Psychological intervention for victims and helpers after disasters

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SUMMARY. Disasters can have long term and damaging effects on survivors. In addition, those who are involved in disaster work, such as rescue and medical personnel, may become hidden victims. Different kinds of psychological assistance can be provided but this must be systematic and well organized. Professional help should supplement and facilitate community, personal and social resources rather than supplant them. This paper provides guidelines for providing such help.

Introduction

DISASTERS are neither new nor uncommon occurrences and in the United Kingdom a succession of major tragedies has highlighted the devastating and disruptive effects such incidents can have on individuals and communities. Research in this field is, however, bedevilled by methodological difficulties[1] and by the pernicious influence of post-disaster litigation and compensation. There is, therefore, much uncertainty about the prognosis and management of post-traumatic symptoms.

Although it is not at present included in the standard psychiatric classification used in the UK (*International classification of diseases,* 9th revision), 'post-traumatic stress disorder' is widely used to describe a range of symptoms which are commonly seen in the victims of disasters. There are five principal feaures of this syndrome: (1) repeated re-experiencing of the traumatic event, for example, through dreams and nightmares, (2) intensive psychological distress in the face of reminders of the event, (3) marked increase in anxiety and arousal, problems of concentration, exaggerated startle response and increased autonomic activity, (4) marked avoidance of things which are reminders of the trauma, and (5) reduced interest in pleasureable activities, including personal relationships.

It is worth remembering that, although disasters on the scale of Lockerbie and Piper Alpha capture the news headlines, there are many examples in everyday life of 'mini-disasters' in which the suffering is no less for their victims.

Clearly, because the nature and extent of disasters vary it is hard to generalize, but the evidence suggests that long term effects, lasting up to five years, are most common in major disasters at sea involving fire. More generally, chronic symptoms such as chronic anxiety, depression, alcohol abuse and marital/family problems can be observed two to four years after the event. Disasters which expose victims to prolonged risks of death and mutilation are more likely to produce severe and chronic post-traumatic effects.[2]

Unfortunately, in relative ignorance and often without training or experience, many doctors (general practitioners in particular) are called upon to provide counselling and other forms of psychological help in the aftermath of a major catastrophe.

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General practitioners are in a particularly good position to help because of their knowledge of the victims, their families, the local sources of help and the cultural milieu to which the victims belong. Knowledge of cultural values and attitudes is important because these are likely to shape, in part, the manner in which the individual will react to adversity and make use of the sources of help available. It is important that in disaster planning regional differences are not obscured.

This paper gives some general guidelines for providing psychological assistance after major trauma, based on the work of several investigators[3-5] as well as on the author's own experience after the Piper Alpha oil rig disaster.[6] The emphasis is on survivors and helpers (for example, emergency personnel, medical and nursing staff) and not on the bereaved, as the literature on bereavement is extensive.[7]

Primary stage of intervention

Immediately following a disaster, victims commonly experience such feelings as confusion, shock, fear, disorientation and of being overwhelmed. It is not surprising, therefore, that they have basic needs for comfort, reassurance and protection. Also, reuniting victims with their natural groups, whether these be family, friends or co-workers, helps to restore a sense of security. Survivors from the Piper Alpha disaster emphasized the value of being in the same ward in which mutual support quickly developed. Where reunion cannot be achieved, good communication and accurate information relieve much anxiety and restore a sense of order. Survivors should be given information as quickly as possible, not only about significant others, such as their families, but about themselves — what has happened, what is happening and what is going to happen. Survivors in hospital may be particularly sensitive to uncertainty about the time they are due to go to theatre or the dates of discharge from hospital, as was the case with the victims of the Piper Alpha disaster.

This is a time for 'psychological first aid';[5] it is not a time for exploratory counselling or the deliberate eliciting of powerful emotions. In any case, the struggle to survive and the relief at having done so is likely to subordinate many other psychological reactions and needs.

Mental health professionals may feel reluctant to appear early on the scene or they may not be encouraged to do so, but there are four possible advantages in their early intervention. First, personal experience of the disaster and its immediate aftermath may increase their credibility in a way which is likely to facilitate their subsequent work with victims. Secondly, early intervention allows the professionals to be seen as part of the medical team rather than as distant and possibly threatening figures to whom survivors are subsequently referred. Thirdly, in the emotionally charged atmosphere of the post impact phase of a disaster, a special bonding may occur between victim and helper. Piper Alpha survivors commented on the importance and durability of these early relationships, and on how these subsequently facilitated counselling and psychiatric treatment. Finally, early intervention provides an opportunity for 'psychological triage'[5] and for identifying those who may be particularly at risk of adverse reactions.

Factors which increase the likelihood of adverse reactions

In the past it was believed that those who reacted adversely to trauma were weak or constitutionally predisposed to develop psychological problems. However, the complexity of the relationship between trauma and the individual's reactions is now acknowledged. Current research emphasizes the role played by a number of factors: the specific features of the trauma, the way in which the individual perceives the trauma, the nature of the individual's reactions in response to the trauma, and the extent of the support available to the victim after the trauma. This does not mean that personality features are unimportant in determining the outcome. For example, some individuals will tend to focus on specific aspects of the unpleasant experience, thereby shielding themselves from the full brunt of it.[8]

There is evidence[5] to suggest that survivors are at greater risk of adverse reactions if they are unemployed, from lower socioeconomic groups, from larger families, divorced or female, although it has been observed[9] that, while women might be more vulnerable than men initially, elderly women ultimately adjust as well as their male peers. Previous psychiatric history plays a minor part in predisposing individuals to post-traumatic symptoms, and there is an increased relapse rate among patients with bipolar affective illness following a disaster.[10] Age is an important factor, with younger individuals being found to be more vulnerable.[11] Children should be carefully observed because although they might appear to cope well in the first few months after a disaster their problems often emerge later.[11] Parents may be reluctant to admit that their children are suffering, particularly if they feel in any way responsible for the traumatic events.[11] In addition, there is evidence that adverse reactions can occur in the children of survivors even if they are born after the disaster.[11] The elderly also constitute a group at particular risk because of their reluctance to accept offers of help.[2] For this group it may, therefore, be particularly helpful for the general practitioner to take proactive steps rather than to wait until the elderly victims seek help. Protracted exposure to death, injury and mutilation also increases the likelihood of a poor outcome, as does guilt and conflictual feelings about having survived.[5]

Many survivors are likely to feel that they are not entitled to help, and that they should merely be grateful they have survived. It may be that their needs go undetected, particularly if they appear to be coping. The family doctor is well placed to combat such reluctance and to persuade victims of their need for and entitlement to help. The general practitioner can direct individuals to the most appropriate local form of help, which may not be evident to the victims themselves. For example, it might be most helpful for families suffering recent trauma to be put in touch with other families who have shared such experiences.

Poor prognostic indices for families include previous interpersonal difficulties, multiple problems and a lack of social support. Some disasters render families at risk because they entail not only injury and loss of life but loss of homes and communities, creating 'dislocation stress'.[5]

It is worth noting that if the onset of the symptoms is delayed by six months after the trauma and then endured for six months without treatment the prognosis is likely to be worse.[12] In addition, the methods of self-protection used by victims in the early phases of the disaster can lead to longer-term problems.[13]

Secondary stage of intervention

Once the initial threat to life has ended and basic needs have been met, counselling is a realistic possibility in response to the symptoms which appear later, including anger, despair, anxiety, guilt, irritability, a sense of helplessness and problems of living. Counselling should aim to:

- ease the expression of feelings;
- help in the understanding of reactions and methods of coping;
- educate with regard to what can be expected;
- identify specific problems and realistic solutions;
- inspire hope;
- identify positive achievements.

Such help may be provided on a one to one basis, but frequently it is provided to groups, and this has the advantage of providing mutual support among individuals who have shared the same experience. It is probably more effective to aim for a small number of long sessions rather than many shorter ones as the former are more likely to allow the uncomfortable feelings and memories to habituate and fade.

Facilitating the expression of powerful and difficult feelings has long been regarded as a cathartic exercise. However, three points should be borne in mind. First, individuals must be allowed to proceed at a pace with which they can cope; they will often need time to assimilate and consolidate what they have experienced.[14] Opening up a Pandora's box of uncomfortable and unmanageable emotions will simple heighten the victims's fears of being out of control. Secondly, it should be noted that certain feelings are more easily expressed than others after trauma. For example, survivors can usually express anger at their plight, and as a counsellor it is easy to over-identify with the victim and share this sense of injustice and outrage, but the anger may mask other feelings which are harder to express. Thirdly, it is not likely to be helpful for those counselling to take sides, in response to the victim's anger, and become embroiled in issues of culpability.

Mere ventilation of feelings is rarely enough: victims also have to make some sense of what has happened to them and their reactions to the disaster. Sometimes they display inappropriate and unrealistic beliefs and reactions. For instance, some may feel guilty about what they did or did not do. A thorough analysis of the realities of the situation ('reality testing') is usually sufficient to dispel false beliefs of this kind.

General practitioners can also help by pointing out to victims how normal are their reactions, and by helping them to understand the relationship between these reactions and the trauma. Families and spouses may also benefit from hearing information of this kind so that they can understand why their relatives or loved ones feel and behave the way they do.

Disasters will have direct effects on their victims, but they may also bring to the surface latent problems in a family or marriage, and others may need to be involved in the counselling. In order to gain a realistic view of their circumstances, victims should be helped to identify the different kinds of problems facing them, the origins of these problems and their possible solutions. Some survivors may find it easier to relinquish their responsibilities and let others solve their problems; some doctors may enjoy their position of being needed to such an extent that they foster this dependency. While temporary respite from the pressures of life is helpful for victims, professionals must avoid fostering undue dependency. The ultimate aim of counselling is to help victims to become self-determining individuals and to retrieve a sense of control over their own life again.

Counselling must also inspire hope for the future as even in the face of dreadful adversity individuals are remarkably resilient and adaptable. Counselling should identify positive gains which may have been made as a consequence of the disaster. Some victims may have found strengths and abilities they did not know they had, some can take pleasure in what they did for others

during or after the disaster, and some may report the development of new relationships or the reaffirmation of existing relationships following the trauma. On a broader front, it has been observed that disasters can bring communities and families closer together.

Helping the helper

Fuelled by altruism, commitment and courage various groups of professionals, such as doctors, nurses, firemen and policemen, may become deeply involved in the demanding and harrowing tasks generated by disasters. The follow-up research findings on rescuers and other helpers are ample testimony to the adverse consequences of disaster work.[4,15,16] Such research studies have shown that post-traumatic symptoms, such as instrusive and unpleasant thoughts, may continue to occur many months after disaster work.

Unfortunately, the suffering of professional helpers can go unnoticed, partly because they may find it difficult to reveal their own emotions and difficulties as they are trained and commonly expected by others to be 'copers'.[17] Often they do not regard themselves as real victims and some will, therefore, deny or cover up adverse reactions, only to find that these surface later when assistance is less available. In view of the risk of hidden victims an active 'outreach' policy is advisable to identify those at risk and to ensure that help is readily available.

Some helpers might be at greater risk than others of having bad reactions to trauma. These include those who are required to deal with mutilated bodies and human remains (particularly those of children), the inexperienced, the young and those who have had to work at the actual scene of the disaster.[18] Other investigators have suggested that extended exposure to disaster[15] and the experience of considerable immediate post-traumatic stress[19] are also associated with subsequent psychiatric morbidity.

Debriefing

As a preventive measure, therefore, it has been advocated[4] that helpers and rescuers take part in regular group debriefing sessions. Debriefing should aim to:

— review the helper's role;
— ease the expression of feelings;
— explore particular problems encountered and solutions found;
— identify positive gains;
— explore consequences of disengagement;
— identify those at risk.

Those being debriefed usually find it easier to begin by first reporting factual information. This description of their professional activities can lead on naturally to the more delicate issue of their emotional and psychological reactions. Professional helpers, such as police officers and doctors, may find this particularly difficult for the reasons given above. Empathic awareness of the reasons for such resistance, and gentle probing are, however, usually enough to encourage a more open expression of feelings and awareness of problems. A respect for these individuals' methods of coping should also be shown because these methods are the ones which have proved effective in the past. It is also important to avoid suggesting there has been any failure to cope on the part of the helper.

Reviewing how helpers felt and coped requires consideration of positive as well as negative aspects. On the negative side, these individuals may have experienced a sense of despair, a fear of being useless and overwhelmed, or they may be having problems at home because of their involvement in disaster work. Some may suffer from 'performance guilt', that is, a belief that their contribution was inadequate.[4] Positive reactions may include a feeling of satisfaction at a job well done, the finding of a victim alive, the forging of important relationships among helpers, or a sense of reassurance about having been able to cope. Sometimes the leader of the debriefing sessions may have to remind the participants of the positive aspects of the occasion, for example, the value to the bereaved of retrieving even mutilated bodies. The positive theme can also be maintained by exploring what has been learned from the rescuers' efforts, such as new ideas and techniques.

This sustained emphasis on the positive aspects of the work provides a powerful antidote to the sense of being overwhelmed, and helps to achieve a feeling of mastery over the unpleasant features of disaster work.

Debriefing also provides an opportunity for the leader to identify those who are having particular difficulties or are at risk and may require more specialized help. A number of warning signs have been described.[5] These include an increased occurrence of accidents, increased use of alcohol and tobacco, poor work performance and chronic exhaustion.

Finally, during plenary debriefing sessions, attention has to be paid to the implications for the helpers of no longer being involved in the disaster. Despite the distastefulness of much of the work it does provide certain rewards. It may, for instance, give certain professional groups a much higher public profile than that achieved through their routine duties, and it may generate a personal zeal and emotional arousal which can be quite addictive. Unless these prospective losses are dealt with it may be difficult for individuals to leave the disaster work behind. On the other hand, some workers may have to be reassured that they may discontinue their work without feeling guilty even though tasks may be incomplete.

Features of effective debriefing

1. Successful debriefing makes many demands on the leader of the sessions. Not only should he/she have some personal knowledge of the specific disaster and its effects but also a knowledge of reactions to trauma and of group dynamics.

2. Creating the right ethos is essential. Debriefing should be conducted as a thoroughly professional exercise. By seeing debriefing as a natural extension to their professional duties helpers are much more likely to find it a valuable and acceptable exercise. Casting it in this light makes it possible to have all helpers involved, rather than leaving it as an option available for those who want it; an option which may imply it is only for those who have failed to cope.

3. The acceptability and effectiveness can also be increased by organizing debriefing sessions in terms of naturally occurring groups — specific squads of personnel engaged in shared tasks — rather than involving a heterogeny of individuals who have little in common. Enhancing the camaraderie among such personnel can do much to offset the adverse consequences of disaster work.

Conclusion

Some disasters are sudden and unexpected, others may develop more slowly, permitting time for physical, social and psychological preparation which might help to mollify the subsequent impact. Disasters at sea, involving fire and explosion, appear to carry a very high risk of post-traumatic psychiatric

morbidity,[5] whereas brief, catastrophic events, with no loss of life, may give rise to lower levels of morbidity.[20] It is, therefore, hard to generalize from one disaster to another.

It is not known why certain individuals do not develop post-traumatic symptoms even after extreme adversity. Clearly, much more research is needed to further our understanding of the relationship between, on the one hand, features of disasters, the personality and coping strategies of the victims and therapeutic intervention and, on the other hand, the nature and severity of post-traumatic reactions. Also needed is a clearer picture of the 'pathogens' which give rise to chronic and intractable psychiatric problems.

Finally, the value of local resources including the general practitioner must not be obscured by the contribution of experts (genuine or putative) from outside the region. Certainly, the latter have much to contribute but not at the expense of the capacity of the local community to help itself.

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