Mental Health Response to the Immediate Impact of a Community Disaster: Common Challenges in Emergency Shelters

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Please note that the featured article is not the verbatim transcription of the author's presentation at the SDPA Conference on "Preparing for the Unthinkable: Mental Health Provider Roles in Disaster Recovery." The transcription has been edited for content, length, copy, and grammar for the purposes of this publication.

Dr. Lipson has been involved with disaster response deployment via the Red Cross in San Diego for a number of years. He discussed his extensive experience with local Red Cross Disaster shelters, which tend to be the primary sites of psychological first aid.

The work of a mental health provider in such settings is challenging; the work conditions are often harsh, uncomfortable for all, and focus on general, basic needs, rather than preferences or individual needs. Survivors in shelters may be wet, dirty, hungry, thirsty, and sleep deprived. The most basic comforts, such as being able to take a shower or maintain cleanliness are a challenge. Meeting these, however, may make a huge difference to the survivors. Simple acts of kindness that let people know that they are being helped by good people they can depend on are vital to the recovery process. A major initial focus for many survivors is to try to assemble a coherent narrative of what happened, which requires filing in information gaps and understanding the sequence of events. Very often, responders and volunteers don't yet have this information either, which can provoke a lot of frustration among survivors.

One of the biggest (and often unexpected) challenges is coping with and helping survivors cope with a high level of anger directed toward the first and second responders. This is especially true when the disaster is "manmade" rather than a natural disaster. Many mental health providers do not have experience dealing with such high levels of anger. The extreme situation can stir up complex issues that cannot be easily or quickly handled. Dr. Lipson stressed how important it can be to acknowledge that as a mental health provider, he may not have the information the survivors are seeking about the situation or the immediate solution for their needs. Mental health providers are often not briefed in the acute phase, so that first responders can focus on those directly in harm's way. Dr. Lipson reminds us that letting survivors know proactively that those on scene don't have

this information, and explaining the complexity of the situation may help mitigate anger directed at second responders.

Given the high levels of confusion and uncertainty, survivors are often looking to place blame for the incident or lack of adequate/immediate resolution, which can lead to further challenges. Certain sub-groups (e.g., immigrants, Muslims) may be scapegoated as "causing" the disaster, which can then fester over the years among individuals and across communities. When an individual becomes stuck in the anger, he or she cannot move forward through recovery. Dr. Lipson referred to the work of the Buddhist monk, Thích Nhất Hạnh, in which he counseled the application of mindfulness, acceptance, and mindful processing of anger to generate calm. The reality at hand can then be investigated and good decisions made to respond effectively to the current situation. Personal or sub-group blame must be shifted to "situational" blame to promote healthy recovery.

This kind of emergency shelter work can be very meaningful and gratifying for the provider, albeit unpredictable and sometimes intense. For mental health providers, fostering compassion and promoting self-soothing, while appreciating that past trauma may be activated, is helpful.

Dr. Lipson shared the helpful acronym, *HEAL*, which stands for **H**ear (listen, validate), **E**ngage (be present in the moment), **A**ccept (no platitudes, sorrow, anger is ok), and **L**augh.

Many absurd and ridiculous situations arise in shelters, so imparting and encouraging humor and laughter can help ease tensions. Simple kindnesses and comforts, including listening to music or using art to express one's losses can also be helpful coping strategies. Dr. Lipson recounted one of his experiences working in a shelter, wherein the environment became soothing with the arrival of a musical group and the resulting respite felt by the survivors.

Dr. Lipson recommends taking courses on Psychological First Aid to gain the specific skills useful in supporting recent disaster victims. One example of a good reference for this protocol can be found in the *Field Operations Guide* developed by the VA. https://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp

There are several apps that one can download on their mobile device that can help with psychological first aid (list compiled by Wendy Tayer, Ph.D.). The following are a few examples:

1. Virtual Hope Box
2. Stress Less Cards
3. Breathe 2 Relax
4. Insight Timer
5. Help Kids Cope by the National Child Traumatic Stress Network
6. Psychological First Aid (PFA Mobile)

Extreme circumstances and traumatic loss often compel application of a spiritual perspective. Dr. Robert Jay Lifton, a psychiatrist famous for his research on the psychological causes and effects of war and political violence has coined the term, "death imprint," to describe the phenomenon of coming so close to near-fatality that the experience leaves a deep mark on the psyche. The "death imprint" may affect not only direct victims of the disaster, but also their loved ones, and the first and second responders involved in recovery. Personal meaning may vary, but there is a general sense of a changed sense of self and relationships with self and other. Grief may be a big part of this shift, since loved ones, homes, pets, and essential personal items may have been lost. Through kindness and the creation of a safe "holding environment" in which to process the event, a person must come to terms with why they experienced the traumatizing event via cognitive, emotional, and sometimes spiritual processes.

Consider, for example, a carpenter, who has lost his tools that enable him to work, ones which took a lifetime to accumulate and are not fully replaceable. The meaning of these lost tools is not just "stuff"; the impact of any loss is unique to each individual, depending on the significance, and should not be prejudged by the mental health provider involved in the recovery process. Values clarification, resulting in a change of priorities, may be a part of the "post traumatic growth" after a disaster; this process benefits the survivor over time, and can help him or her become stronger and more resilient than they were before the event.

Vicarious trauma is a real risk for secondary responders in disaster recovery, given their exposure to people's raw anger, shock, fear, and horror, as they are encountered in shelters and on scene, further amplified by the survivors' repeated recounting of their stories as they process their experiences. This risk may be further exacerbated by sleep deprivation in both survivors and responders. If responders do not process their own disaster-related trauma, they are at risk for a delayed post-traumatic emotional response and maladaptive coping behaviors such as substance use as a form of self-medication. Dr. Lipson led the audience through a guided imagery exercise, of victims in a shelter imagining gentle rain washing away the imprint of their trauma, i.e., the sights, sounds, smells, loss. This can also be a soothing self-care activity for providers, and can be shared with other survivors.

Overall, disaster recovery work is not for the faint of heart, but can be very rewarding and meaningful. Each mental health provider has to determine his or her comfort level with traumatic exposure, assess their own recent emotional challenges, consider their own health and hardiness, the time they have to devote, and whether they can manage being away from family, pets, work, and clients, both on short notice and for varying lengths of time. It is imperative that clients of mental health providers who expect to deploy from time to time in local or national disasters be advised in their informed consent that their regular therapy may be interrupted on short notice should their providers be summoned in the wake of a disaster. As difficult as it is, the rewards of being able to make a positive impact after a disaster, and to use one's professional skills and expertise to make a significant difference in a survivor's outcome are incredibly gratifying.