Mental Health Response to a Disaster

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Forward

The purpose of this reference is to provide religious leaders with a general understanding of the mental health response to a disaster, and to assist in meeting the challenges of providing mental health support to people affected by a disaster. It offers the basics of disaster mental health and describes reactions and needs of all those affected by a disaster. Furthermore, it explains how religious leaders can help to relieve emotional suffering of congregants and provide guidance for when and how to refer for mental health services.

Introduction

Natural or human-made disasters are by definition disturbing and unexpected. Most people react to a perceived threat or environmental challenge with stress. Stress reactions are normal in most cases, but may differ depending upon the severity of the situation. Stress reactions are experienced as physical *(body reactions), emotional (feelings), cognitive (thinking and decision making), behavioral (action), and spiritual (belief and values)* - see Table 1.

As members of the community, religious leaders are in a good position to provide help to people affected by a tragedy. In their daily interaction with others, religious leaders show compassion, willingness, and interest in helping those in need. Similar to other disaster responders, religious leaders can be affected by a disaster, and in order to provide efficient mental health support to the members of their house of worship, religious leaders themselves need to be supported and cared for through training and skill building.

Signs of disaster stress reactions and survivor needs following a traumatic event

Natural or human-made disasters cause many similar predictable stress reactions to the traumatic event. Traumatic events are characterized by a sense of horror, helplessness, serious injury, or the threat of serious injury or death. Traumatic events affect survivors, rescue workers, and friends and relatives of victims who have been directly involved. In addition to potentially affecting those who suffer injuries or loss, they may also affect people who have witnessed the event either firsthand or on television. Stress reactions following a traumatic event are common and resolve within days or few weeks following a disaster. Affected persons reactions and needs are similar. These are:

- A concern for basic survival.
- Difficulty understanding and accepting what has happened.
- Grief over loss of loved ones or loss of valued and meaningful possessions.
- Being unable to stop thinking about the event.
- Being easily reminded of the event by things that are not very related.
- Reliving the smells and sounds, seeing details of the incident.
- Increased difficulty controlling emotions.
- Being easily irritated or startled.
- Fear and anxiety about personal safety and physical safety of loved ones.

Traumatic events affect survivors, rescue workers, and friends and relatives of victims who have been directly involved.

- Sleep disturbances, often including nightmares and imagery from disaster.
- Concerns about relocation and related isolation or crowded living conditions.
- Concerns about backlash and social alienation.
- A need to talk about the events and feelings associated with disaster, often repeatedly.[1]
- A need to feel one is part of the community and its recovery efforts.

Peoples' response following a traumatic event

While the responses outlined above are normal, they can also interfere with a person's ability to return to their pre-disaster level of functioning. By providing compassionate support for people affected by a traumatic event, we can help reduce their stress and make an essential contribution to their recovery.

Examples of ways people cope with a traumatic event:

- Seeking help from others or offering help to others.
- Talking about their experiences.
- Trying to make sense of what happened.
- Hiding until the danger has passed.
- Seeking information about the welfare of their loved ones.
- Gathering their remaining belongings.
- Beginning to repair the damage.
- Burying or cremating the dead.
- Following their religious practices.
- Setting goals and making plans to accomplish them.
- Maintain regular routines.
- Using defenses like denial to reduce the perceived impact.
- Remaining fearful and alert to any further danger.[2]

Phases of stress reaction following a traumatic event

Most people respond to traumatic events in predictable phases. There is a gradual transition from one phase to another depending upon the severity of the symptoms. The duration of the phase may vary from person to person. It is, however, important to note that these phases do not always occur, nor do they always appear in a specific order.

A person exposed to severe stress may pass through one or more of the following phases:

Stress Reaction Phase 1: Immediate response

- Lasting minutes, hours, or days.
- Post traumatic distress: strong emotions, numbness, disbelief, fear, anxiety and confusion.
- Persisting stress response may lead to loss of flexibility in behavior and thinking. "Thinking may become disorganized resulting in fight and flight reflex or a freeze response. During this phase, the risk of panic or acute outbreak of medically unexplained symptoms is at its peak."
- Stress reaction may affect the way people act. It can create narrow-mindedness and make behavior more rigid. The loss of flexibility can cause irritability, anger or in some cases, excessive high spirits.
- Irritation and anger - causes suspicion and the need to look for a scapegoat, or someone to blame when something goes wrong.
- Rigid behavior - complicates communication with others and may lead to withdrawal.
- Feeling of uselessness and helplessness - may lead to restlessness.

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Stress Reaction Phase 2: Intermediate Response: Adaptation, Arousal Avoidance

- Lasting one week to several months after the event.
- Intrusive symptoms: anxiety, restlessness, recollection of events, associated with hyper arousal, insomnia, nightmares, and hyper-vigilance.
- Behavioral distress: increased visits to primary care providers, new symptoms or worsening the old ones.
- Emotional symptoms: anger irritability and apathy.
- Disturbing thoughts about survival, relief, guilt, grief.
- Muscular tension, tremors, and exaggerated startle response.
- Social withdrawal and depression.

Stress Reaction Phase 3: Long-term Response: Recovery, Impairment and Change

- Lasting up to a year or more.
- Some express feelings of disappointment and resentment; continued posttraumatic distress may lead to development of psychiatric disorders.
- Majority rebuild their lives and focus on future.[3]

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS:

Helping people affected by traumatic events, their family members, and emergency rescue personnel requires preparation, sensitivity, assertiveness, flexibility, and common sense. Explain that their symptoms are normal, especially right after the traumatic event, and then encourage a person to:

- Identify concrete needs and attempt to help. Traumatized persons are often preoccupied with concrete needs (e.g., How do I know if my friends made it to the hospital?).
- Keep to their usual routine.
- Keep medical appointments and take medications as prescribed.
- Help identify ways to relax. Rely on regular exercise to help relieve stress. Walking everyday, and managing stress with relaxation techniques can make a big difference in how a person feels.
- Do things they enjoy like renting a movie, reading a book, listening to music, etc.
- Eat right, get enough sleep, and share their thoughts and feelings with people around them.
- Learn how others are coping. This will help a person feel less alone.
- Take the time to resolve day-to-day conflicts so they do not build up and add to their stress.
- Educate people about the negative effect of abusing alcohol/drugs, tobacco, or even taking more medication than a doctor prescribes. People who turn to alcohol and drugs to cope with their feelings following a traumatic disaster are more likely than others to develop serious problems.
- Refer individuals to a mental health professional in your area who has experience treating the needs of survivors of traumatic events (See Referral Section).
- Provide education to help people identify symptoms of anxiety, depression, and PTSD (see resources). [4]
- Follow-up as appropriate.

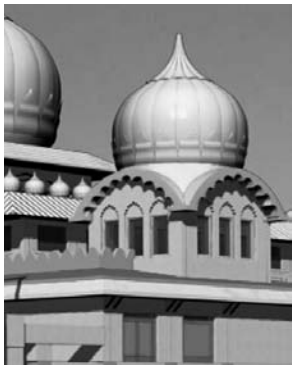
TABLE 1

Cognitive	Emotional	Physical	Behavioral	Spiritual
Poor concentration	Shock	Nausea	Suspicion	Anger at God
Confusion	Numbness	Lightheadedness	Irritability	Feeling distant from God
Disorientation	Feeling overwhelmed	Dizziness	Arguments with friends and loved ones	Withdrawal from place of worship
Indecisiveness	Depression	Gastro-intestinal problems	Withdrawal	Uncharacteristic religious involvement
Shortened attention span	Feeling lost	Rapid heart rate	Excessive silence	Sudden turn toward God
Memory loss/	Fear of harm to self and/or loved ones	Tremors	Inappropriate humor	Familiar faith practices seem empty (prayer, Scripture, hymns)
flashbacks/intrusive images	Feeling nothing	Headaches	Increased/decreased eating	Religious rituals seems empty (worship, communion)
Unwanted memories	Feeling abandoned	Grinding of teeth	Change in sexual desire or functioning	Belief that God is powerless
Difficulty making decisions	Uncertainty of feelings	Fatigue	Increased smoking	Loss of meaning and purpose
Impaired thinking	Volatile emotions	Poor sleep	Increased substance use or abuse	Sense of isolation from God and religious community
Hypervigilance	Anxiety	Pain	Increase alcohol consumption	Questioning of one's basic beliefs
Nightmares	Guilt	Hyperarousal	Pacing	Anger at spiritual leaders
	Grief	Jumpiness	Erratic movement	Believing God is not in control
	Denial	Muscle tremors	Acting out	Believing God does not care
	Irritability/agitation	Chest pain/ difficulty breathing	Change in usual communication	Belief that we have failed God (5)
	Problem controlling ones' emotions	Profuse sweating	Restlessness	
			Emotional outburst	

It is especially important for helpers to be respectful, well-informed, and to dependably follow through on stated plans.

Persons who may be at potential risk for severe and longer lasting reactions to trauma:

- Some people are at greater risk than others for developing sustained and long-term reactions to a traumatic event, including such disorders as posttraumatic stress disorder (PTSD), depression, and generalized anxiety. Factors that contribute to the risk of long-term impairment are listed.
- Proximity to the event. Severe exposure to actual event leads to greater risk.
- Multiple or an accumulation of stressors may create more difficulty.
- History of trauma or previous experience with disaster may lead to higher risk of long-term impairment.
- Degree of harm to self or to loved ones.
- Meaning of the event in relation to past stressors. A traumatic event may activate unresolved fears or frightening memories.
- Persons with chronic medical illness or psychological disorders. Survivors with mental illness function fairly well following a disaster, if most essential services have not been interrupted. However, for others who may have achieved only a tenuous balance before the disaster, additional mental health support services, medications, or hospitalization may be necessary to regain stability.
- Older people or people who are in group facilities or nursing homes during a disaster are susceptible to anxiety, panic, and frustration as a consequence of their limited mobility and dependence on caretakers. The impact of evacuation and relocation on those with health or functional impairments can be tremendous. Dependence on others for care or on medical resources for survival contributes to heightened fear and anxiety. Change in physical surroundings, caregiving personnel, and routines can be extremely difficult.
- Ethnic and racial minority groups can be at higher risk, because of socioeconomic conditions that force the community to live in housing that is particularly vulnerable. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values can present challenges for helpers in gaining access and acceptance. Cultural sensitivity is conveyed when disaster information and application procedures are translated into primary spoken languages and available in non-written forms. Cultural groups have considerable variation regarding views of loss, death, home, family, spiritual practices, grieving, celebrating, mental health, and helping. It is essential that helpers learn about the cultural norms, traditions, local history, and community politics from leaders and social service workers indigenous to the groups they are serving. Establishing working relationships with trusted organizations, service providers, and community leaders often facilitates increased acceptance. It is especially important for helpers to be respectful, well-informed, and to dependably follow through on stated plans.
- *First responders, including survivor support, law enforcement, local government, emergency response, experience considerable demands to meet the needs of the survivors and the community. Depending on the nature of the disaster and their role, relief workers may witness human tragedy, fatalities, and serious physical injuries. Over time, workers may show the physical and psychological effects of work overload and exposure to human suffering. They may experience physical stress symptoms or become increasingly irritable, depressed, over-involved or unproductive, and/or show cognitive effects like difficulty concentrating or making decisions.*[5]



The following are some examples of when to refer for mental health services:

- When a person hints or talks openly of suicide.
- When you realize the problem is beyond your capability or level of training.
- When a person seems to be socially isolated.
- When a person presents imaginary ideas or details of persecution.
- When you become aware of over-reliance on alcohol or drugs.
- When you see the person engaging in risk behavior (carelessness towards oneself/others).
- When you yourself become restless, confused and have persistent bad thoughts, worries, or dreams about the case.[6]

TABLE 2

How to make a referral to a mental health professional:	
As a rule, inform the person concerned about your intentions.	Let him/her know that you care and then explain the reasons for the referral.
If you have the option, you should present different possibilities of referral to the person concerned.	Discuss matters such as fees, location, accessibility, etc.
Assure the person that you will continue your support until the referral is complete.	You might even suggest accompanying him/her to the first visit with the professional.

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Editor's Note: The resources and websites provided here are provided by the authors as resources for issues raised in this chapter. For a list of all the resources provided in this manual, please refer to Chapter 10, just before the Reference Section.

RESOURCES

NYC Office of Emergency Management: Ready New York Household Preparedness Guide
http://www.nyc.gov/html/oem/html/readynewyork/ready_guide.html

Community and Family Preparedness Publications **http://www.fema.gov/rrr/fampubs.shtm**

Disaster Preparedness For People with Disabilities **http://www.fema.gov/library/disprepf.shtm**

New York State Emergency Management Office **http://www.nysemo.state.ny.us**

American Red Cross: Tips On Managing Anxiety In Stressful Times
http://www.nyredcross.org/news/2004/040830_mental_health.asp

Coping With Trauma

Project Liberty **http://www.nyc.gov/html/doh/html/liberty/english.html**

National Institute of Mental Health-Information About Coping with Traumatic Events
http://www.nimh.nih.gov/healthinformation/traumaticmenu.cfm

National Center for Posttraumatic Stress Disorder (PTSD): Disaster Mental Health: Dealing with the Aftermath of Terrorism **http://www.ncptsd.va.gov/disaster.html**

Posttraumatic Stress Disorder (PTSD) Alliance **http://www.ptsdalliance.org**

Public Health & Mental Health Preparedness

Terrorism and Mental Health **http://www.nyc.gov/doh**

World Health Organization: Public Health Response to Biological and Chemical Weapons: WHO Guidance
http://www.who.int/csr/delibepidemics/biochemguide/en/index.html

General Public Mental Health Information

National Mental Health Information Center: Center for Mental Health Services **http://www.ncptsd.va.gov/disaster.html**

The Center for Disease Control and Prevention: Coping With a Traumatic Event: Information for the Public
http://www.bt.cdc.gov/masstrauma/copingpub.asp

Substance Abuse and Mental Health Services Agency (SAMHSA) **http://samhsa.gov**

National Institute of Mental Health (NIMH) **http://www.nimh.nih.gov**

Resources for Children

FEMA: FEMA for Kids **http://www.fema.gov/kids/**

American Red Cross: The Be Ready Book **http://www.prepare.org/children/bereadybook.pdf**

Further Reading

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Worden J W (1996) *Children and grief - when a parent dies?* Guildford Press, NY.

World Health Organization (2000), *Declaration of co-operation, mental health of refugees, displaced and other populations affected by conflict and post-conflict situations*, WHO.

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[1] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters.

[2] International Federation of Red Cross and Red Crescent Societies, Psychological Support: best practices from Red Cross and red Crescent programmes.

[3] National Association of State Mental Health Program Directors-State Mental Health Response to Terrorism.

[4] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters.

[5] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters.

[6] International Federation of Red Cross and Red Crescent Societies.

[7] International Federation of Red Cross and Red Crescent Societies.