

Commentary on “Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence”
by Hobfoll, Watson et al.

**Mass Trauma Intervention:
A Case for Integrating Principles of Behavioral
Health with Intervention to Restore Physical
Safety, Order, and Infrastructure**

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The paper by Hobfoll and colleagues should be read by anyone who has wondered what can be done to support and sustain survivors of mass trauma and especially by anyone concerned with improving actions in the future to promote the well-being of those experiencing such events.

Lessons learned in recent years make it clear that there are needs and opportunities for public mental health and clinical care in the immediate and mid-term periods after emergencies. At the most basic level, the public will need credible and clear information about getting and staying safe as well as the continuum of services that are available to them. There will also be acute needs related to interrupted care for chronic conditions and emerging stress-related problems.

Hobfoll and colleagues have identified elements of public health and clinical care that can bolster efforts to provide for basic necessities as well as to facilitate recovery from mass trauma. Unlike other well-intentioned efforts to offer guidance, points to con-

sider, and even principles of planning and response which have lacked a solid foundation or rationale, Hobfoll and colleagues have compiled a set of guiding principles which are theoretically and empirically defensible and translatable into practical steps for providers, administrators, and policymakers.

While there is growing appreciation for the idea that the public health, including behavioral health, consequences of mass trauma events may outlast, indeed outweigh in overall cost, the physical infrastructure damage of such events, there is little evidence of effort to integrate concepts or social, psychological, and behavioral recovery into disaster and mass trauma recovery planning. Failure to address behavioral health and mental illness (pre-existing and new) in our planning means overlooking a critical element of community and individual recovery with long-term implications.

The mental health community of direct health care providers, researchers, administrators, and policymakers has in recent years

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debated the wisdom, indeed safety, of “mental health” intervention after mass trauma. Noting that resilience is the norm in terms of the human response to stress and adversity, there have been calls for mental health providers to stay back and let natural healing take place. Simultaneously, there are compelling perspectives calling for behavioral health care providers to be informing public health campaigns and recovery efforts and to be on the ground and available to tend to those with pre-existing needs and those with new concerns. Of course, neither perspective is absolutely right or wrong; there exists credible and valuable evidence that certain types of early mental health interventions are at best ineffective and potentially counterproductive in facilitating adjustment and evidence that those with pre-existing mental and behavioral disorders as well as those with trauma-related concerns are in need of and will benefit from additional assistance. From a public policy perspective, it can be challenging to discern the “right” way forward in preparing and deploying a response. What is clear is that many of the response agents and mechanisms in place today can benefit from guidance offered by experts in the study and treatment of those exposed to disaster and mass violence. Such guidance has the benefit of drawing on diverse knowledge and experience to cull from the available evidence what are safe and helpful strategies.

Most promising is the position taken by Hobfoll and colleagues presented in this issue—recognizing that a fundamental aspect of resilience is its link to empathy, sympathy, and a desire to help. Recognizing this is vital, as there will certainly always be a response to emergency events by individual health care providers and public health systems. Behavioral health should be represented and focused. Specifically, as the authors point out, there is a clear relationship between actions taken by authorities in preparation for and in response to mass trauma that on the surface appear to have little to do with behavior and health but, in fact, can have profound implications for the mental well-being and health-related behavior of the population.

In their paper, the authors first define

and then operationalize the following principles to demonstrate their relevance and utility.

- Promote sense of safety
- Promote calming
- Promote sense of self- and collective efficacy
- Promote connectedness
- Promote hope

As noted above, of particular value to policy and emergency response planners and authorities, the authors define the principles, discuss the theoretical and empirical foundations for their relevance, and then provide examples of how response/intervention in multiple arenas can benefit from aligning with the principles offered. For example,

- *Promote a sense of safety*—by minimizing gatherings, discussions, and events that serve only to share rumors and horror stories about the event or that provide unbalanced information and exaggerate potential additional stressors/threats.
- *Promote calming*—by disseminating information about normal reactions to trauma, making self-help and assisted programs available to teach skills for: problem solving and for recognizing/validating and normalizing stress responses; avoiding expectations and situations that require people to rehash their ordeal immediately after an event; and making information about obtaining material resources available.
- *Promote sense of self- and collective efficacy*—by creating opportunities to regain prior roles (in family, work, community) and resources to accomplish this (e.g., points of entry for housing assistance, lists of job openings, public transportation, basic materials to help restore a valued community institution).
- *Promote connectedness*—by making it possible for loved ones to locate one another and communicate as soon as possible. If make-shift communities of displaced persons are created, create meaningful roles for people that will promote interaction, taking steps to identify and assist those who lack support (near or far) and are likely to be so-

cially isolated before, for example, they are the last ones remaining in temporary shelters.

- *Promote hope*—by making services to help people get their lives back in place a highly visible priority (housing, employment, relocation, replacement of essential household items). Create places and processes for volunteer advocates to aid survivors in working through the red tape involved in obtaining services and benefits available to them.

The authors also provide a useful discussion of available evidence on individual and group therapeutic approaches in the immediate and mid-term periods after mass trauma. This discussion adds clarity to the difficult process of deciding the time and place for interventions, including evidence-based treatments, suitable for those who develop more severe stress reactions and the general population of exposed individuals.

Perhaps of most practical value to emergency preparedness and response leadership and policy makers, Hobfoll and colleagues have prepared a tabular summary, worthy of pocket-card lamination and wide dissemination, identifying actions (recommended and NOT recommended) at the public health and individual/group level for promoting their principles of immediate and mid-term mass trauma intervention.

Regardless of where one stands on the sometimes contentious issue of formally intervening in the early stages to minimize psychological adjustment concerns, the authors present ideas and data that make clear the potential influence of recovery efforts at multiple levels on individual and group beliefs, thoughts, and behaviors. Behavioral health

and recovery cannot be seen as solely the purview of the “mental health” community. The authors present a compelling case demonstrating how providing for physical safety, restoring order, rebuilding infrastructure and reclaiming lives can and should be done in harmony with promoting individual and community psychosocial well-being and without neglecting those for whom mental health treatment is necessary.

Finally, the authors observe that “no evidence-based consensus has been reached supporting a clear set of recommendations for intervention during the immediate and the mid-term post mass trauma phases.” It is worth noting that despite a literature on disaster and mass trauma that is fraught with scientific limitations and somewhat redundant reports, the field of investigators interested in such issues has grown in recent years, encompassing multiple disciplines and interdisciplinary teams and approaches. As advances in research methods, tools, and technologies have improved and as awareness that rational decision making about the deployment of limited resources must be based on evidence, it is becoming increasingly clear that well-conceived studies involving representative samples of impacted communities and populations are possible/needed and that such efforts will set the stage for systematically examining the impact of implementing concepts and approaches such as those advanced here. In the interim, Hobfoll and colleagues argue convincingly that what we do tomorrow can be improved by what we know today.

Points of view expressed are those of the author and do not necessarily reflect those of the National Institute of Mental Health, the National Institutes of Health, or the U.S. Department of Health and Human Services.