Disaster mental health and psychological first aid

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Some recent history

- The tsunami was a major **critical incident** of epic proportions, unexpected (scientists discounted a tsunami in the Indian Ocean region, and Japan), and unprepared for as a result.
- However, scientists now agree that another tsunami is likely, the only question is when.
- Further, on average, natural and technological disasters kill 50,000 people each year. An additional 74,000 are seriously injured, 5 million are displaced from their homes, and over 80 million are affected in some way by the effects of earthquakes, hurricanes/typhoons, floods, high winds, landslides, technological accidents, and urban fires (World Disaster Report, International Federation of Red Cross and Red Crescent Societies, 1999)

Critical incident - definition

- Critical incidents (disaster) may be seen along a continuum of scope from:
  - **macro** (disaster affecting the entire country such as war, terrorism or catastrophic natural disaster-volcano, tsunami) to,
  - **meso** (disaster affecting a region such as a airline crash, earthquake, flood, typhoon/hurricane, earthquake), to,
  - **micro** (discrete disasters affecting a locale such as an automobile accident or fire).

The reason for disaster MH services

- In the weeks and months following major disasters, long after the initial stabilization of medical and social relief efforts are in place, and the media attention tapers off, there exists an emerging, long-term effort in dealing with the psychosocial effects of death, injury, grief and loss.

Cont.

- There is a general lack of organized psychological first aid provided to disaster responders.
- Crisis workers and caregivers often feel the cumulative effects of stress, including burn-out or 'compassion fatigue.'

Disaster response: Acute phase

- The Primary Focus of Disaster Support
  - Dealing with disaster induced deprived physical needs
    - Food, shelter, physical security, water, sanitation
    - Access to health care
    - Management of communicable diseases
  - The focus and mission of the well-recognized disaster relief organizations

Bulletin of the World Health Organization, Jan 2005, 83 (1)

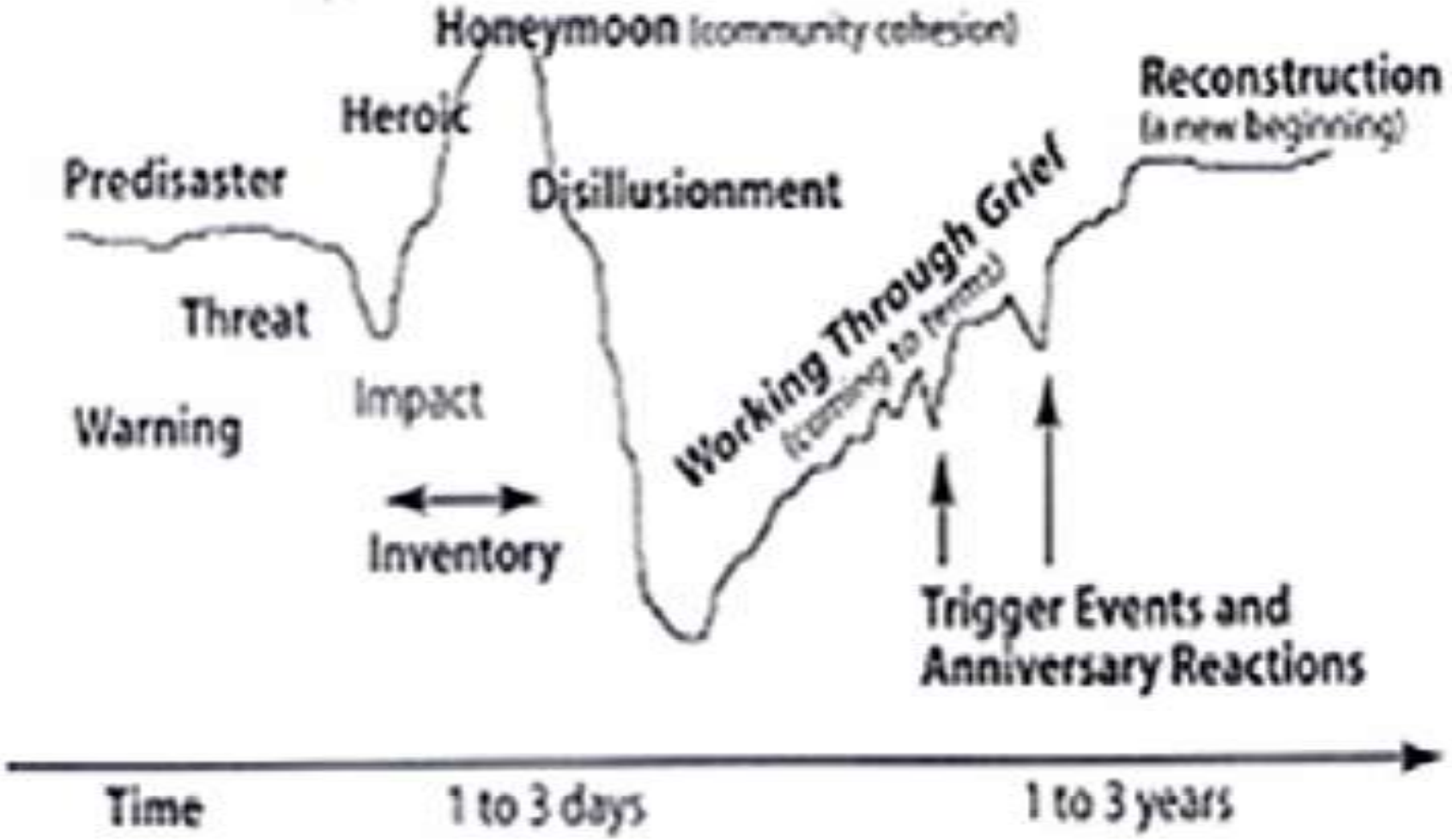
Crisis and post-acute emergency phase

- The Secondary Goal of Disaster Support
  - Implementing culturally sensitive psychological first aid
  - Having local, community-based psychological support teams (chapters) in place, trained and able to be mobilized to:
    - Providing direct care to survivors
    - Providing secondary care to first responders and care-givers

Bulletin of the World Health Organization, Jan 2005, 83 (1)

Figure.

Phases of Disaster



Traumatic events

- Traumatic stressors are events that challenge our existing ways of making sense out of our own reactions, our perceptions of others and challenge our "fair world assumptions": the world is safe, the world is predictable and "bad things do not happen to good people"
- Traumata can evoke fear, uncertainty (can I cope?), helplessness & hopelessness

Coping mechanisms

- People typically rely on past strategies to cope with new stressful situations
- Past coping mechanisms can be functional or dysfunctional.
- Degree of resilience has been identified as a characteristic that can buffer extreme stress in older populations
- Children can be vulnerable because they have no experience or known patterns of actions as a response to the experience.

Psychosocial impact

- Prior experience with a similar event
- Prior trauma
- The intensity of the disruption in the survivors' lives
- The resilience of the individual

Psychosocial impact

- The length of time that has elapsed between the event occurrence and the present

- Man-Caused vs. Naturally Occurring Event

Vulnerable population:

- Children/families/poverty
- Seniors
- Disabled
- Bereaved
- Health impairments
- Women

Consequences of critical incidents

- **Tangible Loss**
  - Loss of loved ones
  - Loss of home
  - Loss of material goods
  - Loss of employment / income

Consequences of critical incidents

Intangible Loss

- Loss of safety / security (*real or perceived*)
- Loss of predictability
- Loss of social cohesion/connection/support
- Loss of dignity, trust and safety
- Loss of positive self-image/self-esteem
- Loss of trust in the future, identity, independence
- Loss of hope
- Loss of CONTROL

Crisis response and recovery cycle

- There is a 'typical' Crisis Response & Recovery Cycle (CRRC) which is common to most people experiencing a traumatic incident (e.g., a fire, explosion, sinking, etc.,).
- Recognising that the CRRC is a normal human response to a disaster is the important first step to planning to manage psychological trauma.

Emergency response plans

- Within your emergency response plans, there is a need to be *as prepared* to manage the *psychological aspects* of the catastrophic incident as you are the physical, medical, environmental, reputational, financial and other aspects.
- The objectives of *Psychological First Aid* (PFA) are:

1. To reduce ongoing distress in your people (anxiety and the four types of early reactions – emotions, physical body, cognitive and behaviour);
2. To facilitate psychological recovery of survivors as quickly as possible; and
3. To reassure your people that they are not suffering psycho-pathology (e.g., PTSD early on).

Crisis response experiences

- Crisis response – as the incident occurs (e.g., fire, explosion or sinking).
- People involved in the incident will typically experience reactions in the following order:

1. Shock;
2. Disbelief (this can't be happening, "*they must be making a movie*");
3. Realisation of problem ("*OMG, it is happening*");
4. Unfeeling survival state (often reported as "frozen"); and
5. Survivor escapes/released (or person entrapped and killed).

- The above may occur over a period from a few seconds to several minutes.

Psychological first aid

Requirement for immediate response ("Psychological First Aid").

- Delivered immediately after the incident (at the scene) or as soon as possible afterwards.
- Basic need is to reassure survivors they are now safe.
- Use "calming response" technique.

Helping after the disaster

- Days and weeks (up to 2-3 months afterwards).
- Basic need is to reassure survivors they are now safe.
- Need to "normalise" the recovery cycle responses.
- Shock, depression, mood swings, anger are all NORMAL reactions to a catastrophic incident.
- THIS IS ALL NORMAL. People are not going mad. Reassurance is a priority.
- Basic need to deal with anxiety (resulting from the catastrophic incident).

Anxiety is normal response

Anxiety is an unpleasant state typified by:

- Negative emotions (fear, nervousness, tense);
- Perceptions of unpredictability and lack of control over external events;
- Physiological arousal (tension);
- Maladaptive shift in attention (mind off-task in hand, false alarms, irrational fears); and
- Avoidance behaviour.

- Need to reassure folks that anxiety is NORMAL. It is the normal response of people to disaster situations.
- Your goal is to yourself and your folks to help people learn to manage negative emotional responses, negative perceptions, negative arousal states and negative behaviours.

When anxiety becomes a problem

- Problems emerge when Anxiety is unnecessary, excessive, avoided or prompts further maladaptive behaviour. Look for prolonged or entrenched reactions in the following:

Anxiety as a problem

- **Emotions**
- Shock
- Distress
- Sadness
- Fear
- Guilt
- Helplessness
- Anger
- Hopelessness

When is anxiety a problem

- **Physical Reactions**
- Upset stomach
- Headache
- Disturbed sleep
- Excessive sleep
- Appetite shift (hungry or not hungry)

Anxiety as a problem

- **Cognitive**
- Difficulty concentrating
- Confusion
- Disorientation
- Flashbacks
- Nightmares
- Impaired decision-making
- Intrusive memory
- Suicidal thoughts

Anxiety as a problem

Behaviour

Avoidance (of similar situations)

Withdrawal (from family life, friendships, etc)

Alcohol or drug usage

Loss of interest – apathy

Objectives for recovery

- Your objective now:

1. To reduce ongoing distress (anxiety and the 4 types of early reactions – emotions, physical, cognitive and behavior);
2. To facilitate psychological recovery as quickly as possible; and
3. To reassure that the person is not suffering psychopathology (e.g., PTSD early on).

- All of the stress/anxiety reactions are NORMAL human reactions to a terrible incident.
- Only if the person is not improving over time should you be concerned (2-3 months time frame).

Normalcy reassurance

- Reassure yourself or other people that all of the anxiety responses are NORMAL reactions and that they can be managed using appropriate techniques.
- If they do not improve over short time frame, seek assistance.
- If after 2-3 months, these symptoms are still highly aroused – may indicate person is not coping and that Post-Traumatic Dress Disorder (PTSD) is developing – seek professional assistance.

Rules of the ROAD

Step 1. Defining the Problem

- Communicate caring attitude
- Establish contact
- Explore meaning of crisis

Step 2. Ensuring Safety

- Use directive, closed end questions
- Determining degree of lethality
- Take immediate action to ensure safety of oneself, the client, or significant others
- Reinforce the client's proactive, safe behavior
- Make owning statements about your responsibility
- Use the Triage Severity Scale as a basis of making decision on client disposition

Rules….

Step 3. Providing Support

- Make very clear owning statements that the client really does count for something
- Positively reinforce even the most minimal client movement
- Searching for external supports is critical in providing continuing help to get through the crisis

Step 4. Examining Alternatives

- Use situational support mechanisms
- Use previously successful coping mechanisms
- Use environmental resources
- Generate positive and constructive thinking patterns
- Reinforcing taking action

Rules, cont.

Step 5. Making Plans

- Emphasize short-term goals
- Make concrete plans

Step 6. Obtaining Commitment

- Review plan
- Establish responsibility

Crisis intervention strategies

Awareness. The crisis worker attempts to bring to conscious awareness warded off, denied, shunted, and repressed feelings, thoughts, and behaviors that freeze the client's ability to act in response to the crisis.

Catharsis. The crisis worker provides a safe and accepting environment for clients to ventilate, air, expose, and bring forth feelings, thoughts, and behaviors generated by the crisis that may be perceived by clients as socially unacceptable or too psychologically hurtful to be shared. There are two primary reasons for promoting catharsis.

Validation. The crisis worker attempts to validate that the clients' reactions are appropriate, normal, customary, and expressed within culturally acceptable limits given the kind, type, and duration of the crisis provided these are not harmful psychologically, physically, or morally to self or others.

Crisis intervention strategies, cont.

- **Expansion.** The crisis worker engages in activities to broaden, open-up, and increase clients' tunnel vision, restricted affect, perception, and interpretation of the crisis so that other affective and cognitive views and behavioral options may be considered.

  Focus. The crisis worker attempts to qualify, narrow, and downsize clients' all encompassing, catastrophic, interpretations and perceptions of the crisis event in to more specific, realistic, manageable components and options.

  Guidance. The crisis worker provides information, referral, and direction in regards to clients obtaining assistance from specific external resources and support systems.

  Mobilization. The crisis worker attempts to activate and marshal both the internal resources of the client and to find and use external support systems to help generate coping skills and problem solving abilities

Crisis intervention strategies, cont.

- **Ordering.** The crisis worker methodically helps clients classify and categorize problems so as to prioritize and sequentially attack the crisis in a logical and linear manner.

  Protection. The crisis worker safeguards clients from engaging in harmful, destructive, detrimental, and unsafe feelings, behaviors, and thoughts that may be psychologically or physically injurious or lethal to themselves or others.

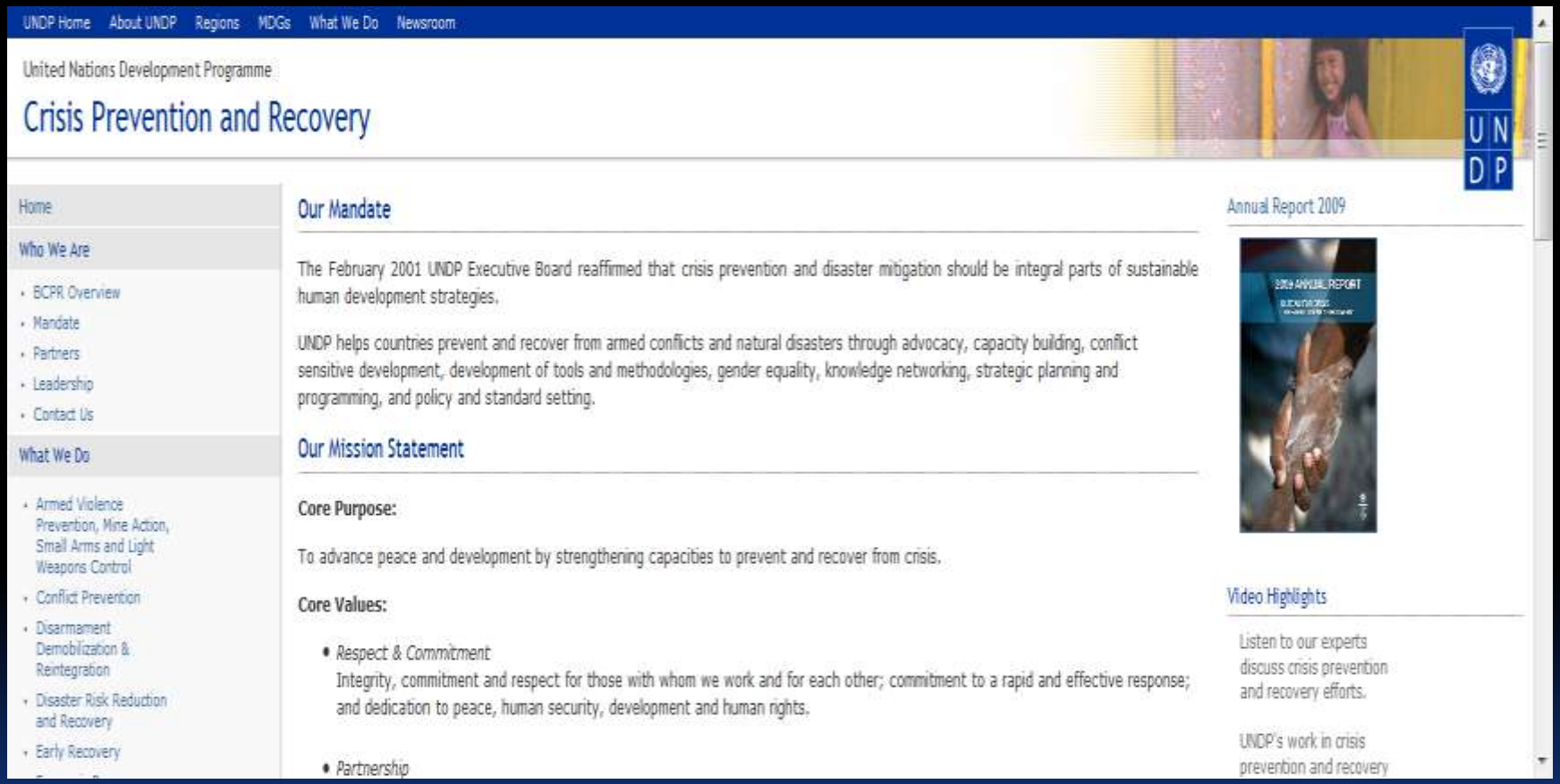
Levels of intervention

Direct Intervention. Crisis worker functions as a manager and instructs clients and to a degree promotes dependency on crisis workers. Much of the time direct interventions will begin with "I" – "I [crisis worker] want/need you to …."

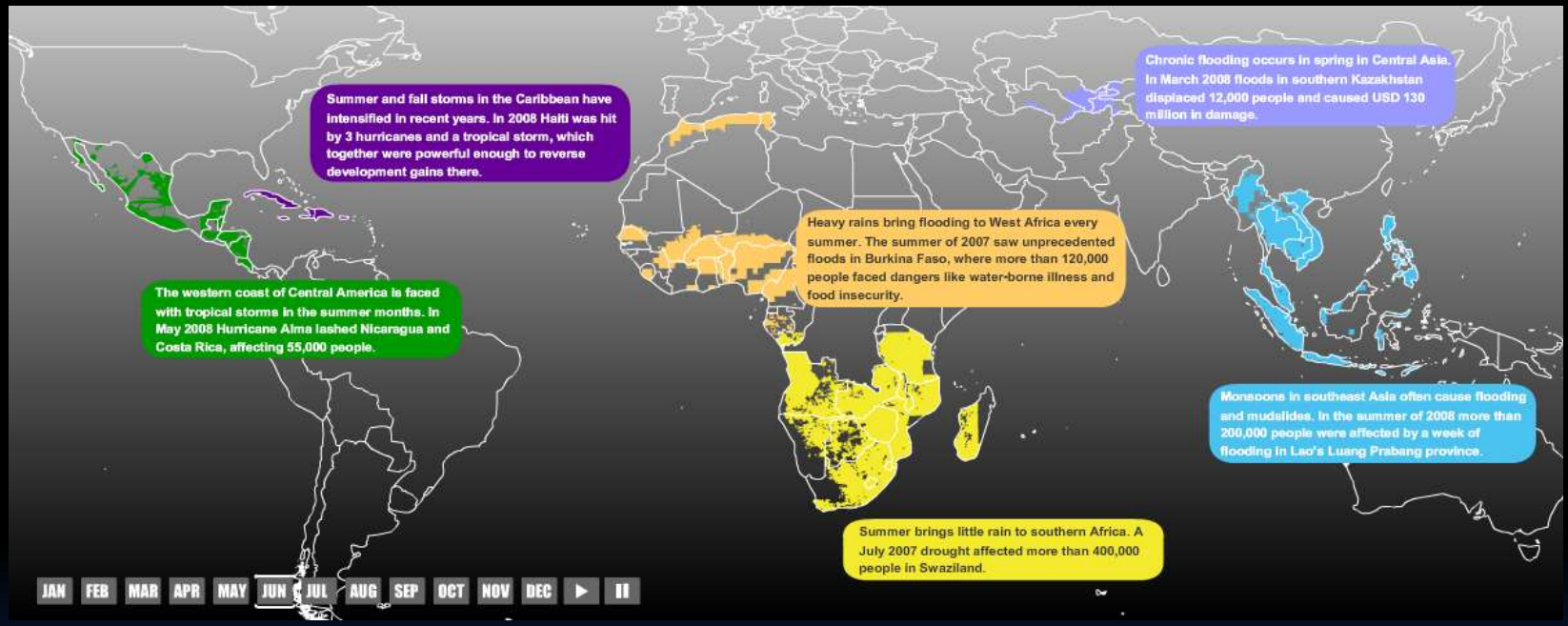
Collaborative Intervention. Crisis worker partners with client, helping clients to organize resources and activate coping-skills to resolve the crisis. The pronoun "we" is used or implied: "Together we can work through this problem" and "You and I will be in this together".

Indirect Intervention. Crisis worker acts as a sounding board. Clients are capable of generating solutions with minimal assistance. The pronoun "you" is used often: "What are you feeling"; "Are there other ways you can think about the situation", and "What can you do to resolve the situation".

UN development program



UN disaster map



Web pages

- http://www.undp.org/cpr/we_are/mandate.shtml