



## Early Mental-Health Intervention for Disasters

The aim of all disaster mental-health management should be the humane, competent, and compassionate care of all affected. The goal should be to prevent adverse health outcomes and to enhance the well-being of individuals and communities. In particular, it is vital to use all appropriate endeavors to prevent the development of chronic and disabling problems such as PTSD, depression, alcohol abuse, and relationship difficulties.

### Factors that Facilitate Positive Outcomes and Prevention

There is much evidence to suggest that a number of factors help to facilitate positive outcomes and prevention <sup>1</sup>. These include the following:

- It is crucial to recognize people's strengths as well as the suffering they have experienced. While survivors' suffering must be acknowledged, and compassion and empathy conveyed to them, it is also important that those who care for them believe in and support their capacity to master this experience.
- Information and education help people's understanding and should be an integral part of the support and care systems. Preparation prior to disaster, information about what has happened, education about normal responses to such events, training in what to do to help psychological recovery, information centers and ongoing information feedback to affected communities, all help people's mastery and recovery.
- Sharing the experience. Many people may display a need to tell the story of their experience, to give testimony, both to externalise it and obtain emotional release, and to gain understanding and support from others. This varies enormously. It may occur spontaneously as natural groups come together after the disaster. However, there will be others who may not feel ready or who may choose not to talk about their experience. Those involved in the mental health response should be aware of these variable needs and be supportive of what the survivor wants. Supportive networks are critical and should be retained, reinforced and rebuilt. These networks help people in the ongoing recovery process, both through the exchange of resources and practical assistance, and through to the emotional support they provide to deal with the disaster and its aftermath. Community groups may develop to facilitate support, and should be encouraged.

### Possible Obstacles to Seeking Help

Several studies have pointed out that following a disaster or terrorist event, such as the Oklahoma City bombing, many of those in closest proximity to the disaster do not believe they

need help and will not seek out services, despite reporting significant emotional distress <sup>2</sup>. Sprang lists several potential reasons for this:

- Some people may feel that they are better off than those more affected and that they, therefore, should not be so upset.
- Some may not seek help because of pride or because they think that distress indicates weakness of some sort.
- Some individuals may not define services they receive as mental-health intervention, especially if such intervention is unsolicited (e.g., lectures, sermons, discussions, community rituals). Indeed, because the goal of many disaster mental-health workers is to have interventions be a seamless, integrated part of an overall disaster effort, those who receive these services may not recognize them as mental-health interventions.
- Many individuals are more apt to seek informal support from family and friends, which may not be sufficient to prevent long-term distress for some.

It is critical to address this hesitance about seeking help. Nearly half of the individuals studied who were directly exposed to the Oklahoma City bomb blast had an active postdisaster psychiatric disorder, with PTSD being diagnosed in 1/3 of the respondents <sup>3</sup>. Major Depression was the disorder most commonly associated with PTSD. No new cases of substance abuse were observed, which is consistent with previous findings. Symptom onset of PTSD was rather immediate, usually within one or two days, and few other cases developed after the first month.

## Crisis Intervention

Generally, there are three stages of intervention, each requiring a different level of involvement:

- **Emergency phase:** the immediate period after disaster strikes
- **Early postimpact phase:** any time from the day after the onset of the disaster until approximately the eighth to twelfth week
- **Restoration phase:** marked by the implementation of long-term recovery programs, generally beginning at about the eighth to twelfth week after the onset of the disaster

## Initial Mental-Health Interventions

Initial mental-health interventions are primarily pragmatic, as reflected by the following stages:

### Protect

Find ways to protect survivors from further harm and from further exposure to traumatic stimuli. If possible, create a shelter or safe haven for them, even if it is only symbolic. The fewer traumatic stimuli people see, hear, smell, taste, and feel, the better off they will be. Protect survivors from onlookers and the media.

## Direct

Kind and firm direction is needed and appreciated. Survivors may be stunned, in shock, or experiencing some degree of dissociation. When possible, direct ambulatory survivors:

- Away from the site of destruction
- Away from severely injured survivors
- Away from continuing danger

## Connect

The survivors you encounter at the scene have just lost connection to the world they are familiar with. A supportive, compassionate, and nonjudgmental verbal or nonverbal exchange may help them experience a reconnection to the shared societal values of altruism and goodness. However brief the exchange, or however temporary its effects, such relationships are important elements of the recovery or adjustment process. Help survivors connect:

- With loved ones
- With accurate information and appropriate resources
- With where they will be able to receive additional support

## Triage

The majority of trauma survivors experience normal stress reactions. However, some may require immediate crisis intervention to help them manage intense feelings of panic or grief. Signs of panic include trembling, agitation, rambling speech, and erratic behavior. Signs of intense grief may include loud wailing, rage, and catatonia. If you see these signs of panic and grief, attempt to quickly (1) establish therapeutic rapport, (2) ensure the survivor's safety, (3) acknowledge and validate the survivor's experience, and (4) offer empathy. Medication may be appropriate and necessary.

It is necessary to be aware that the needs of individual members of a community may vary greatly. The following early intervention strategies can yield positive results:

- Provide direct services as soon as is feasible after the event, which may require temporarily bringing in outside experts. However, **it is of the greatest importance that needs assessment, planning, and service delivery be done in full coordination with local providers.** Outside help should at no time be imposed;

respectful, coordinated interfacing with local resources, however limited these may be, is essential.

- Empower local care-providers to assume increasing responsibility for delivering services in their community. **This can be achieved by providing in-field training from the beginning of the intervention.** Encouraging local providers increases professional self-esteem and helps local resources expand quickly.
- Work with key community figures and leaders, local media, and governmental institutions to make them aware of the benefits of early community-based interventions.
- It is important to recognize that care-providers from within a community may themselves be overwhelmed and/or traumatized. Therefore, ensure that comprehensive professional support and supervision are available for them so that they may also attend to their own mental-health needs.

## Basic Principles of Emergency Care

It is helpful to remember several basic principles or objectives of emergency care.

1. Provide for basic survival needs and comfort (e.g., liquids, food, shelter, clothing).
2. Help survivors achieve restful and restorative sleep.
3. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
4. Provide nonintrusive ordinary social contact (e.g., a "sounding board," judicious uses of humor, small talk about current events, silent companionship).
5. Address immediate physical health problems or exacerbations of prior illnesses.
6. Assist in locating and verifying the personal safety of separated loved ones or friends.
7. Reconnect survivors with loved ones, friends, and other trusted people (e.g., AA sponsors, work mentors).
8. Help survivors take practical steps to resume ordinary daily life (e.g., daily routines or rituals).
9. Help survivors take practical steps to resolve pressing immediate problems caused by the disaster (e.g., loss of a functional vehicle, inability to get relief vouchers).
10. Facilitate resumption of normal family, community, school, and work roles.

11. Provide survivors with opportunities to grieve their losses.
12. Help survivors reduce problematic tension, anxiety, or despondency to manageable levels.
13. Support survivors' local helpers through consultation and training about common stress reactions and stress management techniques.

## Psychological First Aid

The Psychological First Aid Field Operations Guide (early release for Hurricane Katrina response) was created by the Terrorism Disaster Branch of the National Child Traumatic Stress Network and the National Center for PTSD as well as others involved in disaster response. Production of this information was supported by SAMHSA.

It is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism: to reduce initial distress, and to foster short and long-term adaptive functioning. It is for use by mental health specialists including first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings.

For further information on Disaster Mental Health Interventions, please refer to the Disaster Mental Health Services Guidebook for Clinicians and Administrators.

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