Fires, Mudslides, Earthquakes, Shootings: Promoting Personal and Community Resiliency after Mass Trauma

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Approved for
1.0 CNE for RNs
Continuing Nursing Education Information

Learning Outcomes

Upon completion of this presentation, the participants will be able to:

1. Identify 5 essential elements of short-term mass trauma intervention
2. Describe evidence-based approaches to the promotion of resiliency for trauma-exposed individuals
3. Formulate ideas to promote connectedness and hope within your community
Disclosures

• The planners and presenters have relevant financial relationships to disclose.
Continuing Nursing Education Information

Nursing Evaluations

Criteria for successful completion:

• Attendance requirements
  • You must be present for the full duration of the activity
• Complete an online NURSING evaluation
  • Available online at:
    • cne.nursing.arizona.edu
      (go to Quick Links sidebar and click the CPE Evaluation link)
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Tragedy in Tucson, 1/8/11

Mass shooting, Safeway Congress on Your Corner
• 6 killed
• 19 shot
University Medical Center

S. Arizona’s only Level 1 trauma center
Increases in mass shootings

“Despite having less than 5% of the global population (World Factbook, 2014), U.S. had 31% of global public mass shooters.”


FBI, 2017
Increases in natural disasters

EM-DAT International Disaster Database, Center for Research on the Epidemiology of Disasters, University of Louvain (www.emdat.be/).
Fires, mudslides, Western U.S.

2000s: 2x areas burnt by wildfires than in 1990s
Public health relevance

Primary prevention efforts

Preparedness

Secondary prevention – National Disaster Recovery Framework (FEMA)
- Community Planning and Capacity Building – Recovery Support Function ToolKit available (incl Hazard Mitigation, Local Disaster Recovery Manager)
- Economic Recovery Support
- Housing Recovery Support
- Infrastructure Systems Recovery Support
- Natural and Cultural Resources Recovery
- **Health and Social Services Recovery Support**
How events reach traumatic proportions for individuals

1. Overwhelming demands of situation (physical, psychological, social)
2. Devastation of individual and community coping resources
3. Loss of safety/territory -- relocation
4. Damaging effects on meaning, justice, order
Common reactions to trauma

1. **Reactions to reminders**: unwanted memories, dreams, pounding heart, sweating

2. **Avoidance or withdrawal reactions**: avoiding memories, places, conversations that are reminders

3. **Emotional reactions or negative thoughts**: self-blame or having negative views about the world; feeling hopeless, sad, shocked, or feeling nothing at all;

4. **Physical arousal reactions**: Feeling on-guard or alert; being irritable, over-reactive; getting into frequent conflicts; trouble sleeping; difficulties concentrating
Trauma Exposure ≠ PTSD

Acute reactions are expectable

Most people who experience trauma do not develop PTSD.

Studies **do not** support that early psychological intervention after stressful events leads to better mental health outcomes.

Some types of treatment in the early aftermath of a stress event may actually cause harm (increasing PTSD outcomes)¹

Individual variability is a guiding factor. Do not assume that everyone is traumatized or that people who look resilient do not need support.

¹Bisson et al., 2002, 2007
PTSD Diagnosis requires 30 days

AND PTSD is not necessarily the most common negative mental health outcome

Comparison of New Episodes of Depression vs PTSD, After 9/11

- Close associate exposed to 9/11 trauma
- Eyewitness to 9/11 injury or death
- Directly endangered
- Any 9/11 trauma exposure
- No exposure

North et al., 2015, N = 373 NY employees
5 Essential Elements of Mass Trauma Intervention

1. Promote sense of safety
2. Promote calming
3. Promote sense of self- and collective efficacy
4. Promote connectedness
5. Promote hope

*Based on Review by Hobfoll and colleagues, Psychiatry, 70, 2007 (one of the most influential papers in Psychiatry, 4 year cycle)*
IASC Guidelines for mental health and psychosocial support in emergency settings

Examples:

- Mental health care by mental health specialists (psychiatric nurse, psychologist, psychiatrist, etc.).
- Basic mental health care by PHC doctors. Basic emotional and practical support by community workers.
- Activating social networks
  - Communal traditional supports
  - Supportive child-friendly spaces
- Advocacy for basic services that are safe, socially appropriate and protect dignity.

Intervention pyramid

- Social considerations in basic services and security
- Strengthening community and family supports
- Focused (person-to-person) non-specialised supports
- Specialised services
1. Promote Sense of Safety

**Physical Safety**

- Food, shelter, water
- Safe spaces (children, meetings)
- Essential aids, medications
- Safety for vulnerable subgroups
Promote Sense of Safety

Decrease threat perception

- Limit media exposure
- Limit talking about “horror stories” or rumors
- Prioritize information about family members
Promote Sense of Safety

Stabilization (if needed)

- Calm, quiet, present
- Orient emotionally overwhelmed survivors
- Grounding
# Grief

<table>
<thead>
<tr>
<th>Don’t say:</th>
<th>Do say:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know how you feel</td>
<td>What you are experiencing is understandable and expectable</td>
</tr>
<tr>
<td>You are strong enough to deal with this OR That which doesn’t kills us makes us stronger.</td>
<td>Sadness, loneliness, and anger are all normal</td>
</tr>
<tr>
<td>“The deceased” “passed away”</td>
<td>Deceased person’s name, “died”</td>
</tr>
<tr>
<td>Everything happens for the best for a higher plan. OR We are not given more than we can bear</td>
<td>Do you have any religious or spiritual needs at this time?</td>
</tr>
<tr>
<td>You need to grieve. You need to relax. It’s good that you are alive.</td>
<td>Sometimes it can be helpful to talk to a counselor.</td>
</tr>
</tbody>
</table>
When delivering bad news

Don’t rush

Allow for initial strong reactions

Remember that family members don’t want to know how YOU feel (sympathy) but rather they want to know you are trying to understand how THEY feel (empathy)

Make sure social supports are available – try to work with family units

Children should not be left unaccompanied.
  ◦ Should not see morgue photos
  ◦ May have a range of reactions
Grief, Children

Death affects children differently depending on age
Do not push children to talk
Give simple, short, honest, age-appropriate answers to questions
Listen to feelings without judgment
Reassure that they did not cause, it was not their fault or a ‘punishment’
2. Promote calming

Increased emotionality is normal
Calming promotes sense of control

In Natural Recovery:
• Reminders decrease
• Emotional reaction to reminders decrease

Recreated with permission by Resick, ABCT Presidential Address, 2004
## Calming, Dos and Don’ts

<table>
<thead>
<tr>
<th>Potentially arousing</th>
<th>Calming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical incident stress debriefing/management</td>
<td>Grounding, deep breathing, deep muscle relaxation, yoga, imagery, music</td>
</tr>
<tr>
<td>“Venting”</td>
<td>Normalizing – “acting normal in an abnormal situation” (psychoed about natural reactions)</td>
</tr>
<tr>
<td>Activities that promote negative emotional states</td>
<td>Activities that promote positive emotional states (not assoc with event)</td>
</tr>
<tr>
<td>Spinning information to calm</td>
<td>News reports that give facts, few images and hyperbole</td>
</tr>
</tbody>
</table>
Community level calming

Large scale community outreach and psychoeducation normalizes reactions

- Avoid pathologizing the inability to remain calm

Media presentation: relaxation, sleep hygiene, media exposure

- Important if people looking to media for advice about going-out

In natural disasters, the best predictors of later distress is initial and secondary resource loss
Although the world is full of suffering, it is also full of the overcoming of it.

◦ Helen Keller
3. Promote Sense of Self-Efficacy

Belief that one’s actions are likely to lead to generally positive outcomes

- Past Experiences (past outcomes)
- Vicarious Experiences (modeling by others)
- Physiological Feedback (emotional states)
- Verbal Persuasion (coaching & feedback)
Self-Efficacy & Resiliency

“I can cope with this”

Individual intervention can focus on:
- Reminders of past adversity overcome
- Recalibrate expectations formed under ‘normal’ circumstances

Teach how to set achievable goals
- Establish sense of environmental control
- Help with problem solving skills to post-tragedy adversities
Skills and Resources

Self efficacy interventions can backfire without the necessary skills or resources

- Mass trauma is typically an unpracticed experience (*skills develop through practice*)
- Problems with self-help when resources are depleted (e.g., prior exposure, psychological history, poverty)
- Public mental health programs, collaborate with development initiatives
Collective efficacy

Collective efficacy (memorials, meetings, collective mourning), therapeutic
Build on available resources

Assess existing services and identify people in need

Key psychosocial supports come from the affected community.

Local people should maintain control and decisions over factors that affect their lives. Cultural competence is key.

Work on mental health has the potential to create harm because it deals with highly sensitive issues

- Universal human rights
- Power relations between outsiders/emergency-affected people
- Do not use a charity model—facilitate the development of community-owned programs
Additional Recommendations, World Health Organization

One mental health coordination group. Avoid parallel groups for subgroups

Use validated-local assessment tools

Individuals must be trained with ongoing supervision to ensure interventions are appropriately administered

Include psychological and social considerations in the provision of general health care

Provide access to care, protect people with severe mental illness

Minimize harm related to alcohol and other substance use

Provide access to information on coping mechanisms
4. Social connectedness

Increases opportunities for knowledge essential for disaster response

Social support (practical problem solving, emotional understanding, normalizing)

- Delay in making connections with loved ones, increases negative risk (London)
- Connecting, 1 member after immigration reduced risk (Cambodia Pol Pot genocide)
Promote connectedness

- Assist those who lack strong support
  - Train how to access support
  - Provide formalized support
  - Address negative social influences
  - Consider how overuse deteriorates support systems
Other Ways to Promote Connectedness

Psychoeducation

- Types of support
- How to identify support
- How to recruit support

Family Intervention

- Differences in exposure to trauma, loss
- Differences in personal reactions to trauma, loss
Ex. Effective Intervention

Promote social support networks
- Welcoming committees
- Places of worship
- Meeting places
- Entertainment
- Soccer field

Identify people who want to help.
- Help them identify someone they can help
- Help them identify ways they can be helpful to others
- Provide attention, care
5. Instill Hope
Hope, “a sense of coherence”

Holocaust survivors
Antonovsky, 1979

“A pervasive, enduring though dynamic feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected”

- Western, middle SES: emphasizes self-agency
- Others: religious, responsive government, superstition
Assistance instills hope

*Combat PTSD*: employment as primary predictor of hope

*New Orleans*: lack of evacuation due to expectation for negative outcome, no external resources

*Hurricane Andrew*: lack of funds for rebuilding as primary PTSD predictor

Advocacy programs can promote self-efficacy
Individual level, assistance

1. Identify the most immediate need
   ◦ Food, shelter, locating a loved one, completing an insurance form, etc.

2. Clarify the need

3. Discuss an action plan
   ◦ Tell survivors what to expect in terms of services, resources, qualification criteria, application procedures, etc.

4. Act to address the need
   ◦ Help survivors complete form, make a phone call, etc.
Instill hope, individual level

Self blame degrades hope
- *I should have left earlier.*

Increase hope by reducing self blame
- Counter “I should have....” with *I did the best I could given the elements within my control* (strong emotional reactions are not in our control).
Future thinking instills hope

Explicitly educate that most people recover spontaneously after trauma....

Doing things that are active (rather than passive waiting), practical (using available resources) and familiar

Helping envision realistic, yet challenging outcome:

- *It will be painful to live without my wife for some time vs. I cannot live without my wife*
Benefit Finding

Highlight attempts to find benefit/meaning (do not promote, wait for readiness)
Community intervention

More impactful and efficacious?

Media, schools, community leaders can focus on:

◦ More accurate risk assessment
◦ Positive goals
◦ Building strengths in communities
◦ Helping people tell their stores
◦ Clean-up, rebuild, home visits, blood drives, etc.
How does this translate to practice for early intervention with trauma survivors?
Summary: Individual level

Normalization, support, highlight self-efficacy, strengths

Calming: relaxation training and sleep treatment

Bereavement training skills (remember cultural and religious considerations)

Encourage pleasant activities, daily routine, self efficacy

Foster social support

Reframing, cognitive behavioral therapy
Summary: Community level

Provide safe locations
Organized voice, media safety perception
Information and psychoeducation
Provide resources, involve survivors
Foster community activities
Collaborate with the development of programs
Help link with loved ones
Develop advocacy programs
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