

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

The March Toward Evidence Based Criteria for Mass Trauma Intervention

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“Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention” is a landmark paper which will turn the page on how psychosocial intervention after mass trauma is viewed henceforth. This comprehensive synthesis of the modern literature done by 20 outstanding experts from 5 different countries will set the bar for the delivery of evidence-based psychosocial care as well as for a new generation of outcome research in this emerging field.

It is not that our profession has been absent from the table when it came to participating in the mental health care of people involved in individual or mass trauma; to the contrary, psychiatrists and our colleagues have applied state of the art thinking to mass trauma for at least 60 years, as illustrated by Lindemann’s insight into the management of grief from the Boston Grove fire (Lindemann 1944) with roots that go back to Freud and beyond (Freud, 1920). The military provided experience in this area to a generation of psychiatrists entering practice as well as setting up our academic departments after World War II. A philosophy of sending soldiers back to duty quickly evolved as did sophisticated

techniques at the time of hypnosis and sodium amytal interviews as a form of treatment (Ripley & Wolf, 1947). Many therapists had training in psychoanalytic/psychodynamic therapy and their ability to understand psychological defenses greatly influenced the treatment approaches to patients presenting after trauma (Menninger & Nemiah, 2000)). The contribution of civilian psychiatrists coming from many areas of psychiatry, including consultation/liaison psychiatry programs, utilized a combination of many of these techniques as well as the latest pharmacology to treat PTSD. For many years, a technique devised by a firefighter paramedic who became a psychologist greatly influenced the delivery of care to groups who experienced trauma. That was the Critical Incident Stress Debriefing (CISD) devised by Jeffrey Mitchell which was initially used widely by fire departments throughout the world (Mitchell, 1983). This approach relied on reliving and discussing traumatic experiences in a group setting with the assistance of a trained leader.

It has to be appreciated that the overwhelming majority of therapists who became

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involved in the delivery of care following a disaster were usually quite skilled and unquestionably dedicated. They often volunteered extra time to deliver care. These individuals were psychiatrists and other mental health professionals who were mobilized into action because their community suddenly faced an unanticipated disaster. After this initial baptism under fire, many of them developed skills and experience which they wanted to pass on to others so they could meet unanticipated disaster in their community. The American Psychiatric Association (APA) put together a task force initially chaired by Dr. Robert Ursano, which eventually became a standing committee that would meet regularly. It provided educational programs at the annual APA meeting and developed the red caduceus on the APA website which put together important "how to do" papers as well as a very useful handbook for disaster psychiatry (<http://www.psych.org/disasterpsych/>). This material has been called upon by psychiatrists and others at times of disaster and has been translated into various languages. In more recent years, a network of representatives from each district branch of the American Psychiatric Association was formed which was fortified by a network from the Assembly of the APA. Psychiatrists who had experience in weather disasters, plane crashes, military situations, major fires, earthquakes, and so forth, exchanged ideas and reported their experiences in the emerging literature. The National Institute of Mental Health (NIMH) and other sources began to sponsor disaster research. A credible body of research became available and was now more readily accessible with the use of computer technology (Norris et al., 2002). It was also became established that there was no evidence to suggest that Critical Incident Stress Debriefing prevents long-term negative outcomes, and questions were raised about possible long-term negative outcomes from using this approach (Bisson, 2003).

At the time of 9/11 in New York, there was a sudden dramatic perceived need for psychological support from families, schools, corporations, emergency services, and even the working press who were reporting the

event and were traumatized along with everyone else (Simeon D et al., 2003). There was an abundance of mental health volunteers, along with the organized systems of the Red Cross, Disaster Outreach, and of course the Departments of Psychiatry of the major hospitals and medical schools located in New York. However, there was no *one* defined plan or set of principles for acute psychiatric intervention. At the Family Center Pier where mostly relatives and friends of victims were received and assisted, mental health workers intermingled with the Red Cross and social workers providing for the immediate needs of those who were in the earliest stages of acute grief. In other locations, individual mental health professionals found themselves called in to work with groups that wanted someone to help them deal with their overwhelming feelings. Examples were companies where workers had been lost, fire stations which were devastated by the death of many of their comrades, communities where commuters didn't come home, or a TV network staff that was overwhelmed by reporting the continued stories of death, fear, and loss. Many therapists used variations of CISD and Cognitive Behavioral Therapy (CBTS) (with attempts at cognitive restructuring) in a group setting with basic supportive discussions that would later come to be understood as part of psychological first aid. Most mental health professionals working in these settings did not have formal training in application of techniques following mass trauma; in fact, there had not yet been a clear consensus what should be the best techniques in this situation. September 11th became a rallying point for new research and funding as well as a critical review of past literature. The 20 authors of the paper are some the world's leading scientists in this area, and they participated in the explosion of studies and papers that have looked at the problems and possible solutions involved in the psychosocial approach to mass trauma. Numerous journals featured special sections and updates on various aspects of this subject. These are too numerous to site here and are amply covered in the major article discussed in this journal. There also have been many presentations on

this subject at our leading annual meetings, medical school grand rounds, and special educational meetings, including those on the Internet. One such meeting was a conference at New York Medical College in June 2006 on the topic, Psychological Intervention Following Mass Trauma. On the second day of the meeting, the 10 participants (many of whom are authors of the current paper) met in a private session and came up with a white paper called "Strategic Action Plan for the Nation's Mental Health Protection: Resilience after Disaster." These recommendations included a call for specific interventions to build resilience, provide individual care, and foster recovery for communities and individuals which must be "evidence based and built on proven mechanisms of change and recovery demonstrated in studies of risk factors, protective factors and interventions." Papers from this conference, a DVD of the actual conference, and this strategic plan will be in a forthcoming book from Cambridge University Press (Blumenfield & Ursano, in press). This is one of several books from this and other publishers which addresses these topics.

However, none of the previous writings and conferences seemed ready to put forth a clear set of specific evidenced-based principles or recommendations for intervention. The current paper in *Psychiatry* has done that by identifying five empirically supported, intervention principles that should be used to guide and inform intervention and prevention efforts at the early to mid-term states. These are

the promotion of: 1) a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope. This epic paper, which is one-third references, gives us the roadmap for the establishment of treatment programs to address mass trauma. There may be other roads which can lead to other interventions, but there will have to be evidence-based support before they can be tested.

We must now develop demonstration programs using these established components with research arms to look at the effectiveness of the interventions which use them. Whenever possible, control groups must be used. One example of the type of research which can be done is the ongoing research at Hadassah Medical Center in Jerusalem under the direction of Dr. Arik Shalev, where for the past three years every trauma patient seen in their emergency room is evaluated. Those patients found to need intervention and who are accepting of it are put into one of several treatment groups.

Pharmacology is only one possible therapeutic element, and the needed research at this point can't rely on funding from pharmaceutical corporations. There will need to be funding from the NIMH, Department of Defense, Robert Wood Johnson, and other foundations. The authors of the important paper in this issue have clearly established viable concepts built on evidence which can be used for development of intervention programs.

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