

Increasing community capacity to support psychosocial and behavioural health interventions following disasters

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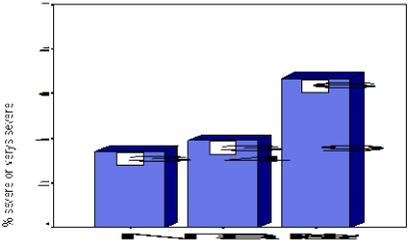


What is the Problem?

- The majority of people exposed to disasters recover fully from any psychological effects within one year
- 50% -65% experience psychological responses to trauma that are subclinical, but still interfere with their quality of life
- 10-35% may require more intensive services
- Many do not self-identify as needing services
- Many will never seek formal help, or not until much time has passed
- For those who need help, post-disaster phase is important
- Community capacity is often stretched
- Funding is transient



Predicting Overall Severity of Impairment: Effects of Disaster Type



The bar chart shows that the percentage of people reporting severe symptoms increases significantly from the first disaster type to the second, and then to the third. The third disaster type shows the highest percentage of severe symptoms.



Effects of Mass Violence

- Disasters caused by human intent are more likely to result in severe impairment
- 39% of these samples evidence rates of psychopathology greater than 50%
- *"Disasters of mass violence may be especially difficult for victims to comprehend or assimilate, making intrusion and avoidance symptoms more likely."*

(Norris et al., 2002)

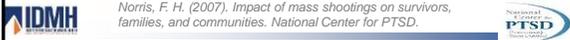


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Consequences Mass Violence

- Prevalence of post-disaster diagnoses: 10% to 36%
- Much reported subthreshold PTSD
- Very few participants reported no symptoms
- Effect sizes large and often persistent
- Local involvement and control are paramount
- Community members resent the media intrusion, the sense that they are being blamed for the violence, and the convergence of outsiders
- The reluctance of some members to focus on the event, while others need to, is consistent with community dynamics observed after other types of disasters
- Recovery in the context of public tragedies is complicated by competing political agendas and other social dynamics that are not yet well understood.

Norris, F. H. (2007). *Impact of mass shootings on survivors, families, and communities.* National Center for PTSD.



What are Common Reactions?



At the disaster site, declining health and control



Changed Perceptions of Self & the World

- At the disaster site, declining health and control
- Decline in perceived level of social support
- Decline in self-reported help from family and community
- Decline in control
- Increase in feelings of vulnerability
- Increase in physical symptoms




Risk Factors in Mass Shootings

Event-Related Factors:

- Level of exposure
- The perception that the incident:
 - Level of threat
 - Caused a great deal of harm
 - Was very upsetting
 - Created longitudinal problems
- Was not accompanied by effective early support

Emotional Reactions:

- Guilt
- Resentment
- Insecurity

Pre-Existing Factors:

- Anxiety sensitivity
- Lack of social support
- Ruminative /avoidant coping
- Punitive attitudes toward crime
- Female gender
- Psychopathology

Johnson et al., 2002; Lowe & Galea, 2015; Murtonen, Suomalainen, Haravuori, and Marttunen, 2012; Schwarz & Kowalski, 1992a; Stephenson, Valentiner, Kumpulainen, & Orcutt, 2009; Littleton et al., 2012; Smith et al., 2014; Vuori, Hawdon, Atter, & Ra'ssaanen, 2013



Post-Shooting Social Risk Factors

- Community fear of another shooting
- "We should have predicted or prevented the shooting or it's impact"
- Community identity becoming linked with the shooting
- Viewing others with distrust
- Differences:
 - Willingness to participate
 - Coping strategies
 - Readiness to "move on"
- Directly affected and indirectly affected

Littleton, Dodd, and Roland, 2017



Post-Shooting Lessons Learned

- Early and proactive outreach should provide support and resources.
- Designated contact persons monitor needs and facilitate services.
- Secondary stressors include witnessing in criminal law trials, medical rehabilitation due to injuries, involvements in legal claims, extended media coverage of the event, and economic hardships.
- Repeat administration of a brief screening instrument can facilitate identification of needs and targeting of interventions.
- Promoting a positive recovery environment may also involve protecting survivors from punitive or blaming others, or an intrusive press.
- After school shootings, counsellors can:
 - Provide support when survivors meet with officials
 - Remind the caregivers of grieving children of the importance of reassurance, safety, routine, and honesty
 - Encourage family members to tolerate each other's different grieving process.

Reifels et al., 2013



How Have We Tried to Find a Solution?




What Protects?

- **Demographic / biological factors**
 - Male gender
 - Greater education
- **Social and emotional resources**
- **Personality factors**
 - Low negative affectivity
 - Capacity for hope
 - Optimism
 - Emotional stability
 - Agreeableness
 - Perceived coping self efficacy

- **Adaptive skills, ability to:**
 - Reframe
 - Use distraction when appropriate
 - Fit coping strategy to the context
 - Make meaning of the situation based on personal values
 - Use positive religious strategies
 - Seek support from others



Coping Lessons from Terrorism Threat

- Actively seek **information**
- Better **structure** the situation to plan for travel, etc.
- **Divert** attention (reframing, humor, acceptance)
- Have **apprehensions circumscribed** to actual threat rather than generalizing to similar situations
- **Shift expectations** about what to expect from day to day and about what is considered a "good day"

Shalev, 2003



Coping Lessons from Terrorism Threat II

- Shift priorities to focus more on **quality time with family**
- Create **routines of living** and not worrying beyond those routines
- **Proceed** with life necessities
- **Maintain faith** in God
- Maintain an **"unyielding attraction for life."**

Shalev, 2003



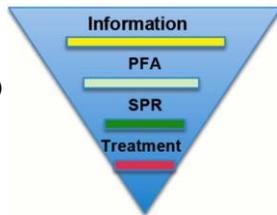
Expert Consensus Guidelines

1. Be proactive, prepared, pragmatic
2. Be flexible and match services across time
3. Individuals and community
4. Do no harm
5. Local
6. Integrate
7. Stepped care
8. Spectrum

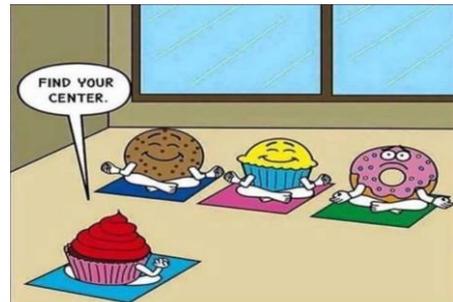


A Post-Disaster Stepped Care Model

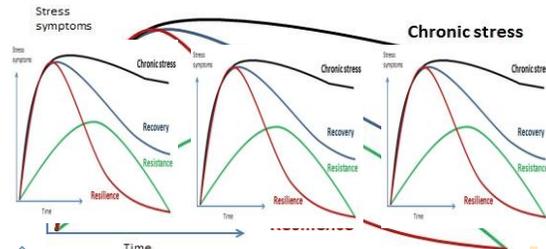
- Informational Resources
- Psychological First Aid (PFA)
- SPR
- Mental Health Treatment



Why is it Hard to Implement Solutions?



What is Resilience?



Coping Strategies Should be Flexible

Distraction:	Forward Focus:
<ul style="list-style-type: none"> • Disengaging attention • Directing attention away 	<ul style="list-style-type: none"> • Maintaining previous goals and plans • Caring for others • Reducing painful emotions • Focusing on the fact that even if one was in a life-threatening situation, when they get triggered by reminders, they are now safe • Using distraction and amusement



Community Resilience

“If you want to build a ship, don’t drum up people together to collect wood and don’t assign them tasks and work, but rather teach them to long for the endless immensity of the sea.”

Antoine De Saint-Exupéry

Five Empirically-Supported Principles: Framework for Intervention

Connectedness

Safety

Self-Efficacy

Hope

Calming

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Time as a Factor: First 2 Weeks

Accepted:

- Primary goals should be to promote safety, attend to practical needs, enhance coping, stabilize survivors, and connect survivors with additional resources
- Psychological First Aid and outreach appear evidence-consistent, non-harmful

Not universally accepted:

- CISD (given the negative findings and the findings re: worsening of symptoms)
- CBT and EMDR may be contra-indicated, given that they both encourage disclosure and emotional processing, take energy and resources, and may interrupt a necessary down-time

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Psychological First Aid: Immediate Response

PFA principle actions aim to:

- Establish safety and security
- Connect to restorative resources
- Reduce stress-related reactions
- Foster adaptive coping
- Enhance natural resilience

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NCPTSD / NCTSN PFA Core Actions

1	Contact and Engagement
2	Safety and Comfort
3	Stabilization
4	Information Gathering
5	Practical Assistance
6	Connection with Social Supports
7	Information on Coping
8	Linkage with Collaborative Services

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2 Weeks – 3 Months

- Crisis Counseling – supportive counseling and connection to resources
- Cognitive behavioral approaches have the strongest empirical support
- Not recommended for routine use for all
- Determined by:
 - the extent to which a sense of threat persists
 - sufficient resources to engage in the intervention
- Use guided self-help, low intensity empirically supported, flexible, modularized approaches

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Potential Barriers to Outreach

Need: ally need

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Potential Solution to Outreach Barriers: Be Person-Centered and Community Centered

Old woman using a marionette to feed squirrels...

Community Outreach to other service providers and systems

- Spiritual leaders
- Community leaders
- Clubs
- School personnel
- First responders
- Public health and health professionals
- Employee assistance programs
- Bartenders
- Hair dressers
- Librarians

Between PFA and Formal Treatment: Skills for Psychological Recovery (SPR)

- Evidence informed modular approach to help children, adolescents, adults, and families in the intermediate (weeks-months) period after disasters and terrorism.

SPR in Relation to PFA

PFA	SPR
Different Time Frames for Delivery	
• First hours and days	• First weeks and months
Different Levels of Engagement	
• More "doing for"	• More "doing with"
• Often one time meeting	• Continued review of skills

Skills for Psychological Recovery (SPR)

- Flexible application of CBT principles in disaster settings
- Resilience building model vs. pathology treatment model
- Modular format
- Rationale is provided
- Helps individuals to identify and prioritize needs
- Helps people to learn new skills to meet needs
- Utilizes simple techniques and handouts

Key Point Emphasis: SPR

- Promote capacity building and action *with* the person vs. doing things *for* the person
- Partnership and facilitation when active listening isn't sufficient
- Responsible *to* the person, not *for* the person
- Success = client empowerment and capacity

Great things happen from the inside

Components of SPR

- Problem-solving
- Activity scheduling
- Managing Reactions
- Helpful thinking
- Rebuilding Healthy Social Connections

sister by phone

best friend by phone

SPR Evaluation Findings: Katrina / Gustav

- The average number of visits was 6
- The majority of visits lasted 60 minutes or more and occurred in the individual's home
- Significant decreases were noted in the number and/or severity of stress reactions
- The proportion of people meeting criteria for referral decreased
- Providers rated SPR positively for "meeting individuals at their level," providing people with lifelong skills, linking them with resources, and facilitating the whole process of recovery
- SPR requires more formal evaluation efforts in order to become evidence-based

SPR in Relation to Professional Counseling

Professional Counseling	SPR
• Focuses on diagnosis and treatment	• Focuses on assessment and fostering of strengths and coping skills
• Office based	• Community based
• May encourage focus on the past and it's influence on current problems	• Goals are more present-centered, behavioral, and focused on immediate activation of change
• Conducted only by health professionals	• Conducted by either health professionals or paraprofessionals and trained community responders
• Longer duration	• Shorter duration
• Larger array of treatment interventions	• More limited, simpler array of interventions, focused on fostering and developing skills

3 Months Onwards Post-Event

- Good research support for cognitive-behavioral approaches for a wide range of problems and after a broad range of disaster types
- Further evaluation and research would help clarify which components of CBT are best tolerated, work most quickly, and are most efficacious

Evidence-Informed Innovative Treatment

- Anticipatory Anxiety CBT
- Brief telephone interventions
- Virtual reality strategies
- Single-session simulations
- Writing exercises
- Internet-based interventions
- School-based interventions
- Adaptation for ongoing threat and culture

CBT for Terrorist Affected Individuals

- Eight weekly 60 minute sessions:
 - Education about trauma reactions
 - PMR and Thai meditation
 - PE and in vivo exposure
 - Taught to identify unrealistic and catastrophic thoughts and to modify thoughts.
 - Taught to evaluate the absolute risk of being harmed and to recognize the benefits of accepting a level of risk in order to permit normal functioning
 - Relapse Prevention
- More patients in the CBT condition (75%) achieved high end-state functioning than participants in the TAU (33%) condition ($\chi^2 = 4.86, p < 0.05$), and had marked reductions in complicated grief reactions.

» (Bryant et al, 2011).

Take Home Messages

- Emphasize resilience and community-building
- Utilize a flexible, tailored approach specific to context, needs, and phase
- Be evidence-informed or consensus-informed as much as possible
- Provide a spectrum of services
- Utilize innovative approaches that map onto individual and community needs
- Teach skills for self-sufficiency and longevity



Resources

The following resources may be helpful:

- NCPTSD PTSD Provider Resilience Toolkit
- NCPTSD PTSD Coach mobile app
- NCPTSD Mindfulness Coach mobile app
- NCPTSD PTSD Coach online
- National Child Traumatic Stress Network
- Fire Hero Learning Network



Thank you!

Questions?

