Commentary on "Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence" by Hobfoll, Watson et al.

Whose Role Is It Any Way?

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The august group of scholars who developed the recommendations and co–wrote the article "Five Essential Elements of Immediate and Mid–Term Mass Trauma Intervention: Empirical Evidence" took on a very daunting task. They have attempted, in the absence of a clear model, to distill from decades of research on coping, disaster, and general psychology, a set of recommendations about the goals for immediate and shorter term intervention in the face of mass violence or disaster. This article does a wonderful job pulling together, from the best information and best experts available, the basic components that should comprise psychosocial intervention in the aftermath of disasters and mass violence: to promote a sense of safety, calming, self– and community efficacy, connectness, and hope. An overarching model for basic achievable goals has been needed ever since mental health professionals began trying to assist in disaster response in the 1980s.

For decades, mental health professionals have wanted to help in times of disaster, and they frequently traveled to disaster locations to provide the best counseling/therapy they had available. They often arrive assuming that someone is in charge, will tell them how they can help, and put them to work. They come armed with compassion and eagerness to help but no sense of whether or how they are needed or what they should do. They often find themselves in chaotic situations where there is no one in charge, or at least no one who seems to know anything about mental health needs in this type of situation. Some end up doing what other disaster workers are doing, assisting with the delivery of basic resources such food and water; some serve as good listeners if someone wants to talk. Some attempt to do therapy or counseling. In the absence of a good model of intervention, mental health professionals may fall back onto what they have been trained in most, the study and treatment of psychopathology. What was notably absent in "Five Essential Elements" was the delivery of traditional psychotherapy in the immediate and mid–term phases post–trauma as a standard intervention. The focus here was on primary and secondary prevention and community-level interventions. What is the role of mental health professionals in these situations, especially if they have been trained in clinical psychology or psychiatry with its emphasis on individual psychopathology,

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rather than community psychology or disaster mental health?

It is not hard to find people who are highly emotional or in shock immediately after a disaster. We see it frequently on television when a reporter sticks a microphone into the faces of people who have just lost their home and possibly family members to a tornado, hurricane, or fire and asks the usual inane questions about how they feel and whether they will rebuild. This action has the intended effect of letting us see the impact of traumatic events, and the level of raw emotion pulls at us to relieve their distress. And because most therapists are in the business of relieving distress, it is also easy for us to confuse this distress with psychopathology. In fact, it is often difficult to determine where the line is between normal and expected emotions that are appropriate and healthy and those that portend the development of chronic problems or disorders. Most of the time, the strong emotions accompanying disaster and trauma dissipate very quickly and are replaced by the more normal and expected emotions in response to the ongoing situation, such as sadness at losses or frustration with the inability to access resources. We have no reliable yardstick at this point to assess who will recover naturally (and will develop a greater sense of efficacy and mastery for having coped with such difficult challenges) versus who will need assistance to move back to the road of recovery. It sometimes seems easier to try to intervene with everyone than to figure out who needs assistance and who does not. We have enough evidence at this point that this is not the benign approach we hoped it to be. At worst, these brief group interventions not only do not appear particularly effective in preventing more serious responses from continuing but might actually harm those who are vulnerable, and at best, they do not appear to contribute to normal recovery.

This article clearly is using research to inform both individual and community-level interventions to restore basic core needs that Maslow would have appreciated and applauded, such as safety, belongingness, and self–efficacy. Where the article leaves off is who is best equipped to intervene and how. While I agreed with the basic approach of the article to lay out a number of solid recommended goals, I was left with a string of questions. Who should implement the interventions that have been described in the article? Is this a government task, and if so, national, state, or local? Should this be a job of Homeland Security? Should we rely on nongovernmental agencies such as the Red Cross or the Salvation Army to develop interventions to assist psychological well-being as well as immediate disaster relief? Who provides the on–the–ground leadership during local disasters? Who calls upon the experts? What is the role of mental health professionals in the immediate and mid–term after disaster or trauma? Should there be a greater development of a specialty area, outside of clinical psychology or psychiatry, whose role it is to work with community leaders and agencies to develop more standardized methods of intervention based on psychological principles, or is the current public health field better positioned to implement these interventions? Conversely, should all mental health clinicians be trained in these basic methods so that should a disaster occur within their communities, they are prepared to step forward? How would such efforts be organized? What is the best method of intervention? Is this the job of the mental health community or those we choose to lead us in our communities and in our government? Clearly our leaders, from the community level right up to the president, need to be educated in these basic goals. They have a level of impact that no one mental health practitioner or organization could hope to have.

In thinking back to my pre–professional days, before traumatic stress was a field of study, I can think of a few examples of how non–mental health professionals provided many of the interventions that have been laid out in this article. From my childhood, I remember the assassination of President Kennedy. Back then we hadn't been told not to watch so much television coverage, so the entire country took three days off from work and school and did nothing but watch televi-

sion. Although there were, of course, rumors and fears about the stability of the government and that it might be a good time for the Soviet Union to attack our country, the newscasters were calming and reported as many facts as they could find. We saw Walter Cronkite cry on the air but speak with such gravity and integrity that we were reassured. He told us that we would be OK. Although we saw the prime suspect murdered before our eyes on live television, we didn't hear about whether children should be allowed to watch television or whether we would develop mental health problems from having done so (I don't think it irreparably damaged me, but others might have a different opinion). There was a great sense of a national community and shared grief. But there were also messages of hope and continuity. One of the most widely shown photographs was of Lyndon Johnson being sworn into office with Jacqueline Kennedy at his side very shortly after the death of the president. The clear message was that the union would stand, that we had leadership and hope. There would be continuity despite the confusion and turmoil.

My second experience with disaster had national scope but was rather personal to me. I had been born and raised in Kent, Ohio, with my father on the faculty of Kent State University, which was the site of my education from 3rd to 10th grade as well as college and literally my playground after school. I was a college student at Kent State and a witness to the events of May 4, 1970. As a townie as well as a student, I watched both communities torn apart and rebuilt. Although the university was shut down immediately after the killings and remained closed the rest of the summer, faculty members met with students from their classes at state parks over the summer to discuss the events of that day. I remember a group of 100 students listening and talking to my geology professor the day we met at a park under one of the larger picnic shelters. Safety, calming, connectness, and hope prevailed (alongside of anger). When the university reopened in the fall, there was a strong sense of community and determination, despite the drop in enrollment, and the next spring, a series of events were planned for May 4, with t–shirts handed out to everyone that said KSU—Kent Stay United. I still have my t–shirt. If there were any psychological interventions present, I don't recall hearing about them. However, the elements of the recommended intervention policy were all there. Our professors and the university administrators were our leaders in this case, and they worked with community leaders to restore everyone's safety, efficacy, and hope.

In contrast, when I think of some more recent events (not to say that some haven't been handled very well), the very people who should provide information and leadership are sometimes working for their own sensationalistic or political gain. As mentioned in the Hobfoll, article, instead of calming, some leaders have instilled fear and used scare tactics for political votes. How long can the country stay at a threat level of orange, meaning high threat level, before the population either loses the basic sense of safety needed to function adequately or disbelieves the rating itself and loses faith in their leadership? The national and local response to Hurricane Katrina is an example of failed leadership at all levels, and no amount of early psychological intervention would have changed the massive resource losses experienced by the populace. At times, the agencies and people who were trying to bring needed resources to the community were stopped from doing so by politics alone. Any training on these policy interventions should start with our elected leaders. Would it be possible to provide these guidelines to leaders prior to events occurring? When governors are elected to office, they attend a governors' conference where they receive some training. If not being done currently, guidance on how to provide leadership in times of disaster and crisis could be invaluable training. Leaders should have the resources they need to provide healing messages and to facilitate the efficacy of the communities involved in disasters.

Training in responsible journalism is another good place for this intervention. Journalists and particularly those who can reach others during disasters through the airwaves

have great impact on perception of safety, calming, connectedness, and hope. Ratings should never come before the best interests of the community. Hobfall and colleagues pointed out that broadcasting is controlled by laws and governing boards that can wield influence over the content of broadcasts. Within the context of national conferences and efforts at continuing educations, these basic recommendations and the rationale for them could be explained. Written materials could be developed for dissemination.

Educators are frequently called upon to deal with traumatic events that affect an entire school. In the news, after a school shooting or a tragic car accident that ends in the death of multiple students, one often hears that counselors have been called in and are available to students. What type of training have they received to provide these services? Is there a standard in the field? What principles are they adhering to and what are the goals for the school community as a whole as well as for individual students? The recommendations proffered in the Hobfall et al. article could augment continuing education efforts in this regard.

In terms of reaching the general population, the public health model of mass dissemination of information may prove useful. However, when information is not apparently relevant, many people pay little attention to public messages, so any kind of information prior to disaster may fall on deaf ears. Depending upon the type of disaster and how disrupted the communications infrastructure is, public health messages may or may not reach their intended targets. Creative ways to educate the population are needed.

One sub-population that was not mentioned in the Hobfall et al. article is the group that had mental health problems prior to the occurrence of the disaster or mass violence. People with serious mental illness may become destabilized, not only from the stress and losses of the disaster itself, but through the inability to access their usual psychotropic medications. People who already had posttraumatic stress disorder (PTSD) from prior traumatic events may be particularly prone to reactivation of prior trauma memories, flashbacks, nightmares, and other PTSD symptoms, thereby compounding responses to the current situation. Those who have struggled with depression or substance abuse may succumb to relapse under the stressful circumstances of disaster and its aftermath. The five stabilization and recovery recommendations are important for this group, but they may need additional attention from mental health outreach efforts, especially if community mental health agencies are disrupted or destroyed by the disaster.

In summary, the five essential elements to immediate and mid–term intervention are indeed evidence–informed and pragmatic. An even greater challenge than testing these recommendations with clinical trials is to determine what groups or individuals are the best agents of change under the circumstances of disaster or mass violence and how these recommendations can be implemented to the best effect. Once this is determined, the challenge will be to find a place in everyone's disaster briefing book and try to do training *before* rather than *after* a disaster occurs. We need to treat these events as expected and planned for, not extraordinary and unique. While we don't know what and where the next event will be, we know that traumatic events will affect whole communities just as they do individuals, and that what we, as mental health professionals do can be inert, damaging, or beneficial.