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impact
Dutch knowledge & advice centre
for post-disaster psychosocial care

MULTIDISCIPLINARY GUIDELINE

Early psychosocial interventions after disasters, terrorism and other shocking events

2007

Under the auspices of the National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care

In cooperation with the participating professional associations and other organisations that are involved

Support and advice: the Trimbos Institute

Contents

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Organisation structure

The multidisciplinary guideline *Early psychosocial interventions after disasters, terrorism and other shocking events* has been developed under the auspices of the National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care. Advice on the methodology and organisation was provided by the Trimbos Institute.

Cooperating professional associations and organisations
Mental Healthcare Nursing Federation [Federatie Verpleegkunde in de Geestelijke Gezondheidszorg (FVGGZ]
Netherlands Psychiatric Association [Nederlandse Vereniging voor Psychiatrie (NVvP)]
Dutch Association for Psychotherapy [Nederlandse Vereniging voor Psychotherapie (NVP)]
Netherlands Institute of Psychologists [Nederlands Instituut van Psychologen (NIP)]
Dutch College of General Practitioners [Nederlands Huisartsen Genootschap (NHG)]
Dutch Association of Primary Care Psychologists [Landelijke Vereniging van Eerstelijnpsychologen (LVE)]
Military Mental Health Care Institute [Militaire GGZ] of the Ministry of Defence
Netherlands Association of Policy, Management and Research Physicians [Nederlandse Vereniging Artsen Beleid Management Onderzoek (NVAG)]
Netherlands Association of Social Workers [Nederlandse Vereniging van Maatschappelijk Werkers (NVMW)]
Netherlands Association of Fire and Disaster Control Services [Nederlandse Vereniging voor Brandweerzorg and Rampenbestrijding (NVBR)]
Netherlands Society of Physicians in Occupational Health [Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde (NVAB)]
Dutch Association of Behavioral and Cognitive Therapy [Vereniging voor Gedragstherapie en Cognitieve Therapie (VGCT)
Institute for Psychotrauma [Instituut voor Psychotrauma (IvP)]
D.O.E.N. [Directe Opvang en Nazorg – Immediate relief and aftercare]
Victim Support [Slachtofferhulp Nederland, formerly National Victim Support Agency]
Council of Regional Medical Officers [Raad van Regionaal Geneeskundig Functionarissen (RGF)]
Regional Department of Emergency and Disaster Medicine Preparedness [Landelijk Bureau Geneeskundige Hulpverlening na Ongevallen en Rampen (GHOR)]
Police Academy of the Netherlands [Politieacademie]

The above-mentioned professional associations and organisations have authorised the guideline, with the exception of:
Institute for Psychotrauma (IvP)
Dutch College of General Practitioners [Nederlands Huisartsen Genootschap (NHG)] – *In line with its general policy the NHG does not give formal authorisation for guidelines in mental health care.*

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Support on the methodology and advice
The Trimbos Institute is the national knowledge institute for mental health care, addiction and social care. The Trimbos Institute seeks to enhance quality of life by engaging in the development and application of knowledge about mental health, addiction and associated physical illnesses.

A: PUBLIC PART

1 Introduction to the public part

In the Netherlands, after shocking events such as disasters and major catastrophes, early psychosocial interventions are offered. These interventions are also referred to as acute psychological trauma support. Individual (BIG-registered) relief workers (workers who are registered under the Dutch Individual Health Care Professions Act), non-profit organisations and also private organisations are engaged in providing this type of relief.
There is increasing demand for early psychosocial interventions. Disasters in the Netherlands, such as the Bijlmer aviation disaster, the Enschede firework disaster and the café fire in Volendam have shown that the psychosocial effects and the health effects of a disaster last longer than was initially thought, sometimes even for years. So psychosocial care is essential, but it must be offered in accordance with the latest practices that have been shown to be effective.
On various points there is a discrepancy between the results of scientific studies into the effectiveness of early psychosocial interventions and what actually happens in practice. In the support that is provided interventions are carried out that have never been studied scientifically or which studies have shown not to be effective and suitable.
There is a debate about the time when early psychosocial interventions should take place, who can carry them out to greatest effect, and what methods should be followed. What form early psychosocial interventions take, how they are carried out and any follow-up that may be involved depends on the views of organisations, individual relief workers and sometimes on commercial interests. The result of this is that this form of aftercare is given in many different ways, and that often those who are affected are not always given the best (*'state of the art'*) care.
The professional community wants clarity and unambiguousness. This evidence-based multidisciplinary guideline on e*arly psychosocial interventions* has been developed as a response. This guideline is a means for providing help with which in accordance with the latest insights from science and based on (systematically collected) practical experience, answers are given to the question of what to do, and what not to do, in the first six weeks after a disaster, terrorism or other shocking event.

Aim and target group
The guideline on early psychosocial interventions gives recommendations for helping people who are involved in carrying out early psychosocial interventions in the first six weeks after disasters, terrorism and other shocking events, namely events of a sudden, unexpected and violent nature. These include events that cause actual death or the threat of death or serious injury, or that pose a threat to the physical integrity of those affected or of others.
The person who is affected experiences reactions of intense anxiety, helplessness or horror (DSM-IV-TR, APA 2000).
The guideline has been developed largely for major disasters (including terrorist attacks), primarily using literature on smaller-scale events. The study group has taken as its starting point the view that this literature can be used for this guideline, given the comparability of the effects of small-scale incidents and large-scale events and the absence of studies to show the opposite.
Based on the results of scientific studies, knowledge from experience and other considerations, the guideline gives an overview of good ('optimum') ways to act in order to guarantee high-quality psychosocial care. With this, the guideline gives a direction as to what (question-led) early psychosocial interventions can involve in the first six weeks. The guideline can also be used for developing (further) legally required disaster and incident protocols for places where large groups of people are accommodated, for example care establishments, schools, sports facilities or prisons.

Study group
A multidisciplinary study group was assembled to develop the guideline. In total, 21 members represented the 5 professional associations under the BIG Act and 13 other associations and organisations that are involved with early psychosocial interventions. For a full list of the members of the study group, the associations and organisations they represent and the other people who assisted with the guideline, see Appendix 1. In total the study group, under the chairmanship of Prof. dr. C. Spreeuwenberg, met 8 times over a period of 18 months.
Separate consultations with professionals involved in support work and those affected by disasters took place on one occasion (Appendix 3). At these meetings the draft guideline was presented and discussed.

The draft guideline was submitted by the members of the study group to their colleagues for comments and approval. After the final comments had been incorporated and authorisation given by the professional associations, the definitive guideline was adopted.

Method
The guideline has been developed in accordance with the methods of multidisciplinary guideline development in mental health care and under the auspices of the National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care. The guideline has been developed on the basis of starting questions (Appendix 2). To answer these questions an extensive systematic literature search was carried out. On the basis of the results of scientific studies (*'evidence'*) along with other considerations on the part of the members of the study group, *'evidence-based'* conclusions have been drawn and recommendations made.
Regarding the scientific literature that is available and was consulted, it should be noted that this concentrates for the most part on post-traumatic stress disorder. The study group emphasises that post-traumatic stress disorder is indeed a disorder that occurs after disasters, terrorism and other shocking events, but that there are various other disorders that are not discussed as much in the literature and which in practice are also important and occur frequently. These include depressive disorders, anxiety disorders, complaints for which there is no physical explanation and drug abuse.

Topicality and revision
In 2010 at the latest, in consultation with the National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care, Impact will decide whether this guideline is still up-to-date. If necessary, a new study group will be set up to revise the guideline. The guideline will become invalid earlier than this if due to new developments work needs to be started on revising the guideline at an earlier stage.

2 Guideline text, public part

The aim of early psychosocial interventions
After disasters, terrorist attacks and other shocking events, most people who have been affected recover by themselves. But a considerable number of people who have been affected develop long-term disaster-related mental health problems and/or mental disorders. Early psychosocial interventions are given in order to ensure the wellbeing of those affected and to prevent psychopathology. The study group recommends that early psychosocial interventions should achieve the following aims:

- Promote natural recovery and the use of natural sources of help;
- Identify those affected who need acute psychological help;
- As necessary, refer and as necessary treat those affected who need acute psychological help.

Screening
Screening is the term used when a specific investigation method is offered on a large scale to the population for tracing certain conditions at an early stage. Based on the current situation, the study group does not recommend the early tracing of those affected who have a high risk of a post-traumatic stress disorder (PTSD). At present, screening on the basis of the diagnosis of acute stress disorder and PTSD questionnaires is not considered to be beneficial. This is because there is insufficient evidence for tracing latent problems and early symptoms in the first six weeks. In many cases, stress reactions in this period are 'normal reactions to abnormal events'. Also, there is not agreement in the literature about the value of the diagnosis of acute stress disorder (ASD) in the first month after a shocking event as being a predictor of a post-traumatic stress disorder (PTSD) at a later stage.
Further studies are needed into the effectiveness of population-wide screening after a traumatic event. Any negative effects and the most appropriate time for screening to be carried out need to be investigated before a questionnaire is used on a large scale for the purpose of population-wide screening. Research also needs to be carried out into the effectiveness of repeating screening in the first six weeks after a disaster, terrorist attack or other shocking event.
Further research is needed into the usability of screening instruments based on risk factors for the early tracing of those affected with a high risk of developing trauma-related mental disorders.
The study group recommends that screening instruments that are not in Dutch (usually English) should be translated and then validated among those affected who are Dutch-speakers. The study group does however consider that screening for trauma-related problems that takes place later than six weeks after a collective shocking event may indeed be useful, but this does not fall within the scope of this guideline. The finding that screening in the first six weeks is not advisable does not however take away from the fact that in this period there should be such (individual) identification of people who are affected who need psychological help. In the case of mental disorders, proper diagnosis and treatment must be provided. Information about children must be gathered both from the child and also from the child's parents/carers.

A supportive context
People who are affected by disasters, terrorism or major catastrophes must be able to obtain support. The study group recommends that after a disaster, terrorism or other shocking event a supportive context is given. As soon as those affected have been brought to safety, the priority is to provide a listening ear, support and solace and being open to the immediate practical needs of those affected; offering factual and up-to-date information about the shocking event; mobilising support from their own social sphere; facilitating reuniting with people closest to them and keeping families together; and reassuring those affected who display normal stress reactions. This is likely to promote the powers of recovery of those affected. A supportive context must be available and accessible all the time in the period to which this guideline relates – the first six weeks. It forms the basis from which early psychosocial interventions are carried out.

Preventive early psychosocial interventions

Information
The study group recommends that after a disaster, terrorism or other shocking event, information is offered to all those affected.
The information is brief, basic and contributes to those affected regaining control and promotes their ability to cope for themselves. This information contains the following 3 components:

- A reassuring explanation about normal reactions;

- Explaining when to seek help;
- Advising the person affected to get on with the daily routine.

The study group does not recommend offering preventive psychoeducation, in the form of structured (often repeated) information and training to those affected and the members of their family with the aim of achieving a change in the trauma-related behaviour.
To enable this information to run smoothly, the study group recommends that this be given a fixed place in the various plans. If children are involved in a disaster, information should be expressed in a way that is specifically geared to children's level of understanding and experience.

Triage

As well as providing information, in the acute phase trained volunteers, preliminary and primary relief workers, with secondary mental health care in the background, have a role in the area of psychological triage. This is above all a matter of identifying those affected who have mental disorders and/or serious clinical symptoms requiring diagnosis and/or treatment. With psychological triage, this must be based on the clinical judgement of volunteers and professionals at preliminary, primary, secondary and tertiary level, and also on the judgement of the person affected himself. Thorough basic training of volunteers and professionals is necessary for this. They need to know that most people affected will display some form of stress reactions. These are normal reactions. For GPs, the standards of the Dutch College of General Practitioners (NHG) for anxiety disorders (NHG 2004) and for depression (NHG 2003) can provide help for identifying and diagnosing problems. Psychological triage can also take place during the further period to which this guideline relates (the first six weeks after a shocking event), for example when a person who has been affected consults a care giver.
The study group is of the opinion that with psychological triage a distinction must be made between:

- Those affected who do not have mental disorders and/or serious clinical symptoms. This is the largest group of those affected. Most recover within a foreseeable time on their own and in the first six weeks if necessary they only need to be reassured and be given a small amount of information.
- Those affected in whom it is thought they may have mental disorders and/or serious clinical symptoms. A small amount of information also needs to be given to this group. In addition, the care giver must arrange a follow-up meeting with the person affected.
- Those affected who have mental disorders and/or serious clinical symptoms. There are evident clinical problems in this group and proper diagnosis and/or treatment should be offered straight away.

In general, the study group concludes that professionals, but others as well, such as the partners of those affected, supervisors and schools, should wait in the first 6 weeks and observe those affected closely, unless there are evident clinical problems.

Psychological debriefing

Psychological debriefing is understood as meaning routine crisis interventions the purpose of which is to prevent and reduce the adverse psychological effects of traumatic events. Psychological debriefing takes many different forms, such as *Critical Incident Stress Debriefing* (CISD). It is often understood as being a one-shot semi-structured intervention.
The study group recommends avoiding one-shot psychological debriefing (including CISD) with the aim of preventing PTSD and other psychiatric problems in those affected. Because there is insufficient evidence of the effect of psychological debriefing in uniformed members of the emergency services, the study group does not recommend psychological debriefing to members of the emergency services either.
For (uniformed) members of the emergency services the study group recommends that relief provided by colleagues (peer support) contributes to a supportive context. It can provide practical and emotional support and can encourage the use of the social support sources of those affected. The study group is of the opinion that the employer should provide counselling (to be carried out by a relief worker or a trained volunteer) if a shocking event takes place at work.
The study group recommends further studies into the effectiveness of CISM, the psychological first-aid module such as developed by the NCPTSD and a structured relief protocol for children.

Collective early psychosocial interventions

Collective early psychosocial interventions relate to the population affected or parts thereof. Without being a complete list, a number of examples of collective interventions are: a single office function such as an Information and Advice Centre (IAC) or a virtual Centre for Information and Referrals,

reporting in the media, a platform for those affected, a specialist mental health care team, health assessment surveys and the government policy that is to be implemented.
Strictly speaking, these fall outside the scope of this guideline. The study group recommends however that collective early interventions form an essential part of the integrated package of post-disaster psychosocial care. The use of these interventions should therefore be ensured. The study group further recommends that in the first six weeks after a disaster a good support system should be put in place and that information be given a fixed place in the various policy plans.

Curative early psychosocial interventions
If there are serious clinical symptoms or mental disorders, as defined in DSM-IV-TR, professionals have a range of interventions available to them. The most commonly occurring conditions after disasters that require treatment are anxiety disorders, depressive disorders, problems for which there is no physical explanation, acute stress disorder, post-traumatic stress disorder, difficulties in adjusting and drug abuse. If ethnic minorities are affected by a disaster, the starting point is to approach these groups as regularly as possible and as culture-specifically as necessary.

Acute stress disorder and serious symptoms of post-traumatic stress disorder
The study group recommends trauma-focused CBT as an effective method for the treatment of those affected who have an acute stress disorder or serious symptoms of acute post-traumatic stress disorder in the first month after a shocking experience. Relaxation may be offered as part of a cognitive behavioural therapy treatment, but is not useful as an intervention (non-trauma-focused) on its own.
The study group is of the opinion that further research into the value of EMDR as a curative early intervention is desirable.

The study group recommends that trauma-focused cognitive behavioural therapy be considered in children with serious symptoms of PTSD in the first month after a shocking event.
The study group is of the opinion that further research into the value of EMDR as a curative early intervention in children is desirable.

Other psychological disorders
For the treatment of an anxiety disorder or a depressive disorder, the study group refers to the multidisciplinary guidelines for anxiety disorders and depression respectively (from 2003 and 2005). A guideline for somatoform complaints and disorders is being developed. For the treatment of other psychological disorders, see the disorder-specific guides, protocols and meta-analyses.

Pharmacotherapy
The study group recommends that in the event of sleeping disorders as a result of a trauma, pharmacotherapy can be considered. For any drug treatment for sleeping disorders, depressive disorders or anxiety disorders, the study group refers the reader to the existing guidelines.

Organisation
Early psychosocial interventions after disasters, terrorism and other catastrophes must take place within the legal framework established for this. The starting points are that the care must be offered as regularly as possible and that there is integrated psychosocial care. The legal frameworks that apply to disasters and major accidents fall outside the scope of this guideline. For more information, see the Disasters and Serious Accidents Act (WRZO), the Law on Medical Help in Disasters (WGHOR), the Disaster Response Improvement Act and the Public Health Collective Prevention Act (WCPV). In order that this guideline may be used to best effect in practice, the study group recommends the profession-specific implementation of this generic multidisciplinary guideline.

3 Overview of recommendations

The study group recommends that early psychosocial interventions should achieve the following aims:
- Promote natural recovery and the use of natural sources of help;
- Identify those affected who need acute psychological help;
- As necessary, refer and as necessary treat those affected who need acute psychological help.

1. As yet the study group does not recommend the early tracing of those affected who have a high risk of a post-traumatic stress disorder using PTSD questionnaires.

2. The study group recommends that screening instruments that are not in Dutch (usually English) should be translated and then validated among those affected who are Dutch-speakers. Validation must be carried out in Dutch populations of those affected by disasters, terrorism or other shocking events.

3. The study group recommends that in the case of pre-existing mental disorders proper diagnosis and treatment should be carried out.

4. The study group does not recommend early tracing of those affected who have a high risk of post-traumatic stress disorder (PTSD) using acute stress disorder (ASD) as a predictor. The study group does however recommend planning a follow-up meeting for further observation.

5. The study group recommends further studies in populations of those affected by disasters, terrorist attacks or other shocking events into the usability of screening instruments that are based on risk factors.

6. The study group recommends that further studies be carried out into the effectiveness of population-wide screening after traumatic events.

7. The study group recommends that if after a shocking event it is decided to screen children and adolescents for symptoms of ASD, information should be gathered both from the child and the parents/carers.

8. The study group recommends further studies into the most appropriate time for screening after a disaster, terrorist attack or other shocking event.

9. The study group recommends further studies into the potentially negative effects of screening of victims of disasters, terrorist attacks and other stressful life events.

10. The study group recommends that after a disaster, terrorism or other shocking event a supportive context is offered that consists of:
    - Offering a listening ear, support and solace and being open to the immediate practical needs of those affected;
    - Offering factual and up-to-date information about the shocking event;
    - Mobilising social support from their own social surroundings;
    - Facilitating reuniting with people closest to them and keeping families together;
    - Reassuring those affected who display normal stress reactions.

11. The study group recommends that after a disaster, terrorism or other shocking event, information is offered to all those affected.
    Information should consist of:
    - A reassuring explanation about normal reactions;
    - Saying when to seek help;
    - Advising those affected to tackle the daily routine.

12. The study group does not recommend offering preventive psycho-education.

13. The study group recommends that in the acute phase trained volunteers, preliminary and primary relief workers, with secondary mental health care in the background, have a role in the

area of psychological triage. This is above all a matter of identifying those affected who have mental disorders and/or serious clinical symptoms requiring diagnosis and/or treatment. Psychological triage often takes place in the acute phase, but can also take place during the further period to which this guideline relates (the first 6 weeks), for example when a person who has been affected consults a care giver.

14. The study group recommends that with psychological triage a distinction must be made between:
    - Those affected who do not have mental disorders and/or serious clinical symptoms. This is the largest group of those affected. Most recover within a foreseeable time on their own and in the first six weeks if necessary they only need to be reassured and be given a small amount of information.
    - Those affected in whom it is thought they may have mental disorders and/or serious clinical symptoms. A small amount of information also needs to be given to this group. In addition, the care giver must arrange a follow-up meeting with the person affected.
    - Those affected who have mental disorders and/or serious clinical symptoms. There are evident clinical problems in this group and proper diagnosis and/or treatment should be offered straight away.

15. The study group recommends avoiding one-shot psychological debriefing (including CISD) with the aim of preventing PTSD and other psychological problems in those affected.

16. The study group also does not recommend psychological debriefing (including CISD) for members of the emergency services.

17. The study group recommends that support from colleagues (peer support) contributes to a supportive context. It can provide practical and emotional support and can encourage the use of the social sources of support of the person affected.

18. The study recommends not offering CISM to a wide population.

19. The study group recommends further studies into the effectiveness of CISM.

20. The study group recommends further studies into the effectiveness of the psychological first aid module.

21. The study group recommends avoiding one-shot psychological debriefing (including CISD) with the aim of preventing PTSD and other psychological problems in those affected.

22. The study group recommends further studies into the effectiveness of a structured relief protocol as a preventive intervention for children.

23. The study group recommends treatment with trauma-focused cognitive behavioural therapy (CBT) for those affected who have an acute stress disorder (ASD) or severe symptoms of post-traumatic stress disorder (PTSD) in the first month after a shocking experience.

24. The study group recommends that relaxation should be offered only as part of CBT, not as a (non-trauma-focused) intervention on its own.

25. The study group recommends further studies into the effectiveness of EMDR as a curative early intervention in the first six weeks after stressful life events.

26. The study group recommends that in the event of sleep disorders as a result of the trauma, pharmacotherapy may be considered. For any drug treatment for sleep disorders, depressive disorders or anxiety disorders, the study group refers the reader to the existing guidelines.

27. The study group recommends that the employer should offer counselling (to be carried out by a relief worker or trained volunteer) if a shocking event takes place at work.

28. The study group recommends treatment with trauma-focused cognitive behavioural therapy (CBT) for children, more than 7 years of age, with severe symptoms of acute post-traumatic stress and/or an acute stress disorder in the first month after a shocking event.

29. The study group recommends further studies into the effectiveness of EMDR as an early curative intervention in children.

30. The study group recommends further studies into pharmacological interventions in children.

31. The study group recommends approaching ethnic minorities as regularly as possible and as culture-specifically as necessary. In the opinion of the study group culture-specific elements may consist of giving information in their mother tongue and involving key figures from ethnic minority groups.

32. The study group recommends that early psychosocial interventions should be carried out by people who are trained/have been given special instruction.

33. The study group recommends that collective early interventions form an essential part of the integrated package of post-disaster psychosocial care. The use of these interventions should therefore be ensured.

34. The study group recommends that in the first six weeks after a disaster a good support system should be set up.

35 The study group recommends that information is given a fixed place in the various policy plans in order for this to run smoothly.

36. The study group recommends the profession-specific implementation of this generic multidisciplinary guideline.

B: SCIENTIFIC PART

1 Introduction

In the Netherlands, after shocking events such as disasters and major catastrophes, early psychosocial interventions are offered. These interventions are also referred to as acute psychological trauma support. Individual (BIG-registered) relief workers, non-profit organisations and also private organisations are engaged in providing this type of relief.
There is increasing demand for early psychosocial interventions. Disasters in the Netherlands, such as the Bijlmer aviation disaster, the Enschede firework disaster and the café fire in Volendam have shown that the psychosocial effects and the health effects of a disaster last longer than was initially thought, sometimes even for years (Gersons et al 2004).
So psychosocial care is essential, but it must be offered in accordance with the latest practices that have been shown to be effective.
On various points there is a discrepancy between the results of scientific studies into the effectiveness of early psychosocial interventions and what actually happens in practice. In the support that is provided interventions are carried out that have never been studied scientifically or which studies have shown not to be effective and suitable.
There is a debate about the time when early psychosocial interventions should take place, who can carry them out to greatest effect, and what methods should be followed. What form early psychosocial interventions take, how they are carried out and any follow-up that may be involved depends on the views of organisations, individual relief workers and sometimes on commercial interests. The result of this is that this form of aftercare is given in many different ways, and that often those who are affected are not always given the best ('state of the art') care.
The professional community wants clarity and unambiguousness. This evidence-based multidisciplinary guideline on early psychosocial interventions has been developed as a response. This is a means for providing help with which in accordance with the latest insights from science and based on (systematically collected) practical experience, an insight is given into the *do's and don'ts* of psychosocial interventions in the first six weeks after disasters, terrorism and other shocking events.

1.1 Aim and target group

The guideline on early psychosocial interventions gives recommendations for helping people who are in any way involved in carrying out early psychosocial interventions in the first six weeks after disasters, terrorism and other shocking events, namely events of a sudden, unexpected and violent nature.
These include events that cause actual death or the threat of death or serious injury, or that pose a threat to the physical integrity of those affected or of others. The person who is affected experiences reactions of intense anxiety, helplessness or horror (DSM-IV-TR, APA 2000). A period of time of 6 weeks after the shocking event has been chosen. Firstly this is because early interventions are often offered in this period, and secondly because in this period most stress reactions become less marked usually 'by themselves'.
The guideline has been developed largely for major disasters (including terrorist attacks), primarily using literature on smaller-scale events. The study group has taken as its starting point the view that this literature can be used for this guideline, given the comparability of the effects of small-scale incidents and large-scale events and the absence of studies to show the opposite.

1.2 Study group

A multidisciplinary study group was assembled to develop the guideline. In total, 21 members represented the 5 professional associations under the BIG Act and the 13 other associations and organisations that are involved with early psychosocial interventions. For a full list of the members of the study group, the associations and organisations they represent and the other people who assisted with the guideline, see Appendix 1. In total the study group, under the chairmanship of Prof. dr. C. Spreeuwenberg, met 8 times over a period of 18 months.
Separate consultations with professionals involved in support work and those affected by disasters took place on one occasion (Appendix 3). At these meetings the draft guideline was presented and discussed.
The draft guideline was submitted by the members of the study group to their colleagues for comments and approval. After the final comments had been incorporated and authorisation given by the professional associations, the definitive guideline was adopted.

1.3 Scientific basis of the recommendations

The guideline has been developed in accordance with the methods of multidisciplinary guideline development in mental health care and under the auspices of the National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care. The guideline has been developed on the basis of starting questions (Appendix 2) that are based on the pressure points that are experienced in post-disaster care. So the guideline is not a textbook containing as much knowledge as possible that is available about a subject, but a document with practical recommendations for dealing with what are pressure points in practice.
To answer the starting questions, working with the Dutch Institute for Healthcare Improvement (CBO), information specialists from the Trimbos Institute looked for relevant research findings by carrying out systematic searches. The researchers looked for publications from the period 1995 to 2006 (supplemented by 'key articles' from before 1995).
The following sources of information were used to look for publications:

- Guidelines: *National Guidelines Clearinghouse* and *Guideline International Network*.
- Systematic reviews: The *Cochrane database* of 'systematic reviews' of the *Cochrane Library* up to 2006.
  Systematic reviews + original research with a high level of evidence: *Medline (PubMed), PsycINFO* and *Pilots*.

The primary search was for existing (foreign) evidence-based guidelines for early post-disaster psychosocial interventions, and systematic reviews or meta-analyses. For starting questions that have not been discussed either in guidelines or systematic reviews, as much as possible the search was limited to original research with a high level of evidence (controlled trials and prospective cohort studies). Search terms such as the following were used: 'disasters', 'terrorism', 'acute posttraumatic stress', 'acute psychological interventions', 'crisis care', 'brief interventions', 'debriefing'. In addition, relevant articles from the bibliographies of selected articles were obtained.
The guidelines that were found were assessed for the quality of the methodology by the advisers at the Trimbos Institute using the AGREE instrument (www.agreecollaboration.org). Only the guidelines that were satisfactory in this respect have been used for this guideline. These include:

- NICE 2005: Anxiety: *Post-traumatic Stress Disorder. Anxiety: Management of post-traumatic stress disorder in adults and children in primary and secondary care.*
- American Psychiatric Association 2004: *Practice Guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder.*

The quality of the articles that were used was assessed with the checklists relevant for the type of study in question, which are based on checklists of the EBRO platform (evidence-based guideline development) (Guide for members of study groups, Dutch Institute for Healthcare Improvement, 2005 [Handleiding voor werkgroepleden CBO 2005]. They were then graded in terms of the quality of the methodology. The classification used is that shown in Table 1.
On the basis of the results of scientific studies, along with other considerations on the part of the members of the study group and knowledge of the experiences of those affected, 'evidence-based' conclusions have been drawn and recommendations made. Unfortunately it has not been possible to answer a number of the starting questions due to the lack of unanimous evidence and conflicting opinions within the study group. To answer these starting questions, the study group has made recommendations for further research to be carried out.
The study group notes that the scientific literature that is available and was consulted concentrates for the most part on post-traumatic stress disorder and emphasises that post-traumatic stress disorder is indeed a disorder that occurs after disasters, terrorism and other shocking events, but that there are various other disorders that are not discussed as much in the literature and which in practice are also important and occur frequently. These include depressive disorders, anxiety disorders, complaints for which there is no physical explanation and drug abuse.

Table 1.1 Classification of the methodological quality of individual studies

	Intervention	Diagnostic accuracy of the study	Damage or side-effects, etiology, prognosis
A1	Systematic review of at least two studies of A2 level carried out independently of each other		
A2	Randomised, double-blind comparative clinical study of good quality of sufficient size	Study in relation to a reference test (a 'gold standard') with previously defined cut-off points and an independent assessment of the results of the test and gold standard, relating to a sufficiently large series of consecutive patients who have all had the index and reference test	Prospective cohort study of sufficient size and follow-up in which there has been adequate checking for 'confounding' and selective follow-up has been sufficiently ruled out
B	Comparative study, but not with all the characteristics as stated under A2 (this also includes patient-control studies, cohort studies)	Study in relation to a reference test, but not with all the characteristics that are stated under A2	Prospective cohort study, but not with all the characteristics as stated under A2 or retrospective cohort study or patient control study
C	Non-comparative study		
D	Expert opinion		

The study group finds that this classification of methodological quality is not entirely applicable to studies into psychological interventions because these cannot be carried out double-blind. The study group decided therefore to give the A level to the single-blind RCTs in this guideline.

Level of evidence force of conclusions

Table 1.2 Level of evidence of conclusions

Conclusion	Based on
1	Level A1 study or at least 2 level A2 studies carried out independently of each other
2	1 level A2 study or at least 2 level B studies carried out independently of each other
3	1 level B or C study
4	Expert opinion

The assessment of the various articles is to be found in the various texts under the heading 'scientific basis'. The scientific evidence is then summarised briefly in a conclusion. The main items of literature on which this conclusion is based are given in the conclusion, including the 'level of evidence'. In order to arrive at a recommendation, as well as the scientific evidence often other aspects are also important, for example: the preferences of those affected, cost, availability (in various scales) and organisational aspects. These aspects are discussed under the heading 'other considerations'. The recommendation is the result of the available evidence and the other considerations. Following this procedure increases the transparency of the guideline and increases clarity for the user of the guideline.

1.4 Legal status of the guideline

Guidelines are not statutory regulations, but as much as possible are evidence-based insights and recommendations from which care givers, policy-makers and advisers on the contents of care can draw knowledge in order to provide and ensure high-quality care. Care givers can, if they feel it to be necessary, on the basis of their professional autonomy deviate from the guideline. If the situation requires it, it is even necessary to deviate from guidelines. If the guideline is deviated from, care givers must provide an argument for doing so and document this.

1.5 Revision

In 2010 at the latest, in consultation with the National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care, Impact will decide whether this guideline is still up-to-date. If necessary, a new study group will be set up to revise the guideline. The guideline will become invalid earlier than this if due to new developments work needs to be started on revising the guideline at an earlier stage.

2 Aim of early psychosocial interventions

This chapter deals with the question of with what aim early psychosocial interventions should be carried out after a disaster, terrorist attack or other shocking event. The questions that are answered in this respect are:

- Are aims described for carrying out interventions?
- If yes, with what aim(s) should early interventions be carried out?

Scientific basis
No scientific studies have been carried out into the correctness of different aims of early interventions.

Other considerations
After disasters, terrorist attacks and other shocking events, most people who have been affected recover by themselves. But a considerable number of people who have been affected develop long-term disaster-related mental health problems and/or mental disorders (Norris et al 2002). The risk of developing PTSD after a stressful life event varies from about 2% after a traffic accident to about 54% after a hijack or abduction with violence (Breslau et al 1998).
There is a consensus that early psychosocial interventions should be given in order to ensure the mental wellbeing of those affected and to prevent psychopathology. In more specific terms, there is a consensus that early psychosocial interventions should achieve the following aims:

- Promote natural recovery and the use of natural sources of help;
- Identify those affected who need acute psychological help;
- As necessary, refer and as necessary treat those affected who need acute psychological help.

Recommendation

The study group recommends that early psychosocial interventions should achieve the following aims:

- Promote natural recovery and the use of natural sources of help;
- Identify those affected who need acute psychological help;
- As necessary, refer and as necessary treat those affected who need acute psychological help.

3 Screening

Screening, or population screening, is the term used when a specific method of investigation is offered on a large scale to the population for tracing certain conditions at an early stage. This chapter deals with the tracing of those affected who have a high risk of developing trauma-related psychological problems. Also, the time of screening, the repeating of screening and the setting in which screening may take place is discussed on the basis of the following starting questions:

- Are there screening instruments or other methods for tracing people who have a high risk of developing problems in the first six weeks after disasters, terrorism and other shocking events? If so, which ones?
- How effective and suitable are these screening instruments?
- Are negative effects known of screening in the first six weeks?
- When should screening be carried out?
- Should the screening be repeated?
- Are there screening instruments or other methods that can be used specifically for certain types of shocking events? If so, which ones?
- Are there screening instruments or other methods that can be used specifically for certain risk groups? If so, which ones?

Before dealing with screening, it is useful to explain the difference between screening (Chapter 3), triage (Chapter 5) and identifying. Screening is looking specifically in a fully defined target population for an illness that has not yet manifested itself or risk factors for an illness. Triage is identifying those people in a disaster situation who need acute care. Finally, identifying is a wider term that aims at being alert to the possible presence of an illness, without specifically examining an entire target population for this.

3.1 Early identification of those affected who have a high risk of psychological disorders at a later stage

In the guideline, early identification of those affected who have a high risk of psychological disorders at a later stage is if this takes place within the first 6 weeks after a disaster, a terrorist attack or other shocking event.
Various types of early tracing are described in the literature: on the basis of screening instruments for early symptoms of a post-traumatic stress disorder (PTSD), screening for an acute stress disorder (ASD), and screening for (combinations of) risk factors for the development of psychological problems after a trauma.

3.1.1 Screening for early symptoms of Post-Traumatic Stress Disorder (PTSD)

First of all this guideline looks at the question of whether early identification of those affected who have a high risk of PTSD, using questionnaires based on PTSD symptoms, is to be recommended.

Scientific basis

In a number of studies the diagnostic accuracy of screening for early symptoms of PTSD as a predictor for the development of chronic PTSD was studied. Shalev et al (1997) interviewed those affected by various traumatic events who reported at an Accident and Emergency department with physical injuries and had them fill in a number of questionnaires 1 week and 4 weeks after the trauma: the *Impact of Event Scale* (IES), the *Spielberger's State Anxiety* (STAI), the *Peritraumatic Dissociative Experiences Questionnaire* (PDEQ) and the *Mississippi Rating Scale for Combat-related PTSD, civilian version* (MISS). The results showed that all scales performed better than chance in the predicting of PTSD (at 4 months after the trauma). The overall diagnostic accuracy of these questionnaires varied between 72% and 81%. No differences were found in taking the questionnaire at 1 week and 1 month after the traumatic event in respect of the predicting of later PTSD.
Brewin et al (2002) found in a non-comparative study that their 10-item *Trauma Screening Questionnaire* (TSQ), if this was taken on average 3 weeks after a traumatic event, can predict well a questionnaire diagnosis of PTSD 3 months after the traumatic event. At a cut-off point of at least 6 intrusion or avoidance symptoms in a random combination, in this sample of 157 victims of a crime the TSQ had an overall efficiency of 90%, a sensitivity of 0.76 and a specificity of 0.97.
Only one study was found in which screening instruments for predicting symptoms other than PTSD were evaluated. Silove et al (2003) investigated the predictive value of 4 recognised screening

instruments for psychiatric symptoms (taken within 2 weeks after a traffic accident) (*Impact of Events Scale* (IES), *Beck Depression Inventory* (BDI), *Beck Anxiety Inventory* (BAI) and the *General Health Questionnaire* (GHQ)) for predicting long-term problems (18 months) after traffic accidents.
Although the authors found a high predictive value in a combination of 2 screening questionnaires (the IES with the BDI), they state that these results must be interpreted as being very provisional/tentative. They recommend follow-up studies with a large study population, using the optimum cut-off points found by them and a fixed time for taking the screening questionnaires after the shocking event.
As far as we are aware, no studies have been published in which Dutch-language screening questionnaires for symptoms of PTSD have been validated, which were also taken soon after a stressful life event.

Conclusion

Level 2	There are indications that those affected who have a high risk of developing chronic PTSD within a few weeks after the traumatic event can be identified with the aid of questionnaires based on PTSD symptoms. B Shalev et al 1997; Silove et al 2003; C Brewin et al 2002

Other considerations
So far the above-mentioned instruments have not been validated in Dutch populations of people affected by disasters, terrorist attacks or other shocking events.
The studies that to date have investigated the predictive value of screening in the acute phase after a shocking event all took place in a 'secondary' setting, whereby those affected reported to a police station or were admitted to hospital with a physical injury.
The study group considers that screening for trauma-related problems that takes place later than six weeks after a collective shocking event may well be beneficial, but this falls outside the scope of this guideline. The study group makes a distinction between screening for existing mental disorders and predicting the risk of mental disorders by using prognostic screening. The study group is of the opinion that if there are existing mental disorders, these require proper screening, diagnosis and treatment.

Recommendation

As yet the study group does not recommend the early tracing of those affected who have a high risk of a post-traumatic stress disorder using PTSD questionnaires.

The study group recommends that screening instruments that are not in Dutch (usually English) should be translated and then validated among those affected who are Dutch-speakers. Validation must be carried out in Dutch populations of those affected by disasters, terrorism or other shocking events.

The study group recommends that in the case of pre-existing mental disorders proper diagnosis and treatment should be carried out.

3.1.2 Screening for acute stress disorder (ASD), as a predictor of PTSD
The diagnosis of acute stress disorder (ASD) was added to the DSM-IV (APA, 2000) to give a place to reactions of extreme stress in the first few weeks after a traumatic event, in view of the fact that the diagnosis of post-traumatic stress disorder can be made only four weeks after the traumatic event. The diagnosis of ASD on the other hand can be made if the disorder persists for at least two days and at most four weeks and occurs within four weeks after the traumatic event (APA, 2000). ASD is characterised, just like PTSD, by intrusions of the event, the avoiding of stimuli that are associated with the event or numbing of general reactivity and increased irritability. Unlike PTSD, the diagnosis can only be made if the person affected has experienced a number of dissociative symptoms at the time of or straight after the traumatic event, such as a numb or detached feeling or the feeling of standing apart from other people or oneself (depersonalisation). Although ASD is a separate diagnosis

in the DSM-IV and treatment methods have been developed for this disorder (see Chapter 6 Curative early psychosocial interventions), also a great deal of research has been carried out into the accuracy of ASD as a screener for the development of later PTSD (NICE, 2005).

Scientific basis
Bryant (2003a) wrote a review of ten prospective studies in which ASD was measured in order to establish whether it is a good predictor of chronic PTSD. The percentage of people with ASD who developed PTSD later varied from 30-83% after 6 months, and the percentage of those affected with PTSD after 6 months who had symptoms of ASD earlier varied from 10-61% (see Figure 1).
He concluded that the diagnosis of ASD does not have sufficient predictive value and argued that biological and cognitive factors straight after a trauma are more accurate predictors of chronic PTSD.

Table 3.1 Predictive studies on acute stress disorder from the review by Bryant (2003a)

Type of trauma	Study	Percentage of people with ASD who developed PTSD	Percentage of people with PTSD who had ASD
Traffic accident	Harvey & Bryant (1998)	78%	39%
Brain damage	Bryant & Harvey (1998)	83%	40%
Violence	Brewin et al (1999)	83%	57%
Traffic accident	Holeva et al (2001)	72%	59%
Traffic accident	Creamer et al (2004)	30%	34%
Traffic accident	Schnyder et al (2001)	34%	10%
Typhoon	Staab et al (1996)	30%	37%
Cancer	Kangas et al (2005)	53%	61%
Traffic accident	Harvey & Bryant (1999)	82%	29%
Brain damage	Harvey & Bryant (2000)	80%	72%

Murray et al (2002) had victims of road traffic accidents fill in questionnaires (the *Posttraumatic Diagnostic Scale* (PDS) and the *State Dissociation Questionnaire* (SDQ)) within 48 hours after an accident and 1 and 6 months afterwards in order to measure ASD and PTSD.
Also, the investigators examined to what extent in the four weeks after the accident the patients met the DSM-IV criteria for ASD when the measurement was first carried out. The authors report that 77% of the patients who meet all the criteria for ASD in the first 4 weeks after the trauma also met the criteria for PTSD 6 months after the accident. The authors do say however that the timing of the establishing of the diagnosis of ASD can be crucial for predicting PTSD later. It is possible that the ASD status may vary during the first few weeks and that more persistent ASD is a better predictor of chronic PTSD than immediate ASD.

Conclusion

Level 3	There is insufficient consistent evidence that the presence or absence of the diagnosis of ASD predicts later PTSD. C Bryant 2003a

Other considerations
The study group finds that in practice it transpires that if after a shocking event a care giver observes those affected with dissociative reactions or serious intrusion, avoidance and hyperalertness reactions, they will not always develop PTSD. The study group notes that in such cases, at least however a follow-up meeting should be arranged with the person affected. The purpose of this is continuing observation whereby it will be investigated whether at a later stage PTSD or another disorder develops that needs treatment. Those affected also stress that it is important to keep an eye on those affected for a longer time by monitoring. They reason that: 'It is only later that some people suffer a backlash from the trauma. It is also these people that you need to reach with aftercare.'

Recommendation

The study group does not recommend early tracing of those affected who have a high risk of post-traumatic stress disorder (PTSD) using acute stress disorder (ASD) as a predictor.
The study group does however recommend planning a follow-up meeting for further observation.

3.1.3 Screening for other risk factors

This section deals with the question of whether other risk factors (as well as early symptoms of PTSD and ASD) for the development of PTSD can be used as a means for the early identification of those affected who have a high risk of later psychological disorders.

Scientific basis

Meanwhile, two major meta-analyses of the influence of the various risk factors for the development of PTSD have appeared (Brewin et al, 2000; Ozer et al, 2003). In both meta-analyses studies were analysed that date from 1980 to 2000. Brewin et al (2000) come to the conclusion that there are three main factors associated with the development of PTSD; the seriousness of the trauma, a lack of social support, other stressors in the life of those affected. Other factors into which there has been a great deal of research and that have less predictive value are a psychiatric history, mistreatment as a child, and a positive history of psychiatric problems in the family.
Ozer et al (2003) come to the conclusion that dissociation at the time of the trauma has the strongest association with the development of chronic PTSD. This factor is closely followed by two other factors: (a lack of) experienced (social) support and a life-threatening situation that has been experienced. Despite a number of methodological objections, these reviews are of good quality and appear to give a representative picture of the literature up to 2000. The factor 'dissociation at the time of the trauma' was not included in the review by Brewin.
Neither of the reviews included other potentially important factors, such as: physical injury, comorbidity, the presence of a claim for compensation. In both reviews a relatively low connection was found between the factors and later PTSD (up to r=0.4). They are in agreement that pre-traumatic factors have less of a connection with later PTSD than peri- and post-traumatic factors. The NICE guideline (2005) describes a number of studies from after 2000 (Holbrook et al, 2001; Mayou et al, 2002; Van Loey et al, 2003) that studied the same factors as in the reviews by Brewin and Ozer. These studies found a positive connection between PTSD and an experienced life-threatening situation, the female gender, dissociation at the time of the traumatic event, a low income, and the presence of claims for compensation. Later qualitative reviews support these findings (McNally 2003, Rose et al 2003).
A number of screening instruments have been developed on the basis of risk factors for PTSD. These are discussed below.
In a Dutch study (Wohlfarth et al, 2002), 128 victims of a crime filled in a questionnaire about risk factors when they reported at the police station. It transpired that a questionnaire diagnosis of PTSD after 3 months could be predicted by 4 dichotomous items with a diagnostic accuracy of 0.06, a sensitivity of 1.00 and a specificity of 0.62.
The dichotomous items on the questionnaire were: being a victim of a violent crime, knowing the perpetrator, experiencing the effects of the crime more seriously than expected, and blaming oneself for the crime.
RISK(10) is a Dutch screening instrument that has been developed for the early detection (and prevention) of long-term *'postvictimization distress'* by police officers in victims of violent crimes. The long-term psychological problems are translated among other things into the occurrence of a chronic adjustment disorder or PTSD. The instrument is built up of a selection of 10 risk factors, for which the empirical evidence and theoretical significance has been established before. It consists of a questionnaire of 11 dichotomous questions (yes/no). Winkel et al (2004) studied the predictive value of the RISK(10) for predicting chronic psychological problems in people who reported a crime. They concluded that most RISK(10) components have a significant positive correlation with 'postvictimization distress' 3 months later. Also, various components have a unique value for predicting different forms of adjustment disorders.
The authors say that the predictive capacity of the instrument is comparable with the predictive capacity of the diagnosis of ASD for predicting chronic PTSD, as found by Brewin (1999). They are of

the opinion that the present results provide first evidence that the RISK(10) forms a basis for the developing of *Early Detection and Prevention* programmes (EDP programmes).
The *Screening Tool for Early Predictors of PTSD* (STEPP) is an English-language *'stand-alone'* screening instrument which was developed in 2005, and this has been examined for its ability to identify children with physical injury (and their parents) who have a high risk of developing permanent psychological problems after a shocking event. The instrument consists of 4 dichotomous questions to children, 4 for one of the parents and 4 questions the answer to which can easily be found in the medical files. Winston et al (2003) investigated the predictive value of the STEPP in relation to PTSD and other psychological problems 3 to 13 months after a shocking event (on average after 6.5 months). They used the STEPP instrument as soon as possible after an accident (but definitely within a month) in children and their parents and after 3-13 months PTSD symptoms and other psychological problems were measured with the *Clinician-Administered PTSD Scale for Children and Adolescents* (CAPS-CA), the *Child Abuse and Trauma Questionnaire* (CATS), the *Multidimensional Anxiety Scale for Children 10* (MASC-10) and the *Children's Depression Inventory – S* (CDI-S). Winston et al report that the odds ratio for predicting permanent traumatic stress was 6.5 in children and 2.6 in their parents. They also report that the instrument has high sensitivity and moderate specificity, which in their eyes confirms its role as a screener (instead of a diagnostic test). They also argue that the extremely high negative predictive value suggests that the instrument can be used above all as a triage instrument, for 'screening out' those people who probably have least need of psychological help. So far the STEPP has not been validated in Dutch populations of those affected by disasters, terrorist attacks or other shocking events.
Murray et al (2002) investigated to what extent victims of road traffic accidents displayed signs of direct dissociation (within 48 hours after the accident) and of persisting dissociation (in the first 4 weeks). These signs were measured with the *State Dissociation Questionnaire* (SDQ). The scores on this list (within 48 hours and within 4 weeks) were compared with the severity of the PTSD symptoms after 4 weeks and after 6 months (with the *Posttraumatic Diagnostic Scale* (PDS). They conclude that dissociation at the time of the accident predicts the severity of later PTSD symptoms.
The presence of persisting dissociation 4 weeks after the accident does however predict the severity of PTSD symptoms after 6 months better than dissociation at the time of and immediately after the trauma. They conclude that dissociative symptoms help to predict chronic PTSD better than other clusters of early symptoms of PTSD.

Conclusion

Level 1	Studies show a number of clear risk factors for PTSD. The predictive value of the different factors is however too small to be used in practice for the early tracing of those affected who have a high risk of PTSD. A1 Brewin et al 2000; Ozer et al 2003

Level 3	There are indications that those affected who have a high risk of developing PTSD within a few weeks after the traumatic event can be identified using screening instruments based on predictors of PTSD. C Wohlfarth et al 2002; Winkel et al 2004

Other considerations
A disadvantage of the use of screening instruments that are compiled on the basis of risk factors other than early symptoms of PTSD is that many of these risk factors do not apply to all types of traumatic events, which makes it difficult to make a generalisation to other populations (Brewin, 2005).
In practice, the presence of a number of clear risk factors in individuals who have been affected can however give cause for care givers to be more alert to the possible development of PTSD later.
Before these instruments can be used after disasters, terrorist attacks and other shocking events, further validation studies must be carried out in these populations.

Recommendations

The study group recommends further studies in populations of those affected by disasters, terrorist

attacks or other shocking events into the usability of screening instruments that are based on risk factors.

3.2 The setting of screening: population-wide screening

Scientific basis
As far as we are aware, hitherto no scientific studies have been carried out into the effectiveness of population-wide screening after traumatic events.

Conclusion

Level 4	As far as we are aware, hitherto no scientific studies have been carried out into the effectiveness of population-wide screening after traumatic events.

Other considerations
Although no scientific studies have been found that have investigated the effectiveness of screening after traumatic events, various authors give their opinion of the value of population-wide screening. According to Rose et al (2005) and McNally et al (2003), it seems to be appropriate to continue to focus on means of identifying (and treating) people who are very likely to develop chronic disorders. More emphasis needs to be placed on the early identification of people who have a high risk of developing psychopathology and early interventions must be aimed at this group (Rose et al 2005). The NICE guideline for PTSD states that the use of screening programmes and/or validated screening instruments must be developed.

In the Population Screening Act, drawn up by the Health Council of the Netherlands (www.gr.nl), criteria have been drawn up for whether large-scale screening programmes can be carried out. A consent can be given only if:
- the screening is scientifically valid;
- the screening is in line with statutory regulations governing medical practice;
- the expected benefit from the population screening outweighs the risks of the study for the health of the people who are to be screened.

In the case of population screening for serious diseases or abnormalities which can neither be treated nor prevented, a permit will only be granted if special circumstances can be cited.
Before a large-scale population screening programme may perhaps be carried out in the future, these criteria will therefore have to be satisfied.

Recommendation

The study group recommends that further studies be carried out into the effectiveness of population-wide screening after traumatic events.

3.3 Screening in children

Scientific basis
Various instruments are being developed in the Netherlands for drawing up an inventory of post-traumatic reactions in children. In clinical practice the *Schok Verwerkings Lijst voor Kinderen* (Shock coping list for children) and the *Schok Verwerkingslijst voor Jonge Kinderen* (Shock coping list for young children) (Eland & Kleber 1996a and b) are used widely. These are currently being standardised and validated for the Dutch population.

There is some evidence that early screening can be successful in identifying groups of children with ASD symptoms and/or a high risk of developing PTSD. Chemtob et al (2002b) studied a screening test for children at schools who had been exposed to a disaster, with the aim of identifying those who had the greatest need for interventions. These researchers found that identifying symptomatic children only from the observation of teachers was not a good strategy.

The NICE guideline (2005) points out that children (particularly those less than 8 years old) sometimes do not report symptoms of PTSD, such as intrusion and avoidance. Instead, they say they are having problems sleeping. So it is important that all possibilities are used for identifying children with PTSD. Asking both children and their parents helps in identifying PTSD symptoms.
Based on this information, the NICE guideline (2005) makes the following recommendations. If it is being investigated whether children and adolescents display symptoms of PTSD, health workers should question the child or the adolescent separately for the presence of symptoms of PTSD. They should not make any assessment solely on the basis of information from the parents or carers.

Conclusion

Level 3	There are indications that screening in children is successful in identifying symptoms of ASD. C Chemtob et al (2002b)

Other considerations
There are considerable problems in carrying out screening like this in the acute phase after a shocking event. Understandably, parents and professionals in schools are protective towards children and above all are resistant to outsiders who want to obtain information about and from the children.

If a child has been through a traumatic event and is treated at an Accident and Emergency department, the A&E staff should tell the parents or the people with the child about the possibility of PTSD symptoms developing (for example sleeping problems, nightmares, concentration problems and irritation) and advise them to contact the GP if these symptoms persist for more than a month.

Recommendation

The study group recommends that if after a shocking event it is decided to screen children and adolescents for symptoms of ASD, information should be gathered both from the child and the parents/carers.

3.4 Time of screening

Scientific basis
There is one study in which early screening for symptoms of PTSD (1 week after the traumatic event) was compared with later screening (1 month after the traumatic event) with the aim of predicting a diagnosis of PTSD after 4 months (Shalev et al 1997, see also section 3.1). No difference was found in overall diagnostic accuracy if the screening was carried out 1 week or 1 month after the trauma. The authors conclude that early screening is not a reason for waiting a month before usable data can be obtained.

Silove et al (2003) conclude that the severity of PTSD symptoms appears to increase in the first month in all patients after a traffic accident. This makes the time of carrying out the screening in this month an important determining factor for the score with the screening instrument.

Conclusion

Level 3	There are provisional indications that early screening for the development of PTSD can be carried out with comparable accuracy as later screening. B Shalev et al 1997

Other considerations
Brewin (2005) posits that the immediate establishing of PTSD symptoms after a trauma is not wise, because the degree of PTSD symptoms immediately after a trauma is not a good predictor for the risk of the disorder occurring later.
In a section on screening Wessely (2003) describes a number of disadvantages of early screening, namely that cases of PTSD that have a delayed start can be missed, that there is a high chance that people with temporary disorders/problems are selected and that at that time those affected may perhaps not be ready to accept an intervention. As a disadvantage of late screening he cites a reduced possibility of using early interventions to prevent problems from becoming chronic. He reports that there is noticeably little information about the best time for screening to be carried out.

Recommendation

The study group recommends further studies into the most appropriate time for screening after a disaster, terrorist attack or other shocking event.

As yet the study group does not recommend early tracing of those affected who have a high risk of PTSD.

3.5 Negative effects of screening in the first six weeks

Scientific basis
As far as we are aware, no comparative scientific studies have been carried out into the negative effects of screening in the first six weeks after disasters, terrorist attacks or other shocking events.

Conclusion

Level 4	As far as we are aware, no scientific studies have been carried out into the negative effects of screening in the first six weeks.

Other considerations
Negative consequences of screening were found in an epidemiological study into the aftermath of the Bijlmer disaster among those affected, residents and members of the emergency services. After extensive physical and psychological screening, some people who took part in the screening reported greater sensitivity to physical sensations, fears for their health, fatigue and post-traumatic stress problems than before this screening (Verschuur et al 2004)

The study group finds that possible negative effects of screening may be the ‘medicalising’ of people who suffer acute symptoms of stress as part of the natural process. Also, screening will produce false-positives and false-negatives. Another negative side-effect can be that the screening of the whole group of those affected involves a great deal of cost (too much cost) and a great deal of organisation in relation to the benefit in terms of health outcomes.

Recommendation

The study group recommends further studies into the potentially negative effects of screening of victims of disasters, terrorist attacks and other stressful life events.

4 Supportive context

Chapters 4, 5 and 6 deal with the question of what early interventions should be used after a disaster, terrorist attack or other shocking event. More specifically, in these chapters the study group seeks to answer the following starting questions:

- What early interventions are described in the literature?
- In what form and at what stage(s) should the various interventions be carried out in the first six weeks?
- How many sessions (at least) should early interventions consist of?
- When should they be started?
- When should the early interventions be repeated?
- Which of these early interventions should be carried out in groups and which should be carried out individually?
- How effective and suitable are these early interventions?
- What is known about the side-effects and contra-indications of early interventions?
- What competences are needed to carry out these early interventions?
- At what stage(s) should the effect of the early interventions be evaluated?
- Are there early interventions that can be used specifically in certain types of shocking event? If so, which ones?
- Are there early interventions that can be used specifically in certain risk groups? If so, which ones?

4.1 Supportive context for adults

People who are affected by disasters, terrorism or other shocking events must be able to obtain support. As soon as those affected have been brought to safety, the priority is to give practical support, display empathy and encourage the use of own social sources of support. This is likely to promote the powers of recovery of those affected and this must also be available and accessible all the time in the period to which this guideline relates – the first 6 weeks. This forms the context in which early psychosocial interventions are carried out.

Scientific basis

There is a broad consensus that offering solace, information and support, and attending to immediate practical and emotional needs, plays a valuable role in the acute coping of those affected by a stressful event (Litz et al 2002). There is also agreement that practical and social support can play an important part in recovering from PTSD symptoms, in particular directly after a trauma (NICE, 2005). In a review on social support, Kaniasty (2005) says that most trauma studies show a great healing effect of the degree to which social support is experienced on psychological wellbeing after a trauma.

Conclusion

Level 4	There is a broad consensus of the value of offering a supportive context. B Expert opinion

Other considerations

The study group is of the opinion that all those affected are entitled to a supportive context. A supportive context is created by:

- offering a listening ear, support and solace and being open to the immediate practical needs of those affected;
- offering factual and up-to-date information about the shocking event;
- mobilising social support from their own social surroundings;
- facilitating reuniting with people closest to them and keeping families together;
- reassuring those affected who display normal stress reactions.

(Parker, 2006; NICE, 2005; Raphael, 1996, NIMH, 2003, Watson et al, 2003).

Both the study group and those affected agree that this supportive context does not have to be provided by mental health care professionals. Furthermore, those affected believe that an *outreaching*

approach should be used both in the acute phase and also later. Relief workers and volunteers should not wait until someone who has been affected brings his problems to people's notice of his own accord. Those affected also stress the importance of letting them tell their *own* story.

Those affected point out that this supportive context should also be made available by making it possible, after a disaster or other shocking event, for people in this situation to make contact with other people who have been affected who have had similar experiences. These contacts can be organised in self-help groups or groups of people with similar experiences.

Recommendation

The study group recommends that after a disaster, terrorism or other shocking event a supportive context is offered that consists of:

- Offering a listening ear, support and solace and being open to the immediate practical needs of those affected;
- Offering factual and up-to-date information about the shocking event;
- Mobilising social support from their own social surroundings;
- Facilitating reuniting with people closest to them and keeping families together;
- Reassuring those affected who display normal stress reactions.

4.2 Supportive context for children

In the case of giving children support, the providing of a supportive context takes place through adults who are known to the children and in social networks with which they are familiar. This is usually the school. If a shocking event occurs within a club, a sports team or another organised association, then the recommendations apply for the adults who within that association actually provide the relief and guidance for children.

5 Preventive early psychosocial interventions

After the description of the general supportive context that should be provided after a disaster or other shocking event, and within which early psychosocial interventions should be carried out, there follows in this and the following chapter a description of these specific interventions.

There are two types of early psychosocial intervention: preventive and curative interventions.
Preventive interventions are for the aims described earlier:

- to encourage natural recovery and the use of natural sources of help;
- to identify those affected who need acute psychological help;
- to refer as necessary and to treat as necessary those affected who need acute psychological help.

Curative interventions are used if there are evident psychological problems in the first 6 weeks. This chapter deals with preventive interventions. Curative interventions are dealt with in Chapter 6.

5.1 Information and preventive psycho-education in adults

The aim of information is to reassure those affected and explain normal stress reactions. Information fits in closely with the information needs of those affected. As well as information, sometimes psycho-education is given. Psycho-education consists of structured (often repeated) information and training to those affected and members of the family and is sometimes given in the form of a course. The aim is to bring about change in trauma-related behaviour using information and psychosocial strategies. Unlike psycho-education, information is not given in a structured way or repeatedly.

Scientific basis

There is little or no evidence of the value of offering general information to all those who have been affected after a shocking event. There is however a broad consensus that this is needed. According to the *Best Practice Guidelines* by Ritchie (2003), a brief, early and focused 'psycho-educative information' session for those affected who have lost a child, parent and partner is effective.

Ehlers et al (2003) showed that offering a self-help manual within six weeks after a shocking event was no more effective in preventing chronic PTSD than repeated measurements. Studies by Ehlers et al (2003) and Turpin (2005) show that providing a great deal of brochure material (22 pages with information about disorders that could develop) is not effective and in some cases can even be harmful. According to the NICE guideline as well, providing a self-help intervention has no additional value (NICE, 2005).
Rose et al (1999) investigated in a RCT what the effect was of a 30-minute educative intervention in victims of violence. The intervention was offered 9 to 31 days after the shocking event. The intervention was geared to the experiences of those affected and consisted of information given verbally about the help that was available and a written flyer. This study showed that this intervention did not make any contribution to preventing a diagnosis of PTSD 6 months later.
The NICE guideline describes a number of studies (Bryant et al 1998; Bryant et al 1999, Bryant et al 2003) in which supportive psychotherapy (*supportive counselling* or psycho-education) was compared with *trauma-focused* cognitive behavioural therapy (CBT). These studies show that trauma-focused CBT is more effective than psycho-education. However, none of these studies had a control group. Therefore it is not possible based on these studies to draw any conclusions as to the difference between psychotherapy and no treatment or *treatment as usual*.
Ehlers & Clark (2003) wonder whether supportive counselling, just like *single session debriefing*, could perhaps have damaging effects. Devilly (2002) too warns against the use of supportive counselling in those affected who have a psychological condition.

Conclusion

Level 4	There is little or no evidence of the value of offering general information to all those who have been affected after a shocking event. There is however a broad consensus that this is needed.

Level 1	There is no scientific support for the effectiveness of preventive psycho-education, either verbal or in writing. A2 Rose et al 1999; Turpin et al 2005; Ehlers et al 2003; Sijbrandij 2007 D NICE guideline 2005

Other considerations
The study group is of the opinion that giving information is worthwhile if it is focused on the normal course of events after a shocking event and limits are put on it (by saying when the person concerned should not wait but should seek help). The following information at least should be given.

- A reassuring explanation about normal reactions after a shocking experience and about the self-healing capacity of the human spirit.
- Say that help should be sought if the reactions persist for more than 4 weeks or become worse.
- Advise that the daily routine should be tackled as soon as possible after the shocking event, or if this is not possible, develop a new routine.

The study group is of the opinion that in order for the information to be disseminated to best effect, it needs to be investigated what the social makeup is of where the shocking event took place. On this basis it can be established what channels should be used to disseminate the information in order to reach the population affected as effectively as possible. Examples of how the information could be disseminated could include: brochures, the internet, TV, local broadcasters, community centres, employers, schools, churches and mosques. In the case of shocking events that occur within the work environment, these could include internal channels of information such as the intranet, internal TV and/or radio (hospitals), and company newspapers.

Recommendation

The study group recommends that after a disaster, terrorism or other shocking event, information is offered to all those affected.
Information should consist of:

- A reassuring explanation about normal reactions;
- Saying when to seek help;
- Advising those affected to tackle the daily routine.

The study group does not recommend offering preventive psycho-education.

5.2 Information and preventive psycho-education in children

There is no reason to assume that different conclusions apply for children than for adults. Of course, in the case of children it must however be looked at what information is appropriate for their specific age group and what information should be given to parents/carers. Also, pupils and their parents are entitled to information and support that is low-threshold and familiar, i.e. that takes place within their own existing social networks, such as their class, team or club.

In this process, teaching professionals check whether the information provided for their own pupils is appropriate for their developmental level and what they can understand. They also help the parents in this respect. Parents and carers are given more detailed information about what possible reactions there may be and what the best way is of dealing with this. Even if this information is provided through other channels, teaching professionals (and other professionals who normally also support parents with education and care) have an important task.

5.3 Psychological triage

The purpose of psychological triage is to distinguish a pathology from 'normal stress reactions', in other words: to trace those affected with clinically evident problems (as defined in the DSM-IV-TR). In many cases psychological triage will be carried out in the acute phase by trained volunteers and preliminary and primary members of the emergency services. Secondary mental health care should be present in the background so that support and advice can be given on the spot to volunteers, and acute psychological help can be given to those affected with serious clinical symptoms. Psychological triage can also be carried out in the further period to which this guideline relates (the first 6 weeks after), for example if a person who has been affected consults a care giver.

Scientific basis

There is no scientific evidence regarding the effectiveness of psychological triage.

Conclusion

Level 4	No scientific studies into the effectiveness of psychological triage are known.

Other considerations

In order to determine to what extent clinically evident problems are present, the care giver can use the diagnostic criteria from the DSM-IV-TR (APA, 2000) and questionnaires for PTSD problems, depressive problems, anxiety problems and alcohol and drug abuse (see Chapter 2).

The study group is of the opinion that with psychological triage a distinction must be made between:

- Those affected who do not have mental disorders and/or serious clinical symptoms. This is the largest group of those affected. Most recover within a foreseeable time on their own and in the first six weeks if necessary they only need to be reassured and be given a small amount of information.
- Those affected in whom it is thought they may have mental disorders and/or serious clinical symptoms. A small amount of information also needs to be given to this group. In addition, the care giver must arrange a follow-up meeting with the person affected.
- Those affected who have mental disorders and/or serious clinical symptoms. There are evident clinical problems in this group and proper diagnosis and/or treatment should be offered straight away.

With psychological triage, this must be based on the clinical judgement of volunteers and professionals at preliminary, primary, secondary and tertiary level, and also on the judgement of the person affected himself. Thorough basic training of volunteers and professionals is necessary for this. They need to know that most people affected will display some form of stress reactions. These are normal reactions.
For GPs, the standards of the Dutch College of General Practitioners (NHG) for anxiety disorders (NHG 2004) and for depression (NHG 2003) can provide help for identifying and diagnosing problems.

In general, the study group concludes that professionals, but others as well, such as the partners of those affected, supervisors and schools, should wait in the first 6 weeks and observe those affected closely, unless there are evident clinical problems.

Recommendation

The study group recommends that in the acute phase trained volunteers, preliminary and primary relief workers, with secondary mental health care in the background, have a role in the area of psychological triage. This is above all a matter of identifying those affected who have mental disorders and/or serious clinical symptoms requiring diagnosis and/or treatment. Psychological triage often takes place in the acute phase, but can also take place during the further period to which this guideline relates (the first 6 weeks), for example when a person who has been affected consults a care giver.

The study group recommends that with psychological triage a distinction must be made between:

- Those affected who do not have mental disorders and/or serious clinical symptoms. This is the largest group of those affected. Most recover within a foreseeable time on their own and in the first six weeks if necessary they only need to be reassured and be given a small amount of information.
- Those affected in whom it is thought they may have mental disorders and/or serious clinical symptoms. A small amount of information also needs to be given to this group. In addition, the care giver must arrange a follow-up meeting with the person affected.
- Those affected who have mental disorders and/or serious clinical symptoms. There are evident clinical problems in this group and proper diagnosis and/or treatment should be offered straight away.

5.4 Psychological debriefing and Critical Incident Stress Debriefing

Initially, debriefing was used mainly for ambulance personnel and in the army. In the eighties and nineties of the last century, debriefing was used more and more and in different groups. Also, different forms were introduced, which were used on an individual or on a group basis, or in an unstructured or structured way.

One of the specific forms of one-shot debriefing is *Critical Incident Stress Debriefing* (CISD) (Mitchell & Everly, 1996). CISD was developed in 1983 by Jeffrey Mitchell, as part of a wider programme. CISD is preferably carried out two to three days after the incident and on average takes two hours. It is a structured discussion in which participants go through seven phases on a one-shot basis.

Scientific basis

Various systematic reviews (Aulagnier et al, 2004; Lewis, 2003) have not shown any proven effectiveness of one-shot psychological debriefing (PD) in preventing chronic post-traumatic stress reactions. These reviews even describe a number of studies in which a negative effect of one-shot PD was found. According to a review by Bisson (2003) these negative effects can be explained on the basis of: a disturbance in the natural reaction, secondary traumatisation, medicalising of normal stress and cultivating the expectation that the person affected will become ‘ill’. A meta-analysis by Nachtigall et al (2003) shows that PD in the form of a single group session does not bring about any significant improvement in symptoms compared with a control group. Nachtigall et al also conclude that PD in a single group session can have damaging effects. In this review it is not easy to assess whether the treatment groups and control groups in the various studies are comparable. According to a review by Bryant (2005), the general conclusion in the current literature tends to the view that psychological debriefing is ineffective. A cautious conclusion seems to be that PD could be damaging, which indicates that there could be a potential problem with offering interventions without assessing beforehand whether the participants in these interventions meet inclusion criteria (such as having a high risk of developing chronic psychosocial problems). Arendt & Elklit (2001) conclude in their review that PD does not prevent the developing of a psychological disorder and that the intervention does not reduce the effect of traumatic stress. These results are confirmed in two recent RCTs (Sijbrandij 2007; Marchand 2006).

Hitherto few systematic and controlled studies have been carried out into the effectiveness of the various stress debriefing models.
The meta-analysis by Van Emmerik et al (2002) showed that CISD interventions do not significantly reduce post-traumatic stress symptoms and the other psychological symptoms. In the groups that

were given non-CISD interventions and no interventions respectively, a significant reduction in post-traumatic stress symptoms was found.
In the study by Macnab et al (1999) into the long-term effects of CISD, here too no significant differences were found between people who had been given CISD and control subjects.

Conclusion

Level 1	It has been shown that psychological debriefing after a shocking event is not effective in preventing PTSD and other psychological problems and that single-session debriefing can even have damaging effects. A1 Van Emmerik et al, 2002; Lewis, 2003; Aulagnier et al, 2004; Nachtigall et al, 2003 A2 Sijbrandij et al, 2007; Marchand, 2006 C Macnab et al, 1999

Other considerations
After disasters, terrorism and other shocking events a small percentage of those affected develop chronic psychological problems. Against this background it is sensible to allow those affected to cope with their shocking experience of their own accord.
Both from the literature and from what those affected have said, it is clear that those affected are themselves positive about undergoing psychological debriefing (PD) and the effect of it. There has not been sufficient research into the cost-effectiveness of PD. Offering it may perhaps have positive economic effects (Arendt & Elklit 2001).

There is considerable debate about the question of what is the purpose of debriefing: to prevent PTSD in the longer term or to reduce stress and help people in the short term. According to Miller (2003), debriefing should take place in a social (family) network and should be carried out with the idea of looking at people in their own surroundings, by working in natural groups, encouraging joint help and support, and focusing on people's strength and resilience. Miller also argues that multidisciplinary teams should be used.

Arendt & Elklit (2001) say that the range of specific objectives for using PD is confusing. The main advantage of PD seems to be its use as a screening procedure (Arendt & Elklit 2001). It is also reported in the meta-analysis by Everly (1999) that a PD session is also intended to identify people who may need further relief or referral. Just like with individual psychological debriefing, in a large RCT, group debriefing of soldiers did not prove to be effective. No damaging effects were found however and the soldiers enjoyed the intervention (Litz et al, Plenary talk ISTSS, 2004).

A survey (Ørner 2003) among British emergency services staff (police, fire service, ambulance, etc) showed that after shocking events first of all they use 'peer support' (support from colleagues) and later seek help from friends or other people they trust. They say that they prefer not to have help imposed on them by external trauma experts. Ørner & Schnyder (2003) argue that there is more and more scientific support for offering so-called phased psychological first aid: first of all have faith in natural recovery processes and only bring in trauma experts if this is indicated.

For members of the emergency services (the army, police, fire service, etc), the study group believes that it is important that the management works on good team-building, where there is room for support, humour and proper consideration for each other. It also believes that consideration for their 'home front' is important, because support is guaranteed at home. All this is aimed at social support and encouraging the natural coping process.

Recommendation

The study group recommends avoiding one-shot psychological debriefing (including CISD) with the aim of preventing PTSD and other psychological problems in those affected.

The study group also does not recommend psychological debriefing (including CISD) for members of the emergency services.

The study group recommends that support from colleagues (peer support) contributes to a supportive context. It can provide practical and emotional support and can encourage the use of the social sources of support of the person affected.

5.5 Other preventive interventions

5.5.1 Critical Incident Stress Management (CISM)

CISM is an integrated approach that consists of various interventions. The complete CISM programme consists of: psycho-education prior to a shocking event; individual support at the site of the event; demobilisation after major disasters (information and rest and food); *defusings* (discussions in small groups, 8-12 hours after the trauma); CISD; support for those who are directly affected; follow-up meetings and as necessary referral for further diagnosis and treatment. Although CISM was originally developed for first-aid staff, the method is flexible and can be adapted so that it can be used for any organisation or existing group.

Scientific basis

Roberts & Everly (2006) have carried out a meta-analysis of 36 studies into early psychosocial interventions. They conclude that CISM is effective in reducing symptoms of depression, PTSD and suicidal thoughts. They do note however that only 12 of these studies were randomised. In their meta-analysis (studies up to 2000), Everly et al (2002) describe the effectiveness of the CISM method as described by Everly & Mitchell (1999) and Flannery (1999). They find a high measure of effect for the effectiveness of CISM. The authors stress that this result is specific for the CISM method that is offered in a standardised form by trained course leaders, and that this cannot be generalised to other methods of crisis intervention. They also point out that the studies that were analysed were naturalistic in design and that good RCTs are needed.

Bledsoe (2003) concludes in his systematic review into the effectiveness of CISM that despite the shortcomings of the current literature it can be asserted that CISM is not effective in preventing PTSD. This may perhaps be explained by the fact that he included studies into CISD and also PD in his review as well. In the introduction the author says that over time the process of CISD changed its name to CISM, in order to describe a more global approach that a wide set of aims seeks to achieve. Unfortunately Bledsoe did not describe the search strategy used in his review in any great detail and in his selection of articles also used *'case reports'* and *'narrative reviews'*.
Mitchell (2003) stresses that CISM is not intended as a replacement for psychotherapy. CISM has a supportive function, while psychotherapy has a curative function.

Conclusion

Level 1	CISM has been studied primarily by those who developed the method. This research suggests that CISM can be effective in reducing psychological problems after shocking events. There are no indications that CISM prevents the development of chronic psychological disorders. A1 Roberts & Everly 2006; Everly et al 2002 A2 Bledsoe 2003

Other considerations
Everly (2002) states that good controlled studies are needed in order to establish the effectiveness of CISM.
The study group stresses that the full CISM programme can only be used in settings in which preparation for a shocking event (one of the interventions in a CISM programme) can also be given. Because this is not the case for most people who are affected by a shocking event, the study group is of the opinion that CISM cannot be widely recommended (yet). The study group is also of the opinion that good quality studies are necessary in order to study further the effectiveness of CISM for a wide population.

Recommendation

The study group recommends not offering CISM to a wide population. The study group recommends further studies into the effectiveness of CISM.

5.5.2 Psychological first aid as a module
The National Center for PTSD (NCPTSD) has developed a modular early intervention for all those affected, young and old, by disasters and terrorism, called *'psychological first aid'* (www.ncptsd.va.gov). Although promising and scientifically well-founded, the effectiveness of this intervention has not yet been sufficiently proven in scientific studies.

Conclusion

Level 4	No scientific studies into the effectiveness of psychological first aid as a module are known.

Other considerations
Scientific studies are needed in order to establish the effectiveness of psychological first aid.

Recommendation

The study group recommends further studies into the effectiveness of the psychological first aid module.

5.6 Preventive interventions for children

Scientific basis
Stallard et al (2006) carried out a RCT into the effectiveness of debriefing in a group of 158 children aged between 7 and 18 who had been involved in a road traffic accident. In this study debriefing did not prove to be more effective than natural recovery. The level of mental wellbeing after 8 months was comparable in all groups.
An intervention that is used frequently in the Netherlands is the structured relief programme for traumatised children, young people and their parents, which was developed by the Institute for Psychotrauma (Eland et al, 2002). This intervention is used for the relief of children between 4 and 18 years of age who have been affected by an acute shocking event, and in helping their parents or carers. However, no scientific studies have been carried out into the effectiveness of this relief programme as a preventive intervention.

Conclusion

Level 2	Evidence does not support the use of psychological debriefing for children either. A2 Stallard et al 2006

Level 4	No scientific studies have been carried out into the effectiveness of a structured relief programme as a preventive intervention for children.

Recommendation

The study group recommends avoiding one-shot psychological debriefing (including CISD) with the aim of preventing PTSD and other psychological problems in those affected.

The study group recommends further studies into the effectiveness of a structured relief protocol as a preventive intervention for children.

6 Curative early psychosocial interventions

This chapter comments on the effectiveness of early curative interventions that can be used for those affected who have clinical problems such as described in the Diagnostic and Statistic Manual Fourth Edition (DSM IV, APA, 1994).
According to the DSM IV (APA, 1994), post-traumatic stress disorder (PTSD) can be diagnosed from 4 weeks after a stressful life experience. This time falls within the period at which this guideline is aimed, namely the first 6 weeks after a stressful life event. Since the treatment of post-traumatic stress disorder (PTSD) has already been dealt with in the Multidisciplinary Guideline on Anxiety Disorders (National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care, 2003), for the treatment of post-traumatic stress disorder readers are referred to this guideline. For the treatment of other disorders that can occur in the first 6 weeks after a stressful life event, such as other anxiety disorders and mood disorders, the reader is also referred to the guideline and consensus statements on the psychological disorder or cluster of disorders in question (Guideline on Depression, NVvP, National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care; Guideline on Anxiety Disorders, NVvP, National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care).
This chapter will be devoted solely to early curative interventions that have been studied in the first 6 weeks after disasters, terrorist attacks and other shocking events.

6.1 Cognitive behavioural therapy (CBT)

The combination of cognitive and behavioural therapeutic procedures is called cognitive behavioural therapy. Cognitive behavioural therapy is based on the idea that thoughts, feelings and behaviour are associated with each other in a certain way. A person's thoughts influence his/her feelings and behaviour. Relaxation can form part of cognitive behavioural therapy treatment.

Scientific basis
Cognitive behavioural therapy in the first six weeks after a stressful life event has been studied in a number of comparative studies. These can be subdivided into studies into the effect of a short period of cognitive behavioural therapy in the treatment of Acute Stress Disorder (ASD), and studies into the effect of cognitive behavioural therapy in the treatment of acute post-traumatic stress disorder (PTSD). Acute Stress Disorder is a DSM IV disorder which – unlike PTSD – can be diagnosed within 1 month after the stressful life event (see also section 3.1.2 in Chapter 3, Screening). The aim of treating ASD is to reduce the risk of PTSD later. As far as we are aware, all the studies into the treatment of ASD have been carried out by the Australian research group led by Bryant.
Bryant et al (1999) compared the effectiveness of CBT, CBT in combination with anxiety management (breathing exercises, muscle relaxation exercises, and *'self-talk'* exercises), and supportive counselling in the treatment of ASD. Both CBT and also CBT in combination with anxiety management led to a reduction in later PTSD symptoms. Anxiety management did not have any added value above CBT. A study by Echeburua (1996) also showed trauma-focused CBT to be more effective than relaxation.
A RCT by Bryant et al (2005) into the treatment of acute stress disorder (ASD) with CBT or a combination of CBT and hypnosis showed that both CBT and also CBT with hypnosis led to a reduction in PTSD symptoms compared with supportive counselling. CBT with hypnosis led to a greater reduction in flashback symptoms than CBT on its own.
A study by Andre et al (1997) into the effect of CBT shortly after aggression with regard to bus drivers shows that the anxiety was reduced after a single session of CBT.
A randomised study by Bisson et al (2004) shows that a short period of CBT that was offered 5 to 10 weeks after a road traffic accident involving physical injury has a positive effect on the reduction in PTSD symptoms compared with a control group (waiting list). This CBT consisted of 4 weekly sessions each lasting 1 hour and on average began 5 weeks after the accident.
In a randomised study by Sijbrandij et al (2007) into the effectiveness of 4 sessions of CBT given from 3 weeks to 3 months after a shocking experience, a week after the intervention a positive effect was measured on PTSD symptoms, anxiety and depression. However, 4 months after the intervention the differences between the group that was given the short period of CBT treatment and the control group (waiting list) was no longer significant.
Foa et al (2006) compares the effect of 2 short interventions (4 sessions of CBT and 4 sessions of supportive counselling) with a waiting-list control in women who had been victims of a violent crime 2 days to 46 days before. They found that both interventions led to a reduction (self-reported) in the severity of PTSD, depression and anxiety. A short period of CBT also led to a greater (self-reported)

reduction in the severity of PTSD and anxiety than supportive counselling. After 9 months the outcomes of the 2 interventions were the same. According to Foa et al, these results suggest that a trauma-focused intervention speeds recovery in victims with severe PTSD symptoms. Bryant et al (1998) also found a greater reduction in PTSD symptoms as a result of a short period of CBT compared with supportive counselling.
This reduction was found both immediately after treatment (on average 9.5 days after the trauma) and 6 months after the trauma.

Conclusion

Level 2	A short period (5 sessions) of trauma-focused cognitive behavioural therapy for the treatment of Acute Stress Disorder leads to a reduction in PTSD symptoms a number of months after the stressful life experience. A2 Bryant et al 2005 B Bryant et al 1999

Level 1	A short period (4 or 5 sessions) of trauma-focused CBT in the first few weeks after a shocking event leads to a reduction in PTSD symptoms a number of months after the stressful life experience. A2 Bisson et al 2004; Bryant et al 2005; Sijbrandij et al 2007 B Bryant et al 1998; André et al 1997; Foa et al 2006

Level 4	Studies show that relaxation does not have any added value above trauma-focused CBT. B Bryant et al 1998; Echeburua 1996

Other considerations
A psychological intervention must only be offered after people have been brought to safety, and are in a more stable situation. Those affected by disasters, terrorism or other shocking events probably do not benefit from traditional psychological interventions that are focused on symptoms of anxiety and grimness if they are rightly concerned about their physical welfare, safety, shelter or financial problems (Litz et al 2002).

Recommendation

The study group recommends treatment with trauma-focused cognitive behavioural therapy (CBT) for those affected who have an acute stress disorder (ASD) or severe symptoms of post-traumatic stress disorder (PTSD) in the first month after a shocking experience.

The study group recommends that relaxation should be offered only as part of CBT, not as a (non-trauma-focused) intervention on its own.

6.2 Eye movement desensitization and reprocessing (EMDR)

Eye movement desensitization and reprocessing (AMDR) is a psychotherapeutic procedure that is aimed explicitly at the treatment of PTSD and other anxiety disorders after a shocking event. EMDR was introduced in 1989 by the American psychologist Francine Shapiro.
A striking difference compared with other treatment methods, such as 'imaginary exposure', is that with EMDR, after activating the traumatic memory an external stimulus is introduced (usually the therapist's hand moving backwards and forwards, which is followed by the patient's eyes). After each set of eye movements the patient is asked to concentrate on the most striking change in his perception, after which he follows a new set (for about 45 seconds). Although the element of the eye

movements has been given the most attention, Shapiro (1996, 2001) stresses that EMDR is a treatment that contains several components.

Scientific basis
There is now evidence of the effectiveness of EMDR as a treatment for chronic PTSD. For example, a number of meta-analyses and systematic reviews have determined the effect of EMDR on chronic problems of PTSD (Maxfield & Hyer 2002; Van Etten & Taylor 1998). A recent meta-analysis by Seidler & Wagner (2006) shows no difference in effectiveness between trauma-focused CBT and EMDR as a treatment for chronic PTSD. The guidelines of the International Society for Traumatic Stress Studies (Foa et al 2000) also concluded that EMDR is an effective treatment for PTSD. There is no scientific support for the use of EMDR in the first six weeks after a stressful life event, since no RCTs have been carried out yet into the effect of early EMDR (Watson et al, 2002; Watson et al, 2003). In a non-controlled study by Silver et al (2005) in those affected by the terrorist attacks of 9 September 2001 in the USA, the effectiveness of early EMDR was compared (2-10 weeks after the disaster) with EMDR given later (30-48 weeks after the attacks). No difference was found between the two groups. A clear limitation of this study was that there was no control group.

Conclusion

Level 3	There is insufficient scientific support as yet for the use of EMDR in the first six weeks after a stressful life event. C Silver et al (2005)

Other considerations
Silver et al (2005) point out that symptoms may increase unnecessarily if an intervention is delayed, whereas an effect can be achieved even in the acute phase after a disaster.

Recommendation

The study group recommends further studies into the effectiveness of EMDR as a curative early intervention in the first six weeks after stressful life events.

6.3 Relief with medication

Scientific basis
Two randomised controlled studies into the use of medication shortly after a trauma are known (Schelling et al 2001; Pitman et al 2002). In view of the small size of these study populations it is not possible to draw conclusions about pharmacotherapy as an early intervention.
A small study carried out by Gelpin et al (1996) showed that benzodiazepines are not effective as a treatment for acute post-traumatic stress reactions.
At present there is no scientific evidence to show that any form of pharmacotherapy is effective as an early intervention in the treatment of PTSD symptoms or other trauma-related problems such as anxiety disorders and depression. Studies are however being conducted in which it is being investigated what substances may indeed be used as an early intervention.
According to the NICE guideline, pharmacotherapy may be considered in the acute phase of PTSD for the treatment of sleep disorders. If medication for sleeping is being considered, non-benzodiazepines can be chosen (mirtazapine, zolpidem, zopiclone).
If benzodiazepines are chosen nevertheless, it is preferable to take medication with a short half-life – so-called soporifics (NICE guideline, NHG Standard on sleeping problems and sleeping tablets, 2005). Benzodiazepines are expressly not indicated as a treatment for ASD (Gelpin et al 1996). If medication is needed for a lengthy period, antidepressants may be considered in order to reduce the risk of dependency.

Other disorders that can develop after a traumatic event are depression or anxiety disorders. For the drug treatment of these disorders, see:

- Guideline on Depression (NVvP, National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care)
- Guideline on Anxiety Disorders (NVvP, National Steering Committee on Multidisciplinary Guideline Development in Mental Health Care)

Conclusion

Level 4	Experts are of the opinion that pharmacotherapy may be considered in the acute phase of PTSD for the treatment of sleep disorders. D NICE guideline

Level 3	There are indications that benzodiazepines are not indicated for the treatment of ASD. C Gelpin et al 1996

Other considerations
The study group does not have any other considerations.

Recommendation

The study group recommends that in the event of sleep disorders as a result of the trauma, pharmacotherapy may be considered. For any drug treatment for sleep disorders, depressive disorders or anxiety disorders, the study group refers the reader to the existing guidelines.

6.4 Workplace-focused interventions

Workplace-focused interventions are interventions that take place after shocking events that are related to the activities or the working conditions. In the case of individual psychological interventions, the company doctor works in accordance with the guidelines of the Netherlands Society of Physicians in Occupational Health [Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde (NVAB)]: *Handelen van de bedrijfsarts bij werknemers met Psychische Klachten* [Practice among company doctors for employees with mental problems].
As well as acute relief among colleagues after a shocking event, employees who stand out due to persisting problems or long-term absence from work can be brought to the attention of the company doctor and any other company relief workers via the Social Medical Consultative Body.

If necessary, consultation takes place in accordance with the NVAB-LHV (guideline for company doctors on working with GPs, NVAB and the Dutch General Practitioners Association [Landelijke Huisartsen Vereniging (LHV)]. Referral to a (company) psychologist or other treatment institute is also possible. In this way, during treatment for problems after disasters, terrorism or other shocking events the factor of work can also be taken into account. In the event of (recurring) shocking events at work, workplace-focused interventions can be developed. The nature of the shocking event plays an important part in the developing of interventions. Individual aspects to be assessed include the occurrence of limitations, absence from work and the establishing of a possible industrial illness in the employee(s) as a result of exposure to one or more repeated shocking events. In general, attention is devoted to possible social and economic consequences. These results may lead to a study in the workplace (*Stock-taking of Risks and Evaluation*) working with other disciplines such as safety experts and occupational health experts. In the plan for the approach for work-related interventions in CBO guidelines of the NVAB (*Blaudruk voor de aanpak van werkgerelateerde interventies in CBO-richtlijnen)*, a general methodology is described on the basis of which interventions can also be developed for limiting or even preventing the employee from being exposed to shocking events.

Scientific basis
Boscarino et al (2005) conclude, on the basis of their prospective study after the attacks of 11 September, that early interventions at the workplace result in a significant reduction in psychological problems, up to 2 years after the first interventions. The study was about all the short early

interventions (related to dealing with the effects of the attacks on 11 September) that were led by a mental health care worker or counsellor and that were organised by employers for their employees (among others, CISM, PD, and other trauma-focused short interventions). The results show that the optimum effect is achieved with 2 to 3 short sessions. The investigators report that they were surprised at the consistent effect that was visible by any measure, and conclude that this underlines the importance of their results. Devilly & Cotton (2003) believe that it can be concluded from this study that a healthy workplace is a more productive workplace. The most reliable method of preventing a workplace from becoming disturbed after a shocking event is however still open for discussion.

Conclusion

Level 3	There are indications that workplace-focused interventions result in a significant reduction in psychological problems, up to two years after the interventions. B Boscarino et al 2005

Level 4	It is still unclear what method of workplace-focused interventions is the most effective. C Devilly & Cotton 2003

Other considerations
In practice, consideration, recognition and the sharing of experiences with colleagues by those affected appear to be valued positively. In the case of workplace-related shocking events in this way the natural sources of help are used by those affected.
Those affected also stress that employers have a responsibility to help those who have been affected by a shocking event at work or away from work in coping with these events. They point out that in the event of a shocking event during working hours the employer should ensure that they are provided with information properly and support the normal process of recovery. The employer should also look out for chronic problems so that professional aftercare can be deployed.

Recommendation

The study group recommends that the employer should offer counselling (to be carried out by a relief worker or trained volunteer) if a shocking event takes place at work.

6.5 Curative interventions for specific risk groups

6.5.1 Children

6.5.1.1 General

There is consensus among those involved with children and young people about the value and the benefit of protocolled interventions after shocking events in children who have evident psychological problems. If a referral is made at an early stage, a suitable and short period of treatment is possible. The starting point is that in this way lags in development and a long-lasting psychopathology can be prevented.

Scientific basis
The form and content of early interventions in children after shocking events has hardly been studied systematically as yet. There is however agreement that early intervention with children must consist of a number of contacts. By spreading them out over time, the progress of the coping process can be followed over time. Parents play an important part in the recovery of their child and should be involved in support all the time. The more the child is dependent, the more intensively the parents are brought in (De Roos & Eland, 2005).

Conclusion

Level 3	Early curative intervention is needed for children with clinically evident problems. Early interventions in children must consist of a number of contacts. An outreaching approach is advisable. D De Roos & Eland, 2005

6.5.1.2 Trauma-focused cognitive behavioural therapy in children (TF CBT)

Scientific basis
At present, most of the empirical evidence for trauma-focused cognitive behavioural therapy consists of a number of controlled randomised studies, which have mainly been carried out in children who have been sexually abused (Cohen 2003; Cohen, Deblinger et al 2004).
Three of these RCTs evaluate the effect of trauma-focused CBT within 1 to 6 months after sexual abuse (Cohen & Mannarino 1996; Deblinger et al 1996; Mannarino 1998). These trials support the effectiveness of trauma-focused CBT in children in respect of PTSD symptoms, depression, social functioning and behavioural problems.
Cohen (2003) concludes that on the basis of the data that was available at the time trauma-focused CBT appears to be the most promising intervention in the acute phase after a trauma.
Cohen (2003) notes however that few studies attempted to ascertain what components in the trauma-focused CBT are critical elements for its effectiveness. In a study by Deblinger et al (1996), the participation both of parents and of the child in the intervention proved to be essential for an optimum effect to be achieved. It is however unclear to what extent these findings can be generalised to children who have been exposed to traumas other than sexual abuse. Also, Cohen (2003) states that there is still no reliable information available regarding the optimum duration and number of trauma-focused CBT sessions.
The name trauma-focused cognitive behavioural therapy suggests that it is one type of treatment, but each protocol is made up of various elements, the order of which can vary. As a result, the results of the various studies are difficult to compare and it is difficult to draw conclusions (De Roos & Eland, 2005).
In the various protocols, in 10 to 18 sessions there is a significant reduction in various problems. This method is used in particular with children from 6 to 8 years of age. The question is to what extent it is suitable for young children in terms of the requirements it makes on their cognitive abilities.
The NICE guideline (2005) recommends trauma-focused cognitive behavioural therapy in the first month after the shocking event in older children (> 7 years old) with severe symptoms of PTSD.

Conclusion

Level 4	There are indications that early trauma-focused cognitive behavioural therapy (CBT) is an effective method of treatment for severe symptoms of PTSD in children more than 7 years of age

Other considerations
One difference from giving support to adults is that children depend on their parents to find a way to obtain support. The result of this is that often it is only late, or not at all, that they are reported for diagnosis or treatment. There is consensus on the importance of an *outreaching approach* in the support given to traumatised children.
However, even with an active approach it is evident that many children with severe problems do not get support (Dorresteijn et al, 2003). The reasons for this have not yet been explained.
The NICE guideline stresses the importance of adapting a protocol for cognitive behavioural therapy to the age of the child. Involving the family in the therapy is also given as an important point for attention.

Recommendation

The study group recommends treatment with trauma-focused cognitive behavioural therapy (CBT) for children, more than 7 years of age, with severe symptoms of acute post-traumatic stress and/or an acute stress disorder in the first month after a shocking event.

6.5.1.3 EMDR in children

Scientific basis
As yet there is no empirical evidence for the use of EMDR as a preventive intervention in children and adolescents. At present two controlled studies have been published that demonstrate the effectiveness of *eye movement desensitization and reprocessing* (EMDR) in children and adolescents with chronic PTSD (Chemtob et al 2002; Jaberghaderi et al 2004).

Conclusion

Level 4	As yet there is no empirical evidence for the use of EMDR as an early curative intervention in children and adolescents.

Other considerations
The study group is of the opinion that, in view of their age and stage of development, children should be free of symptoms of post-traumatic stress as quickly as possible.

Recommendation

The study group recommends further studies into the effectiveness of EMDR as an early curative intervention in children.

6.5.1.4 Pharmacological interventions in children

Scientific basis
Just one RCT is known in which the effect of pharmacological interventions in children with ASD was studied.
This study (Robert et al 1999) showed that children who had been affected by a fire who were given imipramine in the acute phase developed significantly fewer PTSD symptoms than children who were given chloral hydrate.
An open study by Saxe et al (2001) showed a significant relationship between the dose of morphine that children with burns were given in the acute phase in hospital and PTSD symptoms after 6 months.
Other non-randomised studies also suggest that there are promising pharmacological agents for reducing long-term PTSD symptoms which should be studied further in future controlled trials.

Conclusion

Level 3	There are indications that pharmacotherapy can reduce PTSD symptoms in children.

Other considerations
The study group is of the opinion that the amount of research that has been carried out into pharmacotherapy in children is not enough to make recommendations based on it.

Recommendation

The study group recommends further studies into pharmacological interventions in children.

6.5.2 Ethnic minorities

Scientific basis
Doherty (1999) reports that the symptoms of those affected from different cultures are often associated with PTSD, depression and anxiety disorders.
Doherty (1999) emphasises that if one or more people with an ethnic background are affected by a shocking event, cooperation should be sought with emergency workers and spokesmen from that culture.
Further, Doherty (1999) points out that there should be special consideration and sensitivity to the role of family and of rituals in those affected who have a different cultural background.

Conclusion

Level 3	Those affected from different cultures have identical symptoms that are associated with PTSD, stress and anxiety disorders. C Doherty 1999

Other considerations
If ethnic minorities are affected by a disaster, the starting point is to approach these groups as regularly as possible and as culture-specifically as necessary. This could include, for example, include paying particular attention to language problems, culture-specific (mourning) rituals or a more active approach in offering early psychosocial interventions.
Because for many migrants certainly in stressful circumstances it is difficult to use, talk in or understand Dutch, it is important that information is given in their mother tongue. In addition, key figures from ethnic minority groups should be brought in to make support accessible and to ensure that it fits in with their culture.

Recommendation

The study group recommends approaching ethnic minorities as regularly as possible and as culture-specifically as necessary. In the opinion of the study group culture-specific elements may consist of giving information in their mother tongue and involving key figures from ethnic minority groups.

7 Organisation

7.1 Organisation

In this chapter the study group seeks to give an answer to the following starting questions about how care should be organised after shocking events.

- What is known about the relationship between the type of organisation and the nature of the event?
- What is known about the relationship between the type of organisation and the scale of the event?
- What is known about the relationship between the type of organisation and the target groups affected by the event?
- What is known about the relationship between the type of organisation and the location of the event?
- What is known about the relationship between the type of organisation and the time of the event?
- What other circumstances influence the organisation of care after shocking events?

Early psychosocial interventions after disasters, terrorism and other catastrophes must take place within the legal framework established for this. The starting points are that every disaster has its own characteristics and that the care must be offered as regularly as possible and that there is accessible, low-threshold and integrated psychosocial care.
The legal frameworks that apply to disasters and major accidents fall outside the scope of this guideline. For more information, see the Disasters and Serious Accidents Act (WRZO), the Law on Medical Help in Disasters (WGHOR), the Disaster Response Improvement Act and the Public Health Collective Prevention Act (WCPV).
Legislation and developments in the area of crisis control and disaster control are discussed in detail in the Basisleerstof GHOR (NIFV 2006) [Medical Assistance in Accidents and Disasters]. Further information, about psychosocial care among other things, can be found in the Manual on Preparing for Disaster Control and the National Model Process Plan for Psychosocial Support in Emergencies and Disasters.

The process of psychosocial relief has common ground with other processes in crisis control. This guideline should therefore also be fitted in with the regional systems on crisis control.

7.2 The competences needed for carrying out interventions

The study group is of the opinion that the preliminary and primary sector, working with volunteers and members of the emergency services, are responsible for the first relief and offering early psychosocial interventions. Volunteers, GPs and social workers and those working in psychosocial support after accidents and disasters (PSHOR) have an important part to play here. If they suspect that there may be a psychopathology, they bring in the secondary sector. People working in the secondary sector should be trained in the specific interventions they offer. The relief workers in the primary and preliminary sector, volunteers and the emergency services personnel who are deployed after a shocking event must have a number of competences, which are described below.

Scientific basis
Parker et al (2006) are of the opinion that most *'public health workers'* have no training or experience in giving early psychosocial interventions. They argue that neither is it realistic to train this group in offering the whole range of early interventions. Offering psychological first aid – a supportive context – can however be a suitable task for those who are willing to take special training. They suggest a number of *evidence-informed* competences that *'public health workers'* must satisfy:

- be able to listen actively;
- be able to prioritise and react to the needs of those affected;
- be able to recognise minor psychological problems and give information about it;
- be able to recognise potentially serious psychological problems and give information about it;
- communicate techniques for dealing with ASD;
- be able to recognise risk factors for a poor outcome for mental health and reduce this risk through greater alertness;
- be able to recognise and use informal and formal sources for inter-personal support;
- know when and how to refer someone for more formal forms of mental health care.

Conclusion

Level 4	There are indications in the literature that early interventions should be carried out by people who are trained/have been given special instruction. D Arendt & Elklit 2001

Other considerations
Straight after a disaster often there is no time to give volunteers and professionals thorough training. For this reason basic training in the preparatory phase is important. In addition to basic training, after disasters it is often necessary to give information specifically about the disaster situation (for example about burns or legionella), perhaps combined with supervising. After some time has passed the specific information can be given in a more structured way in the form of follow-up training by specialist experts.

Recommendation

The study group recommends that early psychosocial interventions should be carried out by people who are trained/have been given special instruction.

7.2.1 The competences needed for carrying out interventions in children
To enable the professionals who work with children on a daily basis to offer the children a supportive context after a shocking event, schools are entitled to be supported by behavioural experts who help to:

- manage the professionals' own reactions to what has happened;
- discuss how the professionals can act as a model for the children and their parents in coping with what has happened;
- give the professionals a grip on the events in the initial period after the event and together with parents and children choose how they want to arrange things and activities.

Teaching professionals must also be able to call on behavioural experts who make them alert to children who have a high risk of coping problems and signs of clinically evident problems. Further help for children who cannot cope with the normalising approach in groups and who create unrest in the group must be available close to school and at home.

7.3 Collective preventive and community-based interventions
After a disaster, both collective (in groups of those affected) and individual early psychosocial interventions are offered. Strictly speaking, collective early interventions fall outside the scope of this guideline. Because however they form an essential part of the integrated package of post-disaster psychosocial care, they are dealt with here nonetheless.

Those affected are also in favour of a single contact point being established for questions and problems after a disaster or shocking event. What they have in mind here are interventions such as a buddy system, a single office system or the use of victim support.
Without being a complete list, a number of examples of collective interventions are: a single office function such as an Information and Advice Centre (IAC) or a virtual Centre for Information and Referrals, reporting in the media, a platform for those affected, a specialist mental health care team, health assessment surveys and the government policy that is to be implemented. A number of recommendations for some of these collective interventions are given below.

7.3.1 Information and Advice Centre (IAC)
An IAC should be set up in the week after a disaster. The IAC itself does not provide any help. This is the task of the support agencies. An IAC is the only organisation that comes about because of a disaster and which is also responsible for the ups and downs of those affected. An IAC should therefore always be aware of how things are with those affected in order, on the basis of this, to activate and guide the support. So the IAC must constantly be obtaining information, but also give help and advice to those affected and the support agencies. A disaster can be compared to an epidemic in

which a certain approach is needed in order to reach large numbers of people. Those affected are large in number, but they usually have the same questions. By using the media all those affected can be reached within a short time. The period for which an IAC is active can vary. In Norway experience has been obtained with an IAC that was active for a short period (Weisath, 1991), in Enschede and Volendam with an IAC for a period of 3-5 years (Gersons et al, 2004; Assocation of Netherlands Municipalities [Vereniging Nederlandse Gemeenten (VNG)], 2004; Health Council of the Netherlands, 2006). After the firework disaster in Enschede a long period was chosen in the expectation that the extra structure that the IAC creates for monitoring the recovery of those affected would then have a sufficient effect. Further studies will have to be carried out in order to establish to what extent a long-term IAC is beneficial in limiting the consequences of a disaster.

The main activities of an IAC are:
- to reach and keep contact with all those affected (outreach);
- to collect all the questions of those affected;
- to find and give answers to the questions;
- to monitor the condition of those affected;
- to give advice about help if this is sought.

7.3.2 A platform for those affected
Without wishing it, people who have been affected by a disaster find themselves in a dependent and sometimes a handicapped situation. In Enschede 1,250 people lost their homes. The IAC helped to make those affected not dependent on a range of agencies. The experiences with the Bijlmer disaster and also the Faro aviation disaster (Ten Hove, 2002) have made it clear that those affected need an organised association to speak for them. This is why with the Enschede disaster the creation of an association for residents and those affected with professional support was actively encouraged. This *'empowerment'* contributed to the residents actively promoting their own interests with the authorities and agencies. The Association for the Victims of the Enschede Firework Disaster also fulfils a role in providing information about the material, physical and psychological consequences of the disaster and what can be done about it. This residents association has been actively involved in dealing with the compensation claims and the plans for rebuilding the district. It is also actively involved with the memorials. The setting up of platforms such as this should be encouraged after any disaster.

7.3.3 Specialist mental health care team
The key task of mental health care in aftercare following a disaster is the diagnosis and treatment of the psychological disorders brought about by the disaster, in particular PTSD, anxiety, depression, problems for which there is no physical explanation and problems of addiction. After the firework disaster in Enschede the local mental health care organisation Mediant set up a specialist 'Firework team' of about 30 mental health care relief workers. These people are trained in specific forms of treatment focusing on PTSD (Gersons & Carlier, 1998) for adults and children. By having the relief workers carry out intakes no more than 2-3 days a week the aim was to avoid secondary traumatisation of the relief workers and ultimately 'monotonousness'.
As well as this key task, a mental health care team can have a range of tasks after a disaster, such as: additional training and consultation for other relief workers, prevention activities in the form of discussion groups for adults, support for ethnic minorities, activities for young people, support for teachers and schools and other forms of public information. In 2003 a campaign was held through 'Loesje' to encourage more people who are having problems to seek treatment. These activities can be arranged and carried out in cooperation with other care providers such as social services, the primary health care sector and home care.

7.3.4 Health assessment surveys
An important lesson of the consequences of the Bijlmer disaster was the setting up of the Health Monitoring Programme for those Affected by the Enschede Firework Disaster (GGVE) in order to be able to monitor the health of those affected and based on this direct the support appropriately. Two measurements were carried out, one 3 weeks and the other 1.5 years after the disaster (Van Kamp & Van der Velden, 2001); Van Kamp et al, 2006; Van der Velden et al, 2002, 2005, 2006: Grievink et al, 2002, 2004; Dorresteijn, 2003).
The third measurement took place after 2.5 years. Monitoring examinations are carried out by GPs and company doctors. Surveys are carried out among young people and ethnic minorities, and also an in-depth study into how their health progresses in connection with biological factors.

Recommendation

The study group recommends that collective early interventions form an essential part of the integrated package of post-disaster psychosocial care. The use of these interventions should therefore be ensured.

The study group recommends that in the first six weeks after a disaster a good support system should be set up.

7.4 Information

Information must be provided after a disaster, terrorist attack or other shocking event. For this to run smoothly, information must be given a fixed place in the various policy plans. The municipalities control information through the media. If children are involved in a disaster, the way in which the information is expressed must be specifically tailored to children's level of understanding and their experiences. Work can be carried out with youth health care services, within which in particular the Municipal Health Services play a central role. The work also has to be coordinated with the Information and Advice Centre.

Recommendation

The study group recommends that information is given a fixed place in the various policy plans in order for this to run smoothly.

Appendix 1 Names

The members of the study group and the organisation they represent or from which they bring in expertise.
The study group was chaired by Prof. Dr. C. Spreeuwenberg, senior lecturer in the integration of care for chronic illnesses, University of Maastricht.

Name of study group member	Organisation	Works at/with
Mw. dr. E.C. van Doorn	Netherlands Institute of Psychologists [Nederlands Instituut van Psychologen (NIP)]	University of Utrecht, lectureship Behavioural problems in teaching
Prof. dr. B.P.R. Gersons	Netherlands Psychiatric Association [Nederlandse Vereniging voor Psychiatrie (NVvP)]	AMC de Meren
Drs. W.C. Tuinebreijer	Netherlands Psychiatric Association [Nederlandse Vereniging voor Psychiatrie (NVvP)]	Municipal Health Services, Amsterdam
Drs. R. van Doesburgh	Dutch College of General Practitioners [Nederlands Huisartsen Genootschap (NHG)]	GP in Enschede
Dhr. T. Siersma[1]	Mental Healthcare Nursing Federation [Federatie Verpleegkunde in de Geestelijke Gezondheidszorg (FVGGZ]	Mental health care association [GGZ] De Grote Rivieren
Dhr. W. van Dalen[1]	Mental Healthcare Nursing Federation [Federatie Verpleegkunde in de Geestelijke Gezondheidszorg (FVGGZ]	Municipal Health Services, West Brabant
Drs. J.J. Berendsen	Dutch Association for Psychotherapy [Nederlandse Vereniging voor Psychotherapie (NVP)] Institute for Psychotrauma (IvP)	Institute for Psychotrauma
Mw. drs. C.J.A.M. de Roos[2]	Dutch Association for Psychotherapy [Nederlandse Vereniging voor Psychotherapie (NVP)]	Psychotraumacentrum Kinderen en Jeugd, GGZ Rivierduinen
Mw. A.J. Roes	Netherlands Association of Social Workers [Nederlandse Vereniging van Maatschappelijk Werkers (NVMW)]	GIMD B.V.
Dhr. H. Ensing[1]	Council of Regional Medical Officers [Raad van Regionaal Geneeskundig Functionarissen (RGF)]	Regional medical officer (RGF), IJssel-Vecht region
Dhr. C. Dekkers[1]	Council of Regional Medical Officers [Raad van Regionaal Geneeskundig Functionarissen (RGF)]	Regional medical officer (RGF), Zuid-Holand-Zuid region
Drs. W.A.L. Godefroy	Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde (NVAB)	KLM Health Services
Dr. W.H.M. Gorissen[2]	Netherlands Association of Policy, Management and Research Physicians [Nederlandse Vereniging Artsen Beleid Management Onderzoek (NVAG)]/Society and Healtchare Physicians Umbrella [Koepel Artsen Maatschappij en Gezondheid (KAMG)]	AMC de Meren, mental health care
Prof. dr. A. de Jongh	D.O.E.N. [Directe Opvang en Nazorg – Immediate relief and aftercare] bv	D.O.E.N. [Directe Opvang en Nazorg – Immediate relief and aftercare], Academic Centre for Dentistry in Amsterdam (ACTA) and Centre for Psychotherapy and Psychotrauma
Drs. P.M. Sanders	Military Mental Health Care Institute [Militaire GGZ] of the Ministry of Defence	Ministry of Defence
Drs. A. Laney	Victim Support Netherlands [Slachtofferhulp Nederland]	Victim Support Netherlands[Slachtofferhulp Nederland]
Ing. D.P. Pattynama, MCDM	Medical Assistance in Accidents and Disasters Department [GHOR] - Fire Department	Relief work service [Hulpverleningsdienst] Brabant-Noord
Dhr. J.G.J. Tuinder	Police	Police Academy of the Netherlands
Mw. drs. E.M. Sijbrandij[2]	Science	Psychotrauma Premium Care Programme [Topzorgprogramma Psychotrauma] - AMC de Meren
Dr. A.A.P. van Emmerik[2]	Science Dutch Association of Behavioral and Cognitive Therapy [Vereniging voor Gedragstherapie en Cognitieve Therapie (VGCT)	Leiden University, Faculty of Social Sciences, Clinical and Health Psychology department
Mw. dr. M. de Vries[2]	Impact, Dutch knowledge & advice centre for post-disaster psychosocial care	Impact

[1] These members shared a place on behalf of the organisations they represented.
[2] These members made up the editorial committee.

During the development of the guideline the following members of the study group left the study group – for reasons not connected with the contents – or never appeared.

Name of study group member	Organisation	Works at/with
Mw. T. Hoekstra	Mental Healthcare Nursing Federation [Federatie Verpleegkunde in de Geestelijke Gezondheidszorg (FVGGZ]	MEDIANT
Mw. K. Matlung	Netherlands Psychosocial Disaster Relief Consultative Body (OPRON) Institute for Psychosocial Support for Emergency and Disaster Preparedness [IPSHOR]	IPSHOR
Dhr. W. van Broekhoven	Pastoral service at Schiphol Airport	Pastoral service at Schiphol Airport

Names of other colleagues.

Colleagues	Organisation	Works at/with
Mw. dr. M. de Vries	Impact, Dutch knowledge & advice centre for post-disaster psychosocial care	Project leader, Impact
Mw. drs. D. van Duin[2]	Trimbos Institute	Project leader, Trimbos Institute, and Guideline adviser
Mw. drs. E. Fischer[2]	Trimbos Institute	Guideline adviser
Dhr. dr. L. Henkelman	Trimbos Institute	Secretary of the National Steering Committee on Multidisciplinary Guideline Development
Mw. L. Muis	Trimbos Institute	Project assistant

Present at the meeting of those affected

Name	
Dhr. T. Smedes	Police
Mw. M.A. Schutte-Fiolet	Affected by a fire
Mw. H. Wanders	Affected by a fire
Mw. Nese Dogan	Amercentrale disaster (neighbour)
Dhr. Akin	Amercentrale disaster (neighbour)
Dhr. J. Derks	Fire Service
Mw. J. Janboers	Faro plane crash
Dhr. Janboers	Faro plane crash
Mw. H. Spreij	Bijlmer disaster
Mw. D. Klanke-Heil	Bijlmer disaster (nurse)
Mw. M. Perk	Zanderij plane crash

Appendix 2 Starting questions

Aim (see Chapter 2)	
1.1	Are aims described for carrying out interventions?
1.2	If so, with what aim(s) should early interventions be carried out?

Screening (see Chapter 3)	
2.1	Are there screening instruments or other methods for tracing people who have a high risk of developing problems that can be used in the first 6 weeks after disasters, terrorism and other shocking events. If so, which ones?
2.3	How effective and suitable are these screening instruments?
2.4	Are negative effects known of screening in the first six weeks?
2.5	When should the screening be carried out?
2.6	Should the screening be repeated?
2.7	Are there screening instruments or other methods that can be used specifically in certain types of shocking events? If so, which ones?
2.8	Are there screening instruments or other methods that can be used specifically in certain risk groups? If so, which ones?

Intervention (see Chapter 4, 5 and 6)	
3.1	What early interventions are described in the literature?
3.2	In what form and at what stage(s) should the various interventions be carried out in the first six weeks?
	• How many sessions should early interventions consist of (at least)?
	• When should they be started?
	• When should the early interventions be repeated?
	• Which of these early interventions should be carried out in groups and which should be carried out individually?
3.3	How effective and suitable are these early interventions?
3.4	What is known about side-effects and contra-indications of early interventions?
3.5	What competences are needed for carrying out these early interventions?
3.6	At what stage(s) should the effect of the early interventions be evaluated?
3.7	Are there early interventions that can be used specifically in certain types of shocking events? If so, which ones?
3.8	Are there early interventions that can be used specifically in certain risk groups? If so, which ones?

Organisation (see Chapter 7)	
4.1	What is known about the relationship between the type of organisation and the nature of the event?
4.2	What is known about the relationship between the type of organisation and the scale of the event?
4.3	What is known about the relationship between the type of organisation and the target groups affected by the event?
4.4	What is known about the relationship between the type of organisation and the location of the event?
4.5	What is known about the relationship between the type of organisation and the time of the event?
4.6	What other circumstances influence the organisation of care after shocking events?

Appendix 3 Experiences of those affected

Introduction

Among the various providers of 'early interventions after a disaster' there is a need for a national guideline with an overview of the most up-to-date scientific facts and recommendations based on these facts and on a consensus between key figures. But however well a guideline is supported based on scientific evidence, if the recommendations do not fit in with the wishes and needs of those affected, the guideline is unusable in practice. Those affected can draw little benefit from a guideline that does not take their needs into consideration or in which recommendations are made that cannot be implemented in practice because the costs involved are too high, or if they cause a great deal of inconvenience or entail high risk. The Health Council (2000) argued that as well as being 'scientifically solid', guidelines must also reflect the preferences of patients (in this guideline those affected).
This is why as part of the development of the guideline Impact and the Trimbos Institute took stock of the preferences of those affected with regard to early interventions after shocking events. To do this, various organisations involved in promoting the interests of those affected by different disasters and other shocking events were approached, asking people to represent these organisations. For example, contact was made with the association for people suffering from burns, the Impact national knowledge centre for post-disaster psychosocial care, the police, the fire service, Victim Support, the association for parents whose children have been murdered and Vangrail support and aftercare. Following this invitation, fourteen representatives were put forward. At a group interview twelve of them gave their views on what psychosocial care is needed for people who have been affected. The reactions from this group interview were put into a document that was sent to all the representatives for them to comment on and which was approved by the Client Participation Committee. Where this appendix refers to people who have been affected, this means those who have been affected directly and also indirectly.

Acute phase

Those affected say that for them, in the acute phase after a disaster or other shocking event it is important that the relief consists of things such as attention, coffee and something to eat. At that stage the most important thing is that straight away there are people there with a friendly word, some gestures of comfort or a cup of pea soup. That people say: 'Are you OK, do you want something to drink, take a seat'. Those affected agree that it is not a bad thing if professional mental health care workers do not come until a few hours or days after the disaster. This 'psychological first aid' can also be given by (trained) volunteers, fire service personnel, ambulance personnel, members of the family or colleagues.

Consideration

Psychological first aid should be offered in the initial phase after a disaster. This help does not have to be provided by mental health care professionals.

Active support

Those affected appreciate it if in the case of relief being provided on a large scale, such as in a gym for example, it is not announced that there are psychologists available who you can go to if you are having psychological problems. At that stage people who are affected often do not realise yet that they have a problem or do not make themselves known because they want to give the impression that everything is all right. They prefer to see small groups form at the place in question to talk about what has happened. Those affected stress: "Try to get those affected to talk. It is only when you tell your own story that the problem comes to the surface". In the case of shocking events that are on a smaller scale, if necessary someone to talk to can be allocated for each person.
Above all it is important that those affected can tell their *own* story, which can then be taken up by someone else. It is experienced as being upsetting if 'emotions are rooted around in' with questions such as: 'What happened then? What did you feel? What did you see?'
If necessary, after telling his story someone who has been affected can be referred for more professional help.
In the follow-up period as well, those affected are in favour of an *outreaching* approach. If straight after the trauma those affected say they do not need any help, it may be prudent to try to make contact

again after a while. If they see worrying symptoms, care givers cannot wait for those affected to act on their own initiative. Those affected are not the right people for that.

Those affected also point out the importance of making it possible, after a disaster or other shocking event, for people to make contact with people who have had similar experiences. These contacts should be organised in self-help groups or groups of people with similar experiences.

Consideration

Actively offer all those affected a listening ear and do not wait until they themselves contact a relief worker. Give those affected the opportunity to tell their *own* story.

Also, offer those affected the opportunity to make contact with people who have had similar experiences in the form of self-help groups or groups of people with similar experiences.

The time when care is given
The people who had been affected who were present are of the opinion that if an investment is made on the spot in some gestures of comfort and a listening ear, this can prevent psychological problems occurring later. They reason that it is better to let too many people tell their own story than miss out some people who badly needed to do so. If you do not invest enough in this in the early phase, in their view in a later stage it is much more difficult 'to put it right' with psychosocial treatment. They say that this opportunity must be given to those affected within 24 hours after the disaster. It is also important to let people tell their own story also after a long time has passed. Coping can be a lengthy process. Those affected can feel very much that they are not understood and are lonely if their friends and family assume that it is no longer a matter of concern for them because 'after all it is so long ago now'. With some people who have been affected the GP has helped greatly by visiting regularly, letting those affected tell their own story and referring them after a period.

If those affected have been in a coma, then within 24 hours from the time they can be talked to they must be given the opportunity to tell their story. Those affected and next of kin emphasise that it is important that when these people come round there must be someone sitting next to the bed. Care must be taken that these people do not fall between two stools. It is important that a type of organisation is found to ensure this. For example, a buddy could be brought in as soon as the person comes out of the coma. Once physical recovery is at an acceptable level, then the first six weeks of early psychosocial interventions start. In the case of people affected who have suffered burns it is known that in the first period of physical recovery these people are not open to psychosocial interventions. For this group too, therefore, the period of 'early interventions' starts only when an acceptable level of physical recovery has been reached.
For patients who have been in a coma it is also important that somewhere it has been established what happened with the person on the day of the disaster. In this way this prevents the person affected from having to look for all sorts of documents later, with a great deal of difficulty, and having to wait with a great many questions and uncertainty.

Consideration

Within 24 hours after the disaster (or within 24 hours after they come out of a coma) give those affected the opportunity to tell their story. Give them this opportunity after a long period as well.

In the case of those affected who come out of a coma or who have suffered any other serious physical injury, the period of the first six weeks of early psychosocial care starts once physical recovery is at an acceptable level.

Point of contact
Those affected say that it is important that after the acute phase there is one point of contact where an answer can be found to practical questions. For example, one of the people who were present said that her sick leave had been cancelled by her employer when after the disaster she took this sick

leave with her family in Surinam. At the time she did not know who to phone to resolve this. This issue took up a great deal of her energy and caused her further anxiety. Again, a possible strategy for organising a point of contact is a buddy system. With this, someone who has been affected is linked up with someone who has himself lived through a disaster, or feels capable in some other way. This person can be phoned for questions. This person does not have to be able to provide answers for everything himself, but should however know where help can be found. Other strategies for creating a point of contact are a single-office system after a major disaster, or setting up Victim Support. Those affected feel that it is particularly valuable that Victim Support comes to one's own home and can be used flexibly, whereby if necessary a visit can be made every day, and then the frequency of visits is reduced. They experience a disadvantage in the fact that you yourself as someone affected have to ask them to visit: 'As someone who has been affected, you have to get over so many obstacles'.

Consideration

After the disaster provide those affected with one point of contact for questions and problems. This could for example be through a buddy system, a single-office system or Victim Support.

Screening and monitoring
Those affected who were present are of the opinion that people who have been affected have no problem with filling in a questionnaire the purpose of which is to determine whether someone is at a high risk of chronic psychological problems. Certainly if this questionnaire is presented after about six weeks it does not cause any great problem. Those affected say that a distinction must be made between 'immediate help with normal coping' and 'later psychological care in the event of coping problems'.

If screening is carried out in the acute phase, these two worlds may intersect. Another risk with direct screening is that many normal reactions are also measured which disappear of their own accord. For this reason their advice is not to screen too quickly.

Those who attended also believe that sometimes those affected need help with medical terms and the Dutch language. In the case of people who have been affected who are from ethnic minorities, they advise that this help should be offered by a man and not by a woman. Those affected see the main potential hurdle to be overcome is the difficulty in obtaining the addresses of all those who have been affected. As a solution to this they suggest that people who have walked away after a disaster should be invited by the media to phone a contact number or another point of contact. Another approach that is suggested is to send a text message with information and an invitation to everyone in the area.

Those affected also stress that it is important to keep an eye on those affected for a longer period by monitoring. They reason that: 'It is only later that some people suffer a backlash from the trauma. It is also these people that you want to reach with aftercare.'

Consideration

If screening is used, do no present this to those affected in the acute phase and as necessary offer help in how this is carried out.

Also consider (long-term) monitoring of those affected.

The role of the employer
A number of those affected say that the conflict with the employer following a disaster or other shocking event is sometimes felt to be more traumatic than the disaster itself. Often the employer does not take any responsibility in offering help and in some cases after taking sick leave the person who has been affected is not even taken back in employment. Those affected argue that the employer must recognise his responsibility and support his employees if they have gone through a shocking event inside or outside the company. This support can consist of, among other things: providing space

for the normal coping process, showing understanding, giving permission for sick leave if necessary, or organising psychosocial care. The main thing is that the employer does not drop the employee. Those affected make a plea: ‘Prevent the disaster after the disaster!’

Consideration

Employers have a responsibility to support employees who have been affected by a shocking event inside or outside the company in coping with such an event.

If the shocking event has taken place during working hours, the employer has more specific responsibilities.
For example it is very important that the providing of information about an accident or other shocking event takes place smoothly. All the employees who are affected and the people who are close to them must be aware of: what happened when, and what were the causes and what are the consequences? To do this, an analysis must be carried out shortly after what has happened, the results of which must be communicated within a day. If certain details still have to be investigated, this should be said. It is important that information is communicated well! Clarity should be given as soon as possible. These sorts of reports can also be used later in aftercare. This can help to find back the days that one has ‘lost’ later. Those affected say that this can be extremely valuable.

In the aftercare provided by the employer a clear distinction should be made between normal coping with the traumatic event, whereby for example someone must be able to tell his story, and the professional aftercare in the case of chronic problems. For this, those affected should be followed/monitored carefully in the work environment so that specific care can be provided if this is needed.

It must be realised that sometimes immediate colleagues of the person who has been affected also have very great difficulty with what has happened. Sometimes they are forbidden by their employer from talking with the person affected because the investigation at work has yet to take place. This is damaging both for those affected and their colleagues.

Consideration

If a shocking event occurs during working hours, the employer should ensure that there is a good supply of information, support normal recovery and look out for chronic problems so that professional trauma care can be deployed. This applies both for those affected and also their immediate colleagues.

In the case of organisations such as the fire service, the ambulance service and the police, the employer must realise that uniformed members of the emergency services are people too, and that they too must be able to tell their story! Those affected argue: ‘Also pay enough attention to the coping process on the part of volunteers and other emergency workers’.

For example, volunteers and other emergency workers sometimes worry that in the aftercare phase they have made a wrong decision. If this question of guilt is discussed as soon as possible and perhaps can be removed, the sting can be removed from the problem of coping.

An opportunity to tell their story can be organised with colleagues and volunteers. If debriefing is used for this, in the view of volunteers who are affected a distinction must be made between a form of operational debriefing and a form of more emotional debriefing. First of all a clear story must be established by the service so that everyone has the same picture of what has happened, and then the emotional side can be talked about.

Attitude and tasks of the authorities
Some of those affected and next of kin have found that after a disaster there is a great deal of activity between different representatives of the authorities and that taken together it is difficult to get information. In practice it turns out that remaining well informed is a major problem. Policy-makers and investigators say that they cannot give any information because this might jeopardise the course of the inquiry. Those affected and next of kin say however that after a disaster they have a great need for openness. They suggest that if necessary the results of the inquiry do not have to be given, but that it should be disclosed what inquiry or report is still being waited for and when it is expected to be ready. The literature shows that more health problems occur if the inquiry remains closed. After various disasters it has emerged that it is more difficult for people as soon as more mistrust of the authorities arises and more conspiracy theories arise.

Something else that those affected and next of kin would like is that ministers should keep themselves properly informed of the facts surrounding a disaster. In practice this does not always happen. When in the past it emerged that people had based their actions on incorrect information there was a tendency always to go on the defensive and refuse to make excuses for mistakes that had been made. Those affected and next of kin therefore appeal to representatives of the authorities to accept that it is not their intention to blame the authorities. They argue that the standpoint and the actions of the authorities should be expressed humanly and respectfully. As far as they are concerned there should not be any conflict. This can be prevented by displaying as much openness and respect as possible.

Consideration

The authorities should be as open as possible about the disaster and ongoing inquiries, ministers should be properly informed about the facts and communication should take place humanly and respectfully.

As well as being open, properly informed and acting respectfully, the authorities should also support those affected with targeted activities and by showing concern and involvement. Those affected who were present have in mind such things as money and help in identifying those affected. For example, seventeen years after the Zanderij plane crash there are still eight victims who have not been identified. It would now cost a great deal of money and time to exhume those people who have not been identified. It would have been better if this could have been done straight away. Another important activity with which the authorities can support those affected and next of kin is by organising memorial services. Those affected emphasise that ‘so many psychosocial interventions can still be made, but that this waste of time and effort is when things are not arranged properly by the powers that be’. They make a plea that those affected and next of kin should be prevented from suffering unnecessary stress in the first phase, because ten years on it costs a lot of money and difficulty putting them right again.

Further, those affected say that organising this sort of activity is important for disasters in the Netherlands, but also for disasters that have taken place abroad and in which Dutch people were affected. Here too the authorities have to accept their responsibilities. In the past, people from the Netherlands who had been affected by disasters that occurred abroad, and next of kin, have not always been given help by the authorities. In these cases the help had to come from local initiatives, such as mutual support from a solidarity committee with another country and local discussion groups. Support from the Dutch authorities could have prevented a great deal of emotional and practical damage. Recognising a disaster as a ‘Dutch problem’ can also be important. For example, the ‘Zanderij’ plane crash is not seen as a Dutch disaster, whereas most people who died were Dutch. This makes the coping process more difficult for those affected and next of kin.

Consideration

The authorities should support those affected and next of kin, in the event of disasters both at home and abroad, by activities such as identifying those affected and organising memorial services.

The role of the media
Those affected who were present agree that the media can play a positive part after a disaster, but also that they can cause a great deal of unrest. One of the things that should be looked out for is that reports about a disaster should not be given that change a lot. If it is reported on one day that certain harmful substances have been released and that a certain number of people who have been affected have died, and the next day it emerges that these substances were not present after all and the number of people affected is different, this creates a great deal of uncertainty and confusion. Those affected therefore appeal to the media not to draw conclusions too quickly if the information is not yet definite. Instead, the media should provide good quality information and openness about what investigations and other procedures are still ongoing and how long people have to wait still for a report to be produced or decisions to be made. In addition, the media can be put to positive use in reaching people who have been affected who have not left a name and address.
In other areas too those affected stress the importance of careful reporting after a disaster. The media have the power to influence public opinion regarding the question of what is seen as a disaster to which a great deal of attention and care should be devoted. For example, the media paid a great deal of attention to the fire in Volendam. As a result, a great deal of additional resources were made available for those affected by this fire. Those affected find it very difficult to talk about all the generous gifts, but do however ask that there should be equality in such matters. If emergency relief supplies, preferential treatment and gifts are given only to those affected by this disaster, while those who have been affected by other fires lie beside them, this can cause unnecessarily awkward situations. In this respect too careful reporting is in the interests of everyone who has been affected.

Consideration

The media should report carefully and in a balanced way, based on established facts.

Those affected and next of kin should be aware of the fact that they can exercise some control in their contact with the media. For example, they themselves can choose what type of media and what programme to talk to. It can also help to say that before an interview the person concerned wants to see the questions. Another piece of advice is that before an interview it is a good idea to calmly write down one's own story on paper. These sorts of activities can help to keep the situation under one's own control as much as possible. At the same time, those affected point out that if a person becomes a victim, at that time he might not be able to exercise some control in their contact with the media.

For this reason those affected express the wish that a media protocol should be established that takes into account the interests of those affected.

Consideration

A media protocol should be established for the role of the media after disasters and other shocking events that takes into account the interests of those affected.

Other tips for relief workers from those affected and next of kin
- A trauma is a trauma; it does not matter how major and shocking the disaster or the accident was and whether someone has been in a coma or not. It is about how a person reacts to it from within. So any trauma is 'person-dependent'. There is no point comparing traumas!
- Take seriously people who have been affected who following the disaster or the accident were not injured but later on develop physical problems. If for example years later someone develops thyroid gland problems, a physical cause should not be ruled out straight away because someone has suffered a trauma. Those affected also ask that a medical examination after a disaster should not be targeted only at certain problems that might be expected in connection with the disaster.
- When a questionnaire is presented to someone who has been affected, it should be explained clearly why he is being asked to fill in this questionnaire. Those affected may be tired or have

limited energy that they need to spread over a number of relevant matters. So think carefully when using questionnaires.
- With accidents the 'victim/perpetrator question' has to be dealt with carefully. It is not uncommon that victims are treated later, unjustly, as the perpetrator. This creates a hindrance to coping well.
- Look out not only for those who are directly affected but also for people and next of kin who are affected in different ways!
- Humanity is extremely important in every phase after a traumatic event!

Implementation of the recommendations
In order to prevent the guideline from straight away ending up under a pile of paper, those affected stress the importance of the support process being driven properly. Further, they would like to see procedures that the guideline recommends being exercised. To encourage the adoption of the recommendations they would like to see the authorities support their adoption. The study group also recommends the profession-specific implementation of this generic multidisciplinary guideline.

Appendix 4 List of abbreviations

ABBREVIATION	EXPLANATION
DSM	The **Diagnostic and Statistical Manual of Mental Disorders** (DSM) is an American manual for the diagnosis and statistics of mental disorders that is used in most countries as the standard for psychiatric diagnostics. The current version (from 2000) is a revision of the text of the fourth edition, called the **DSM-IV-TR**.
PTSD	**Post-traumatic stress disorder** (PTSD) is a psychological condition which in the DSM-IV is classified along with anxiety disorders. The condition is caused as a result of seriously stressful situations in which there is a threat to life, serious physical injury or a threat to physical integrity. These situations are traumatic for the person concerned. The symptoms are intrusions (nightmares or flashbacks), the avoiding of memories or switching them out emotionally), clinical depression, severe irritability with sleep disorders, extreme agitation as a result of certain stimuli, irritation and severe shock reactions. It is also possible that the person may display symptoms of other psychological conditions. PTSD is described as being acute if the symptoms last for less than three months and chronic if they last longer than three months. The condition can be cured or improved with treatment. Sometimes this can also happen spontaneously. PTSD is an anxiety disorder and must not be confused with the normal coping process following a traumatic event. For most people the emotional consequences of a trauma disappear after a few months. If they persist longer, however, than there may be a psychological disorder. If the disorder is not treated, it can take very serious forms.
ASD	**Acute stress disorder** (ASD) is a psychological condition which in the DSM-IV is classified with anxiety disorders. The disorder can occur if someone has been exposed to a serious traumatic experience (shock). The reactions to this trauma are strong feelings of anxiety, terror, powerlessness and hopelessness. People suffering from acute stress disorder usually have a sense of numbing, develop problems with memory, sleeping and concentration, are irritable, jumpy or anxious and regularly re-experience the trauma.
NICE guideline	A guideline drawn up by the **National Institute for Clinical Excellence** (NICE)
BIG Act	Among other things the **Professions in individual Health Care Act** provides for the authorisation to be able to exercise a profession in individual health care. Only those people who have met the statutory training requirements can be enrolled in the register. Only those people who are enrolled in the register can bear the title which is protected by the Act. Restrictions on this authorisation lead to a note being made on the enrolment or cancellation of the enrolment. This means that anyone can see whether someone exercising a profession is authorised to exercise the profession.
CBT	**Cognitive behavioural therapy.** Behavioural therapy and cognitive therapy are both closely connected with scientific principles and studies. Both psychotherapeutic methods are strongly focused on current events. Behavioural therapy and cognitive therapy deal in particular with difficulties in the present and much less with problems that existed in the past. Cognitive therapy and behavioural therapy are both founded on an open and equal relationship of cooperation between the therapist and the client. Treatments are symptom or problem-focused and last for short periods.
EMDR	**Eye movement desensitization and reprocessing** (EMDR) is a psychotherapeutic procedure focused explicitly on the treatment of PTSD and other anxiety disorders after shocking events.

PD	**Psychological debriefing** (PD) is a one-shot semi-structured conversation with a person who shortly before was affected by a shocking event. In most cases the aim of debriefing is to prevent psychological damage by informing people about their experience and providing the opportunity to talk about it.
CISD	**Critical Incident Stress Debriefing** (CISD) is a form of one-shot debriefing. Preferably the intervention takes place two to three days after the event and on average takes about two hours. It is a structured conversation in which the participants go through seven phases on a once only basis.
CISM	**Critical Incident Stress Management** (CISM) is an integrated approach that is built up of various interventions.
MCDM	Master of crisis and disaster management
RCT	A **randomized controlled trial** (RCT) is a scientific procedure used mainly in studies into medical procedures. It is a study in which a randomised control group is used. This is generally regarded as being the most reliable form of scientific evidence because it rules out cognitive bias. The basic idea is that types of treatment are distributed randomly over a number of groups. This prevents cognitive bias.

Appendix 5 Overview of recommended research questions

- The study group recommends the translating and then the validating of non-Dutch screening instruments (usually English-language). Validation must take place in Dutch populations of those affected by disasters, terrorist attacks or other shocking events.
- The study group recommends further studies in populations of those affected by disasters, terrorist attacks or other shocking events into the usability of screening instruments that are based on risk factors.
- The study group recommends that further studies be carried out into the effectiveness of population-wide screening after traumatic events.
- The study group recommends further studies into the most suitable time for screening after a disaster, terrorist attack or other shocking events.
- The study group recommends further studies into the potentially negative consequences of screening in victims of disasters, terrorist attacks and other stressful life events.
- The study group recommends further studies into the effectiveness of CISM.
- The study group recommends further studies into the effectiveness of the psychological first aid module.
- The study group recommends further studies into the effectiveness of EMDR as a curative intervention in the first six weeks after stressful life events.
- The study group recommends further studies into the effectiveness of EMDR as a curative early intervention in children.
- The study group recommends further studies into the effectiveness of a structured relief protocol as a preventive intervention for children.
- The study group recommends further studies into pharmacological interventions in children.

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