PSYCHOSOCIAL ISSUES IN EMERGENCIES: IMPLICATIONS FOR NURSING

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Abstract. Nurses are a significant component of the emergency responder workforce and are ideally placed to respond to the complex range of psychosocial issues associated with emergencies. A population health perspective provides a framework to inform individual, family and community interventions in preparedness, response and recovery phases. It is essential that nurses understand the normal emotional reactions to emergencies and support recovery through evidence based strategies for individual, families and communities. While many people will experience emotional distress after an emergency, only a small proportion will develop a mental health problem. Interventions should focus on ensuring people are safe, active listening, promoting social connectedness, empowerment and creating hope for the future. Vulnerable populations such as children and young people and people with existing serious mental health problems require specific consideration. It is also essential that there is support for the psychosocial needs of nurses who are affected by emergencies either directly as members of the affected community and/or indirectly through their exposure to the trauma of others.

INTRODUCTION

In many countries, nurses are a significant component of emergency responders and frequently remain within that community long after the initial response, supporting the long term recovery of individuals, families and communities. The emerging evidence of the psychosocial impact of emergencies highlights the importance of ensuring that nurses are adequately prepared to respond to these challenges (The term "psychosocial" is used throughout this paper to reflect the complex interactions between psychological and social factors that impact on the mental health of individuals, families and communities).

The psychosocial impacts of emergencies are varied. While the majority of the population will recover with no adverse mental health effects, the World Health Organization estimates that twelve months after an emergency there is an increased prevalence of severe mental health problems from 2-3% to 3-4%, and an increase in moderate mental disorders from 10% to 20% (Van Ommeron *et al*, 2005). Emergencies disrupt the lives of individuals, their families and the social structures in which they live. They are often associated with multiple deaths and injuries. Families may be separated, schools and workplaces may be closed, and religious obligations may become difficult to fulfill. This disruption further contributes

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to the emotional distress of people and increases the risk that a mental health problem will develop. The greater the exposure to a traumatic event, the person experiences, the higher the likelihood that their mental health will be adversely affected (Fullerton and Ursano, 2005; McFarlane and Van Hooff, 2009).

This paper aims to outline the critical role that nurses play in the psychosocial preparedness, response, and recovery. It also explores the psychosocial consequences for nurses themselves who work in emergency situations.

POPULATION HEALTH PERSPECTIVE

A population health perspective should inform the nurses' psychosocial response to the emergency. Mental health is influenced by socioeconomic and environmental factors such as poverty, discrimination, exposure to violence, quality of housing and access to productive occupation (WHO, 2001). For example, stressful life events and poor physical health are both risk factors for mental disorders and more likely to experienced by people who are poor (Miranda and Patel, 2005).

The Inter Agency Standing Committee Task Force on Mental Health and Psychosocial Issues in Emergencies has identified five principles that should be used to inform the nursing response during an emergency (IASC, 2007):

- Human rights promotion and protection;
- Participation of affected communities;
- Multisector services;
- Do no harm;
- Integration of mental health and primary care.

A population health perspective also emphasizes the promotion of mental health as well as the importance of supporting people who develop mental health problems. Interventions should be implemented at both the individual, family and community level. Psychosocial recovery is supported by ensuring access to basic needs such as food, water, shelter and information. Community and family support is critical to rebuilding the disruption to social bonds that is associated with emergencies. Individualized psychological supports such as counseling and mental health support will only be needed by a proportion of the community. This intervention pyramid is illustrated in the following diagram (Fig 1).

This perspective also ensures a long term focus on recovery. While a lot of assistance may be provided during the acute phase of the emergency, it is long term interventions that will have the greatest impact on the mental health of individuals and the community. For example, individual and community responses to trauma vary over time. People will require ongoing information about normal reactions to trauma. Emotional distress may be heightened at other times, such as anniversaries or key events. Previously happy events, such as the birth of a baby, may cause emotional distress. Providing information about the range of normal reactions to emergencies, and how they can change over time is important.

PREPAREDNESS

Preparation is crucial to ensuring an effective psychosocial response following an emergency (International Council of Nurses, 2001). When communities are well prepared, they are better able to respond to and recover from an emergency (Peek and Mileti, 2002). The provision of psychosocial services during an emergency may be very

Table 1
Common emotional responses to an emergency.

Sleep disturbances and nightmares
Jumpiness – easily startled
Hyper-vigilance – scanning for danger
Crying, sadness and grief
Increased conflict with family, friends, neighbors
Shock, disbelief
Anxiety, fear, worry about safety
Numbness
Powerlessness and vulnerability
Disassociation (disconnected, dream-like)
Anger, rage, desire for revenge
Physical symptoms such as fatigue, headaches, nausea
Poor concentration and memory problems
Impaired thinking and decision making

Source: US Department of Health and Human Services, 2004.

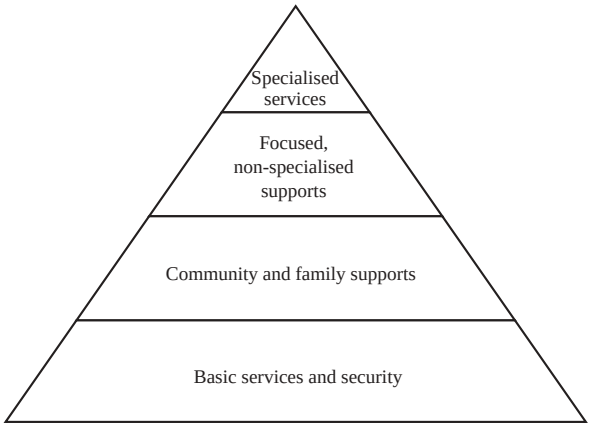

Fig 1–Intervention pyramid for mental hand psychosocial support in emergencies (Source: IASC, 2007).

different from the services provided before the emergency. A larger number of people may require or request assistance, or existing services may have been damaged or destroyed. Critical infrastructure, such as rooms for community meetings may not be available. Service delivery needs to be flexible, innovative, and mobile adapting to the environment or conditions.

As part of the healthcare team, nurses are in a unique position to provide psychosocial support and promote recovery from the effects of an emergency. Basic nursing courses and continuing education programs should enable nurses to work in emergencies, and include consideration of psychosocial issues. Information about the health system, such as the location and number of patients in psychiatric hospitals, the number of patients treated in the community, and the availability of nurses, particularly those who can be deployed should be readily available. Particular attention should be given to developing contingency plans within healthcare institutions.

NORMAL EMOTIONAL RESPONSES TO EMERGENCIES

Most of the severe emotional responses experienced by people after an emergency are normal, and will gradually reduce over

time with no formal interventions. In the immediate aftermath of the bushfires, people will feel numb, disorientated and confused. They will often have difficulty with concentration, problem solving, planning and anticipating future needs (Gordon, 2009). Relationships may be strained as people try to manage their own reactions.

Over the weeks and months following the emergency people experience a wide range of intense emotions such as grief, fear, sadness, anger or uncertainty (Gordon, 2009). There may be strong feelings of altruism, with people wanting to help friends and neighbors. People will experience intense changing emotions, often feeling overloaded and distressed for many months. Families may experience conflicts or disagreements as people manage their different emotions.

Recovery from the trauma associated with an emergency is not linear and it can take years to work through the grief and distress. Typically, there is a sense of cohesion and a 'honeymoon' in the initial period with people seemingly working together well. Over time, disillusionment, mistrust, and conflict are more common, and false rumors can circulate quickly. There may be a focus on accountability or blaming someone for the event and scapegoating may occur. There will be many milestones throughout that provide challenges or opportunities. Anniversaries will often bring renewed feelings of loss and grief (Ursano *et al*, 2007). It is important to remember that recovery is not the return to the previous state, but a new beginning.

For most people, fear, anxiety, re-experiencing the trauma, avoidance of situations associated with the trauma, and hyperarousal symptoms, decrease gradually over time (Foa, 2002). While these responses generally relate to events that have already happened (*ie*, recent trauma), many people in emergency situations will have extreme fear of the future such as experiencing another emergency, providing for their family, having the resources to pay school fees, etc. These responses can last for many months, often fluctuating in severity. Table 1 summarizes some of the common emotional reactions to an emergency.

Many individuals who have experienced an emergency display some signs of psychological distress. However, a recent Cochrane review of 11 studies concluded that there is no evidence to support routine psychological interventions for all people affected by an emergency (Roberts *et al*, 2009). Emotional distress is normal after an emergency and it is neither appropriate nor effective to implement formal intervention strategies during the immediate post-impact phase of a disaster.

Five evidence supported intervention principles have been identified that should be used to guide any nursing interventions (Hobfoll *et al*, 2007). These principles form the basis of Psychological First Aid and aims to reduce the acute stress reactions of people in the immediate aftermath of the emergency and help them focus on meeting their basic needs (National Institute of Mental Health, 2002). Key strategies of Psychological First Aid (US Department of Health and Human Services, 2005) are:

Safety: Helping people meet basic needs for food and shelter; obtaining emergency medical attention, where necessary, and protecting them from further harm;

Calm: Listening to people who want to share their stories and emotions; being friendly and compassionate, even with individuals who may be difficult; and offering accurate information about the emergency and relief efforts underway;

Connectedness to others: Helping people contact friends/loved ones and reuniting and

keeping families together, where possible;

Self efficacy/empowerment: Providing practical suggestions that guide people towards helping themselves and being able to meet their own needs; and

Hope: Determining the types and locations of government and non-government services and directing people to available services; and informing them if further help and services are on the way when they express fear and worry.

COMMON MENTAL HEALTH PROBLEMS AFTER AN EMERGENCY

Depression

While many people may describe feeling low, sad or even miserable after an emergency, clinical or major depression can be distinguished from minor forms by the quality and severity of the symptoms and the associated decline in social and occupational functioning (Barton *et al*, 2007). Emotional and behavioral symptoms include sadness, misery, loss of interest in usual activities, feelings of guilt, tiredness, fatigue, aches and pains, hopelessness, difficulty making decisions, low self-esteem, suicidal thoughts, disturbed sleep, and changes in appetite. In severe cases, the person might experience hallucinations or delusions.

While many people have emotional symptoms following a disaster, a small number develop a serious problem that affects their ability to cope or disrupts their relationships with family or friends. Acute stress disorder (ASD) is a transient response to trauma and begins during or shortly after the disaster. Symptoms of an acute stress disorder include an initial dazed state followed by agitation, emotional numbing, acute anxiety, amnesia, intrusive memories and a hyperarousal state (Barton *et al*, 2007). The disturbance lasts between 2 days and 4 weeks, with the symptoms resolving for the majority of people with no intervention. However, for a small number of people, symptoms persist and are associated with significant impairment and distress resulting in a diagnosis of post-traumatic stress disorder (PTSD).

PTSD

Symptoms of PTSD may present following ASD, or be delayed with no apparent stress symptoms at the time of the disaster. The core symptoms of PTSD include re-experiencing the traumatic event through dreams or flashbacks, avoidance of situations, activities or stimuli that remind the person of the traumatic event, loss of interest in usual activities, restrictions in the normal range of emotions, and a hyperarousal state such as insomnia, hypervigilance, poor concentration or irritability. PTSD symptoms can persist for many years (Baton *et al*, 2007).

Psychological debriefing is a brief crisis intervention usually administered within days of the disaster to individuals (McNally, 2004). The routine use of psychological debriefing is not recommended in emergencies (Litz *et al*, 2002) as there is limited evidence that it has any impact on PTSD, and some evidence that a small proportion of people are worse, in the long term (Rose *et al*, 2002).

Grief

Grief is highly individual and can vary across cultures; there is no right or wrong way to grieve. Bereavement following a emergency can be more complex, particularly if there is a disruption to the usual rituals of grief such as burial or support structures. The majority of people recover naturally from grief with no intervention. People who are bereaved are in pain, and they may cry easily or feel distressed. They may be angry, and, indeed, that anger may be projected towards the emergency responders who are trying to assist the community. As

a consequence, nurses working in emergencies may be exposed to criticism, abuse and even violence.

Following an emergency, some people may increase their use of alcohol and other drugs. This is particularly likely in communities with easy access to alcohol and other drugs. Specific symptoms will depend on the type and quantity of the substance that the person is using. It is important that nurses are aware of the type of substances (both legal and illegal) that may be used by people in their community and routinely ask people about substances they are using.

The specific nursing interventions will depend on the specific needs of the individual, but the following general suggestions will support psychosocial recovery (Australian Centre for Posttraumatic Mental Health, 2009):

- Gather information to prioritize interventions, with a focus on meeting basic needs;
- Support people to solve their problems;
- Promote positive activities;
- Help people manage their distressing emotions;
- Promote hopeful thinking; and
- Help people rebuild their social connections.

PRE-EXISTING SEVERE MENTAL DISORDERS

People with severe mental disorders, particularly those living in custodial settings, are particularly vulnerable during an emergency. Living in custodial environments isolates people from the protection of families and communities, and they may be abandoned or left unprotected by staff in the aftermath of an emergency. Responses should focus on the protection of vulnerable people and the re-establishment of basic care including the provision of clothing, food, shelter, access to physical treatments and continuity of psychiatric treatment (including medication and psychosocial support).

Post the emergency it may be possible to close some psychiatric hospitals and develop community care consistent with WHO (2001) recommendations. Many psychiatric hospitals have been associated with widespread human rights abuses, often consume a high proportion of the mental health budget leaving few resources for other services, and isolate people with mental disorders from their communities (WHO, 2003). In sum, large, stand-alone, psychiatric hospitals are ineffective, inefficient and often abusive. Emergencies can provide the opportunity to close such psychiatric institutions and to develop community models of care.

MENTAL HEALTH NEEDS OF CHILDREN AND YOUNG PEOPLE

Children and young people who have experienced an emergency or disaster situation initially display symptoms of psychological distress. The nature of impact on the child or young person will depend on their developmental stage (McDermott and Palmer, 2002) as well as the level of exposure to trauma. However, most will recover once their basic survival needs are met, safety and security are returned, and developmental opportunities within the social, family and community context are restored. Children and young people are particularly vulnerable to the trauma associated with emergencies (Pynoos *et al*, 2007) and may remain vulnerable to mental health problems even into adulthood (McFarlane and Van Hooff, 2009).

Interventions should be age appropriate and focus on practical problem-solving and coping with the stresses after the emergency. Helping to restore family functioning

and normal routines, including providing parenting support to primary caregivers is also important. Opportunities to promote constructive activities, particularly with peers is also useful (Pynoos *et al*, 2007).

IMPACT OF EMERGENCIES ON NURSES

While nurses generally focus on their caring roles, it is important to note that they may be impacted through personal loss, exposure to the trauma of others, the disruption of the healthcare system, or social and political instability. For example, the devastating effects of witnessing the impact of the emergency on others (*eg*, observing the burial of people in mass graves, the inability to meet the health needs of large numbers of injured people, witnessing the death of children) may have a negative effect on the mental health of the nurse. The healthcare system may be affected, resulting in loss of employment, disruption to training programs, deterioration in work environments, and reduction in staff as well as professional standards. Internal displacement can result in overstaffing in secure areas and desertion in insecure areas (Paganini, 2003).

It is important that nurses understand not only the common symptoms of stress, but are able to use simple strategies to reduce its negative impacts such as (Hyogo University, 2005):

- Do not try and do too much,
- Work with others,
- Talk about your experience,
- Acknowledge your achievements,
- Take regular breaks,
- Look after your physical health,
- Stay in contact with your family, and
- See a counselor.

It is crucial to consider the work environment after an emergency, and ensure that it is a safe and healthy workplace. For example, shifts should not be excessive in length and the tasks should be a mixture of high stress and low stress. It is essential that there are sufficient breaks both within and between shifts to ensure time for adequate nutrition and rest. Communication is critical, and regular staff meetings should be conducted. The team approach to relief work is necessary to avoid emphasis on an individual's responsibility or role in rescue operations.

Providing nurses and other healthcare workers returning to work after a disaster with support will increase the available human resources, reduce reliance on external health professionals who have responded to the disaster, and aid recovery of the local community. It is essential that the basic needs of nurses (and their families) be met before they return to work. Unless people have a safe place to live, food to eat and have their emergency health needs met, they will not be able to return to work. As many health workers are women, issues of childcare may emerge, particularly if there is social dislocation and people do not have their usual support structures. Nurses will not be able to return to work unless their children (and other dependents) are able to be cared for safely.

CONCLUSION

Nurses are an essential part of the preparedness, response and recovery of emergencies. They are ideally placed to integrate psychosocial perspectives across the spectrum of nursing activity to support the emotional recovery of communities.

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