Early psychosocial intervention after disaster: Psychological first aid

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The Japanese earthquake in 2011 caused two other major disasters: a tsunami and a nuclear power disaster. After these incidents, the Japanese Government assessed the need for mental health interventions to deal with the aftermath of these problems. A chronic shortage of mental health responders was previously reported in Japan, and this triple disaster spotlighted the problem (Yamashita, 2013). A statement was issued in March 2011 by the Japanese Society of Psychiatry and Neurobiology regarding provision for, and assistance with, long-term mental health support for all survivors of the disaster (Kim, 2011; Takahashi, 2014). In response, Tohoku University founded the International Research Institute of Disaster Sciences in April 2012 to study disasters from around the world and improve local disaster response. The aim of this institute is multifaceted. These are their research areas: (a) To identify social, psychological, and biological factors involved in the pathophysiology of, and recovery from, disaster-related mental health problems; (b) to develop a system for disaster prevention, disaster response, and recovery, considering disaster-related psychiatric and psychological issues; (c) to develop useful tools for the prevention, screening, diagnosis and treatment of disaster-related disorders; (d) to archive information regarding disaster psychiatry; and (e) to cooperate with other countries regarding disaster-related psychiatric issues (Tomita, 2014). Japan now advocates educating first responders to use psychological first aid following disasters to mitigate long-term mental health problems, in the survivors and responders (Yamashita, 2013). To accomplish all of the above, there is a need for recruitment, education and screening of potential mental health providers to assure professional behavior and have a prepared group ready to respond to the short- and long-term needs of individuals recovering from disaster (Veenema, 2013). Meta-research has shown that the availability of psychological first aid has a moderating effect on the risk for long-term mental health issues (Norris et al., 2002).

As the field of disaster mental health was reviewed and studied over the last 15 years in the United States, it became apparent that there had been a void in the service delivery operations of many disaster relief organizations (Bolin, 1985; Brymer et al., 2006; Call & Pfefferbaum, 1999; Fullerton, Ursano, Vance, & Wang, 2000). Since 2002, the Office of the Surgeon General of the United States Public Health Service (USPHS) has been a leader in credentialing and educating mental health professionals and volunteers for disaster response. One version of a Psychological First Aid (PFA) manual was commissioned by the United States Substance Abuse and Mental Health Services Administration based on growing consensus and evidence that psychological first aid should be utilized immediately after a disaster strikes. A work group was convened consisting of the National Child Abuse Traumatic Stress Network of the United States and the U.S. National Center for Post-traumatic Stress Disorder (PTSD), with the U.S. Medical Reserve Corps partnering in this effort. The goal of creating a PFA program was to provide immediate psychosocial care for survivors of, and responders to, disasters. Another focus was to educate non-mental health volunteers and to deliver PFA early in the disaster to support professionally licensed mental health practitioners who are usually not widely available during disaster response. (McFarlane &
Williams, 2012). Prior to this program, there were guiding principles for disaster mental health responders, but no widely accepted program. The principles included items such as being truthful and giving accurate information, protecting privacy, using naturally occurring support systems and avoiding re-traumatization, to list a few. The new PFA program created a multitude of on-line resources for many different audiences including parents, religious personnel, first responders, educators, and people for whom English was not their primary language (Brymer et al., 2006).

In 2009, the U.S. National Association of County and City Health Officials (NACCHO), The U.S National Child Traumatic Stress Network (NCTSN) and The U.S National Center for PTSD (NCPTSD) held train-the-trainer sessions for mental health professionals who were nominated by their county disaster response agencies. The NCTSN and the NCPTSD serve as national resources for developing and disseminating evidence-informed interventions, trauma education and psychological consequences of trauma. I was fortunate enough to be selected, and attended an educational session in February 2009 to become a PFA trainer, because I am an American Red Cross Disaster Mental Health responder and a Clinical Specialist in Psychiatric–Mental health nursing. This article will share some of the highlights of this PFA program that were presented in Japan, at a conference sponsored by Hyogo University, in October 2014.

Psychological first aid has many strengths: (a) It assumes that most disaster survivors will not develop long-term mental health problems. In fact, only 4–6% will need professional intervention if immediate needs are met after a disaster; (b) PFA uses a modular approach, which makes it very responsive to individual needs. Although PFA has eight Core Actions, seldom will all eight be used in any contact; (c) PFA is useful for individuals across the life-span, in different cultures and with diverse populations. Not only is the manual published in several languages, but it also gives helpful tips on how to approach different cultures. For instance, learning how a variety of cultures express grief is discussed; (d) PFA identifies survivor’s strengths and does not “diagnose” or “treat”; and (e) PFA can be delivered by non-professional mental health providers, so is economical as well as supportive of the licensed mental health professionals.

There are eight Core Actions in PFA, derived from disaster and trauma research, systematic review of other programs, survivor’s comments and professionals’ feedback (Brymer et al., 2006). These eight Core Actions are: Contact and Engagement, Safety and Comfort, Stabilization, Information Gathering, Practical Assistance, Connection with Social Supports, Information on Coping, and Linkages with Collaborative Services. The rest of this paper will be devoted to a brief overview of each Core Action. Material is being used from the PFA Medical Reserve Corp Facilitator’s Guide (www.nctsnet.org and www.ncptsd.va.gov). Each Core Action has many ideas for implementation, but only one or two will be shared in this paper, for the sake of brevity.

CONTACT AND ENGAGEMENT

This action calls for establishing contact with survivors in a compassionate and respectful manner. It includes such things as asking permission to talk to a survivor and asking about immediate needs. In establishing contact, cultural norms need to be taken into consideration; that is, can you use touch? Is there a family spokesperson? Are certain words to be avoided, like the dead person’s name?

SAFETY AND COMFORT

The goal here is to assure immediate and ongoing safety, and provide physical and emotional comfort. In this Core Action, you would do things that are familiar, practical and soothing; that is, providing clear, reliable information or keeping things that “pop” such as balloons out of schools after a shooting. People also need to know how to deal with ongoing safety concerns such as aftershocks from an earthquake or the wind changing during a fire causing the fire’s path to change.

STABILIZATION

This action teaches you to deal with individuals that are emotionally overwrought. It uses actions such as “grounding” and breathing techniques. Grounding is a technique used for extremely agitated people, those that seem to be losing touch with reality or those with very strong emotions. It combines breathing with relaxation and selective concentration. This action is probably the least used because most people will cope well even after horrific disasters.

INFORMATION GATHERING

The intent here is to gather just enough information to discover the immediate needs and concerns of individuals. Minimal information is needed to determine the most immediate need. Survivors should not be encour-
aged to tell their entire story of the event, because this recital may re-traumatize a person and actually cause harm. Asking questions such as, “Are you injured”, or “Did you lose a loved one?” will assist in deciding the most pressing need.

**PRACTICAL ASSISTANCE**

Practical Assistance will empower people to act to get their needs met and give them hope that things may return to a new normal. Providing familiar foods, housing, clothing and phone access are some things to consider. PFA providers may also assist survivors to clarify their priority need, come up with an action plan and act to address the need. PFA workers do not try to meet all the needs, but they provide an environment where survivors can be proactive and resume control of their own lives again.

**CONNECTION WITH SOCIAL SUPPORTS**

Reconnecting people to social supports is one of the actions most positively linked to well-being and recovery after disaster (Brymer et al., 2006). Actions might include things such as reuniting families, teaching ways to give and receive support, avoiding isolation, reuniting with pets and using social media to connect people to one another and needed resources.

**INFORMATION ON COPING**

After a disaster, a range of emotions may be experienced. People may think they are weak, spiritual beliefs may be challenged and disruptions in developmental processes can occur. Survivors may need information on dealing with such issues as guilt, anger management, dealing with sleep problems, changes in their child’s behavior and alcohol problems. Survivors have reported that PFA responders should not use the word “normal” to describe reactions. Survivors state that nothing is normal about their situation. PFA responders should instead use words such as “common” or “expected” instead of “normal”.

**LINKAGE WITH COLLABORATIVE SERVICES**

The goal of this action is to connect people with the services they need, immediately and in the future. Survivors may need referrals for medical care or mental health intervention by a licensed professional on an ongoing basis. More often, they need to know what community resources are available to them and how to access these.

This new program comes with a 168-page Field Guide that has many copy-ready handouts for workers to give survivors to assist them to cope with a disaster. A few of the titles are: “Psychological First Aid for Schools”, “Psychological First Aid Field Operations Guide for Community Religious Professionals”, “Psychological First Aid Medical Reserve Corps Field Operations Guide”, “Psychological First Aid for Families Experiencing Homelessness” and “Psychological First Aid for Youth”.

Other steps may be taken immediately after a disaster to reduce the risk of psychological harm. These include: (a) Prevention of re-traumatization by limiting the number of times a person must tell their story; (b) prevention of new trauma by limiting exposure of all non-essential personnel to the disaster site; and (c) prevention of pathologizing distress by not labeling common reactions as diagnosable psychiatric problems. If this last step is not taken, people with mental health issues will often avoid seeking assistance (Meeker, Plum & Veenema, 2013).

Psychological first aid is equally concerned with disaster responders’ mental health needs. A section of the Field Guide discusses things such as mandated rotation of workers, limiting hours worked, requiring workers to receive and use time off, making sure adequate supervision is provided, and providing stress management and other actions. Workers must keep healthy so they can assist survivors.

To summarize, PFA is an evidenced-based, culturally informed, modular program, responsive to life-span needs. It has eight Core Actions to use to respond to people’s needs in the immediate aftermath of a disaster and assist survivors in preparing for challenges ahead in dealing with disasters. In many cases, PFA Core Actions can mitigate escalating frustration or maladaptive behaviors that can interfere with healthy coping. Also, non-professional but educated PFA workers can identify survivors and responders at risk or those that may need more professional long-term mental health support because of social or occupational decline, and initiate early referrals (Meeker et al., 2013). This program is endorsed by the NCTSN, the NACCHO and the NCPTSD, which are U.S. national resources for developing and disseminating evidence-informed interventions, trauma education and psychological consequences of trauma. The program is being taught regularly in the U.S. It could be a program that other countries might
consider adopting to standardize mental health care following disaster, for survivors and responders.

REFERENCES


RESOURCES

- Disaster Preparedness and Response (online course) from ARC and STTI http://www.nursingknowledge.org/Portal/main.aspx?PageID=36&SKU=91775
- Emergency Preparedness from AHRQ http://nursing.vanderbilt.edu/incmce/modules.html (online modules)
- CDC Health Information and Disaster Relief http://www.bt.cdc.gov/disasters/volunteers.asp