

Mental health interventions for people involved in disasters: what not to do

Over recent decades our knowledge about the psychological impact of disasters has increased exponentially. Hand in hand with this increase in understanding has been a dramatic growth in claims of effective intervention techniques and approaches which purport to mitigate the effects of exposure to traumatic events upon mental health.

Furthermore, modern media reporting has made the general public all too aware of the frequency of disasters. Indeed, it is a rare day when we do not hear about a disaster, man-made or natural, somewhere in the world. As such the public frequently expect the authorities or another responsible organization to “do something” to alleviate the distress, and the less frequent cases of mental ill health, which disasters inevitably cause. So what should be done?

As a general principle, we repeat what sadly continues to require frequent repetition. Just as we find it difficult to accept that the idea of a panic prone public is just a myth¹, we also find it difficult to accept that, in general, people are rather more resilient than people like us – experts – think they are. Be it psychiatrists, politicians or planners, there is a long history of overestimating vulnerability and underestimating resilience stretching back many generations².

Towards the end of the last century, it became a commonly held belief that people who had been exposed to disasters or other traumatic events should be provided with psychological debriefing or immediate “trauma counseling”. Critical incident stress debriefing, which was the first of these techniques to be developed in the late 1980s in the US, was a seven stage structured therapeutic intervention originally designed to be used with emergency responders. However, this technique was frequently used with those directly exposed to traumatic events as well. The original intent of this intervention, and indeed other forms of psychological debriefing, was to prevent the onset of post-traumatic stress disorder (PTSD).

However laudable the objective, it became clear that debriefing was a flawed process³. Indeed, available evidence seems to strongly suggest that individuals provided with psychological debriefing approaches actually have poorer long-term mental health than those who are not debriefed at all. Such is the evidence against the use of debriefing that, outside of overly enthusiastic and non-evidence based guideline documents, it is now accepted that such techniques should not be routinely used. Instead, as the UK National Institute for Health and Care Excellence recommend in its PTSD management guidelines⁴, watchful waiting for the first month after exposure to a traumatic event is current best practice.

Another approach which is often used by organizations which routinely deploy staff to high threat environments (e.g., the military, emergency services) is to screen them after they return from such duties. Such screening aims to identify the

presence of the early symptoms and signs of post-traumatic mental health difficulties in order to advise, or even mandate, that individuals who exhibit these signs seek professional help.

Screening programs such as these are routinely used by the US, Canadian and Australian military with the intent of protecting the mental health of troops returning from operational deployments. Such screening programs are not easy or cheap to administer and there is some evidence from other health screening that they may cause considerable distress if people are incorrectly labelled as having a health problem when in fact they do not⁵.

In spite of their widespread use, until recently there was a distinct lack of evidence of their effectiveness. The first randomized controlled trial of post-deployment screening, carried out in the UK military, examined the potential benefits of screening in around 10,000 troops returning back from intense operations in Afghanistan⁶. The results of the trial were that, some 15 months or so after returning from deployment, there was no apparent beneficial impact of screening in terms of either mental health status or help seeking. Whilst no evidence of harm was found in this study, its results call into question the usefulness of establishing such screening programs within organizations where staff members are likely to fear being stigmatized or having limitations placed on their career if they answer questions honestly. Given that many people recover spontaneously, and others do not become unwell for what might be a considerable period of time, the benefits of screening are always going to be much less than in disorders with a well-established trajectory, such as cervical cancer.

Whilst population screening and that within organizational settings has not been found to be effective, selected screening programs for those at high risk has shown promise. In the aftermath of the London bombing of 2005, a “screen and treat program” was set up for those directly affected in the trains and bus that were attacked. This is a very different situation from, for example, well-trained professionals with established social ties returning from deployment where the expected prevalence of disorder is low. Evaluation of this program suggested that it was able to attract many people who had not otherwise sought care, and many of those who were found to need treatment recovered with the care they received⁷.

Although the results of screening programs are mixed and the use of debriefing is to be avoided, recent decades have provided some positive findings in respect of improving mental health after disasters. There is good evidence that social support both within communities and organizations can be highly protective of mental health. For instance, within the military, camaraderie has been shown to be protective of troop's mental health both whilst deployed and when in safer environments⁸.

The social bonds between people have also been found to be protective within community settings⁹ after disasters. More recently, peer support programs have been trialed within organizations in an attempt to ensure that consistent social support is available to trauma-exposed individuals. The most widely researched of these is the Trauma Risk Management program which started in the UK Royal Marines Commandos and has since been adopted by the whole UK military, many UK emergency services and a number of other trauma exposed organizations¹⁰.

Trauma Risk Management has been the subject of a number of research studies which show that it helps to mobilize social support and improve post-traumatic help seeking as well potentially having a positive impact on sickness absence post-disaster in emergency service personnel¹⁰. Whilst certainly not a panacea for dealing with any traumatic incident, there appears to be good evidence that peer support systems such as this program may be of benefit within trauma-exposed organizations.

In summary, over recent decades, science has helped confirm that it is better to rely on supporting the bonds between people within communities and trauma-exposed organizations to mitigate the psychological impact of disasters than it

is to fly in “experts” who neither properly understand those involved or the situation which people have been exposed to.

In the end, we can do well to remember what was learned by previous generations about the immediate versus longer term responses to trauma. The best immediate mental health measures turn out to be practical, whilst our more skilled psychological interventions only really come into their own later on².

Neil Greenberg, Simon Wessely

King's Centre for Military Health Research, King's College London, London, UK

1. Shephard B, Rubin J, Wardman J et al. *J Publ Health Policy* 2006;27:219-45.
2. Jones E, Woolven R, Durodie W et al. *J Soc Hist* 2004;17:463-79.
3. Van Emmerik A, Kamphuis J, Hulsbosch A et al. *Lancet* 2002;360:766-71.
4. National Institute for Health and Care Excellence. *The management of PTSD in adults and children in primary and secondary care*. London: National Institute for Health and Care Excellence, 2005.
5. UK Panel on Breast Cancer Screening. *Lancet* 2012;380:1778-86.
6. Rona R, Burdett H, Khondoker M et al. *Lancet* 2017;389:1410-23.
7. Brewin CR, Fuchkan N, Huntley Z et al. *Psychol Med* 2010;40:2049-57.
8. Jones N, Seddon R, Fear N et al. *Psychiatry* 2012;75:49-59.
9. Jones N, Greenberg N, Wessely S. *Psychiatry* 2008;70:361-5.
10. Whybrow D, Jones N, Greenberg N. *Occup Med* 2015;65:331-6.

DOI:10.1002/wps.20445