Dealing with the Demons Provoked by Emergencies, Disasters, Major Incidents & Terrorism

Professor Richard Williams OBE TD
University of South Wales

Contents

- The myths & realities of the impact of conflict, natural disasters & terrorism on people's psychosocial experiences, needs & mental health
- The psychosocial impacts of sudden & sustained adversity, conflict & displacement
- Psychosocial resilience, social connectedness & social support
- The psychosocial approach to meeting people's needs

Learning objectives

1. How do people cope after disasters: a summary of people's psychosocial responses
   a. Myths
   b. The Realities
2. The psychosocial conditions and the psychiatric disorders that some people may develop
3. Risk factors for adverse impacts
4. Trajectories of people's psychosocial and mental health responses to traumatic events
5. The nature of psychosocial resilience

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Principles for responding to people's psychosocial and mental health needs after disasters

Richard Williams, Jonathan Bisson & Verity Kemp

OCCASIONAL PAPER

Phases

1. **Prior to Events**: Emergency Preparedness & Resilience and Recovery (EPRR): disaster risk reduction planning, national & community work towards emergency preparedness prior to events
2. **During Events and the Immediate Aftermath**: Responding to, and coping with the events & their immediate aftermath
3. **The Short- and Medium-Terms**: Recovery after events settle
4. **The Longer-Term**: Developing the abilities of people, families, communities and nations to become adaptable in the light of lessons from events with a view to mitigating responses to future events

Panic

"It is a myth that a community's first response to a crisis is panic. Yet, contingency planners have too frequently incorporated the images of a hysterical or lawless mob in their discussions and response exercises"

Glass et al, 2002

Relating to the San Francisco earthquake of April 1906, Solnit says, " … the people were for the most part calm and cheerful, and many survived the earthquake with gratitude and generosity ... Disaster requires an ability to embrace contradiction ..." Solnit R. A Paradise Built in Hell. New York: Penguin Books, 2010.

Definition of panic

- Behaviour that is intended to increase one's chances of receiving apparently scarce or dwindling resources
- Putting personal safety ahead of assisting other people
- 'Contagiousness'.
- Irrational behaviours

Sheppard et al, 2006

Other misunderstandings

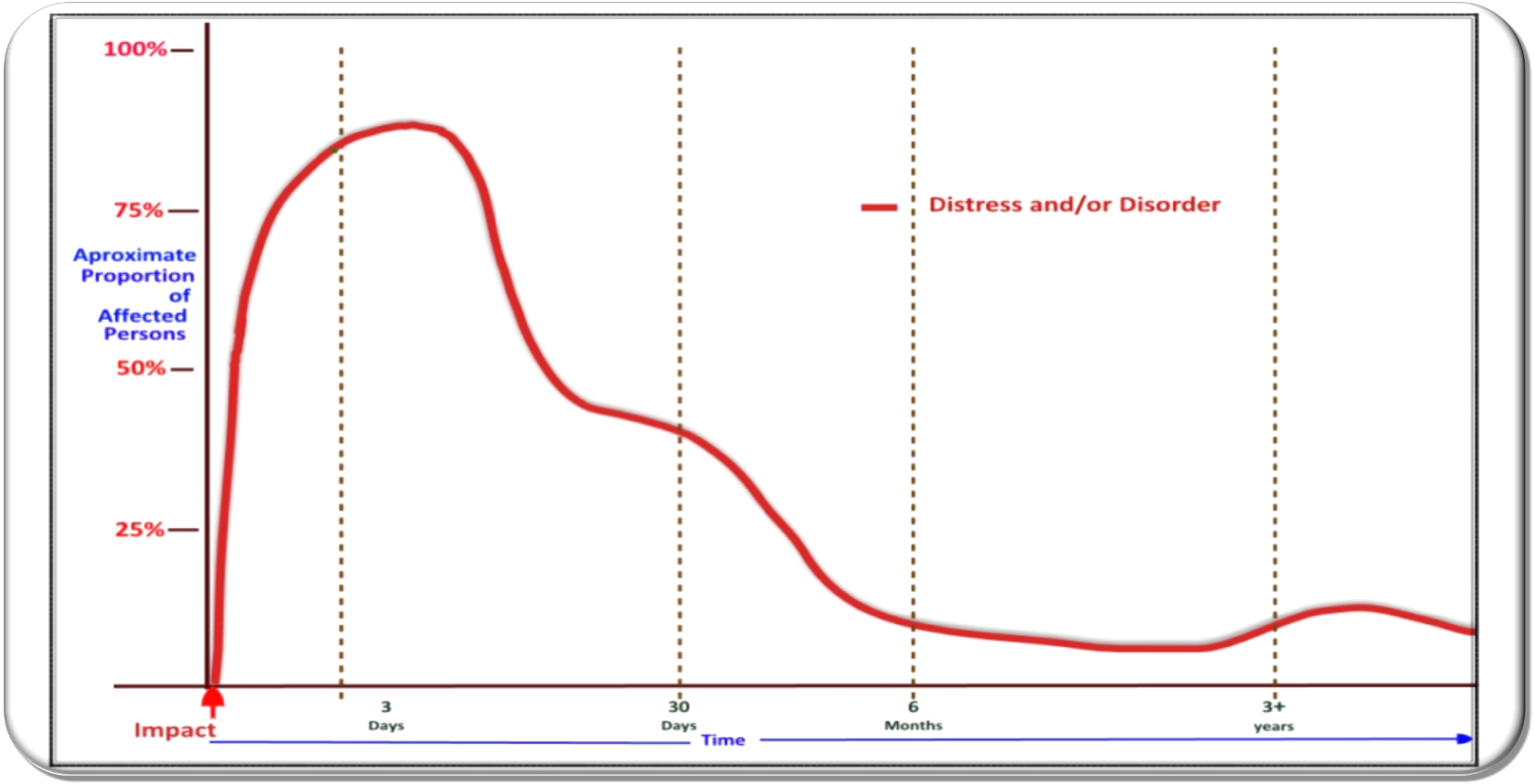
- Everybody involved needs counselling or psychiatric treatment in the immediate aftermath [1, 2]
- If a person develops a mental health problem after an emergency or disaster, post traumatic stress disorder (PTSD) is the most likely psychopathology
- First responders, including staff of the rescue services and healthcare workers are substantially unaffected by their work on emergencies

1. Social support especially is a natural and powerful intervention that can help people and it is supported by evidence.
2. NICE recommended in 2018 ‘Do not offer psychologically-focused debriefing for the prevention or treatment of PTSD’.

As events unfold

- Often, the attention of people who are directly involved is very focused during emergencies.
- Many go through one or more brief cycles of Delay and Deliberation before they arrive at a point when they Decide to take action (the 3 Ds).
- People who are affected by large-scale events that destroy the infrastructure, may be immobilised by fear, helplessness & hopelessness, but these responses are not common.
- People's behaviour in the interval between discovering an incident & the emergency services arriving is being studied by several fire & rescue services in England. People may weigh the risks & come to conclusions about how they should act that are at odds with advice given by public services.
- Most people are altruistic in the immediate aftermath & many people who are directly involved are first to take action; **they are the actual first responders**.

Psychosocial responses of a population



Indicators of distress in the immediate aftermath & short to medium terms

Emotional reactions	Cognitive reactions
~~Shock and numbness~~	Impaired memory
Fear and anxiety	Impaired concentration
Helplessness and/or hopelessness	Confusion or disorientation
Fear of recurrence	Intrusive thoughts
Guilt	Dissociation or denial
Anger	Reduced confidence or self-esteem
Anhedonia	Hypervigilance
Social reactions	**Physical reactions**
Regression	Insomnia
Withdrawal	Hyperarousal
Irritability	Headaches
Interpersonal conflict	Somatic complaints
Avoidance	Reduced appetite
	Reduced energy

People's responses to single major events

Direct effects of single event disasters on otherwise well people

1. Stress: often, distress & dysphoria
   a. *Immediate and short-term*
      I. Resilient responses
      II. Distress
      III. Acute stress reactions
   b. *Medium-term*
      I. Persistent distress maintained by secondary stressors
      II. Grief
2. Mental disorders
   a. *Substance use disorders*
   b. *Adjustment disorders*
   c. *PTSD*
   d. *Anxiety disorders*
   e. *Depression*
3. Longer-term impacts on personality & social relationships

Indicators of acute stress

- Has upsetting thoughts or memories about the event that come into mind against the person's will
- Has upsetting dreams about the event
- Acts or feels as though the event is happening again
- Feels upset by reminders of the event
- Has bodily reactions when reminded of the event
- Has difficulty falling or staying asleep
- Is irritable or has outbursts of anger
- Has difficulty concentrating
- Is overly aware of potential dangers to self or others
- Is jumpy or is startled at something unexpected

People's responses to repeated, sustained or continuing major events

Direct effects of complicated multi-event disasters on people who are at higher risk

1. Sustained distress & dysphoria that impacts on people's functioning
2. Exacerbation of existing mental disorders
3. Precipitation of new episodes of previous mental disorders
4. Increasing frequency of new mental disorders

Indirect effects of disasters on people who are exposed

Conflict & disasters increase psychiatric & physical morbidity because they change the social conditions that shape mental health through:

1. Increased poverty, community dislocation & loss or work
2. Changed social & societal relations & social disconnection
3. Domestic and community violence
4. Threats to human rights

Primary & secondary stressors

- Primary stressors

  Primary stressors are inherent in emergencies & arise directly from events. They are highly likely to cause suffering, pain and distress.

  People who are affected & their relatives may undergo great upheavals & immediate, short-, medium- & long-term changes in their lifestyles as a consequence of their experiences, injuries, physical care, recovery and rehabilitation, & the effects on their families that continue beyond their injuries, illnesses & adversity. Most people recover quite quickly from distress given social support from relatives, friends & colleagues.

- Secondary stressors

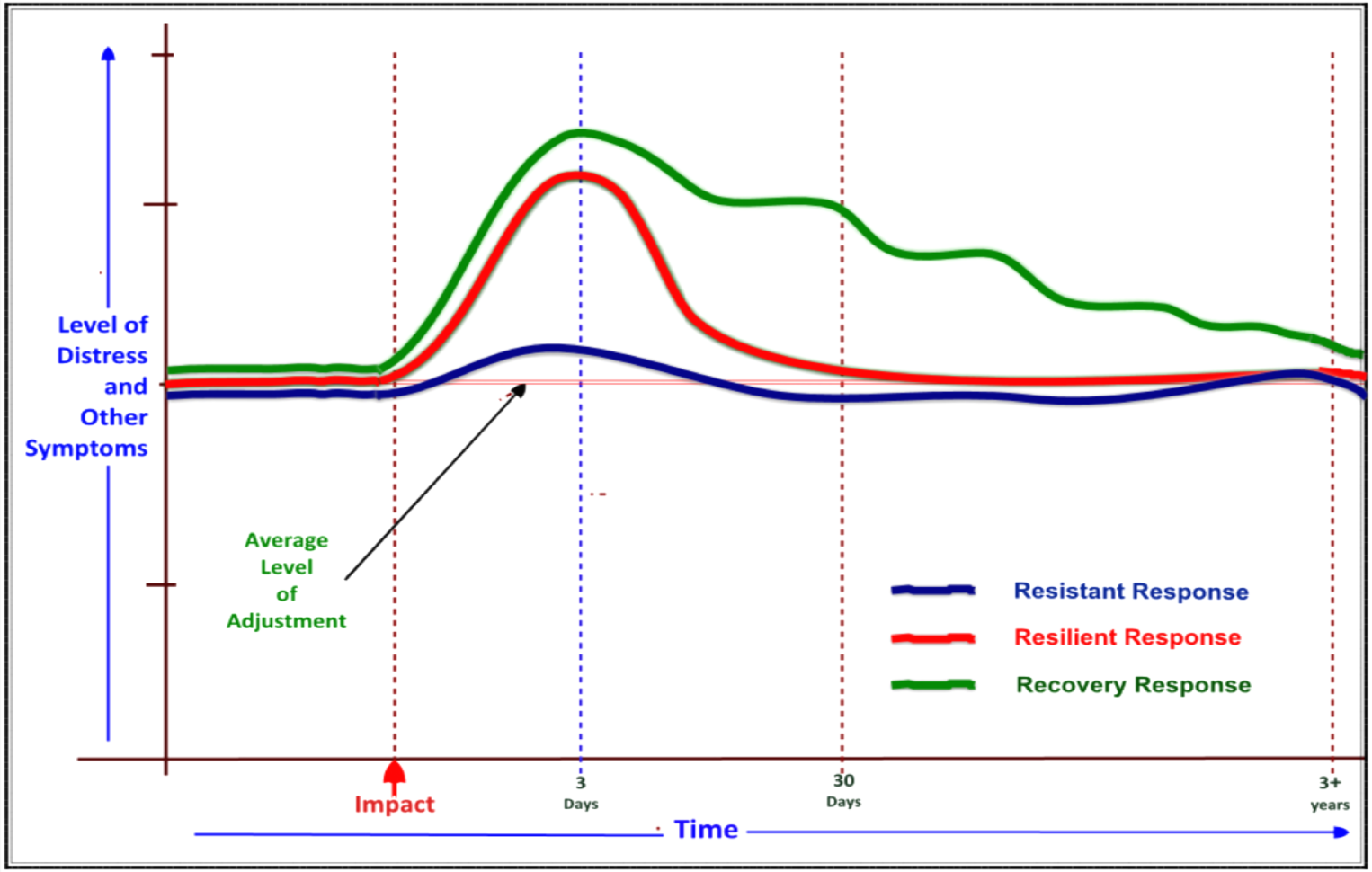
  Secondary stressors are circumstances, events or policies that are not inherent in events. The term describes conditions that persist for longer than the emergencies.

  They include failure of infrastructure recovery, gaps in provision of services, failures in rebuilding, problems with insurance & consequential impacts on communities' economies and people's employment and incomes.

Trajectories of stress responses

1. **Resilient Response**
   Depending on the nature of events, most people (70%) are psychosocially resilient. They suffer distress, usually mild to moderate, that reduces in severity if they receive support they perceive as adequate.
2. **Slower Recovery**
   Some people (10%) experience distress of moderate severity initially and then recover over time. The duration of their distress may be increased by secondary stressors.
3. **Deteriorating Response/Prolonged Stress [*]**
   Some people (10%) experience distress of moderate severity initially and these stress levels may later become prolonged or associated with significant dysfunction.
4. **High Stress Responses [*]**
   Some people (10%) may have high levels of stress after events (at above a level that is consistent with a psychiatric diagnosis). The symptoms, signs and dysfunction of about one half may be prolonged, while others improve.

[*] People who follow deteriorating or high stress trajectories tend to have had greater exposure to events, greater exposure to secondary stressors after the events & experience persisting adversity


Level of Distress and Other Symptoms
Average Level of Adjustment
Resistant Response
Resilient Response
Recovery Response
Impact
3 Days
30 Days
3+ years
Time

Psychosocial and mental health risk factors

The risk of morbidity or developmental problems is greatest for people who:

- Have perceived high threat to life
- Have been exposed to dead bodies and grotesque circumstances and odours
- Are faced with a circumstance of low controllability and predictability
- Have experienced great loss and physical injury
- Have experienced higher degrees of community destruction
- Have to live with the possibility that the disaster might recur
- Have relatives, friends or colleagues who develop a psychiatric disorder

NB Socioeconomic and interpersonal problems that may follow incidents predict long-term problems & enter affected people into cycles of disadvantage

Risk factors for medium and longer-term problems

- Felt out of control during events
- Felt that their life was threatened during the event
- Felt blamed by others for what happened
- Feels ashamed about their behaviour during the event
- Experienced acute stress after the event
- Problems with day-to-day activities since the event
- Been involved in previous traumatic events
- Has poor social support
- Has been drinking excessively to cope with distress

The problems with understanding resilience

- A multitude of uses of the term at many levels
  (e.g. culture, society, policy, planning, communities, organisations, people)
- Diverse definitions
- Assumptions - that it:
  - Relates to outcomes
  - Lies at the opposite end of the spectrum to vulnerability
- Reification of the construct leads to its attribution to people and systems in the absence of evidence & circular statements

Two systematic reviews of community resilience

1. A review of UK government statements

   "… treating resilience as the opposite of vulnerability and vulnerability as the opposite of resilience can lead to circular reasoning" … "in which the concept of resilience is employed by certain institutions as an explanatory concept to account for individuals' and communities' resilience"

   "the reification of resilience can be problematic since it occludes the processes that lead a community to being resilient in the first place" Ntontis et al, 2018

2. A review of the literature

   Three general types of definition were found:

   a. 'process' definitions
   b. 'absence of adverse effect' definitions
   c. 'range of attributes' definitions

   Patel et al, 2017

Psychosocial resilience

- The process of harnessing biological, psychosocial, structural & cultural resources to sustain wellbeing in the face of challenge &/or adversity Journal of Child Psychology & Psychiatry, 2013
- Psychosocial resilience describes social and personal processes by which people act singly or together to mitigate, moderate or adapt to the effects of events Williams, 2012
- A process linking a set of adaptive capacities to a positive trajectory of functioning & adaptation after a disturbance Norris, 2010

Core features for coping with disasters

1. Social support
   - The abilities to accept and use social support &
   - The availability of support

   are two of the key features of resilience that may have greater effects than exposure to events
2. Strong acceptance of reality
3. Is influenced by people's experiences in childhood
4. Relates to people's:
   - Attachment styles & capabilities
   - Intelligence
   - Temperament
   - Belief in selves supported by strongly-held values

Social support - research findings

- Social Support (SS) consists of **social interactions** that **provide people with actual assistance**, but also **embed them in a web of relationships** that **they perceive to be caring** and **readily available in times of need**
- SS is of three main kinds:
  - Informational
  - Emotional
  - Practical interventions
- SS may be:
  - Personal
  - Instrumental in getting things done based on cooperation & coordination
- **Collective efficacy** is the belief that a group can effectively meet environmental demands & improve their lives through concerted effort

Adaptive resources

- Personal resources include:
  - Attachment capacity
  - Interactive relationships and social skills
  - Personal beliefs and attitudes
- Collective resources include:
  - The level and equitable distribution of economic resources
  - A culture of care
  - Psychological safety within families and working groups
  - People’s and groups’ social capital
  - Information & communication
  - Social support
  - Translational leaderships

The psychosocial approach to meeting people's needs

The approach recommended here espouses current professional opinion (Patel, 2014) that commends:

- Distinguishing people who are distressed from those who require biomedical interventions
- Providing assistance for the greater number of distressed people through lower intensity psychosocial interventions
- Basing the distinctions between the two sorts of conditions on symptom patterns and trajectories of people's experiences observed in general populations

Defining psychosocial & mental health care

- Psychosocial refers to

  The emotional & cognitive (psychological), social, & physical experiences of people in the context of their particular social, cultural & physical environments. It describes psychological & social processes that occur within people, between people, & across groups of people.

- Psychosocial care

  The numbers of people who require supporting interventions to assist them to cope with distress consequent on major incidents is very substantial despite the majority of distressed people not being likely to develop a mental disorder. Many of them may be psychosocially resilient despite their distress. But, intervening early can reduce the risks of their developing disorders later. These interventions are termed psychosocial care.

- Mental healthcare

  Formal biomedical and psychological interventions from which people who have disorders may benefit. Usually, they also require psychosocial care as a platform on which their mental healthcare is based.

Five objectives for psychosocial and mental health care

Objectives in the short- and medium-terms:

1. Making psychosocial supportive care available to everyone who is affected
2. Preventing suffering and, if possible, people developing mental disorders
3. Detecting and taking steps to resolve secondary stressors
4. Providing surveillance/monitoring for people at greater risk of developing mental disorders
5. Providing primary and secondary mental healthcare for people who require it

Core principles for preparing and supporting people who are affected 1

1. Early intervention

   "Early interventions in communities suffering mass trauma should consist of general support and bolstering of the recovery environment rather than psychological treatment" Shalev, 2004

2. Approaches that are based on personal psychology
   - Helping people to normalise their experiences while being aware that some people do develop a disorder
   - Enabling people by providing social support
   - Providing reflective listening and honest, accurate and timely information
   - Helping people to restore their agency and perceptions of themselves as effective persons
   - Enabling people to seek further help
   - Peer support
   - Training & supervision

Core principles for preparing and supporting people who are affected 2

3. Practical interventions based on PIES
   - **P**roximity
   - **I**mmediacy
   - **E**xpectancy
   - **S**implicity of responses

4. Approaches that are based on supporting people's memberships of families and social groups
   - Social support
   - Leadership
   - Teambuilding & training in groups that work together
   - Creating & sustaining psychosocial safety in work cultures
   - Psychosocial interventions based on the principles of psychological first aid & community development
   - Access to employer-based or employer-arranged health surveillance & healthcare

Core interventions

1. Universal psychosocial care delivered using the principles of psychological first aid
2. Selective psychosocial care for people who have high loading on the risk factors
3. Indicated more intensive psychosocial care for people whose distress persist and is associated with dysfunction and who appear to have symptoms of mental disorders who are below threshold for diagnosis
4. Mental healthcare for people who cross diagnostic thresholds

Psychological first aid

Psychological first aid (PFA) is:

"providing a supportive and compassionate presence that is designed to enhance natural resilience and coping, while facilitating access to continuing care, if it is necessary"

modified after Everly & Flynn, 2006

Examples of PFA activities

1. Initiating contact & engaging with affected people in a non-intrusive, compassionate & helpful manner
2. Providing immediate & ongoing safety & physical and emotional comfort
3. Stabilising survivors who are overwhelmed & distraught
4. Gathering information to determine immediate needs & concerns
5. Providing information on coping, stress reactions etc
6. Providing practical assistance to assist survivors to address their immediate needs & encourage purposeful activities
7. Providing support through comforting & reflective listening
8. Assisting people to feel in control of themselves & their circumstances (restore their agency)
9. Ensuring adequate welfare, social & health care responses are directed to reducing the effects of secondary stressors
10. Prioritising attention to people who have severe reactions
11. Assisting reunion with loved ones
12. Identifying people who need contact with more specialised or longer-term help

6 core messages about people's responses

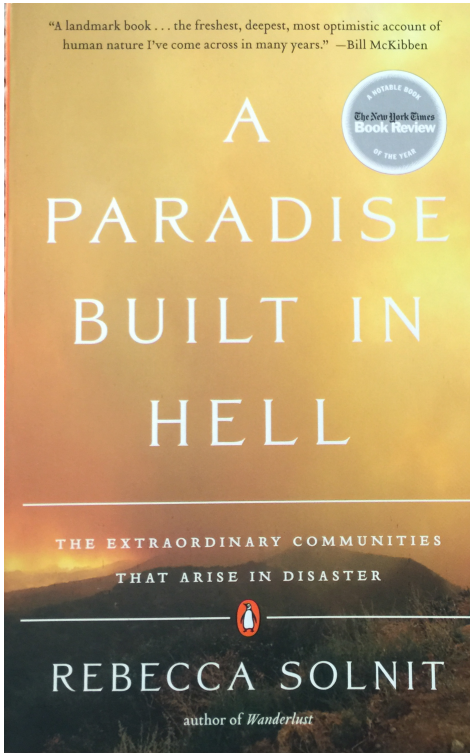
- Distress after disasters and major incidents is very common
- In most cases, distress is transient and not associated with dysfunction
- Often, the responses that are experienced by resilient people can be difficult to distinguish from symptoms of stress & later post-traumatic conditions: the differing trajectories of people's experiences are important in distinguishing them
- Some people's distress may last much longer and be more incapacitating
- Around 15 to 20% of people may have longer-term problems or mental disorders & more if they have been effected by a previous disaster or if they are injured or affected by terrorist incidents
- Substantial resilience of persons and communities is the expected response to a disaster, but is NOT inevitable
- Often, how different people respond turns on interactions between their capabilities, their past experiences, the particular situation they are facing, & the support with which they are provided: these features determine their psychosocial resilience in each situation

Themes

The importance of recognising that:

1. Distress after disasters and major incidents is very common
2. In most cases, distress is transient and not associated with dysfunction
3. Differentiating distress from disorders &, thereby, distinguishing psychosocial care & community development from mental healthcare can be difficult
4. Planning & preparation for delivering psychosocial & mental health care is vital
5. Social connectedness & social support in preventing people from developing mental disorders, resolving distress & promoting recovery
6. Caring for the carers in the face of catastrophes as well as routinely

A Paradise Built in Hell



"People know what to do in a disaster". [But] "… loss of power [is] the disaster in the modern sense … [though] … solidarity, altruism, and improvisation are within most of us and reappear at these times.

This is the paradise entered through hell".

Solnit R. A Paradise Built in Hell. New York: Penguin Books, 2010.