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Fundamentals of Disaster Mental Health Practice

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Training Program Goals/Objectives

After participating in this day-long training, you will be able to:

- Describe **how disaster mental health differs** from more traditional mental health practices

- Understand the **range of typical reactions** that are expectable in survivors following a disaster, including physical, emotional, cognitive, behavioral, and spiritual responses, as well as the collective effects on families, groups, and communities

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Training Program Goals/Objectives

- Understand and be able to recognize the **extreme reactions** experienced by some disaster survivors and identify evidence-based best practices for longer-term treatment of PTSD and other reactions

- Identify **risk factors** that make certain groups or individuals more vulnerable during and after disasters

- Become familiar with the procedures of DMH deployment to a disaster recovery site

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Training Program Goals/Objectives

- Review the principles of **Psychological First Aid** and practice its elements

- Understand **early interventions** and the role of screening and referral to identify and assist those demonstrating a need for mental health interventions

- Understand the importance of **self-care** for disaster responders, and consider healthy coping mechanisms in preparation for participation

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Module 1

What is Disaster Mental Health?

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Case Study
Tropical Storm

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How Does DMH Differ from Traditional Practice?

- None of the typical comforts of private practice are available
- Client assumptions have been shaken or shattered
- Need to expect the unexpected, and at least to *appear* comfortable with what is profoundly uncomfortable for most people
- No scheduled appointments; counseling can last a few minutes or a few hours

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How Does DMH Differ from Traditional Practice?

- No insurance forms!
- Everything is unpredictable, with unusual sights, sounds, and smells
- May be underwhelmed one day, overwhelmed the next
- Must be able to triage needs
- **Helper flexibility and open mindedness are essential**

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The Role of the Helper

- DMH is *NOT* traditional therapy

- We assume the survivor isn't suffering from a disorder, but is struggling to process extreme but understandable stress

- Our help must adapt to each client's situation, actively addressing acute needs

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"I Don't Need Mental Health"

- We may face resistance from:
  - Emergency management officials who don't recognize need for DMH (for themselves as well as survivors)
  - Survivors who are reluctant to seek or accept professional assistance, but may welcome human contact and assistance

- Don't emphasize titles and credentials – connect first and build trust to provide DMH help

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DMH Settings

- Disaster site
- Disaster Recovery/ Assistance Center
- Family Service Center or Family Assistance Center
- Medical Points of Distribution (PODs)
- Outreach teams

- Headquarters/Emergency Operations Center
- Hospital Family Assistance Center
- Shelters
- Schools
- Memorial services
- On the phone

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Settings: **Disaster Recovery Centers**

- Joint operation between FEMA and NYS agencies

- Provide information and referral services to individuals and families affected by disaster

- DMH responders support the DRC operation by ensuring that visitors/clients and staff at the center obtain immediate emotional support if needed

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Settings: **Disaster Recovery Centers**

Your role at a DRC:

- Check in with the DRC Site Manager who coordinates all activities and introduce yourself to workers at each table

- Let DRC staff know who you are, what your primary role at the center is, and that they can look to you for assistance should someone appear to be in need of emotional support

- Stay mobile when not working directly with an individual or group, circulating throughout the center to identify situations that might benefit from your assistance

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Settings: **Disaster Recovery Centers**

- If someone appears to be in distress, assess the situation and provide necessary assistance

- Be prepared to make a referral to local outpatient services or a hospital if necessary

- Provide a calming presence for DRC staff and educate them about the need for self-care

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Settings: **Shelters**

- Typically staffed by American Red Cross or local government housing services personnel and volunteers
- Often located in schools, churches, or other facilities via prearrangement
- Atmosphere is often hectic; conditions often crowded with little privacy

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Settings: **Shelters**

- Residents likely to be stressed and anxious
- Rules to ensure safety can be perceived as restrictive or upsetting

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Settings: **Family Assistance Centers**

- Same term used for two situations:
  - Centers set up after major transportation disasters, often in a hotel or conference center, involving many agencies (NTSB, Airline, FBI, law enforcement)
  - Centers set up in hospitals after mass casualty incidents
- Goal in both cases is to create a private, secure meeting place for survivors, family members, and friends

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Settings: **Family Assistance Centers**

- Regular briefings provide survivors, families, and friends updates about the event, the investigation, memorial services, and other relevant information

- Differs from DRC by focusing on unique needs of family members of those killed or injured in disaster

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DMH in Public Health Emergencies

- Incidents that threaten or compromise the physical health and welfare of a population:
  - spread of disease
  - intentional release of a chemical or biological agent
  - disaster that impacst hospital functioning
- Cause unexpected number of deaths, injuries, or illnesses
- Exceed therapeutic capacity of healthcare system

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DMH in Public Health Emergencies

- Response is often long-term as an outbreak spreads and is eventually contained, so no single beginning or ending date, with different timing for those impacted

- Cause is often invisible; may be a delay between exposure and development of symptoms so fear and anxiety are common among people who believe they've been exposed and are going to become ill

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DMH in Public Health Emergencies

- Healthcare and mental health workforces may be depleted by the disease, and professionals may face their own/ families' fears of exposure

- DMH may be provided via phone or social media, providing limited cues about client reactions

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DMH in Public Health Emergencies

- DMH may need to address specific stressors related to public health emergencies:
  - Real or perceived threat of pandemic outbreak
  - Anxiety around mass dispensation of medications at Points of Dispensing (PODs)
  - Emotional distress of quarantine or isolation
  - Addressing overwhelming demand for services in a hospital surge

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DMH Role Over Time

- Specific stressors DMH helpers address vary by timing, setting, and client role:
  - Working the crowd of distressed or frustrated clients waiting for services in a DRC
  - Stepping into an interaction when a client is clearly upset
  - Supporting other workers by providing practical assistance, psychoeducation, and a chance to vent

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DMH Role Over Time

- In all situations, DMH serve as "emotional shock absorbers"

- Must be aware of practical considerations (like how to dress) as well as own emotional strain

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Who Responds to Disasters in New York State?

- Regardless of role, specific training is essential! Spontaneous volunteers should be turned away, encouraged to seek training

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Who Responds to Disasters in New York State?

- Main responder affiliations:
  - State or County Mental Health Responders
  - American Red Cross
  - Office of Children and Family Services
  - Office of Temporary and Disability Assistance
  - Other Agencies

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Spiritual Care in Disaster Response

- Includes anything that assists an individual, family, or community in drawing on their spiritual perspective as a source of strength, hope, and healing
- Disaster Spiritual Care providers may not share a faith with those they try to help, and recipients may not belong to a religious community
- Underlying goal is to provide sensitive, appropriate care for all people and to celebrate and respect every spiritual perspective

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Spiritual Care in Disaster Response

- Short-term purpose is to offer security and safety
- Longer-term purpose is to facilitate the restoration of faith and hope, and to help find meaning in life following a disaster, particularly when there has been a loss of life
- Disaster Spiritual Care and Disaster Mental Health both provide invaluable assistance, but they do so on parallel tracks – one is not intended to be employed as a substitute for the other

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Who Are Your Clients?

- Potentially everyone impacted by disaster – but remember that not everyone is receptive to accepting help
- In DMH role, may need to be more proactive than usual yet not intrusive or overbearing
- Some survivors benefit most from help and support from family, friends, and clergy

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Who Are Your Clients?

- May be obvious who needs help with distress, anxiety, anger

- Other actions are more subtle – you could:
  - Check with the shelter managers about residents or staff members who could use support
  - Walk around a shelter or DRC, introduce yourself to residents/visitors and let them know you're available if they need anything

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Who Are Your Clients?

  - Check to see if people are generally comfortable – decent lighting, food, and clean bathrooms
  - Let people know food is on the way, toys are available for children, the storm has passed, the local sports team won the game
  - Listen to complaints about shelter life or frustrations with response resources
  - Check in with response leaders, reporters outside the operation, or first responders coming in for a break

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Remember…

- People don't always want to talk about the disaster – sometimes they need a break

- Appropriate humor can provide needed relief, but be cautious – allow the survivor to take the lead

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Remember…

- Survivors may find it difficult to tell their stories multiple times to different DMH workers – be sensitive to this when you meet a client and, if possible, introduce the client to the worker taking over your role to provide a soft handoff

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Module 2
Disaster's Impact: Range of Reactions

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Range of Reactions: Key points

- Group-level patterns vs. individual reactions
- Inter-individual differences AND intra-individual differences over time
- No knowledge of client's pre-disaster functioning
- **Post-disaster traumatic stress may resemble Posttraumatic Stress Disorder, but doesn't equal it!**

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Reactions by Type

See the manual for complete lists of reactions in each realm:

- Emotional
- Behavioral
- Physical
- Cognitive
- Spiritual

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Reactions by Type

- This vast range makes assessment difficult, but underscores importance of providing support to all survivors
- These reactions make sense, but still feel overwhelming to the survivor – don't minimize them by describing them as "normal"
- Knowing reactions are likely to improve over time shouldn't be used as an excuse not to provide assistance

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Reactions Throughout the Disaster Life Cycle

- Most (but not all) events have an identifiable impact phase
- Survivors may divide their lives into pre- and post-disaster

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Reactions Throughout the Disaster Life Cycle

- The "disaster life cycle" provides insight into *typical* patterns of reaction, though characteristics of the event, the individual, and the response impact any given person's state at a particular time

- Don't expect every person you help to follow this pattern in a linear fashion

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Reactions Throughout the Disaster Life Cycle:

Pre-Impact

- Receiving a warning creates a decision-making situation where most factors in the decision will point to NOT taking the recommended action

- If warning was received and ignored: guilt, self-blame

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Reactions Throughout the Disaster Life Cycle:

Pre-Impact

- If no warning was received: Survivor may feel stunned; be unable to process experience immediately; look for someone to blame for lack of warning; feel vulnerable about future events

- DMH probably not present, except in shelter opened in advance

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Reactions Throughout the Disaster Life Cycle:

Impact

- Characterized by magnified arousal levels as the fight, flight, or freeze response is activated – survival is the goal
- Panic is rare; purposeful and productive actions are more the norm

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Reactions Throughout the Disaster Life Cycle:

Impact

- How competent or helpless a person acts and feels at this time can play a key role in how they'll process the disaster experience later
- Again, DMH probably not present, except in shelter opened in advance

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Reactions Throughout the Disaster Life Cycle:

Post-Impact

- Heroic / Rescue
- Honeymoon
- Disillusionment
- Reconstruction

Timeframe for each stage varies depending on the scope, intensity, and duration of the catastrophe as well as the resources available for recovery

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Reactions Throughout the Disaster Life Cycle:

Post-Impact

Heroic / Rescue

- Adrenaline-fueled rush to save lives and protect property
- Physiological and psychological arousal may limit thinking and coping capacities
- Focus is on action – emotional effects are just beginning to be absorbed, so little role for DMH

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Reactions Throughout the Disaster Life Cycle:

Post-Impact

Honeymoon

- Strong sense of community as those impacted feel unified by their collective experience
- Influx of attention, media, money, and personnel at the scene

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Reactions Throughout the Disaster Life Cycle:

Post-Impact

- Survivors often downplay significance of material losses in their elation at having survived
- DMH should ideally establish a presence now, in order to have foundation for helping in later, more difficult stages

NOTE: Honeymoon phase may not occur in events with fatalities, very extensive damage, or a lack of response resources

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Reactions Throughout the Disaster Life Cycle:
Post-Impact

Disillusionment

- "Reality check" – full extent of losses and challenges of recover are absorbed
- Outside assistance and attention begins to pull out

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Reactions Throughout the Disaster Life Cycle:
Post-Impact

- Community bonding fades as disparities in damage and resources emerge
- Lowest point, where DMH help is most needed

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Reactions Throughout the Disaster Life Cycle:
Post-Impact

Reconstruction

- Community and individuals accept they must adjust to changed circumstances on their own
- Goal is to establish a "new normal," including accepting things won't be the same as before – but could be better in some ways

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Reactions Throughout the Disaster Life Cycle:

Post-Impact

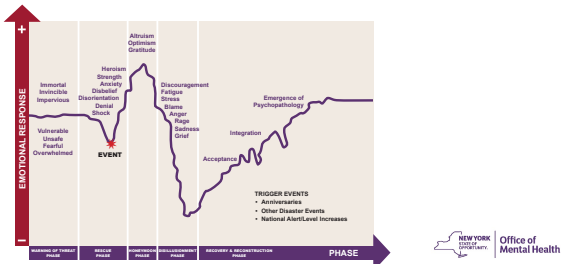- Provision of mental health services shift from deployed DMH to local helpers

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Reactions Throughout the Disaster Life Cycle:

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Reactions Throughout the Disaster Life Cycle

- Response stages are not always a clear and linear process
  - People will progress at different rates
  - May skip some stages, esp. Honeymoon
  - May revisit earlier stages, especially when reminded by anniversaries or repeated events
- But, knowing patterns of reactions allows for planning and anticipation of future needs

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Proximity and the Dose-Response Relationship

- Those closest to the point of impact typically :
  – demonstrate stronger emotional reactions and the most need for support
  – have the most resources directed towards them

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Proximity and the Dose-Response Relationship

- This focus may lead to overlooking other groups in distress:
  – Those who identify closely with victims
  – Responders, esp. unofficial/volunteer

- Keep an open mind about who may need DMH support

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Risk Factors

- What puts people at risk for more extreme reactions to disasters?
  – Dose (intensity/length/proximity of exposure to event)
  – Lack of resources/social support
  – Membership in a vulnerable population

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Vulnerable Populations

"Groups whose disaster-related needs may be more complex or intense than most survivors' needs, exceeding what can be fully addressed by traditional service providers."

(Halpern & Tramontin, 2007, p. 138)

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Vulnerable Populations

Examples of additional needs:
- Assistance evacuating
- Special sheltering conditions
- Restoration of medications or assistive devices
- Provision of assistance with activities of daily living

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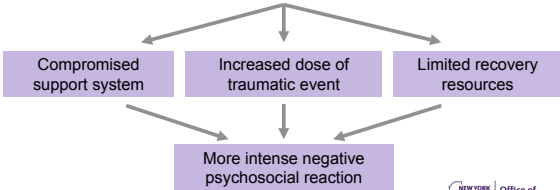

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Mediating Factors

Characteristics of vulnerable individual

Compromised support system

Increased dose of traumatic event

Limited recovery resources

More intense negative psychosocial reaction

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Vulnerable Populations: **Children**

- May be unable to physically escape a situation, so more susceptible to physical injury and traumatic exposure

- Depend on caregivers for physical and social-emotional safety – at risk if caregivers are physically or psychologically unable

- May suffer disruption to their normal development, leading to prolonged social-emotional difficulties if not resolved

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Vulnerable Populations: **Children**

- Reactions and needs must be viewed in context of family system:
  - Did parents/other family members also experience the event? If so, how are they coping?
  - What were pre-existing strengths and weaknesses in the family? (i.e., SES, parental conflict/unity, communication patterns, other stressors)
  - Do they feel capable of handling the child's reactions?

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Vulnerable Populations: **Children**

- DMH focuses on helping caregivers help their children via psychoeducation and by giving caregivers tools to support their children and themselves

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Vulnerable Populations: **Frail Older Adults**

- Pre-existing limitations that impact activities of daily living may limit ability to take protective action or cope with shelter conditions

- Medical conditions may be exacerbated, especially if access to medications or assistive devices is disrupted

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Vulnerable Populations: **Frail Older Adults**

- Cognitive limitations likely to worsen under stressful or chaotic post-disaster conditions

- Extreme resistance to evacuating – leaving home, mementoes, pets

- May have a foreshortened sense of future – believe they won't live long enough to create the "new normal" younger adults hope for

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Vulnerable Populations: **Frail Older Adults**

- Often have a limited social circle to turn to for support
- May resist seeking or accepting help because they don't want to feel like a burden to others
- BUT: many older adults exemplify strength, resilience, and inspiration, and can be a source of knowledge, experience, skills, and wisdom provided physical needs are addressed

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Vulnerable Populations:
People with Physical Disabilities

- Far from a homogenous group, but often treated like one in planning so many needs are overlooked

- People with serious disabilities may be on lower SES spectrum with few resources for preparation or recovery

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Vulnerable Populations:
People with Physical Disabilities

- May feel guilt or shame about needing additional assistance, or anger about needs being overlooked

- Post-disaster needs primarily logistical, not emotional

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Vulnerable Populations:
People with Serious Mental Illness

- Widely prevalent: ~1 in 5 American adults have had some mental illness, esp. anxiety or depression (NAMI, 2015)

- People with a history of SMI are at higher risk of recurrence post-disaster but **not** destined to it

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Vulnerable Populations:
People with Serious Mental Illness

- Stigma from other survivors may cause anxiety or hostility, esp. in shelter settings
- DMH focus is on helping the survivor reconnect with support systems and restoring access to needed medications
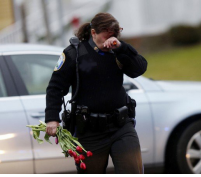
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Vulnerable Populations: **Responders**

- Professional responders (including journalists) are generally highly resilient, but everyone has a breaking point
- Take care not to overlook specialized DMH needs among these groups

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Cultural Competency

- Cultural factors like religion, language, beliefs, and traditions influence how people understand and respond to their experiences
- Especially powerful in times of great stress

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Cultural Competency

- Competency involves understanding appropriate behaviors (i.e., eye contact, touching) but also broader reactions to disaster:
  - Individual's **appraisal** of a traumatic event
  - How they **express** their distress
  - How they **cope** with it

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Cultural Competency

- Expressions of mourning and grief are strongly tied to cultural beliefs and customs

- Expected levels of expressiveness vary widely, can make assessment challenging

- Inability to follow sacred traditions may compound the loss, adding a sense of guilt or failure to honor the dead to the grief about the death itself

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Cultural Competency

- Cultural beliefs shape survivors' perceptions of responsibility for an event:

  - God's will
  - Karma/fate
  - Random act of nature

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Cultural Competency

- Also expectations about consequences, esp. for human-caused events:
  - Desire for vengeance
  - Desire for justice via legal system
  - Punishment is God's role, not man's

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Cultural Competency

- Some survivors may mistrust authorities and resist seeking help:
  - Undocumented immigrants fearing deportation
  - Immigrants from countries with corrupt or abusive rulers or regimes
  - Members of racial groups with history of mistreatment by police and authority figures

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Cultural Competency

- Build connections (in advance if possible) through clergy, community leaders, other trusted group members to overcome suspicion

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Disaster Loss and Grief

- Disasters cause a wide variety of tangible losses:
  - Death of loved ones
  - Death of pets
  - Valued property (home, treasured mementoes, important documents)
  - Health
  - Occupation

- Also more existential losses: Faith, sense of personal invulnerability, self-esteem, identity

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Disaster Loss and Grief

- All of these losses must be mourned

- Ongoing process, not a fixed series of stages

- Outcome is not "closure" but adjustment – rebuilding one's life around the missing pieces that can't be replaced

- Requires acceptance of permanence of the loss, and resulting change to one's identity and roles in life

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Disaster Loss and Grief:
Complicating Factors

- Survivor may have experienced the disaster personally and be dealing with traumatic memories

- Almost always sudden and unexpected so no chance to say goodbye or resolve issues with the deceased, or to prepare emotionally or practically for the loss

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Disaster Loss and Grief:
Complicating Factors

- If human-caused, likely to be anger, blame, and a desire for justice or vengeance
- Survivors may get involved in lengthy legal or criminal proceedings
- If the survivor received and ignored a warning, self-blame, guilt, and shame are common

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Disaster Loss and Grief:
Complicating Factors

- Survivor may be dealing with multiple deaths at once, and/or with other losses → "bereavement overload"
- Or may downplay their own distress, recognizing other survivors had more extensive losses

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Disaster Loss and Grief:
Complicating Factors

- Media attention means survivors may be forced to do their mourning in public, or face constant reminders of the loss
- Disrupted post-disaster conditions, or situations like the inability to recover remains, often mean survivors are unable to complete customary rites

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Disaster Loss and Grief: **DMH Role**

- Awareness of complexities of disaster-related loss will help you validate experiences of victims who may be unable to understand or legitimize their sadness or grief

- May be able to help with difficult decisions related to viewing remains and ritualizing death when remains aren't available

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Disaster Loss and Grief: **DMH Role**

- DMH often provide support at public memorials – may be little to do beyond provide visible, calm presence which reaffirms trust and reminds mourners that people are not indifferent to their suffering

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Survivor Guilt, Self-Blame, and Shame

- Many survivors experience some form of self-judgment about their role in the event

Survivor guilt:
- Trying to understand why one lived when others died, or why one's losses were less severe than others'
- Involves comparing one's good fortune with misfortune of others, so characterized by uncomfortable interplay between relief and empathy for others who weren't so lucky

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Survivor Guilt, Self-Blame, and Shame

Performance guilt:
– Belief one could and should have done better – been better prepared, acted more bravely, rescued more people (or been present at all

• Self-judgments often involve misappraisals or distortions, overestimating what one could have accomplished or underestimating how much one actually did

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Survivor Guilt, Self-Blame, and Shame

• Sometimes self-judgments are realistic and can't be corrected or dismissed, leading to **shame**:
– Judging the core self as weak, worthless, or powerless in the eyes of others, unable to take action or protect oneself or loved ones
– Reflects fundamental devaluing of the self in relation to others
– Restoring connectedness with the DMH helper can begin to help the shamed survivor reconnect with others whose acceptance of their worth they rely on

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Addressing Guilt and Shame

• Self-judging emotions are painful but may serve a defensive or protective function against even more confusing feelings of powerlessness

• Underlying cognition is something like "The damage was my fault, so by changing my behavior I can make sure that never happens again"

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Addressing Guilt and Shame

- As DMH responder, try to:
  - Recognize cognitions that suggest the presence of shame or guilt
  - Gently correct potential misappraisals
  - Help survivor work towards acceptance of what they did or didn't do – and what they can or can't control in the future

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Resilience

- Resilience is the ability to *resist* developing serious negative reactions in response to traumatic experience

- Different than recovery, which refers to bouncing back from negative reactions

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Resilience Factors

- Bonanno's (2004) "pathways to resilience":
  - **Hardiness**: personality trait involving three dimensions:
    - Commitment to finding meaningful purpose in life
    - Belief one can influence one's environment and the outcome of external events
    - Belief one can grow and learn from both positive and negative life experiences

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Resilience Factors

– **Self-Enhancement**: tendency to over-inflate own skills or importance

– **Repressive Coping**: emotional-level suppression of distress

– **Positive Emotion & Laughter**: used to undo negative emotion

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Resilience Factors

- From Norris et al. (2002):
  – Membership in majority culture
  – Previous experience of less serious disaster
  – Professional training
  – Stable, calm personality
  – **Perception of social support**
  – **Belief in own coping capacity**

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Community Resilience
FEMA's Whole Community approach:

- All members of a community are considered part of emergency management team
  – members of social and community service groups and institutions
  – faith-based and disability groups
  – academia
  – professional associations
  – private and nonprofit sectors
  – other government agencies

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Community Resilience

- Each group can contribute essential insights to strengthen disaster planning and response

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Post-Traumatic Growth

- Distinct from resilience and recovery
- Not just maintenance of pre-event functioning, but an actual *increase* in functioning in one or more realms:
    - Relating to others
    - New possibilities
    - Personal strength
    - Spiritual change
    - Appreciation of life

(Posttraumatic Growth Inventory, Tedeschi & Calhoun)

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Post-Traumatic Growth

- Achieving PTG appears to require a period of negative response before growth occurs:
    - In one study of 9/11 survivors (Butler, 2010) growth was more likely to occur among people who experienced higher levels of initial global distress and higher levels of event-related changes in existential outlook
    - Those who demonstrated more resilience initially were less likely to report subsequent growth as measured by the Posttraumatic Growth Inventory

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A Caution About Resilience & PTG

- Current buzzwords in DMH field and popular media

- Nice to emphasize positive outcomes – but:
  - Not very comforting to discuss with survivors in the early stages of post-disaster distress
  - We need to be sure expectations of resilience aren't used by authorities to excuse not providing services!

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Extreme Reactions

- Most post-traumatic reactions are transient and resolve over time

- Less common but more severe reactions:
  - Impede the survivor's natural recovery process
  - May require formal long-term treatment

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Extreme Reactions

- That treatment is NOT part of DMH response, though it may be delivered by same mental health professional in different role

- **Self-referral of a DMH client for long-term treatment is neither appropriate nor ethical**

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Extreme Reactions:
Posttraumatic Stress Disorder

- Essentially an inability to integrate memory of traumatic experience

- Event is perceived as ongoing threat, activating physiological arousal and distress each time it's remembered

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Extreme Reactions:
Posttraumatic Stress Disorder

- Sufferer learns to avoid triggers – often generalized to chronic emotional numbing

- Negative alterations in cognition and mood accompany the avoidance and vigilance

- Much higher rates of PTSD follow intentional interpersonal violence than natural events

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Extreme Reactions:
Posttraumatic Stress Disorder

- Can only be diagnosed after symptoms present for 30 days

- Symptoms tend to become self-reinforcing – essential to identify and treat early or disorder becomes more difficult to reverse

- But, PTSD can be entirely cured with appropriate treatment

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Extreme Reactions: **Complicated Grief**

- Grief is not a mental disorder but a painful and expectable process of adjustment to loss

- Often takes much longer than expected, but not viewed as disordered provided some improvement occurs

- Some people get "stuck" and avoid people, activities, or places that evoke reminders of the death – they may benefit from professional assistance

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Extreme Reactions: **Substance Abuse**

- Few new onsets of alcohol or drug use disorder seen after disasters

- But, those in recovery are at high risk of relapse post-disaster, and those with current use disorders likely to continue

- DMH efforts should target those with SA histories, encouraging positive coping and attendance at 12-step meetings or other sobriety practices

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Summary: Disaster's Impact

DMH responder role is not treating the minority of survivors with extreme reactions, but trying to **prevent** those reactions by providing **timely universal support** to all impacted.

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Module 3
**Psychological
First Aid and Other
Early Interventions**

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The Importance of Early Intervention

- Disasters involve three traumatic events:
  - The disaster itself
  - Negative messages survivors receive from others
  - Negative self-talk by the survivor: Judgments about one's behavior and actions; seeing the self as inadequate, inferior, helpless

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The Importance of Early Intervention

- Traditional therapy addresses the third level – but **DMH targets the first two to ensure a positive recovery environment**

- Supporting natural recovery processes reduces need for long-term counseling

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Evidence-Based Principles of Early Intervention

Intervention and prevention efforts should include:
- Promoting sense of safety
- Promoting calm
- Promoting sense of efficacy in self and community
- Promoting connectedness
- Instilling hope

(Hobfoll et al., 2007)

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Defining Psychological First Aid

- Evidence-informed and pragmatically oriented early interventions that address acute stress reactions and immediate needs for survivors and emergency responders in the period immediately following a disaster

(NIMH, 2002)

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Defining Psychological First Aid

- The goals of psychological first aid include the establishment of *safety* (objective and subjective), *stress-related symptom reduction*, *restoration of rest and sleep*, *linkage to critical resources* and *connection to social support*

(NIMH, 2002)

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PFA Characteristics

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- Short-term; here and now
- Focus on interrelated practical, physical, and emotional needs
- Goal is to remove any barriers to survivors' natural recovery processes and to provide basic, immediate supportive care
- **Universal – can and should be provided to all survivors**

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Elements of Psychological First Aid

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- PFA is not a process, but a toolkit of components to be used as needed, in any order appropriate
- Different models exist, but all share core principles

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Providing Comfort Care: **Being Calm**

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- Disasters increase physical and emotional arousal levels, and anxiety is contagious
- A core aim of PFA is to reduce this globally heightened arousal level
- Your remaining steady and calm helps survivors master or regulate their feelings

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Providing Comfort Care:
Warmth and Genuineness

- "Unconditional positive regard" is valuing the client and offering him or her a warm, prizing acceptance

- Compassion and kindness is expressed in attentiveness, open posture, soothing tone of voice, and acceptance of anything the client says

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Providing Comfort Care:
Warmth and Genuineness

- Only *genuine* empathy and warmth are helpful for clients

- Remaining genuine during a major response requires self-care

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Recognizing Basic Needs:
Attending to Safety and Physiological Needs

- Survivors need to feel that they, and their loved ones, are safe in order to begin their recovery

- Protect survivors from any threat or danger from the ongoing disaster, especially those who may be so disoriented that they are not able to care for themselves

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Recognizing Basic Needs:
Attending to Safety and Physiological Needs

- Clients can be taken to receive medical attention
- Clients may be offered water, hot drinks, or blankets
- Support client stability by encouraging families to maintain their routines

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Recognizing Basic Needs:
Assisting with Problem Solving

- Survivors are often distracted and confused, and may struggle with decisions they could usually handle

- You can assist clients in finding shelter, or deciding which friend or relative to stay with

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Recognizing Basic Needs:
Assisting with Problem Solving

- You may need to be more directive than in your usual professional role, but still try to involve the client in decision-making to reactivate their autonomy

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Validating Survivors' Feelings and Thoughts:
Providing Acknowledgement and Recognition

- Survivors require acknowledgement and validation they've experienced a trauma and their stress reactions are understandable

- The fact that others suffered worse losses doesn't minimize the impact of that individual's own losses

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Validating Survivors' Feelings and Thoughts:
Providing Acknowledgement and Recognition

- If the significance of the trauma is downplayed by helpers or others, survivors may not take the necessary time to rest and recover

- Media attention can provide validation and/or feel insensitive or voyeuristic

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Validating Survivors' Feelings and Thoughts:
Expressing Empathy

- **IF** survivors want to describe what happened to them, be prepared to listen, but do NOT push them to talk
- Attend to all aspects of the survivor's communication at both the emotional and cognitive levels

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Validating Survivors' Feelings and Thoughts:
Expressing Empathy

- You must be willing to enter the survivor's world of pain, loss, anguish, hopelessness, rage, shock, and despair

- Survivors should not be left alone with unmanageable or uncontrollable feelings

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Connecting People with Their Support Systems:
Helping Clients Access Social Support

- Social support can be expressed as **instrumental**, **emotional**, or **informational support** - all can help an individual cope with stress

- Perceived social support can be a significant buffer to stress, even if the support comes exclusively from one reliable person

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Connecting People with Their Support Systems:
Helping Clients Access Social Support

- Survivors should be physically reunited with loved ones who can provide emotional support and security

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Connecting People with Their Support Systems:
Helping Clients Avoid Negative Support

- Not all relationships are supportive; relationships can be sources of stress and misery

- When you encourage clients to contact their natural support system, first try to be sure that these contacts will not strain the client with additional stress

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Connecting People with Their Support Systems:
Helping Clients Avoid Negative Support

- A recovery environment that's impoverished, punitive, blaming, demanding, anxiety-filled, and invalidating is one that creates a risk for PTSD

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Providing Accurate and Timely Information

- Accurate information is an important antidote for the uncertainty and anxiety survivors experience following a disaster

- Survivors will need a number of different kinds of information:
  - What happened? Who was responsible?
  - Is it truly over?
  - How extensive was the disaster damage?
  - When will we be able to return home?
  - What recovery resources are available?

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Providing Accurate and Timely Information

- Be aware of any up-to-date lists of available resources
- Frame important communications in simple language and provide in writing if possible
- Be sure never to provide unconfirmed news, or divulge information you're not authorized to

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Providing Education About Anticipated Stress Reactions

- Psychoeducation is an important element of PFA but can be provided at any time
- Goal is to demystify the experience, explain why reactions make sense given the circumstances

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Providing Education About Anticipated Stress Reactions

- Educate about stress management and stress reduction:
  – Teach effective coping mechanisms
  – Promote awareness of ineffective coping mechanisms
- Don't force information on those who aren't receptive

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Reinforcing Strengths and Positive Coping Strategies

- Survivors can be cautioned about ineffective coping mechanisms that provide momentary relief but ultimately cause additional problems, and encouraged to use more effective approaches

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Reinforcing Strengths and Positive Coping Strategies

Effective Coping Mechanisms

- Getting enough sleep
- Taking breaks
- Eating a balanced diet
- Connecting with others
- Limiting TV exposure
- Exercising
- Allowing yourself to receive as well as give
- Using spiritual resources
- Balancing work, play, and rest

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Reinforcing Strengths and Positive Coping Strategies

Ineffective Coping Mechanisms

- Not getting enough rest or sleep
- Overworking
- Binge eating
- Isolating oneself from other
- Excessive television watching
- Drinking and smoking
- Attempting to regain a sense of control by becoming overly controlling of others - bullying those around you

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Some Cautions When Using PFA

- Goal is to help survivors return to pre-disaster functioning, not fix all of their problems

- Survivors of a disaster should not be treated identically; individual needs and cultural differences must be respected

- Some survivors may prefer the comfort and support of peers or clergy, while others prefer to work their problems out alone or only want support from family members

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Early Interventions Beyond PFA

- Correcting distorted self-cognitions
- Rumor control
- Mitigating conflict
- Assessment and screening
- Referrals for long-term care

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Correcting Distorted Self-Cognitions

- Trauma survivors often think in ways that are distorted and not helpful:

  - It was my fault
  - I am shameful or
  - I am stupid
  - I am weak
  - I cannot protect myself or my family
  - I am inferior to other people

  - I will never get over this
  - It will happen again
  - I am in danger
  - I cannot trust anybody
  - I want to get revenge
  - I want it to be undone

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Correcting Distorted Self-Cognitions

- You can try to help clients find a more helpful perspective **that is consistent with reality**, but don't attempt to dismiss their actual responsibility for decisions

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Rumor Control

- Rumors are common in disasters, wars, public health emergencies, and other times of uncertainty as anxiety, stress, and lack of reliable sources increase acceptance of questionable information

- Caution people about the likelihood of rumors and misinformation which can increase distress and cause hostility against scapegoats

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Rumor Control

- Take a proactive position on rumor control, including a commitment to providing accurate information – no matter how dire

- There should be consistency in the information provided, which requires cooperation and coordination among authorities, the media, other sources

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Mitigating Conflict

- The frustration and scarcity caused by disaster increase conflict:
  - Survivors may feel they need to compete for shelter space, cleanup supplies, recovery funds, etc.
  - Competition for emotional support and disparate coping styles cause conflict within families
  - Overstretched disaster workers can experience tension with each other and with clients

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Mitigating Conflict

- Prevent conflict by monitoring stress levels, encouraging workers to take breaks or take time off, and encouraging survivors to use healthy coping mechanisms
- Intervene if necessary by stepping in and helping de-escalate arguments

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Assessment and Screening

- DMH helpers should conduct ongoing needs assessment throughout the response:
  - What additional interventions and resources are required?
  - Is the environment is suitable for psychological recovery?
  - Is it physically safe? Is it unnecessarily noisy or chaotic?
  - Is information being provided regularly?
  - Are practical issues like dietary needs being addressed?
  - Is there a need for more staff? Should some staff members be rotated out? Should spiritual care providers be included?
  - Is the community angry or disappointed for reasons that could be addressed?

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Mental Health Assessment: **Behavior-Based**

Watch for those who are:
- threatening harm to self or others
- expressing irrational thoughts or beliefs
- experiencing significant cognitive impairment
- enacting ritualistic behaviors
- hysterical or panicking
- dissociating

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Mental Health Assessment: **Experience-Based**

Intended to identify those:
- who have acute stress disorder or other clinically significant symptoms stemming from the trauma
- who are bereaved
- who have a preexisting psychiatric disorder
- who require medical or surgical attention
- whose exposure to the incident is particularly intense and of long duration   (NIMH, 2002)

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Mental Health Assessment: **Symptom-Based**

Trauma Screening Questionnaire (Brewin, 2008)

Survivors are asked if they have experienced the following at least twice in the past week:

1. Upsetting thoughts or memories about the event that have come into your mind against your will
2. Upsetting dreams about the event
3. Acting or feeling as though the event were happening again
4. Feeling upset by reminders of the event

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Mental Health Assessment: **Symptom-Based**

5. Bodily reactions when reminded of the event
6. Difficulty falling or staying asleep
7. Irritability or outbursts of anger
8. Difficulty concentrating
9. Heightened awareness of potential dangers to yourself and others
10. Being jumpy or being startled at something unexpected

Answering yes to more than six items indicates the need for additional assessment.

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Referrals for Long-term Care

- People may self-identify as wanting mental health assistance beyond PFA, or you may identify them through any assessment method
- DMH responders should know before disaster strikes where and how to make a referral for follow-up care:
  – What local agencies are available to provide continuity of care?
  – Will there be fees for services?
  – Is there a waiting list?

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Referrals for Long-term Care

- Some clients may feel embarrassed or ashamed about needing help, or reluctant to face the traumatic memory; reassure and support them for seeking treatment

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Recommended Evidence-Based Long-Term Care Approaches for PTSD

- Prolonged Exposure Therapy
- Cognitive Processing Therapy
- Stress Inoculation Training
- Other forms of cognitive therapy
- Eye Movement Desensitization and Reprocessing
- Medication

(International Society for Traumatic Stress Studies, 2008)

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Module 4
Practicing Psychological First Aid

Role plays in groups of three
One hour

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Module 5
Disaster Recovery Center Exercise

Entire group
One hour 15 minutes

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Module 6

Helping in Chaos:
Practical Considerations
and Self-Care

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Logistics of Deployment

Note: This module refers to "deployment" – typically travelling to a distant location to participate in the response when local resources can't meet post-disaster demands – but most points apply when you get involved in a response in your own community, likely resulting in:

- Fewer concerns about issues like who is looking after your family in your absence
- Less stress from trying to help in an unfamiliar environment

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Logistics of Deployment

- More stress because you may have experienced your own disaster-related losses
- Need to essentially work a double shift, juggling professional responsibilities with your own recovery needs

In all responses, flexibility and adaptability are essential!

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Is it the Right Time for You?

- *IF* you have a choice about whether to respond, start by assessing your personal readiness and addressing barriers to deployment (if possible)

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Is it the Right Time for You?

- Primary considerations (Rosser, 2008):
  - Ethical considerations to family: Could my family manage well in my absence from home?
  - Professional obligations: Is there anything so important in my work that I could not respond immediately?
  - Ethical consideration to self: Could I be useful and am I volunteering for the right reasons?
- Be sure to discuss these points with family and colleagues before accepting an assignment

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Is it the Right Time for You?

- You may decide it's NOT an appropriate time due to:
  - Family obligations
  - Work obligations
  - A recent personal loss or stressor
  - The nature of the disaster
  - The population impacted
  - Lack of confidence

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What Information You'll Be Provided

- Where are you being assigned?
- How do you get there?
- Will you require any specific identification to gain access to the site?
- Will you need any specialized protective clothing?
- Are there health hazards associated with this service site?
- How long are you expected to work?
- Who is your supervisor and how can you contact him or her?
- Is there anything specific you need to bring?
- What are the reimbursement procedures for expenses?

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What to Bring

- Try to balance packing efficiently with making sure you have what you'll need to function in potential deployment settings:
  – Comfortable, washable clothing
  – Sturdy but comfortable footwear
  – Seasonal needs (gloves, hat, sunscreen)
  – Phone/tablet with useful apps – and all needed chargers
  – ID and evidence of credentials
  – Medications and hygiene supplies
  – Comfort/stress relieving items

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What to Bring

- See the **DMH: Preparing for Deployment tipsheet** in the appendix for detailed packing guidelines
- If possible, pack a "go bag" in advance so you don't forget anything if you need to deploy quickly, or at least prepare a packing checklist to follow

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Reporting Expectations

- On OMH deployments, the *DRC Daily Report* includes:
  - Number of families received at the DRC
  - Number of individuals seen by mental health staff
  - General description of the mental health services provided
  - The nature of challenges being encountered
  - The methods you employed to address those concerns
  - Any other noteworthy events/issues occurring that day

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Self-Care

- DMH helpers report satisfaction from their involvement with disasters:
  - Immediate gratification from helping others
  - Feelings of empowerment during crisis times
  - Relief from routine mental health work and demands
  - Emotional closeness with other responders
  - A sense of unique privilege

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Self-Care

- However… without the proper preparation, responders can also suffer adverse impacts to effectiveness and competence

- **Practicing good self-care is not a luxury, but an ethical responsibility**

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Occupational Hazards of DMH Work

- **Burnout**: gradual exhaustion and depletion of emotional energy that comes from being overworked, without sufficient rest, reward, or recovery

- **Compassion fatigue:** emotional duress caused by overextending one's capacity for selflessness, resulting in general disengagement from the desire to help others

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Occupational Hazards of DMH Work

- **Vicarious trauma:** helper experiences a trauma reaction due to exposure to a client's traumatic experiences

- **Physical health concerns:** potential for injury or illness while deployed, poor air quality, disease exposure, other unrecognized hazards

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Preparing Mentally for Deployment

- "Stress inoculation" is a kind of mental dress rehearsal for what you might experience and how you'll successfully cope with it

- SI assumes that an upcoming experience *will* expose you to some unavoidable level of strain – rather than trying to eliminate that stress, goal is to manage it by taking mental steps in advance:

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Preparing Mentally for Deployment

– **Identify potential stressors** – what do you expect to find most troubling?

– **Appraise those stressors** – how likely is each one, and do you perceive it as a threat or a challenge?

– **Identify potential coping strategies** – what specific actions can you take to handle each stressor?

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Managing Stress During a Response

- Good self-care practices (eating well, sleeping enough) are often difficult to maintain in daily life let alone during periods of intense demands, so having multiple strategies to call on is essential

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Managing Stress During a Response

- Best-practice self-care strategies used by veteran DMH professionals include:

  – Social support and countering isolation professionally and personally, including staying in touch with family and friends, sharing with disaster "buddies," and seeking supervision as needed

  – Physical self-care through taking breaks, exercising, and eating as healthy a diet as possible

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Managing Stress During a Response

– Mindful awareness and self-reflection, including journaling and meditation
– Spiritual activities including praying, speaking with a chaplain, cultivating meaning in the experience, appreciating nature, and empathetic engagement with clients
– Relaxation exercises such as stretching, guided imagery, or deep breathing

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Managing Stress During a Response

• Not all practices appeal to every person, so think about what helps you deal with stress and plan for how you can practice that during and after a disaster response

• Plan ahead: Develop your own self-care plan now

• **The bottom line:** Identify what works for you, and be sure to do it!

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Staying Resilient when Disaster Hits Home

Mirta San Martin

South Beach Psychiatric Center Psychologist;
Administrator, South Beach Critical Incident Response Team;
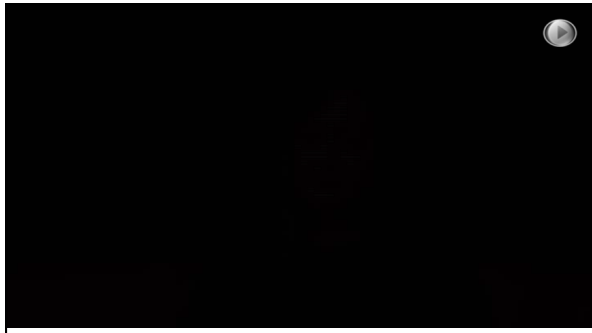and Consulting Clinician for Police Organization Providing
Peer Assistance

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Disengaging and Transitioning Back to Normal Life

- Often one of the most challenging parts isn't the intense period of deployment, but the return to ordinary life afterward:
  - Difficult to slow down from the intense tempo during deployment
  - You may be full of stories that family and co-workers don't want to hear, or you may feel they don't understand what you've been through

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Disengaging and Transitioning Back to Normal Life

  - They may resent covering for you during your time away
  - Routine work matters may seem dull relative to DMH demands
- If possible, take some time off to decompress before returning to work
- Seek out support, possibly from another DMH worker who understands first-hand

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Summary

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- We hope this training has provided understanding of the mental health issues created by disasters, and how to respond to them to support survivors' recovery

- If possible, seek out additional training, and prepare yourself mentally to respond

- As a mental health professional you can play a vital role throughout the disaster cycle in preventing, mitigating, and treating the psychological effects of disaster

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