Module 11: Interventions for Primary and Secondary Survivors
Psychosocial Impact of Disasters

Distress Response

Behavioral Changes

Psychiatric Illness

(Ursano, 2002)
Classification of Survivors
Survivors are distinguished by:

Proximity to event
Degree of exposure
Degree of personal harm
Role in response and recovery
Primary Survivors

Directly exposed or injured
Secondary Survivors

Family, Friends and Witnesses
Tertiary Survivors

Disaster Responders
Quaternary Survivors
Concerned community members
Principles of Treatment

- Provide a sense of safety
- Opportunities for abreaction
- Reconstruct the individual’s narrative of what happened
- Assess the meaning of the trauma to the child
- Identify inventory of stressors
- Clarify reality
  » Shaw, 2002
Principles of Treatment

- Identify family and social supports
- Always involve family/caretakers in treatment
  - Assess for psychological morbidity
- Identify the child’s definition of the situation
- Identify cognitive distortions
  - Shaw 2002
**Principles of Treatment**

- **Titrated re-exposure to the trauma**
- Assess the impact on development
- Identify themes of guilt, betrayal, revenge, helplessness, excitement
- Assess the defenses against helplessness, rage, guilt etc.
  - Shaw 2002
Principles of Treatment

- Work with changed attitudes toward self, others and the future
  - Loss of cherished beliefs systems
  - Bereavement of childhood innocence
- Assist assimilation and integration of the traumatic experience
- Identify traumatic reminders
  - Shaw 2002
Principles of Treatment

- Provide therapy for full spectrum of psychological morbidity
- Promote and facilitate emergent adaptive and coping capacities
Principles of Treatment

- Facilitate family and social support systems
- Facilitate affect and ideational tolerance
Key Components of Early Intervention
Secure Basic Needs

Provide:
- Safety
- Security
- Food
- Water
- Shelter
Psychological First Aid

Psychological first aid employs

- Psychosocial supports
- Crisis intervention

Psychological First Aid: **Foci of intervention**

- **Arousal:** decrease excitement
- **Behavior:** assist survivors to function effectively in disaster
- **Cognition:** provide reality testing and clear information
Psychological First Aid

- Provides comfort
- Mitigates distress and physiological arousal
- Restores adaptive and coping capacities of child and family
- Attempts to reunite family members and loved ones
- Provide opportunities for communication among family members
- Provides credible information
Psychological First Aid

- Educates survivors about trauma effects
- Identifies resources
- Facilitates
  - Task-focused behaviors
  - Problem-solving techniques
  - Rapid return to routine activities
Role of Helpers

- Be active and direct
- Be calm
- Be firm and interactive
- Listen empathically
- Respect individual beliefs and values
- Assess stressors
- Be non-judgmental
Role of Helpers

- Allow survivor to tell their own story
- Clarify what happened
- Be supportive
- Normalize
- Identify resources
- Refer as needed
When To Refer To A Mental Health Professional

- Unable to meet the ordinary demands of everyday life
- Unable to make decisions
- Disorientation
- Mutism
- Psychological numbness
- Dissociative behaviors
- Seriously regressed
- Suicidal or psychotic behaviors
Psychological Debriefing
Debriefing as an Intervention
Developed in the Military

Developed by SLA Marshall

- Met with group of soldiers
- Participants tell their story of what happened
- Bring together different perceptions, memories, cognition and sequencing of events
- Developed shared narrative and meaning
- Appears to lessen distress
- Integrated with concepts of Proximity, Expectancy and Immediacy
Debriefing

Technical term -

- Specific and active intervention
- Structured process
- Implemented after an exercise or event
- Reviews what happened
- Opportunity for ventilation
- Provides information
- Assessment and triage
- Goal is to learn from the experience
Psychological Debriefing

- The centerpiece of new trauma industry
- Applied to almost any life experience
- Individual and group intervention
- Seen as the “magic bullet” to prevent suffering and chronic debilitation
- Perceived helpfulness does not correlate with outcome
- Perceived unhelpfulness does correlate with bad outcome
Applications of Debriefing

Has been used with:

- Critical incidents
- Traumatic Stressors
- Bereavement
- Separations and dislocations
- Disasters/Terrorism
- Chronic stressors
- Primary, secondary and tertiary victims
CISD

Seven Steps/Phases

1. Introduction
2. Fact phase
3. Thought phase
4. Emotional Reaction Phase
5. Symptom phase
6. Information phase
7. Re-entry phase

Mitchell 1983
Psychological Debriefing

**Negative Dimensions:**

- Individuals may become more aroused
- Pathologizes and medicalizes the response
- Learn maladaptive behaviors
- Disparate individuals pulled into a group exercise without choice
- May tell their story without resolution
- Does not prevent onset of PTSS or PTSD
Psychological Debriefing

- Who should participate?
- Inclusion and exclusion criteria?
- Optimal timing?
- “Single stand alone session” vs. comprehensive anxiety management program?
The Timing of the Debriefing

- Initially recommended at 24-72 hours post-crisis
- Early debriefing may be hazardous:
  - Stress and trauma may still be operative
  - Survivor may be in stage of physiological arousal
  - Aversive learning may take place during this period
The Timing of the Debriefing

- Debriefing should be provided after the arousal phase has subsided
- May be more useful after the child has been reintegrated into the home or school setting
- Focus on psychoeducation/cognitive distortions
Single Episode vs. Multiple Episode Debriefing
<table>
<thead>
<tr>
<th>Study</th>
<th>Outcome</th>
<th>Sample Size</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bordow &amp; Poritt (1979)</td>
<td>Better</td>
<td>70</td>
<td>3 mo.</td>
</tr>
<tr>
<td>Bunn &amp; Clarke (1979)</td>
<td>Better</td>
<td>30</td>
<td>1 mo.</td>
</tr>
<tr>
<td>Stevens &amp; Adshead (1996)</td>
<td>No difference</td>
<td>42</td>
<td>3 mo.</td>
</tr>
<tr>
<td>Conlon (1998)</td>
<td>No difference</td>
<td>40</td>
<td>3 mo.</td>
</tr>
<tr>
<td>Lavender et al</td>
<td>Better</td>
<td>114</td>
<td>3 wk</td>
</tr>
<tr>
<td>Donlon (in press)</td>
<td>No difference</td>
<td>68</td>
<td>6 mo.</td>
</tr>
</tbody>
</table>

Bison et. al. Psychiatric Annuals, 2003
There is little evidence that early single session intervention prevents psychopathology or reduces risk although it is generally well received by participants.

*Bison Psychiatric Annuals, 2003*
## Multiple-Session Psychosocial Intervention

<table>
<thead>
<tr>
<th>Study</th>
<th>Result</th>
<th>Duration</th>
<th>Participants</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bordow &amp; Poritt (1979)</td>
<td>Better</td>
<td>2-10hrs.</td>
<td>70</td>
<td>3 mo.</td>
</tr>
<tr>
<td>Brum et al (1993)</td>
<td>No diff</td>
<td>3-5</td>
<td>151</td>
<td>6 mo</td>
</tr>
<tr>
<td>Andre et al (1997)</td>
<td>Better</td>
<td>1-6</td>
<td>132</td>
<td>6 mo</td>
</tr>
<tr>
<td>Bryant et al (1999)</td>
<td>Better</td>
<td>5</td>
<td>45</td>
<td>6 mo</td>
</tr>
<tr>
<td>Bison (2001)</td>
<td>Better</td>
<td>4</td>
<td>152</td>
<td>13 mo</td>
</tr>
</tbody>
</table>

*Bison 2003, Psychiatric Annuals*
Multiple-Session Early Psychosocial Intervention

The data suggests that multiple session early psychosocial interventions targeting symptomatic individuals commencing post arousal are more effective than single session early interventions.
Debriefing: Helpful Guidelines

- Participants should be clinically assessed
- Debriefing should be part of a comprehensive intervention program—not a stand-alone intervention
- Debriefing should be provided after the arousal phase has subsided
Debriefing: Helpful Guidelines

- Leaders should be experienced
- Group format is appropriate—should not be used as an individual intervention
- Debriefing should be voluntary
Individual Treatment Approaches
Individual Treatment Strategies

- Anxiety management
- Cognitive therapy
- Exposure therapy
- Psychoeducational therapy
- Psychodynamic therapy
- Play therapy

J. Clin. Psych. 1999 (supp) 16
Anxiety Management Techniques

Reduce anxiety/arousal

- Breathing retraining
- Muscle relaxation
- Guided imagery
- Meditation
Cognitive-Behavioral Therapies

- Psychoeducation
- Cognitive triangle
- Identity cognitive distortions
- Challenge cognitive distortions
  - Overly generalized beliefs
- Cognitive restructuring
- Develop realistic thinking
Exposure Therapies

- Development of an anxiety hierarchy
- Titrated confrontation of the traumatic stimuli
- Exposure may include reliving memories, repeating written narratives of the trauma, or introduction of traumatic scenery
- May include psychoeducational or relaxation technique training
Psychodynamic Approaches

- Focuses on the meaning of the trauma
- Resonance of the trauma experience with childhood experiences
- Relationship to internal conflict, defense constellation, and character structure
- Trauma is associated with the loss of cherished, narcissistic beliefs
- Integration of the meaning of the traumatic experience into one’s pre-traumatic view of the world
Psychopharmacology for Children and Adolescents with Traumatic Stress Reactions
Psychopharmacological Interventions for Children

- Adjunctive therapy with psychosocial interventions
- Adult studies are guidelines
- Children’s metabolism and drug response is different from adults
- Treat
  - Specific target symptoms
  - Comorbidity
  - Specific phase of disorder
Psychopharmacological Interventions

Treatment for PTSD
FDA approved: Sertraline and Paroxetine
Paroxetine not used <18 years

Limited efficacy:
- Monoamine oxidase inhibitors (MAOI’s)
- Tricyclic antidepressants (TCAs)
- Venlafaxine
- Propranolol
- Anti-adrenergics (clonidine & guanfacine)
- Benzodiazepines
- Mood stabilizers
- Atypical neuroleptics
Psychopharmacology of Children and Adolescents with PTSD

Single case and open trials

- Alpha-2-agonists
- Anxiolytics
- Propranolol
- Tricyclics
- Mood Stabilizers
- Atypical Neuroleptics
- Venlafaxine (questionable)
- SSRI’s
  - Sertraline and Citalopram efficacious
Benzodiazepines

- Reduce distress
- Promote sleep
- The early use of benzodiazepines did not alter the course of the psychological response to trauma

The Expert Consensus Guideline Series: PTSD

Treatment: Sleep Disturbances

- Trazodone
- Zolpidem
- Benadryl
- Tricyclics
- Benzodiazepine

*J. Clin. Psych. (Supp.) 16*
The Expert Consensus Guideline Series: PTSD

Treatment Strategies

When there is comorbid mood disorder, bipolar disorder, or substance abuse with PTSD begin with combination of psychotherapy and medications

*J. Clin. Psych. 1999 (supp) 16*