HELPING PEOPLE WITH POSTTRAUMATIC STRESS IN THE COMMUNITY

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The psychological impacts of trauma include both fight and flight biopsychological responses that may be distressing in the short-term but are essential for survival; and long-term distressing and dysfunctional responses which could compromise the health of the individual. While resilience, which indicates rebounding of functions to pre-trauma level after a transient period of distress, constitutes the experience of the majority, some survivors of trauma may experience mental distress that requires professional support.

Who are affected?

People who could be psychologically affected by a traumatic event do not only include the so called “direct” victims who have direct experience of the traumatic event whether or not s/he is injured or not in the incident. Family members of these direct victims and witnesses of the traumatic event could also become “indirect” victims shouldering the burden of the psychological impact of the event. Emergency personnel including policemen, fire-fighters, health care workers, volunteers, and media workers who were exposed to the aftermath of the traumatic event could also become “hidden” victims. This is because the psychological impact of vicarious traumatisation could often be overlooked for these individuals as they expect themselves and are expected by others to provide help and support and may not be prepared to be the receiver of help themselves. Having an awareness of these different possible types of victims who could experience negative psychological impact from traumatic event is essential for acknowledging the potential needs and provision of necessary support and resources in the community after the occurrence of a traumatic event.

What are the outcomes?

Extreme, unstable and distressing psychological responses which include fear, shock, sadness, guilt, anger, irritability, grief, flashbacks, insomnia etc. are common human experiences

immediately after a traumatic experience. Though mobilization of resources and support like company of others who could offer practical help and empathy are usually required and beneficial during this acute phase, these distressing responses are not regarded as pathological or abnormal. Instead, these temporary responses could be regarded as normal human responses in reaction to an abnormal and traumatic situation. As long as these responses are consistent with the context of the reality, they could often serve as a signal of crying for help and enhance the mobilization of resources for the individual. Nevertheless, if these psychological responses became prolonged or too distressing, the mental health of the individual may be compromised. According to the Diagnostic and Statistical Manual of Mental Disorder, 4th edition (American Psychiatric Association, 1994), the prevalence rate of Acute Stress Disorder for individuals exposed to trauma ranges from 14-33%. The lifetime prevalence rate of Posttraumatic Stress Disorder (PTSD) in community-based studies is approximately 8% for the adult population. However, PTSD is not the only possible aversive outcome of traumatic incident and disaster. According to World Mental Health Survey 2000 data, the prevalence of mild or moderate mental disorders including depression, anxiety and PTSD after disaster is 20% (World Health Organization, 2005).

How social workers can help?

As social workers working in the frontline of the community play an essential role for provision of support and bridging of professional mental health services for victims of different kinds of traumas including family violence, crime, and disaster, it is essential to equip ourselves with knowledge and skills to conduct effective screening and provision of appropriate support for survivors of traumatic incident. According to international guidelines, services should be provided to the affected based on their needs and clinical evidence. A number of the suggestions highlighted in these guidelines are pivotal and should be familiarized by frontline workers (NICE: National Institute for Health and Clinical Excellence, 2005; WHO: World Health Organization, 2005). Some of the important points are discussed in the following.

Differentiating needs

First, a common misconception highlighted by WHO is that PTSD is the main or most important mental disorder to be focused after a disaster. In fact, PTSD is only one of the common mental disorders among other mood and anxiety disorders that could be resulted from experiencing a disaster. In addition, the low level of help-seeking behaviour for PTSD symptoms in many non-western cultures suggests that PTSD is not the focus of many disaster survivors and there is a concern that agencies are over-emphasizing PTSD and are creating narrowly defined services that do not serve people with other mental problems. For majority of disaster survivors who experienced

temporary and non-dysfunctional traumatic responses, it is essential not to mistaken them as having mental disorder. Psychological first aid from community level workers to ensure the provision of safety, empathy and practical support are usually sufficient. For disaster survivors who experienced persisting and dysfunctional traumatic responses, referral to specialist mental health care would be required (World Health Organization, 2005).

Single-session debriefing should not be routinely offered

Local service providers and frontline workers should also observe and not to ignore the recommendations regarding the use of single-session debriefing for people affected by traumatic incident and disaster. According to existing evidence, single-session debriefing that focus on the traumatic incident should not be routinely given immediately after the disaster due to the lack of evidence supporting its efficacy and the documentation of harmful effects in some studies. In addition, for survivors who experience mild symptoms of less than four weeks after the trauma, watchful waiting, as a way of managing the difficulties, should be considered. A follow-up contact should be arranged within one month (NICE, 2005; Rose, Bisson, & Wessely, 2002). Perhaps, it is justified to summarize the recommendations based on existing evidence that it is essential to provide practical support, empathy, and assistance for mobilization of social resources for people affected by traumatic incident to ensure their safety and facilitation of natural recovery. Single-session debriefing that focus on the traumatic incident may affect the process of natural recovery and should not be provided unless there are exceptional justifications or adaptation in the procedures so that possible harmful effects could be minimized. On the other hand, watchful waiting does not mean that nothing could be done. Besides provision of practical support with a safe and supportive environment, provision of information like health tips, self-care, and contacts for further mental health service may enhance a sense of mastery. The utilization of self-report screening measures by frontline mental health workers could also be considered as one of the procedures to be included during the period of watchful waiting (Wu & Leung, in preparation).

Empowering clients with knowledge

Frontline workers are encouraged to empower the public and clients with research evidence that facilitate adaptive coping as well as early identification and intervention for those who are at-risk for prolonged distress (Wu, 2007). Research findings confirming that majority of survivors would have resilience and recover after the acute phase of the traumatic event can be used for educational purpose at the acute phase after trauma as it helps frontline workers to normalize acute but transient distress experienced by the majority of people after a traumatic experience, and educate them on the probability and help-seeking procedures for prolonged distress. The risk factors identified in this

research can also guide frontline workers in early identification of the at-risk survivors and to provide early treatment and psychosocial support. Research findings on prevalence and risk factors of posttraumatic stress reactions can also become valuable information for clients helping them to have an increased sense of mastery and facilitating effective self-care particularly for those who are at-risk for prolonged distress. Research findings can also be utilised in explaining the rationale of treatment procedures to encourage early help seeking behaviour. Frontline workers can also utilise local findings in educating the clients to enhance acceptance and recognition of existing evidence (Cheng, Wong et al. 2004; Ho, Kwong-Lo, & Mak, 2005; Wu, Chan, & Ma, 2005a; Wu, Chan, & Ma, 2005b; Wu & Cheung, 2006). In terms of format and tools of information provision, besides using pamphlets and audio-visual aids, the availability of frontline worker for verbal discussion with immediate clarification for victims after a major traumatic event is suggested.

Encouragement for adaptive behaviour

Encouraging and helping people affected by traumatic event to mobilize support from their natural sources (i.e., family, relatives and friends) and continued engagement in adaptive behaviour as early as the situation allows would usually facilitate natural recovery. When hospitalization is required, the aim is to facilitate the individual to reintegrate back to the community as early as possible. Thus, prolonged hospitalization which may take the individual away from his/her natural environment of support or encourage maladaptive avoidance behaviour should be avoided.

Continuing education for workers

Frontline workers are encouraged to make use of local platform and training opportunity provided by different professional bodies for updating knowledge and skills. The Asian Society for Traumatic Stress Studies (AsianSTSS) which was set up in Hong Kong in 2005 is among one of these organisations that provides a platform for different disciplines to exchange knowledge and experience in trauma psychology. Resources including useful websites, downloadable educational pamphlets, and calendar of local and overseas training activities are available in the website of AsianSTSS: http://www.asianstss.org.

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