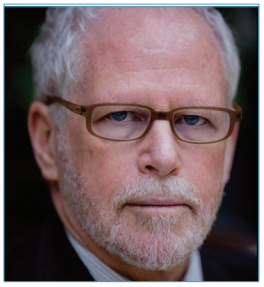

Prevention of Posttraumatic Stress Disorder

Arieh Y. Shalev, MD

Lifetime trauma exposure affects over 80% of living adults in the United States.[1] Converging evidence from basic and clinical studies suggests that there might be a critical threshold, or window of opportunity, to help those who are vulnerable to developing chronic posttraumatic stress disorder (PTSD) in the early aftermath of trauma. When fully developed, PTSD can be pernicious and disabling for many across the lifespan. Even more alarming, when people with chronic PTSD overcome various personal, familial, cultural, economic, and logistical barriers to care, they may still not get the care they need,[2] fail to benefit from formal treatment, retain residual symptoms,[3] or drop out of treatment prematurely.[4] As a result, finding early interventions to prevent chronic PTSD is a critical public health mandate.

Arieh Y. Shalev, MD, is the Barbara Wilson Professor of Psychiatry, Department of Psychiatry, NYU Langone Health.

Address correspondence to Arieh Y. Shalev, MD, Department of Psychiatry, NYU Langone Health, 1 Park Avenue, 8-221, New York, NY 10016; email: arieh.shalev@nyulangone.org.

Disclosure: The author has no relevant financial relationships to disclose.

doi:10.3928/00485713-20190522-01

This issue of *Psychiatric Annals* outlines early intervention modalities for adults and children, discusses assessment and diagnostics, and outlines stress management approaches to reducing traumatic events' impact. As the readers will quickly realize, randomized controlled trials have addressed several treatment modalities, but conclusive evidence of efficacy has only been reached for variants of cognitive-behavioral therapy. Tentative evidence of efficacy is available for collaborative care and arguably for an early use of cortisol in injured survivors. Evidence of no efficacy is available for psychological debriefing and several pharmacological agents (benzodiazepines, propranolol, specific serotonin reuptake inhibitors).

Many other forms of preventive interventions have not been convincingly explored. This leaves numerous conditions encountered by clinicians, and documented modalities of helping patients (eg, psychological first aid, traumatic stress mitigation) insufficiently explored.

Particularly intriguing is the fact that controlled clinical trials to date compare average groups' outcomes yet overlook heterogeneities in individual responses. As clinicians know well, patients' responses differ. Moreover, specific circumstances surrounding trauma and its aftermath (eg, injury, loss, relocation, stressors' continuation) affect survivors' symptom trajectories and their availability for treatment.

These gaps in knowledge, however, do not take away the clinician's need to be optimally informed and to professionally respond to the demanding and distressing situations that traumatic events create. Moreover, in the absence of studies informing responses variability, individualized care is administered, quite well in fact, by educated, well-informed practitioners who can combine their knowledge of the evidence with their access to patient realities, resources, and aspirations.

Thus, beyond repeatedly covering studied interventions, this issue shares with the reader information about dimensions affecting trauma severity and recovery likelihood, knowledge informing approaches to survivors, and ways to respond to traumatic emergencies. It also warns against providing interventions known to be potentially harmful and providing them without prior assessment; and discusses the proper timing of those interventions and ways to identify survivors at risk for PTSD.

It is hoped that these articles and the corresponding continuing medical education quiz will inform and improve clinicians' and service providers' practices in an area that is frequent-

ly encountered, less than optimally documented, and often presenting as emergencies and requiring prompt decisions and well-informed measures.

REFERENCES

1. Kilpatrick DG, Resnick HS, Milanak ME, Miller MW, Keyes KM, Friedman MJ. National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *J Trauma Stress*. 2013;26(5):537-547. doi:10.1002/jts.21848.
2. Kantor V, Knefel M, Lueger-Schuster B. Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: a systematic review. *Clin Psychol Rev*. 2017;52:52-68. doi:10.1016/j.cpr.2016.12.001.
3. Schnurr PP, Lunney CA. Residual symptoms following prolonged exposure and present-centered therapy for PTSD in female veterans and soldiers. *Depress Anxiety*. 2019;36(2):162-169. doi:10.1002/da.22871.
4. Steenkamp MM, Litz BT, Hoge CW, Marmar CR. Psychotherapy for military-related PTSD: a review of randomized clinical trials. *JAMA*. 2015;314(5):489-500. doi:10.1001/jama.2015.8370.