month rotations. Front-line conditions increasingly mirrored and instigated broad-based sociopolitical developments stateside. For instance, an increasingly radical and articulate human rights movement drew attention to the fact that disproportionate numbers of ethnic minority soldiers were called up for front-line service. Soldiers and civilians started questioning the merits of this war, and front-line protests were expressed as ordinary soldiers openly defied the authority of officers. Crises of morale and motivation caused a collapse of coherent military purpose in full view of the world’s media.

Within the broader moral, ethical, political, military, and racial crises embodied in this war, acute care could not resolve behavioral and disciplinary problems, manage drug abuse, moderate soldier and civilian opposition to the war, or change the perception of its lack of purpose and meaning. It should not go unnoticed that no significant innovations in CSR care took place during the Vietnam War era. If there were any early interventions to speak of, they consisted largely of outspoken opposition to political, social, and military complacency. Never before or since has the model of early intervention been as explicitly political as it was during this time and up to the mid-1970s.

Weisaeth (2001) undertook a comprehensive review of early intervention for soldiers during recent wars, covering the period of armed civil conflict in Northern Ireland that started during the late 1970s, the Falklands War in 1982, and subsequent wars in the Balkans. Significant steps have been taken to interrupt recurrent cycles of gaining experience in the delivery of early intervention that is later forgotten, along with a denial of soldiers’ acute-care needs. To this end formal structures are in place to monitor quality of provision (Solomon & Benbenishti, 1986). The BICEPS model of early intervention has been simplified to be synchronous with the nature of modern warfare. It draws extensively on principles of proximity, immediacy, and expectancy (PIE). This is the model applied for NATO forces (Mehlum, 2003).

A 1993 review of early intervention for United Nations peacekeeping operations and troops mobilized for the First Gulf War (1990–1991) drew attention to the diversity of
CSRs evoked by modern warfare. A case in point is “UN Soldiers’ Stress Syndrome,” a significant risk factor for which are situations in which soldiers are scared of their own anger. This tends to arise when rules of engagement do not allow action to be taken to stop atrocities, injustices, and suffering. Evoked syndromes of reactions are associated with relatively high morbidity (Weisæth, Aarhaug, & Mehlum, 1993; Weisæth & Sund, 1982). In contrast to traditional guidelines for CSR, UN soldiers experiencing problems with self-control are typically evacuated from front-line duties and sometimes returned to their countries of origin.

In keeping with a growing appreciation of diversity in CSRs, the First Gulf War is clinically notable for generating a new diagnosis of Gulf War syndrome. Its complexities have set the stage for a broader recognition that recent wars are fought on many different fronts simultaneously and by different means. Past conceptualizations of CSRs may therefore not apply for more recent or future wars. Models of early intervention deemed effective in past conflicts may no longer be so. Furthermore, clinical observations made in the early aftermath of recent combat exposures point to presentations closely related to medically and psychologically unexplained syndromes such as chronic fatigue syndromes or multiple chemical sensitivities rather than the more typical post-traumatic stress syndromes (Wessely, 2001).

It is a matter of historical record that these more recent observations about the diversity of CSRs and presumed effectiveness of acute intervention for preventing later trauma-related sequelae are echoed in post-war experiences of many veterans of earlier conflicts. Contrary to expectations, many have found that the presumed benefits of acute- and intermediate-phase interventions were more a promise than reality. Possible reasons are that assumptions of etiological similarity between reactions evoked by different trauma in diverse survivor groups are incorrect. Such a formulation fails to consider differences that arise through long-term exposures to intense battle trauma and the typically less dramatic responses evoked in the wake of civilian trauma. Actual life-threatening trauma engenders qualitatively different psychological responses and processes compared to those mediated by dynamic conflicts unfolding within a person’s imagination (Gersons, 2003).

Evolving Models for a Rapidly Changing World

The role and status attained by early intervention both military and civilian settings are some of the positive legacies of the Vietnam War. First inspirations were drawn from the long-term plight and problems experienced by some of its veterans. Given their suffering and postwar adjustment difficulties, pertinent questions were soon asked about the prospect of preventing such functional disorders by early intervention initiatives. Thus it came to be that unsubstantiated claims were made for certain forms of early intervention being effective means of preventing post-traumatic stress disorder (PTSD) and related conditions evoked within military, emergency services, and civilian settings (Michell, 1983).

Consideration of which models of acute intervention informed these claims of effective prevention gives rise to much confusion. For instance, Mitchell’s (1983)
assertions that crisis theory was the basis for critical incident stress debriefing and its numerous derivatives were summarily dismissed by Gersons (2003). A crisis of theory has effected a change toward more pragmatic and practically focused models of acute care. More than ever, interventions take account of survivors’ actual needs established through negotiation, consultation, and accumulated experience. For instance, an information-sharing model of early intervention gives priority to explaining the nature of reactions evoked by trauma, their likely development over time, and when to seek professional help. To this end, a booklet or leaflet handed to survivors for their safe keeping might be used (Avery, 2003), as might trauma-related psycho-educational web sites. Gersons and Carlier (1993) adhered to a psycho-educational model in their approach to early intervention after major incidents in the Netherlands.

While past “product promotions” of early intervention claims a heritage derived from particular theories or etiological formulations, current approaches are primarily underpinned by a strong sense of pragmatism. Their objective is to deliver practical help in keeping with survivors’ expressly stated wishes (Ørner and Schnyder, 2003) and facilitate psychosocial support with the aim of improving the quality of the recovery environment. Empirical support for this approach is provided by Brewin, Andrews, and Valentine (2000). In their review of the influence of post-incident variables for outcomes, not only did post-trauma social support emerge as the most powerful predictor of the course and development of trauma reactions, but also, on its own, it proved more powerfully predictive than all other variables combined.

As a diversity of early intervention models is being tolerated, so has a change in their presumed objectives and aims. Claims of clinical effectiveness have been substantially moderated in the light of systematic investigations of outcomes, a series of Cochrane Reviews (Rose & Bisson, 1998), and clinical guidelines such as those published by the National Institute for Health and Clinical Excellence (NICE). A more reasoned and rational aspiration to link practice to evidence has brought with it considerable moderations in claims about outcomes that are both realistic and realizable. For instance, claims of effects are no longer phrased in terms of “symptom elimination” or “preventing onset of PTSD.” This is entirely consistent with recent more general developments within psychotraumatology. Firstly, that acute symptoms evoked by trauma have little predictive power of later adjustment difficulties (McFarlane, 2003). Secondly, that early reactions may have significant adaptive functions in improving chances of survival. If this is correct, it is ill-advised to intervene with the intention to eliminate reactions that are conducive to survival and improved longer term adjustment (Shalev, 2003; Shalev & Ursano, 2003). No longer preoccupied with symptoms, the focus of early intervention is to foster group cohesion and optimize benefits derived from using social support networks. Reflective practice has tempered impulsive overzealousness in responders and made sincere wishes to help resonant with the actual needs of recent trauma survivors.

Recently advocated approaches to early intervention, such as Support Post Trauma (SPoT) (Rick, O’Regan, & Kinder, 2006) and Trauma Risk Management (TRiM) (Greenberg et al., 2005), derive their models of care directly from the notion of psychological first aid that was first advocated by Raphael (1986). No single model prevails but they have some common elements. Acute interventions are phased according to survivors’ needs and incorporate elements of disparate theories and
models. In these ways they foster a climate in which tolerant pluralism can set roots. With this changed ethos has come greater tolerance of coexistence and cohabitation so that flexibility of approach is no longer anathema.

Once again, and truth told, when historical perspectives are under consideration, recent transformations of models for acute care mirror ongoing social, political, and military trends. Above all else, more humanitarian approaches have emerged from worldviews that are increasingly global paired with respect for evidence published in the public domain. “Product champions” know they are subject to the balances of public scrutiny and must generate evidence of effectiveness or risk being dismissed.

References


