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Reports of the Death of Psychoeducation as a Preventative Treatment for Posttraumatic Psychological Distress are Exaggerated

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Wessely and colleagues present a useful review and critique of psychoeducation, a type (or component) of intervention frequently used to prevent mental health problems following exposure to potentially traumatic events (PTEs). Psychoeducation, as the authors define it, is “the provision of information, in a variety of media, about the nature of stress, posttraumatic and other symptoms, and what to do about them.” More specifically, the method they critique involves the “provision of information given to people about a future aetiology, either what might happen should they be exposed to trauma, or, having been exposed, should they develop symptoms.” They argue that while randomized controlled studies that directly test the utility of psychoeducation are lacking, the available data suggest no benefit from this intervention, with some exceptions related to behavioral medicine approaches or those that address specific practical coping strategies to deal with managing an event itself or its impact. In addition, they suggest that educational messages promoting resilience rather than merely specifying symptoms may be beneficial. They also discuss ways in which psychoeducation may actually lead to the development of posttraumatic stress disorder (PTSD) symptoms via an increased sensitization to such symptoms.

There is much with which to agree in the paper by Wessely and colleagues. It is hard to argue with the paper's basic take-home point—that all preventative interventions, including psychoeducation, should be rigorously evaluated with respect to efficacy and safety. We agree with Wessely and colleagues that considerably more research is needed on this important topic. We also agree with much of the authors' review of the evidence of the extent to which psychoeducation designed to prevent distress following exposure to PTEs has been demonstrated to be effective. In particular, we think the authors' documentation of the problems with psychological debriefing and critical incident stress debriefing approaches is a real service to the field because it provides convincing evidence that continued use of these procedures is contraindicated. Finally, we agree with the authors that it is important to evaluate the safety and efficacy of psychological first aid because it is the most promising psychoeducational procedure advocated for use in disaster situations.

However, we disagree with some aspects of the paper. First, we believe that the paper's review is not sufficiently impartial and focuses considerably more attention on the potential limitations of psychoeducation than its benefits. Second, the paper omits reference to some key research that is supportive of psychoeducation. Third, the paper includes some sweeping arguments that

could benefit from a more nuanced presentation of key issues. Fourth, the authors' suggestions for further research on psychoeducation should be expanded.

In Act 3, Scene 2 of William Shakespeare's play, *Julius Caesar*, Mark Anthony addresses an angry mob and states, "I come to bury Caesar, not to praise him." This statement was disingenuous in that Mark Anthony's intent was actually to garner support against Caesar's assassins. However, in this case, we suspect that Wessely and colleagues really came to bury psychoeducation, and certainly not to praise it. In our view, the review of evidence regarding psychoeducation appears out of balance with considerably more attention having been focused on evidence that is not supportive of psychoeducation and/or ways in which psychoeducation might be harmful than ways in which it could be beneficial.

In their discussion of psychoeducation, the authors did little to acknowledge its multi-component nature. The devil is in the details; arguably, the content of some types of psychoeducation is better than the content of others and the content of some psychoeducation may be worse than providing nothing at all. This is a point the authors acknowledge but do not give appropriate consideration, and we believe they are too eager to throw the baby out with the bath water. We believe focus should first be given to interventions that have shown promise in order to further understand and identify the exact components contributing to recovery, perhaps through the use of dismantling designs. Such research is very laborious, though we believe it is of vital importance.

The authors give considerable weight to the untested assumption that informing a PTE victim about PTSD symptoms is likely to produce such symptoms in individuals who would otherwise have followed a natural recovery. The supposedly low prevalence rates of neuroses among the London population following the Blitz and among soldiers following the First and Second World Wars are cited as evidence for the potential value of downplaying or denying symptoms. We take issue with this line of argument for several reasons. First, the authors failed to present data on the actual prevalence of PTSD-like problems experienced by veterans of WWI, WWII, or Londoners exposed to the Blitz. Without such information, it is impossible to determine whether the policy of downplaying acknowledgement of traumatic reactions had an actual effect on whether problems developed or merely suppressed the willingness of people with problems to seek help. The fact is, the authors have no data on the actual level of problems experienced by civilians following the London Blitz because no one measured them systematically, so they cannot argue that there was "a paucity of neurotic disorders in Londoners exposed to the Blitz," much less determine whether this alleged but questionable "fact" might be true.

Second, the authors appear to argue that one should never publicize symptoms of "war neurosis" or place a medical label on the symptoms of war neurosis because some military historians and military psychiatrists think that doing so might create symptoms by suggestion and/or reinforce secondary gain." They also note that World War II psychiatrists would have argued against establishing the PTSD diagnosis on the same grounds. That some military historians and/or WWII psychiatrists may have had this opinion is of some interest, but thinking something does not make it so. Some might argue that military historians have at least some incentive to minimize the extent to which war produces psychological trauma. Likewise, military psychiatrists and other military mental health professionals have, at best, potentially competing loyalties to the well-being and best interests of the warriors they treat as well as to their employer, the military, which needs as many of its warriors as possible "fit for duty." One way of resolving this conflict might be to focus on resilience and to downplay the traumatic impact of war on warriors as well as civilians. We are not questioning the motivation or the observational skills of the military psychiatrists and historians cited by Wessely and colleagues. However, we do question the authors' apparent argument that the lesson to be learned from

military history is that informing warriors or civilians about war-related problems they might have might be more harmful than exposure to war itself.

Third, the authors assume that informing PTE-exposed individuals about potential trauma-related problems is tantamount to creating an expectation that such problems will develop. We believe a more nuanced approach is possible in which individuals are informed of possible symptoms but are also told that most will experience natural recovery. The provision of symptom information need not be done in such a way that is demoralizing to the recipient.

Fourth, we think that it is important to consider whether potential problems are created by failing to properly inform people who are likely to experience trauma-related problems. The authors are concerned primarily that psychoeducation may inhibit natural recovery processes among many who experience a PTE, but they fail to consider that failure to provide symptom information might be harmful to those likely to develop PTSD. Indeed, it is very plausible that an inability to understand and recognize PTSD symptoms may lead to increased suppression and concealment of such symptoms, a process by which distress may be intensified and treatment-seeking delayed. Unfortunately, research is sorely lacking that directly tests these hypotheses.

Fifth, the authors failed to include some relevant research that directly addressed the efficacy of psychoeducation. They mentioned only one trial directly testing the effects of psychoeducation as a secondary prevention strategy to reduce symptoms following exposure to an event—a study that produced null findings (Turpin, Downs, & Mason, 2005), and they devoted the rest of their literature review to criticism of indirect tests of psychoeducation, including PD. We believe this review overlooks recent research carried out by our center that has tested a form of psychoeducation with promising results. We provide a summary of this intervention and its empirical evaluation below.

The psychoeducation intervention we developed consists of a 17-minute video for female rape victims who present for a forensic medical exam within hours of a rape (for complete description see Resnick, Acierno, Kilpatrick, & Holmes, 2005). The first component is designed to reduce distress at the time of the exam by familiarizing women with the forensic medical procedures that will take place. This element is similar to behavioral medicine approaches designed to reduce anxiety to specific medical procedures. In the second component, psychoeducational information is provided that focuses on normalizing the physiological reactions that may occur during rape or other traumatic events. The information is similar to that provided by Barlow and Craske (1988) for treatment of panic disorder. Panic reactions are presented as normal responses that may have been experienced during assault and may become conditioned responses to subsequent rape-related cues. Panic is outlined as a functional, normal response to a dangerous situation that may be learned and then displayed in response to similar situational cues later on. This explanation is used as a rationale justifying exposure exercises. Distressing thoughts or memories of the assault and other symptoms of PTSD (not labeled as such) are also described as reactions that may occur in the days or weeks following assault.

Previous research on an emergency-room population with panic attacks demonstrated that cognitive behavioral approaches that incorporated instructions for exposure successfully reduced panic frequency (Swinson, Soulios, Cox, & Kuch, 1992). These researchers also found that psychoeducation alone, without instructions for exposure, was less effective. Thus, the second component of the intervention also includes information about in-vivo exposure exercises that can be used by victims to eventually extinguish fear in response to cued activities or situations (e.g., darkness, being in public places). The exposure instructions component also includes a model to demonstrate methods of using repeated exposure to reduce anxiety in

potentially fearful situations (e.g., sleeping with the light off at night). Imaginal exposure to the memory of the traumatic event or talking about the event with others is not included or addressed within the intervention.

Finally, due to high rates of depression and substance abuse found in rape victims, attention is also given to these problems. The depression component, based on Lewinsohn and Graf's (1973) reduced reinforcement density theory and similar to contemporary behavioral activation approaches (Jacobson, Martell, & Dimidjian, 2001), includes suggestions for staying busy and positive activities to undertake. The coping model of substance abuse is also outlined, and methods to reduce risk of using (e.g., staying away from people, places, and situations associated with use and doing activities that are incompatible with use) are reviewed. Drug and alcohol use are discussed as behaviors that may prevent successful psychological recovery from rape by interfering with normal emotional responses. They are also identified as potential factors that could increase risk for assault.

Major findings of our research from a randomized clinical trial evaluating this intervention indicate that the video may be helpful in reducing acute exam-related anxiety and frequency of marijuana use over time. The intervention may also accelerate recovery following rape in terms of reduced PTSD and depression symptoms among a subgroup of rape victims. Specifically, we found that, compared to a no-intervention control condition, the video intervention was associated with reductions in immediate post-exam anxiety (Resnick, Acierno, Holmes, Kilpatrick, & Jager, 1999; Resnick, Acierno, Kilpatrick, & Holmes, 2005) and was associated with significantly lower prevalence of marijuana abuse at 6 weeks post-rape (Acierno, Resnick, Flood, & Holmes, 2003) and marijuana use through 6-month post-rape follow-up, among those who reported recent pre-rape marijuana use (Resnick, Acierno, Amstadter, Self-Brown, & Kilpatrick, 2007a).

Regression analyses indicated that among those with a prior history of rape, those in the video condition reported lower frequency of PTSD and depression symptoms at approximately 6 weeks post-rape (compared to scores among women with prior history of rape who were in the standard care group) (Resnick, Acierno, Waldrop et al., 2007b). In contrast, among women without a prior history of rape, frequency of PTSD and general anxiety symptoms were higher at this shorter term assessment point among those in the video versus standard care condition. In contrast to findings related to marijuana use, no differences on psychopathology measures were observed at 6 months post-rape.

Several factors may relate to why this video intervention was associated with several positive outcomes while other forms of psychoeducation were not. Different interventions that include techniques for coping with distress may, as Wessely and colleagues suggest, provide trauma victims with the expectation that such symptoms will occur, may lead to demoralization, and may sensitize them to such symptoms, thus, having paradoxical effects. In contrast, the video intervention we developed contains a more proactive, approach-oriented element that is more in line with the "expectancy of resilience" for which the authors argue. Further, given the importance of panic and anxiety sensitivity in PTSD (Fedroff, Taylor, Asmundson, & Kock, 2000), it is possible that the symptom education in the video intervention that is intended to normalize panic-related physiological reactions helps discourage avoidance behavior, encourage approach of fearful situations, and lead to a decline in panic attacks and PTSD symptoms. The video intervention also differed from debriefing interventions in that it did not include discussion of the traumatic event by the participant as well as their related thoughts and feelings. Finally, practical information about the medical exam procedures was included in the intervention.

It is noteworthy that with regard to PTSD and reduced frequency of marijuana use our video intervention was beneficial mainly for women who reported problems (a previous assault or marijuana use) prior to the rape. These findings, thus, also run counter to research findings related to PD that were cited indicating an exacerbation of symptoms among victimized populations at highest risk (Sijbrandij, Olff, Reitsma, Carlier, & Gersons, 2006). We hypothesized that rape victims with a prior history of rape might be more able to understand and relate to information about PTSD given their prior experience (Resnick et al., 2007b). In addition, those with a prior history of rape were less likely to be resilient and displayed a wider range of distress symptoms that may have allowed us to observe differences. The positive findings related to lower frequency of marijuana use were not restricted to those with prior history of assault and were observed at short- and longer-term post-rape assessments.

Findings from this initial study related to reduced frequency of marijuana use over time among prior marijuana users and reduced frequency of PTSD and depression symptoms among those with prior history of rape in the video intervention condition need to be replicated. Further evaluation of potential increased early post-rape distress associated with the video intervention among those without prior history of rape is also needed. As noted, the pattern of findings indicated that there were no differences associated with the intervention at long-term follow-up assessment. Again, this pattern was in contrast to some findings associated with debriefing interventions in which negative effects were observed in association with intervention at longer-term follow-ups.

While Wessely and colleagues suggest that it is clear that single session interventions are not useful, we think that this issue should also receive further attention in conjunction with greater specificity of psychoeducation content being evaluated and type of population being studied. Rape victims who report the assault to police or other authorities have been found to be at high risk for initial symptoms of PTSD and persistence of symptoms over time (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). They typically undergo a rape exam within 72 hours of assault that contains elements that may serve as reminders of assault and thereby increase distress. Given these factors, it was hypothesized that approaches that might reduce exam-related distress and promote active coping might be beneficial even if delivered as a single session at one specific time. The use of such an approach, if helpful, does not preclude implementation of additional strategies or suggest that more intensive treatment is not needed.

In sum, we agree with much of the authors' critique of psychoeducation approaches and suggestions about the importance of continued research that carefully specifies and evaluates different elements of psycho-education. Given the ubiquity of trauma and the need for brief, inexpensive, feasible interventions, we encourage further examination of these types of methods. We also acknowledge that a more fine-grained component analysis of the intervention we developed is warranted in order to identify the specific techniques likely to improve recovery for traumatized individuals. Further, it remains to be seen whether similar interventions will be effective among men and among people victimized by other potentially traumatic events.

We think it is imperative that future research addresses a more compelling and important question than "Does psychoeducation help prevent post-traumatic psychological distress?" By way of analogy, does it make sense to ask: "Does surgery help prevent death from cancer?" or "Does psychotherapy help people with PTSD?" The first question cannot be answered with a straightforward yes or no because it depends on what type of surgery is performed by what type of surgeon on what type of cancer at what stage of cancer in what type of cancer victim. Likewise, the question of whether psychotherapy helps people with PTSD depends on the type of therapy, the skill of the therapist, and perhaps the type of event that produced the PTSD as well as characteristics of the patient. We submit that the answer to the question of whether

psychoeducation works is likely to be equally complex. Therefore, we do need more research, but this research should focus on the more interesting question of what types of psychoeducation are most useful in preventing PTSD and other types of psychological distress among survivors of different types of traumatic events. Research is also needed on which people respond most favorably to given psychoeducation treatments and which experience negative effects.

Finally, we applaud the authors' call for developing and testing new types of psychoeducation presented in different formats and focusing more on fostering resilience. Clearly, most individuals exposed to PTEs prove to be resilient, although many are not. We view psychoeducation in this context as firmly grounded in the mainstream public health tradition in which individuals are informed about potential health problems, given information about symptoms of such problems, as well as behaviors that increase risk of developing the problems, and provided with information about how to reduce risk and/or when and how to seek treatment if needed.

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