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MOOC 1 – Unit 5:

Specific Targets in Early Psychological Intervention

Developed by Institute of Group Analysis Athens (EL)

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Chapter 3 – Targets

Introduction (1)

- Pre- and post-disaster collection of relevant health-related data and monitoring of these data to evaluate recovery.
- Police, emergency medical service and psychological first aid personnel, fire fighters, emergency managers, are first responders to disasters. Working on the front line, these trained responders are also exposed, at considerable risk, to psychological distress. Their work represents a crucial element of community resilience.
- The use of more natural infrastructure instead of, or in combination with, “grey” (manmade) infrastructure, is recommended to minimize psychological distress. Psychological and physiological health benefits derive from experiencing more natural, “green,” and biodiverse areas.
- During and following evacuations and displacements due to disasters, females, elders, ethnic minorities, people with chronic health problems or economically disadvantaged, are at greater risk for health impairment. So, it is important to avoid extended displacements of disaster victims.

Chapter 3 - Targets

Introduction (2)

- Nature-based treatment and exposure to nature alleviate stress. Pre- and post-disaster effects of stress are not only anxiety and depression, but also loss of community and cultural identity, due to displacement.
- Revision of disaster laws and policies including stress-related impacts. Engage geographically-isolated and/or eco-dependent communities in meaningful ways, transfer knowledge and develop an adaptive capacity for resilience.
- Dealing with damage assessments, housing and payments is one of the most stressful long-term impacts of natural disasters. The consequences on livelihoods and customary ways of life, increase stress that may produce loss of trust in public services, leaving people feeling helpless.

O'Sullivan, T.L., Kuziemsky, C.E., Toal-Sullivan, D., Corneil, W. (2013). Unraveling the complexities of disaster management: A framework for critical social infrastructure to promote population health and resilience. *Social Science & Medicine*. Vol. 93. Pp. 238-246.

M. Oxley. (2015). Review of the Sendai Framework for Disaster Risk Reduction 2015-2030. **GNDR** (**G**lobal **N**etwork of Civil Society Organisations for **D**isaster **R**isk Reduction.

Pearson, L., Pelling, M. (2015). The UN Sendai Framework for Disaster Risk Reduction 2015–2030: Negotiation Process and Prospects for Science and Practice. *Journal of Extreme Events*. Vol. 2(1).

3.1. Targets – Sanitary Emergency Staff

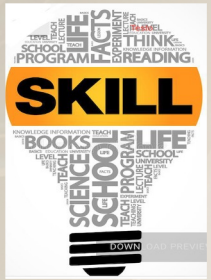
The aim is to foster resilience, reduce burnout and compassion fatigue, as well as the risk of post-traumatic stress disorder (PTSD) for senior staff but also for medical and nurse students.

Front-line health professionals, particularly those working in inpatient medical health settings, are increasingly exposed to psychological distress in a working environment overloaded by high-risk procedures.

Responses to stress include irritability, anger, anxiety, mood and eating disorders, sleep problems, increased alcohol intake and/or smoking.

Burn-out or compassion fatigue symptoms are sequelae to the exposure to a stressful working environment.

It is necessary to continue to support staff after the emergency begins to mitigate.



3.1. Targets – Sanitary Emergency Staff

-Provide all staff with accurate information updates

-Provide support to inexperienced workers, placing them next to an experienced colleague

-Flexible schedule for staff member, directly affected or with a family member affected

-Offer more than single session psychological intervention

-Offer the opportunity of regular group sessions for the staff to talk about their experiences without mandatory attendance

-Role modeling by senior staff on safety, necessity of taking breaks and ensure self-care

-Pay attention to staff members prone to vulnerability, due to pre-existing traumatic experiences, mental health issues, bereavements

-Give regular feedback mechanisms helping in supporting staff needs

-Facilitate team cohesion, supportive and caring attitude between team members

-Continue to support staff after the emergency begins to mitigate

-Implement rotation of workers from higher-stress to lower-stress position

3.1. Targets – Sanitary Emergency Staff

- Reduction of emotional burden by developing skills to cope with the traumatic situation, managing anxiety, episodes of acute stress and fear of contagiousness in the case of infection disease emergency
- Soothing interpersonal distress between colleagues by open and honest communication over daily practice and/or possible misunderstandings
- Awareness of the potential mental health issues reduce stigma and results in early seeking for psychological help
- Reinforcement of safety procedure reduces anxiety about performance, role accomplishment and job's fulfillment
- Maximization of social and peer support at work enhances inclusion in the team of younger and/or new staff members
- A supportive and caring attitude between staff increases the ability to collaborate with each other and to remain focused on work
- In the staff working team, coherency originates from needs for communication, differentiation and development. It is a pendulum-like movement with cohesion, which is a more defensive position that held the members together .

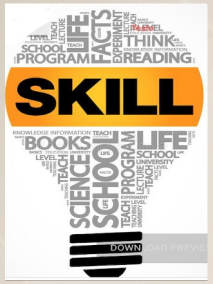
3.2. Targets – Refugees

Considerable emphasis on the need for interventions that rely less on medical models of psychological distress that excessively emphasize stress-related trauma and **more on psychosocial models that promote positive personal change.**

Practitioners are forced to start **“rethinking a familiar model” of psychotherapy to accommodate clients’ cultural and linguistic backgrounds**, including meanings of emotion, suffering, trauma and support in their original and host cultural contexts.

The experience of migration may include traumatic events before departure, during travel and transit, and after arrival, making the adaptation process complex and stressful.

Some problems include language barriers, lack of information about the health care system in the host country, different attitudes to medical and psychological treatments.



3.2. Targets – Refugees

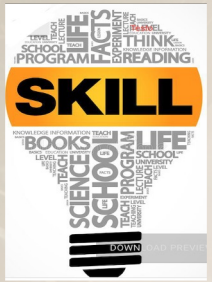
- Development of social skills and assertiveness
- Creative therapies: writing, music, arts, dance/movement, or drama to recall traumatic memories and process trauma associated with PTSD in a non-verbal way. Relaxation, activation and expression of memories and emotions, creating art, exposure through symbolic art, and rebuilding of self-esteem.
- Interpersonal, humanistic, and other integrative therapies, counseling, interpersonal therapy
- Denote the importance of body language, between persons of different cultures
- Be aware of and responsive to the pre-verbal kinds of interactions
- Use simplified, brief, versions of evidence-based psychological therapies
- Offer Cognitive Behavioural Therapy, Family interventions, Narrative Exposure Therapy (NET), Problem-solving counselling
- Provide psycho-education
- Contain aspects of culture in developing intervention settings to meet the specific needs and backgrounds of refugee groups.

3.2. Targets – Refugees

- Cultural adaptations are ensured by interventions that are responsive to the needs of participants, incorporating local cultural and psychosocial factors that influence health behaviours
- Prevention of long-term effect due to trauma experience
- Reducing stressful situations related to threat to life, loss of close, beloved people and values.
- Reconstructing survivors' normal life and restoring their connection with the surrounding normal environment.
- Regaining the ability to plan for the future as well as relieving the fear of the unknown and helplessness.
- Improvement of quality of life of the refugees, sustaining an independent and productive daily life.
- Promotion of social integration
- Overcoming barriers to access for mental health care if needed
- Facilitating engagement with care
- Preserving the emotional connection between persons of different cultures
- Reinforcing bridging from one culture to another

3.3. Targets – First Responders

- A first responder is a person with specialized training who is among the first to arrive and provide assistance at the scene of an emergency, such as an accident, natural disaster, or terrorism. First responders typically include law enforcement officers (LEOs), ambulance personnel (Emergency Medical Team/paramedics), firefighters and other fire personnel (FFs). They often face high-risk situations and daily routine stressors.
- **Occupational (or Operational) Stress Injury (OSI)** defines a range of psychological conditions resulting from duties performed on the job (hyperarousal, anger, irritability, sadness, numbing, nightmares, intrusive thoughts, sleep disturbances, anxiety, depression, PTSD). Furthermore, suicide rates among police officers and firefighters are higher than in general population.
- *Non-occupational risk factors* for OSI are described as (1) historical (family history of psychiatric disorders, education, early conduct problems, childhood adversity and abuse); (2) peri-traumatic (severity of the traumatic event, actual physical injury or assault, perception of the trauma as life threatening, dissociative symptoms and their magnitude during the event), and (3) post-traumatic (poor access to healthy coping skills, limited access to mental health resources, lapse of social support, presence of other life stressors).
- *Occupation-specific risk factors* comprise the cumulative nature of the traumatic events faced on the job, routine occupational stress, the type of traumatic events, the perception of inadequate or insufficient social support at the workplace, experience of gender or ethnic discrimination or stigmatization.



3.3. Targets – First Responders

- Evaluate the unique and shared needs of first responders when conducting **crisis focused** psychological intervention programmes. Use relaxation training, problem-solving skills, and communication techniques.
- Use Critical Incident Stress Management (CISM), Demobilization, various versions of Debriefing, Defusing, Psychological First Aid, Psychoeducation, and Peer Support.
- Ensure training of personnel for peer support psychological intervention programmes, as well as providing supervision and support for personnel.
- Use prevention strategies, such as training and learning approaches, self-assessments, standards of practice, surveillance of risk factors, screening protocols.
- When needed, do rehabilitation through employing therapeutic interventions, peer support programmes, digital interventions, psychological interventions, organizational support systems.
- Promote resilience-building strategies, such as mental health promotion, education sessions, imagery training, shifting organizational culture, overcoming organizational barriers, leadership and management training, overcoming stigma, targeting Occupational Stress Injury, building coping mechanisms while reducing trauma, using of positive coping strategies as humor and positive reframing, and mental skills rehearsal.

3.3. Targets – First Responders

- Ensured feelings of belonging and emotional attachment between team's members.
- Endured perception of the group's ability to accomplish its tasks and Self-efficacy.
- Physiological and emotional balance have been improved.
- Incorporation of positive aspects of trauma situations to achieve good outcomes - "post traumatic growth".
- Building readiness to cope with work-related stressors.
- The increased ability to manage stress, increases resiliency.
- Decreased level of anxiety, substance abuse, depression, suicidal ideation and/or behaviour, physiological responses to stress such as increased heart rate, fatigue, sleepiness.
- Enhanced performance and quality of life.
- Acquired stress and trauma awareness.
- Reduced thoughts and/or fear of being stigmatized.
- Decreased time lost from work due to psychological or somatic health problems.

3.4. Targets – Caregivers (i)

- **Informal caregivers** constitute an essential part of the provision of healthcare services during disasters and of the **Disaster Risk Reduction (DRR**). They constitute an important support to health and social service systems that is often underestimated. The approach **‘‘all-of-society’’** of the Sendai Framework for Disaster Risk Reduction 2015–2030 (UNDRR 2015) intends to achieve disaster risk reduction (DRR). https://www.undrr.org/publication/sendai-framework-disaster-risk-reduction-2015-2030
- A **population health perspective** focuses on health status and determinants of health. Medical system may become vulnerable after a disaster causing an increase of informal caregivers’ delivery care.
- Caregivers are exposed to emotional and mental exhaustion, they may experience anxiety and depression which may change their attitude towards care activities. Caregivers and their recipients should be included in the ‘‘all-of-society’’ approach.
- Informal caregiving during disasters refers to a variety of care recipients such as elders, children, and people with disabilities or chronic illnesses. It is an ongoing care and support during daily living, across the complexity of the health care system
- Informal caregivers usually are family members and friends, who support and care for a person with chronic health issues and/or diseases. Informal caregivers may feel emotionally isolated as a result of their caregiving psychological and medical burden

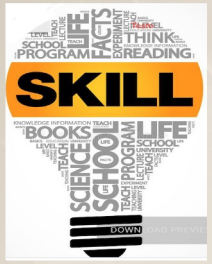
3.4. Targets – Caregivers (ii)

Caregiving is time consuming, complex, expensive, physically and mentally demanding. During a disaster, families with member/s with chronic health conditions are exposed to even more stressful experiences and most of the time they are not prepared for disasters.

Disaster preparedness is important in building individual and community resilience, it should include not only the community but also informal caregivers themselves, care recipients and their families. Better and in time preparedness is associated with longer caregivers' experience, higher family income, and strong family supports.

Caregivers' disaster preparedness is threatened by lack of education and training on disaster risks, which items to prepare in advance, and ~~by~~ how to make a plan encompassing care recipients' and caregivers' needs. Sometimes, caregivers lack a plan assuming they could refer to the pre-existing social support networks.

Shelters are places of social support during the response phase of a disaster, both for care recipients' medical needs and for informal caregivers' non-medical needs.



3.4. Targets – Caregivers

You, as a health worker, should educate and train caregivers during disaster on the below skills:

-Engage any stakeholder during all phases of disaster. Stakeholders may include not only first responders and healthcare providers, but also families of care recipients

-Train formal medical team on how to meliorate communication between informal caregivers, formal caregivers, and care recipients

-Adjust disaster preparation awareness programmes to caregivers' needs

-Prepare and support informal caregivers and care recipients about dealing with disaster

-Provide community support programmes focusing on caregiving

-Increase availability of temporal institutional care during and after disasters

-Recognize and mobilize resources to support informal caregivers' resilience

-Collaborate with social and formal healthcare support systems

-Apply 3 types of support: informational, instrumental, and emotional

-Be aware of the care recipients' medications, health condition status, correlated inabilities and how to use their medical equipment

-Advise family caregivers to store medications for their care recipient in the event of an emergency

3.4. Targets – Caregivers Tips (i)

You as a health worker should collect information about factors affecting the **decision-making process'** effectiveness, performed by informal caregivers in the context of disasters:

- Previous and current social roles during the response phase of disasters, for example the decision to evacuate or shelter-in-place. Social roles refer to the relationship status such as mother-daughter, wife-husband etc.
- The informal caregiver is/isn't accustomed to make decisions on behalf of the care recipient
- Environmental factors: preparedness actions prior to a disaster, cohabitation or living in an evacuation zone
- Socioeconomic status, perceptions of disaster risks, social support, fear, stigma, untrustworthiness towards emergency shelters' ability to support the needs of care recipients
- Emotional burden of decision making, related to the potentially life changing decisions in between two stressor contexts (informal caregiving **and** disaster), especially when the phenomenon that caused the disaster is repeating during time and/or in the case evacuation causes an extensive social support network's loss
- Fear of social stigma and fear of lack of adequate support for the care recipients' medical needs at shelters

3.4. Targets – Caregivers Tips (ii)

Be informed about **barriers leading to disaster-related problems,** such as:

- The level of engagement of the care recipients; the greater their level of engagement, the greater the difficulty in making decisions to evacuate or shelter-in-place. For example, a care recipient with dementia may be engaged, but not fully understand the risks of the situation
- Physical and geographical barriers may produce physical constraints in disaster, i.e. fallen bridge/road after earthquakes may provoke inability of some caregiver-care recipient dyads to travel outside disaster zones
- Excessive barriers to evacuation may lead to staying in disaster zones, i.e. due to the need to walk long distances, disaster relief services become inaccessible to a care recipient with deambulation problems

3.4. Targets – Caregivers

Through education and training: informal caregivers and their care recipients obtain:
- Provision of structured support and anticipatory guidance before disaster
- Improvement of their resilience and independence in the face of disaster
- Support of the resilience of the healthcare system and the community, by understanding and mobilizing assets to support informal caregivers.
- Preparedness to respond to a disaster having knowledge about medication and devices needed by their care recipients

Promotion of resilience among the informal caregiving and care-recipient population by:
- Engagement of the care recipient in the decision making and the preparation for disaster and/or evacuation depending on the care recipients' level of awareness about the disaster situation
- Provision of medical and psychological support in the shelter for care recipients and caregivers, and also relieving caregivers of the burden of caring
- Sustain coping with stress and recovery during and after disasters
- Assuming new role in rescue, guidance, and psychological support having previous experiences and knowledge in informal caregiving
- Education on disaster preparedness, and support from formal healthcare services
- Mitigation of depression, anxiety and their own frustrations
- Enhancement of cognitive and personal skills, wellbeing, family functioning, and physical condition

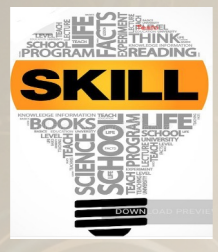
3.5. Targets – Children

Providers serving children's mental health needs face the complexities of tailoring assessment based on developmental stages, family characteristics, school involvement, and cultural and economic factors. This task is even more challenging in the face of a disaster, terrorist incident or other mass trauma event.

Children's post-disaster adjustment reflects a wide range of emotional and behavioural reactions and psychological problems, including distress, sleep problems, post-traumatic stress reactions, depression, anxiety, daily dysfunction, behaviour problems, anger, somatic complaints, learning difficulties, limited concentration, fear and traumatic grief.

Many children exposed to mass trauma events will recover with basic public health interventions and/or due to natural recovery. Some children and their families will not desire intervention services after a disaster.

Because of the diverse post-traumatic trajectories children experience (resilient, recovery and chronic), the choice of the intervention must be matched to the child's reactions and to the course and to symptom development and recovery following exposure to disasters, adopting a **stepped-care approach**.



3.5. Targets – Children

When working with children, you, as health worker, should:

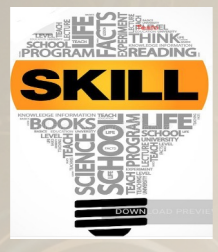
- Ensuring that basic needs (including food, shelter, safety, supervision, communication, and reunification with loved ones) are addressed is the first step to providing emotional support
- Offer Psychological First Aid, which involves psychoeducation both of parents and children and supportive services to accelerate the natural healing process and promote effective coping strategies
- Provide timely and accurate information to promote an understanding that will facilitate adjustment
- Offer appropriate, but not false, reassurance that corrects misconceptions and misperceptions that might otherwise unnecessarily increase the appraisal of risks
- Include parents in interventions
- You can: Provide individual counselling, conduct Group interventions/therapy or do Play therapy
- Conduct Narrative Exposure therapy for children (KIDNET)
- Limit the media coverage in the immediate aftermath of a disaster including television, radio, internet and social media
- Refer for secondary care from mental health professionals

3.5. Targets – Children

- **When working with children, your aim, as a health worker, is to achieve:**
- Parental involvement in assessment, intervention and treatment that enhances outcome.
- Meet basic needs (include food, shelter, safety, supervision, communication, and reunification with loved ones)
- Emotional support
- Facilitation of adjustment
- Acceleration of the natural healing process
- Promotion of effective coping strategies
- Post-disaster psychotherapy for children through listening, clarifying support attachment bonds, facilitating symbolic expression in play and art, and supporting the capacity to imagine repair
- Encouragement of children's feelings and expression of concerns

3.6. Targets – Adolescents

- Parental engagement may be optimal, but it is not a necessity.
- Natural and man-made disasters, like earthquakes, hurricanes, terrorist attacks or war, often lead to psychiatric impairment in child and adolescent survivors. In the light of high and steadily rising numbers of refugees worldwide, health care systems have to adapt to demands imposed by a group that has been subject to potentially traumatizing events, thus often resulting in a high mental health burden.
- Implementation of evidence-based treatments for traumatized children and adolescents has gained increasing political and public interest. Adolescents are a vulnerable group to develop post-traumatic stress symptoms. Disaster interventions for adolescents are clearly efficacious. Longitudinal studies included in both reviews showed rather persistent psychopathology over time and higher risk for psychiatric impairment in adulthood.
- Due to the high risk of persisting psychological impairment in survivors of disasters, psychosocial interventions for adolescents have been developed over the last few years.



3.6. Targets – Adolescents

When working with adolescents, you, as health worker, should:

- Offer psychoeducation
- Provide activity-based cognitive fear-reduction intervention
- Conduct EMDR (Eye Movement Desensitization and Reprocessing) technique
- Conduct Strict CBT, Eclectic with CBT or trauma-focused CBT
- Conduct Narrative Exposure therapy for children/adolescents (KIDNET)
- Develop ERASE-Stress class-room interventions
- Return to routine, such as school, daily care, sports and organized activities as soon as practical after a disaster, as long as the necessary support systems and accommodations are in place
- Encourage adolescents to write positive comments in social media encouraging those who may be isolated and distressed after a disaster
- Do TGCT, that is trauma and grief component therapy
- Develop ERASE-Stress class-room interventions

3.6. Targets – Adolescents

When working with adolescents, the aim is to achieve:

- Through psychoeducation the adolescent can integrate the new information about the traumatic event reaching new understanding of the traumatic experience and the emotional burden related to it. In the case of sexual abuse, the socially-transmitted myths regarding victim's complicity can be erased

- Reduction of fear

- Trauma-focused technique

- Return to routine, such as school, daily care, sports and organized activities as soon as practical after a disaster

- Adolescents can involve others, who may be isolated and distressed, writing positive comments in social media