

The First Month Is Not the Verdict

ISSUE 97 · OCTOBER 6, 2026 · TRAUMA-INFORMED NEURO

In the first weeks after a frightening event, sleep fragments, the startle response sharpens, and the scene replays unasked. It is easy to read that as permanent damage, and equally easy to decide the answer is to sit everyone down immediately and have them retell it. The longitudinal research supports neither reading. A 2018 review of 54 trajectory studies found that resilience, symptoms that stay low, was the most common course after potentially traumatic events, with three smaller groups following recovery, chronic, and delayed-onset paths. Randomized trials of single-session debriefing found no reduction in distress or PTSD, and one found more PTSD a year later. Newer cohort data point to emotional support and symptoms influencing each other over the year after an injury. This brief sets out what each source found, where the evidence is strong and weak, and what none of it proves.

WHAT WAS ACTUALLY STUDIED

01 Galatzer-Levy, Huang and Bonanno (2018), Clinical Psychology Review

TIER 1 · SYSTEMATIC REVIEW OF 54 STUDIES

The base-rate source for this issue. The authors reviewed 54 studies (67 separate cases) that used trajectory modeling to follow symptoms over time after potentially traumatic events, in populations ranging from disaster and injury to illness and bereavement. Four prototypical trajectories recurred. Resilience, symptoms that stayed low, was the modal response, averaging 65.7% across populations (95% confidence interval 61.6 to 69.8). Recovery, symptoms that started elevated and declined, averaged 20.8%. A chronic course averaged 10.6%, and delayed onset, symptoms that appeared later, averaged 8.9%. The authors found that variation in these proportions came mainly from real differences between populations rather than from bias, and that bias appeared where prospective data were lacking.

02 Beaudoin et al. (2023), Translational Psychiatry

TIER 2 · PROSPECTIVE COHORT, MORE THAN 2,000 COLLISION SURVIVORS

A large civilian cohort that gives a picture of the first weeks. More than two thousand motor vehicle collision survivors were enrolled in emergency departments and completed brief smartphone surveys over two months, covering ten symptom domains: pain, depression, sleep, nightmares, avoidance, re-experiencing, anxiety, hyperarousal, somatic symptoms, and mental fatigue. Symptoms across all ten domains were common in the first two months. Risk factors for high-symptom trajectories were largely shared across domains, and across domains the severity of symptoms in the immediate aftermath had the greatest influence on the outcome measured. Early severity therefore carries information, which is why this brief frames the first month as a measuring window and not as noise.

03 Rose, Bisson, Churchill and Wessely (2002), Cochrane Database of Systematic Reviews

TIER 1 · COCHRANE SYSTEMATIC REVIEW, 11 RANDOMIZED TRIALS

The review of single-session psychological debriefing, a structured one-off session soon after an event in which people are encouraged to recount the event and their reactions. It included 11 randomized trials, and the authors rated quality as generally poor. Single-session individual debriefing did not reduce psychological distress or prevent PTSD: at three to five months the odds ratio for PTSD was 1.22 (95% confidence interval 0.60 to 2.46), not significant. At one year, one trial reported a significantly increased risk of PTSD in those who received debriefing (odds ratio 2.88, 95% confidence interval 1.11 to 7.53). The authors concluded there was no evidence that debriefing is useful for preventing PTSD and that compulsory debriefing of trauma victims should cease.

04 Bisson, Jenkins, Alexander and Bannister (1997), British Journal of Psychiatry

TIER 1 · RANDOMIZED CONTROLLED TRIAL, N = 133

The trial that most sharpened the debriefing question. One hundred thirty-three adults with acute burn injuries were randomly assigned to an individual or couple debriefing session or to no intervention, and 110 were interviewed by an assessor blind to group at three and 13 months. At 13 months, 26% of the debriefed group had PTSD compared with 9% of the control group. The authors note that the debriefed group had higher initial questionnaire scores and more severe burns, and that both were associated with a poorer outcome, so the groups were not evenly matched. The finding is a warning about one specific, widely used intervention, not a measurement of its true harm.

05 Roberts, Kitchiner, Kenardy, Robertson, Lewis and Bisson (2019), Cochrane Database of Systematic Reviews

TIER 1 · COCHRANE SYSTEMATIC REVIEW, 27 STUDIES AND 3,963 PARTICIPANTS

The counterweight to the debriefing findings. This review examined multiple-session early psychological interventions, two or more sessions, for adults exposed to a traumatic event and not identified as having specific psychological difficulties. Low-certainty evidence suggested the interventions may lower the likelihood of a PTSD diagnosis at three to six months compared with usual care (risk ratio 0.62, 95% confidence interval 0.41 to 0.93, five studies, 758 participants). There was no statistically significant difference immediately after treatment (very low certainty) or at seven to 12 months (very low certainty, one study), and no significant difference in PTSD symptom severity at three to six months (standardized mean difference -0.10, 95% confidence interval -0.22 to 0.02).

06 Santos et al. (2026), Journal of Mood and Anxiety Disorders

TIER 2 · PROSPECTIVE COHORT, N = 2,943

A recent look at how support and symptoms relate across the year after a traumatic injury. In the AURORA study, 2,943 emergency department patients reported perceived emotional support and PTSD symptom severity at two weeks, eight weeks, three months, six months, and 12 months. A five-wave cross-lagged model found a statistically significant negative association between emotional support and subsequent PTSD symptoms at most time points, and, concurrently, a negative association between PTSD severity and subsequent perceived emotional support. Emotional support was most closely tied to later negative mood and feelings, and avoidant behavior was most closely tied to lower emotional support. The authors emphasize establishing social support early. The design is observational, so it shows influence in both directions without proving cause.

Background on who is at higher risk. The authors meta-analyzed seven predictors of PTSD and its symptoms across 68 studies. All seven were significant. Prior trauma, prior psychological adjustment, and family history were the smallest (weighted $r = .17$), and peritraumatic dissociation was the largest (weighted $r = .35$). The authors concluded that psychological processes during and right after the event predicted PTSD more strongly than pre-event characteristics. It is context for why a very high early start deserves attention, and it is a 2003 review, so it predates the trajectory literature above.

WHAT THEY FOUND

Across 54 trajectory studies, the single most common course after a potentially traumatic event was resilience, with symptoms that stayed low, averaging 65.7% of people. About one in five (20.8%) started elevated and declined, which the literature calls recovery. About one in ten (10.6%) stayed elevated, and about one in eleven (8.9%) looked fine early and developed symptoms later (Galatzer-Levy et al., 2018).

65.7%

Average share of people on a stable, resilient trajectory after a potentially traumatic event, pooled across 54 studies and 67 cases (95% CI 61.6 to 69.8). The share varied with the population studied (Galatzer-Levy, Huang & Bonanno, Clinical Psychology Review, 2018).

The early weeks themselves are symptomatic for many people. In a cohort of more than two thousand collision survivors, symptoms across ten domains were common in the first two months, and the severity of symptoms in the immediate aftermath had the greatest influence on the outcome the researchers measured (Beaudoin et al., 2023). Early severity is information. It does not decide the course by itself, and in the trajectory review, among the groups that start elevated, the group that recovers (20.8%) is about twice the size of the group that stays chronic (10.6%), though proportions vary by population.

The debriefing evidence is the cautionary part. In a 1997 randomized trial of 133 burn patients, 26% of the debriefed group had PTSD at 13 months compared with 9% of controls, though the debriefed group started with higher distress and more severe injuries (Bisson et al., 1997). A Cochrane review of 11 trials, mostly of poor quality, found no reduction in distress or PTSD from single-session debriefing, and one trial found a higher risk at one year (Rose et al., 2002). Multiple-session early interventions fared somewhat better, with low-certainty evidence of a lower PTSD diagnosis rate at three to six months and no clear difference immediately after treatment or at one year (Roberts et al., 2019).

Social context shows up as a two-way loop. In 2,943 injured emergency department patients followed for a year, emotional support predicted fewer later symptoms at most time points, and higher symptom severity predicted lower later support, with avoidance most tied to lower support (Santos et al., 2026).

WHERE THE EVIDENCE STANDS

Where the evidence converges: a rough first month is common, most people are on a resilient or recovering path, and a minority follow a chronic or delayed-onset course. The base-rate picture comes from a systematic review of 54 studies and is consistent in shape across populations, with the exact proportions shifting by population.

Where it diverges or is thin: the debriefing trials are few, mostly small, and mostly of poor quality, and the one trial with a large adverse difference had unevenly matched groups. The multiple-session early-intervention evidence is low certainty and does not hold at one year. The support-and-symptom data are observational. Early severity predicts later outcome, which sits in tension with a purely reassuring reading of the base rates, and this brief treats it as a reason to watch the trend, not as a prediction.

What follows for a reader is a change in how to read the first weeks and how to help, not a treatment recommendation. Treat the first month as a measuring window, pay attention to the direction of change, let the person set the pace of any retelling, keep contact easy, and use persistent, worsening, or severe symptoms as the point to involve a clinician.

WHAT THIS DOES NOT PROVE

Trajectory studies describe groups, not individuals. A 65.7% average resilient share does not tell any one person which path they are on, and the proportions varied by population, so no single number should be applied to a specific event, person, or community.

Several of the trajectory populations were not exposed to the same kinds of events. Combining disaster, injury, illness, and bereavement studies gives a robust pattern but blurs differences, and the review's own finding that proportions differ by population means the real figure for a given event type may sit well away from the average.

The debriefing evidence concerns a specific intervention, single-session debriefing with emotional processing, not talking about an experience in general. Nothing here shows that talking with a friend, a peer, or a clinician at the pace a person chooses is harmful. The 1997 burn trial had unevenly matched groups, and the Cochrane review rated the underlying trials as generally poor quality.

The multiple-session early-intervention results are low or very low certainty and did not persist to the seven-to-12-month follow-up in the one study that measured it. They support further research, not a firm claim that early structured help works.

The AURORA support analysis is observational. A cross-lagged model shows that support and symptoms predict each other over time, which is consistent with a two-way loop, but it cannot prove that more support causes fewer symptoms, and the sample was people treated in emergency departments after injury, not every kind of event.

The early-severity finding means a very high symptom load in the first weeks does carry risk information. A reassuring base rate should never be used to talk someone out of seeking help when symptoms are severe, worsening, or accompanied by thoughts of harming themselves or others.

None of this is medical advice, and none of it is a treatment recommendation. If symptoms are severe, are getting worse after the first month, or you feel unsafe, a clinician is the right next step.

WHAT IT MEANS FOR YOU

Treat the first weeks as a measuring window and watch the direction. A weekly 0 to 10 rating of sleep, startle, and unwanted replays, taken at the same time on the same scale, makes the direction visible, and direction over several weeks is what the trajectory research classifies people by. Let the pace of any retelling belong to the person, because early single-session retelling did not reduce distress or PTSD in the trials. Make contact easy and low-demand, because support and symptoms influence each other over the following year and avoidance wears support down. Set a checkpoint a few weeks out, and if the trend is flat, rising, or severe, involve a clinician, since structured multi-session help exists and a clinician can say which kind fits. If you lead a team, replace a mandatory group retelling with an optional check-in

and repeat it a few weeks later. The newsletter walks through those five moves. The research above is why they are the five, and where each one runs out.

GO TO THE SOURCE

TIER 1 · SYSTEMATIC REVIEW Galatzer-Levy, I. R., Huang, S. H., & Bonanno, G. A. (2018). Trajectories of resilience and dysfunction following potential trauma: A review and statistical evaluation. *Clinical Psychology Review*, 63, 41-55. doi.org/10.1016/j.cpr.2018.05.008

TIER 2 · PROSPECTIVE COHORT Beaudoin, F. L., An, X., Basu, A., Ji, Y., Liu, M., Kessler, R. C., et al. (2023). Use of serial smartphone-based assessments to characterize diverse neuropsychiatric symptom trajectories in a large trauma survivor cohort. *Translational Psychiatry*, 13(1), 4. doi.org/10.1038/s41398-022-02289-y

TIER 1 · COCHRANE SYSTEMATIC REVIEW Rose, S., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, (2), CD000560. doi.org/10.1002/14651858.CD000560

TIER 1 · RANDOMIZED CONTROLLED TRIAL Bisson, J. I., Jenkins, P. L., Alexander, J., & Bannister, C. (1997). Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, 171, 78-81. doi.org/10.1192/bjp.171.1.78

TIER 1 · COCHRANE SYSTEMATIC REVIEW Roberts, N. P., Kitchiner, N. J., Kenardy, J., Robertson, L., Lewis, C., & Bisson, J. I. (2019). Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. *Cochrane Database of Systematic Reviews*, 8, CD006869. doi.org/10.1002/14651858.CD006869.pub3

TIER 2 · PROSPECTIVE COHORT Santos, J. L., van Rooij, S. J., House, S. L., Beaudoin, F. L., An, X., Neylan, T. C., et al. (2026). Social support and post-traumatic stress symptoms: Longitudinal bidirectional relationships in the AURORA study. *Journal of Mood and Anxiety Disorders*, 14, 100180. doi.org/10.1016/j.xjmad.2026.100180

TIER 1 · META-ANALYSIS Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin*, 129(1), 52-73. doi.org/10.1037/0033-2909.129.1.52

Tier 1 means peer-reviewed primary research or meta-analysis, the strongest evidence. Tier 2 means an expert framework or smaller study that traces to peer-reviewed work. We grade every source so you can see the weight behind each claim.

Pegasus Realm publishes Wellness Team Culture and the practice resources behind it.

Education, not medical advice.

