Psychological Interventions in Disaster Management

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Definition of Disasters

- Disasters are traumatic events which are dangerous, overwhelming, and usually sudden (Figley, 1985)
- The American Psychiatric Association (1994) defines a traumatic event as a psychologically distressing event, outside the range of usual human experience that would be *markedly distressing* to almost anyone.

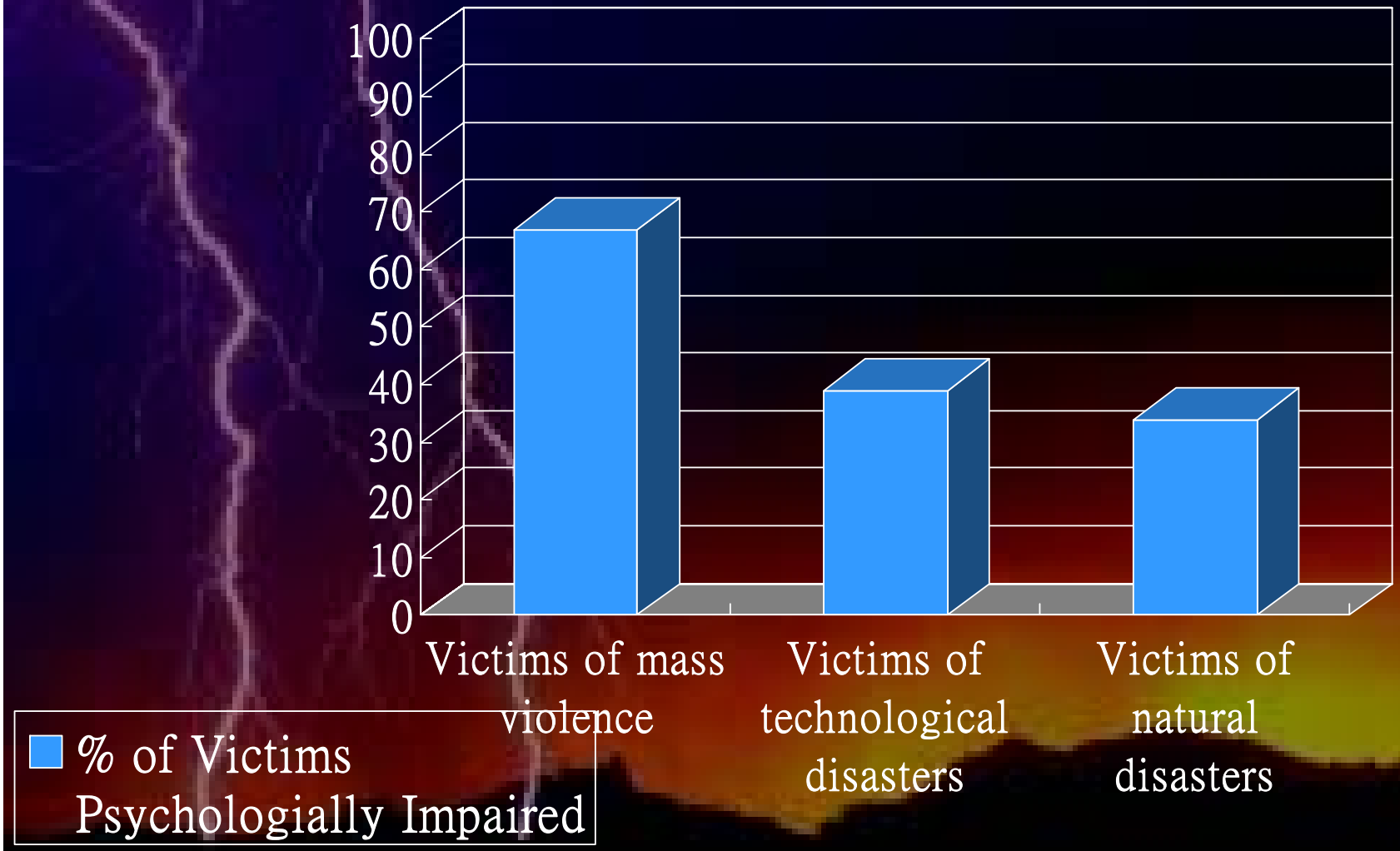
Violence/ Terrorism

- People were more likely to be impaired if they experienced *mass violence* (e.g. terrorism) rather than natural or technological disasters (Norris et al., 2002).

Victims of mass violence – 67% severely or very severely psychologically impaired

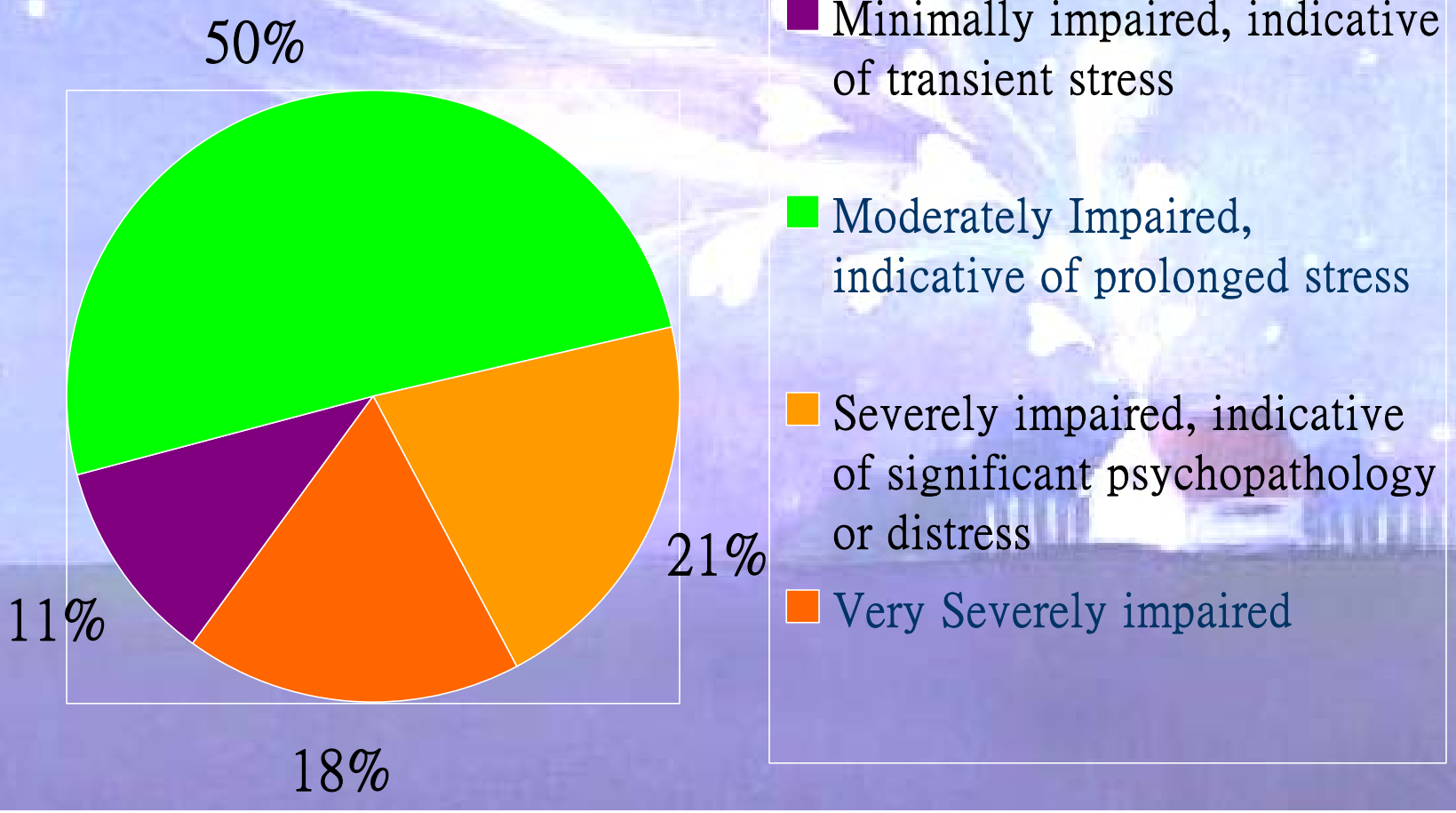
Victims of technological disasters – 39%

Victims of natural disasters – 34%

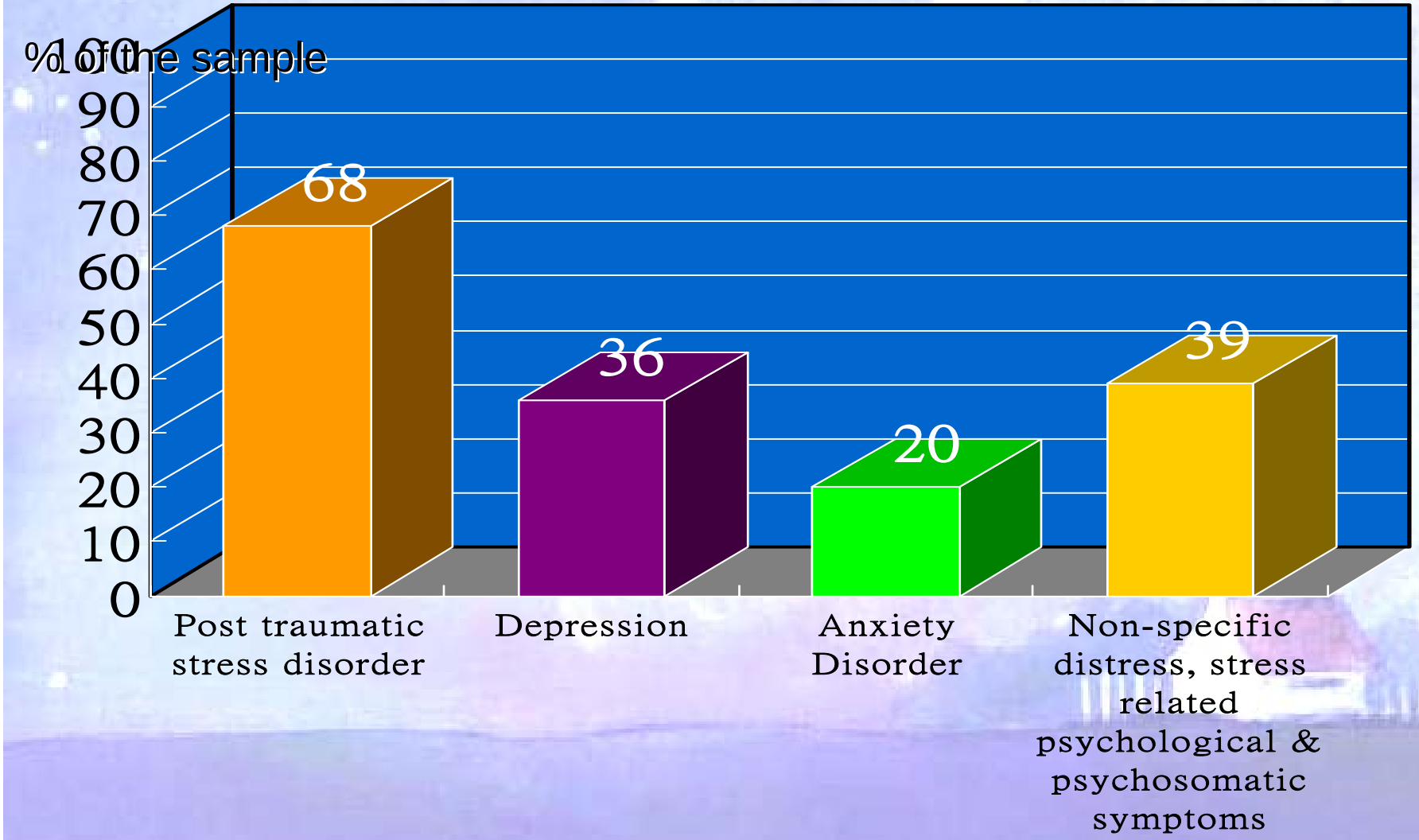


Statistics of Psychological Impairments

- Norris et al. (2002) surveyed 60,000 disaster victims between 1981 and 2001:



Psychiatric Diagnoses Found



Posttraumatic Stress: Normal Reactions to Abnormal Situations

- Posttraumatic stress and acute grief responses are *expected normal reactions* to an extraordinary and abnormal situation.
- The process is natural and *adaptive* and should not be labeled pathological (i.e. a ‘disorder’).

Factors Affecting the Mental Health Impacts of Disaster

1) ***Factors related to the disaster***
   - type and scope of disaster, degree of uncertainty, duration of disaster or continued threat

2) ***Factors related to the individual***
   - premorbid psychiatric status, preexisting stresses, previous traumatic experiences, coping skills, self-efficacy beliefs, cognitive appraisal style

Factors Affecting the Mental Health Impacts of Disaster

3) Interpersonal factors

- strength of social support system, preexisting interpersonal stresses

4) Community factors

- previous degree of social solidarity, amount of social disruption due to the disaster

Perceived Coping Abilities Matters

- What matters most is not how individuals actually cope, but rather how they *perceive* their abilities to cope and control outcomes, as reflected in such constructs as *self-efficacy*.

Nature of Psychological Interventions in Disasters

- Many emotional reactions of disaster survivors stem from *problems of living* caused by the disaster.
- Most people do not see themselves as needing mental health services following disaster and will not seek out services.
- Therefore, disaster mental health assistance is often more *'practical'* than psychological in nature.

Nature of Psychological Interventions

- Mental health staff need to set aside traditional methods, avoid the use of mental health labels, and use an *active outreach approach* to intervention.
- Interventions must be appropriate to the *phase* of disaster and *needs* of the survivors.
- *Support systems* are crucial to recovery such as family, community, and social networks.

Priorities of Psychological Interventions

The first priority following disaster is:

- attending to *basic needs*, such as safety, security, communication,
- reunification of *families*,
- attention to injuries and *medical needs*,
- return to *normal routines* and roles, mutual social support,
- education of survivors and families about *effective coping strategies*.

Priorities of Psychological Interventions

- Beyond this first level of response, psychological debriefing, cognitive-behavioral interventions, and psychopharmacology are the major early interventions following major traumas.

Psychological First Aid

- There is *no evidence* that global interventions for all trauma survivors will serve a function in preventing subsequent psychopathology.
- There is *consensus*, however, that providing comfort, information, support, and meeting people's immediate practical and emotional needs play useful roles in one's immediate coping with a highly stressful event.

Psychological First Aid

- Psychological first aid is conceptualized as *supportive* and *non-interventionist*, definitely not as a therapy or treatment
- Most survivors will have transient stress reactions that will remit with time.
- Psychological first aid aims at reducing the *initial distress* caused by the trauma, and to foster short- and long-term adaptive functioning.

Objectives of Psychological First Aid

1. *Establish a human connection* in a non-intrusive, compassionate manner
2. *Enhance immediate and ongoing safety*, and provide physical and emotional comfort
3. *Help survivors articulate immediate needs and concerns*

Objectives of Psychological First Aid

4. *Offer practical assistance and information* to address survivors' immediate needs and concerns.

5. *Connect survivors* to social support networks, including family members, friends, neighbors, and community resources.

6. *Support positive coping* and empower survivors to take an active role in their own recovery.

Objectives of Psychological First Aid

7. *Provide information* to help survivors cope effectively with the psychological impact of disasters.

8. *Facilitate continuity* in disaster response efforts by linking the survivors to indigenous recovery systems.

Behaviors to Avoid in PFA

- Do not make *assumptions* about what the person is experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not *pathologize*. Most acute reactions are understandable and expected given what people had gone through.
- Do not talk down to or *patronize* the survivor.

Behaviors to Avoid in PFA

- Do not assume that all survivors want to talk. Often, *being physically present in a supportive and calm way* already helps.
- Do not ‘debrief’ by asking for details of what happened.
- Do not speculate or offer unsubstantiated information.

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Critical Incident Stress Debriefing (CISD) (cf. Mitchell & Everly, 1996)

- *A single-session group intervention* with a *standardized sequence* that focuses on disclosure of traumatic experiences, normalization of reactions to trauma, education about stress reactions, enhancement of effective coping, and identification of those who need more intensive services.

The CISD Protocol

1. ***Introduction phase*** – the purpose and nature of the CISD
2. ***Fact phase*** – describe the facts
3. ***Thought phase*** – describe the thoughts during the incident
4. ***Reaction phase*** – focus on the emotional responses and the meaning assigned to these experiences.

The CISD Protocol

5. ***Symptoms phase*** – discuss typical stress reactions
6. ***Teaching phase*** – educate the stress coping strategies
7. ***Re-entry phase*** – sum up and introduce available resources and services

Controversies over Psychological Debriefing

- There are *controversies* over the *effectiveness* of psychological debriefing. Result of RCTs suggest that psychological debriefing delivered to individuals may not prevent PTSD or other psychopathology.

- Recent reviews conclude that psychological debriefing should not be *routinely* provided to individuals immediately after disaster.

Practice Guidelines on Psychological Debriefing

Practice guidelines on debriefing of the International Society for Traumatic Stress Studies (Bisson et al. 2000) stipulate that if psychological debriefing is employed,

- It should be conducted by *experienced, well-trained practitioners;*
- It should *not be mandatory;*

Practice Guidelines on Psychological Debriefing

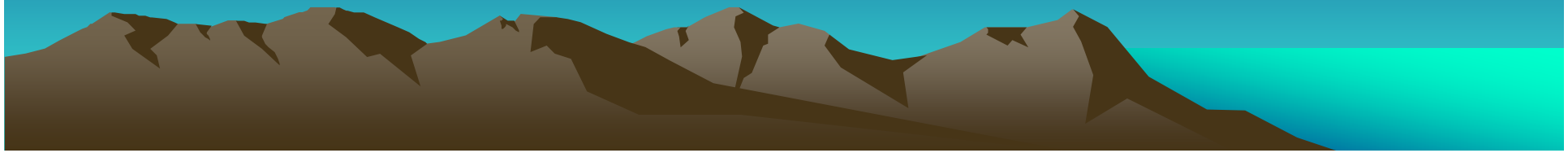
- It should conduct some *clinical assessment* on potential participants;
- It should be accompanied by clear and objective *evaluation procedures.*

Critical Incident Stress Management (CISM) program (Everly & Mitchell, 2000).

- The CISD framework has been recently expanded into a more comprehensive Critical Incident Stress Management (CISM) program.
- A series of interventions with high face validity designed to *comprehensively* address the needs of emergency service organizations and personnel.

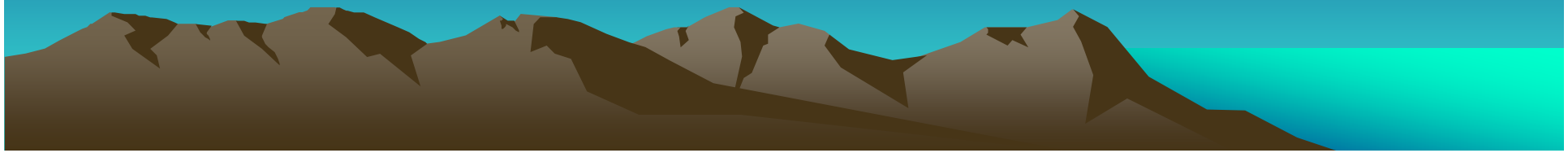
The Core Components of CISM

- Individual crisis interventions
- Pre-crisis preparation
- Demobilizations & staff consultation
- Crisis management briefing
- Defusing



The Core Components of CISM

- Critical incident stress debriefing
- Pastoral crisis intervention
- Family CISM
- Organizational consultation
- Follow-up/Referral



Screening for High Risk Population

- There is a need to pre-screen individuals at risk for having difficulty adapting on their own over time to the trauma.
- Interventions should be devised to treat only those individuals who are not likely to recover over time on their own.
- On the other hand, early identification and screening of individuals could inadvertently produce negative effects (e.g. stigmatization, self-fulfilling prophecy).

Chronic Distress Symptoms

- Most trauma survivors display *PTSD reactions* in the initial weeks after the trauma, but that most of these people adapt effectively within appropriately three months.
- Those who fail to recover by this time are at risk for chronic PTSD, and psychotherapy is highly indicated.

Cognitive-behavioral Therapy as Early Intervention

- Studies showed that victims of trauma who received CBT reported experiencing *significantly fewer symptoms of PTSD* than the control group.
- The use of CBT as *secondary prevention interventions* for trauma is indicated.
- *Brief CBT (5 sessions)* seemed to be able to prevent chronic posttraumatic pathology in recent trauma victims (Foa et al., 1995, Bryant et al, 1998).

Brief Cognitive-behavioral Interventions

The CBT sessions included:

- Education about common posttraumatic reactions
- Relaxation training
- Imaginal exposure to the traumatic event
- Graded in vivo exposure

Brief Cognitive-behavioral Interventions

- Cognitive restructuring
- Teaching of coping skills for managing symptoms of stress and anxiety
- Homework assignments

Conclusion

- We should not overlook people's *resilience* in the face of disasters.
- In spite of the overwhelming prevalence of psychiatric symptoms after extreme traumas, the *majority* of survivors do not become psychiatrically ill.

Conclusion

- However, this optimism must be balanced with ability to recognize *psychiatric morbidities* and direct them to appropriate mental health services.
- There should be more integrative, comprehensive and *culturally sensitive* service models for the psychological management of disasters.

Reference

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THANK YOU !!