Considering Different Experiences of Trauma in the Development of Effective Psychosocial Interventions

With an increased focus on the material and financial loss involved in disasters, the significance of mental health with respect to mitigation, response, and recovery is often underemphasized and generally lacking in the disaster literature (Quitangon, 2015; Steele, 2015). The current approach to addressing mental health after a traumatic event primarily considers individual trauma by treating symptoms of individual psychopathologies, such as depression, anxiety, substance abuse, and post-traumatic stress disorder (Quitangon and Evces, 2015). While individual treatment is important, it is also true that a supportive environment plays a significant role in the success of therapy; therefore, in the context of a large-scale disaster, an approach that only treats individual psychopathology may fail to consider the social, economic, political, cultural, and historic context of a traumatic experience (Steele, 2015).

Instead, a combination of interventions that treat the individual paired with psychosocial interventions that attempt to strengthen social bonds and enhance a community's resilience may deserve more attention in the disaster literature (Tierney, 2014). In fact, psychologists, anthropologists, sociologists, disaster responders, and communities alike are beginning to realize the success of psychosocial interventions in facilitating the collective healing and recovery process (Roth, 2015; Saul, 2013; Steele, 2015). Thus, bringing together existing literature and concepts from multiple disciplines, I explore how trauma is experienced at a variety of levels. I argue that it is critical to understand the diverse ways in which individuals, communities, and mental health providers experience trauma in order to take a more holistic and comprehensive approach

to the development of effective psychosocial interventions. In order to examine the unique abilities psychosocial interventions present with respect to disaster recovery, I first consider three types of trauma—individual, collective, and vicarious—that interventions aim to address. Then, invoking this holistic understanding of trauma, I examine several elements of successful psychosocial interventions, pointing to the significance of designing and implementing multilayered, culturally sensitive, and collectively supportive interventions with pre-prepared, yet flexible guidelines. Finally, I present a discussion regarding gaps in the existing disaster literature, recommendations for future research, and a proposal for a new emphasis on the implementation of psychosocial interventions as an essential element of the disaster preparedness, response, and recovery experiences.

Experiences of Trauma

Individual Trauma

The vast majority of psychological disaster research and disaster response to date has focused on the experience of individual trauma, taking an approach that emphasizes the treatment of individual psychopathologies (Watson, 2015). Peek (2011) defines "individual trauma" as the distress, shock, and sense of helplessness that survivors of disasters experience. Much is known about this type of trauma, particularly with respect to the psychopathologies that small- and large-scale disasters can produce, such as depression, anxiety, and Post-Traumatic Stress Disorder (Fothergill et al., 1999). However, disasters are also known to exacerbate pre-existing psychopathologies, particularly issues like substance abuse, as most people feel an extreme sense of fear and loss of stability in the face of such a traumatic event (Evces, 2015).

Understanding the neurological processes involved in shock and trauma can provide invaluable information to researchers, responders, and those experiencing trauma themselves in order to make sense of and properly address the overwhelming circumstances at hand. When exposed to extreme stress, the midbrain becomes overactive (Steele, 2015). Essentially, this means that during and immediately after a disaster, normal cognitive processes are interrupted as extreme danger and loss takes over one's schema of the typical human experience (Evces, 2015). Basic functions like memory, perception, and emotional responses become untrustworthy, and the traumatic event threatens one's sense of predictability and safety. Thus, an individual's underlying beliefs about their relationship with the world can be completely transformed, and if s/he cannot integrate this traumatic event, distressing and intrusive memories may persist along with intense emotions like anger, fear, shame, anxiety, and guilt (Evces, 2015). These individuals are referred to further psychological or therapeutic interventions later on, which is a crucial part of the disaster recovery process, enabling an individual to regain a sense of stability and security. However, in only looking at trauma as an individual experience, it is easy to miss the broader social, economic, cultural, political, and historic context surrounding such traumatic experiences. Thus, it is crucial to take into account how a family, community, or entire nation can experience trauma collectively.

Collective Trauma

Sociologist Kai Erickson was the first to make the distinction between "individual-" and "collective trauma" in his work on the Buffalo Creek flood in 1972 (Erikson, 1976). As opposed to individual trauma that describes the personal pain and helplessness felt by disaster survivors, collective trauma, which results from disrupted social networks and lost

relationships, is experienced by the entire community (Peek, 2011). Collective trauma is likely to occur when communities are displaced or in any event where there is a collapse of social trust or general morale (Pearce, 2003; Saul, 2013). While re-establishing social networks and social trust after a major disaster can be difficult and time-consuming, it is essential to address collective trauma because it can lead to more individual and structural violence, increased inequalities and social fragmentations, and make the recovery process extremely difficult as communities may have a harder time differentiating between threats and opportunities (Saul, 2013).

Thus, while disasters exacerbate mental health problems like depression, anxiety, and PTSD, they can also impact interpersonal relationships and lead to a loss of resources, like social support, regardless of if this is an actual or perceived loss. The levels and forms of social capital—the social connections that benefit members of the community—and the resilience of a community determine how vulnerable it will be to collective trauma. Tierney (2014) describes resilience as, "… the ability of social entities… to absorb the impacts of external and internal system shocks without losing the ability to function, and failing that, to cope, adapt, and recover from those shocks," explaining that, "…resilience arises from the social order" (p. 6). Furthermore, resilience consists of both inherent and adaptive resilience. Inherent resilience, or the preexisting abilities and qualities that allow social entities to absorb the stress caused by crises and disasters, makes a community less vulnerable to risk, reducing the likelihood of collective trauma while also enabling it to better cope when crisis does occur. If a community has high levels of social capital and inherent resilience to draw upon after a disaster, they may not suffer the same breakdown of relationships (Aldrich and Meyer, 2015). Adaptive resilience, on the other hand, relates

to the activities and processes *after the event* that enhance a community's capacity to cope (Tierney, 2014).

Therefore, a psychosocial intervention has the ability to draw from and enhance a community's inherent resilience while also building up its adaptive resilience. As such, psychosocial interventions, in strengthening inherent and adaptive resilience facilitate the recovery process, particularly that of collective recovery, which is characterized by the rebuilding of social bonds disrupted by the traumatic event (Fullilove, Hernandez-Cordero, Madoff, and Fullilove III, 2004). Even experiences of individual trauma, as previously mentioned, must be addressed for collective recovery to occur in order for individuals across a community to move forward and rebuild their sense of security and connectedness in the wake of a disaster. Thus, interventions designed to address collective trauma should ultimately attempt to promote and enhance a community's resilience.

However, inequality also plays a role in how communities or subgroups within a community experience collective trauma since certain people benefit from different amounts of privilege and resources depending on varying social, economic, political, or cultural factors. For example, Fothergill (1999) and Peek (2011) consider how certain people are more or less vulnerable after disasters, particularly along class, gender, race, religious, and ethnic lines. The ways in which different communities experience collective trauma will be addressed in my discussion of the cultural considerations involved in forming effective psychosocial interventions. This is because a large part of the recovery process must address this collective trauma by strengthening social connections and allowing for collective recovery.

Vicarious Trauma

Another notable form of trauma that psychologists and disaster researchers are just beginning to recognize is "vicarious trauma", which is often experienced by mental health providers and responders that have frequent and/or intensive contact with victims of trauma. Because mental health providers and first responders spend an overwhelming amount of time exposed to the traumatic thoughts, memories, and emotions of disaster survivors, they can find themselves facing some of the most horrific and painful parts of the human experience on a daily basis. "Vicarious trauma" can be defined as, "changes in a therapist's inner world resulting from repeated empathic engagement with clients' trauma-related thoughts, memories, and emotions" (Evces, 2015, p. 11). It negatively affects the mental health provider's underlying beliefs about the self, others, and the world, much the same as individual trauma does. Additionally, responders face a number of other difficulties as a result of indirect traumatic exposure besides, or along with vicarious trauma, such as burnout, compassion fatigue, Secondary Traumatic Stress, countertransference, and shared trauma (Evces, 2015).

Steele (2015) explains the important role of self-care for professionals and volunteers who deal with victims of trauma. Not only can this line of work become seriously distressing for these responders, but if helpers themselves develop vicarious trauma, Secondary Traumatic Stress, burnout, compassion fatigue, etc., they may ultimately face difficulties providing effective help to disaster survivors. Mental health providers and first responders play a key role in the recovery process for individuals and entire communities, as they must help encourage and foster the inner strength and resilience that ultimately allows communities to heal and find meaning (Steele, 2015). As such, the mental

health of those who are actively working to help disaster survivors should also be given attention due to the impact they can have on those with whom they work. However, there are several barriers preventing this from being addressed, such as the stigma associated with mental health providers seeking psychological help for themselves and a lack of organizational oversight regulating and balancing the caseloads of clinicians (Hammerslough, 2015). Therefore, any type of psychosocial intervention aimed at helping a community must also incorporate training in self-care and vicarious trauma along with organizational changes necessary to ensure that mental health providers have the resources to prevent and address vicarious trauma.

Developing Effective Psychosocial Interventions

Now that several different types of experiences of trauma have been considered, it is possible to begin constructing a more holistic picture of what a psychosocial intervention should include. Ultimately, the underlying guiding principles of any psychosocial intervention should be to take a multilayered, culturally aware, and collectively supportive approach, with pre-prepared yet flexible protocols.

Multilayered Interventions

In determining how to design a successful intervention, taking a comprehensive and coordinated approach is key. This means that the intervention should be multilayered both in terms of its design, by involving several different people and institutions, and in terms of its implementation, by providing psychosocial support across multiple levels of the social structures within a community. With regard to the creation of a psychosocial intervention, Roth (2015), Saul (2013), and Steele (2015) all point to the importance of creating a trauma-informed task force of individuals with varying roles in the recovery process.

Taking an interdisciplinary and interorganizational approach enables the inclusion of voices from several different viewpoints while also ensuring that a more comprehensive intervention can be developed and implemented, even if one area of the task force or some thread of the social network is lost in the aftermath of a disaster. For example, Steele (2015) explains what a trauma-informed taskforce should look like in schools, using Sandy Hook Elementary School as an example in how to respond to events such as school shootings. He explains that this task force must include "major mental health facilities, child and family care providers in the community whose staff are committed to working interactively with schools where children are most accessible" (p. 28). This is crucial because it ensures that a range of perspectives is considered in order to identify a community's needs after a disaster or tragedy, taking advantage of existing social capital. Additionally, having a strong network of responders set in place before any disaster involving several different components within the community can help mitigate the loss of social connections and relationships. This would also help reduce the risk and severity of collective trauma for a community, particularly if a disaster response protocol and intervention plan is well integrated into the community already.

Therefore, the general consensus surrounding disasters is to be prepared, at least to the greatest extent possible (Steele, 2015). Using his analysis on the lessons learned from how schools and communities have responded to different disasters, Steele (2015) emphasizes how important it is to have emergency contingency plans and protocols in place before disaster strikes. It is crucial not only for practitioners to know what to do during a disaster, but also to understand what type of crisis team will be required and what is to be expected from the team, particularly with regards to psychological first aid,

counseling, and the implementation of psychosocial support systems. However, practitioners and aid workers are just as vulnerable to trauma as the rest of the community during a disaster, even if they have been trained to respond to such a disaster. As such, understanding the neurological processes behind individual trauma is essential. These processes demonstrate why pre-planned, easily accessible protocols are essential for any effective intervention for mental health providers, first responders, and decision makers. When exposed to a traumatic experience that elicits responses of extreme stress or trauma, the midbrain takes over, which is characterized by, "response-feelings, physiological and biological reactions, and difficulty thinking, hearing what is being said, and processing what is happening" (Steele, 2015, p. 41). First responders are also vulnerable to these same processes, thus, having trauma-training regularly, being prepared, and having a set of instructions or protocols on hand can make all the difference. Steele (2015) also demonstrates the importance of being prepared in his discussion of many of the teachers, school counselors, and administrators who, despite having some training in what to do during a disaster, were unable to take proper action during 9/11 since they had no access to response protocols. Furthermore, many of the individuals were themselves shocked and traumatized by what was going on.

Not only is it important to be prepared in terms of having a plan for immediate response, long-term response, and community interventions, but first responders and mental health providers must be well trained and trauma-informed in order to be helpful and to protect themselves against vicarious trauma and compassion fatigue. It is essential to encourage self-care practices and organizational changes for mental health providers and first responders dealing with vicarious trauma. Training on compassion fatigue and

vicarious trauma at an organizational level should be implemented so that responders and clinicians are aware of and feel comfortable accessing resources available to them (Hammerslough, 2015). However, Roth (2015) points out that often, even when aid workers are aware of such resources, they do not necessarily reach out for them. Much of this has to do with the stigma attached to seeking psychological aid as a mental health professional. Therefore, although self-care practices such as mindfulness should be encouraged at the individual level, interventions at the organizational level must also be implemented to break down the stigma associated with vicarious trauma. Addressing such issues will ultimately improve interactions between survivors and responders and lead to better outcomes throughout the individual and collective recovery process because "in crisis situations, what we say and what we ask are critical to effectively helping survivors stabilize, manage, and discover their inner strength and resilience" (Steele, 2015, p. 40).

In addition to forming multi-level, trauma-informed task forces to create successful and effective interventions, the interventions themselves must include an approach based on multilayered psychosocial support, interacting with different groups within a community and working in a variety of spaces, such as within families, schools, important community centers, religious sites, etc. (Saul, 2013). Any psychosocial intervention should address the various experiences of individual trauma as embedded within the larger social context, while also understanding the unique and individual needs of specific populations within a community. Thus, while being prepared and having a protocol in place is invaluable, the key to a successful intervention is flexibility. Each community will react differently to a disaster, and consequently, any intervention must address the specific needs and desires that are the most important for that population.

Cultural Considerations

The significance of approaching psychosocial interventions with cultural relativism, as in designing interventions based on a community's values, beliefs, and practices and on their own terms, cannot be underscored enough. Not only do different types of disasters elicit different kinds of psychological and psychosocial responses, but certain communities or subgroups within communities are oftentimes more vulnerable than others in the aftermath of large-scale traumatic events; thus, it is especially important for disaster responders to have a strong understanding of the community with whom they are working (Peek, 2011). Disasters have a tendency to exacerbate pre-existing inequalities, particularly along social categories of gender, age, race, ethnicity, class, citizenship status, ability, and religion (Fothergill et al., 1999). A clear example of this can be seen in Lori Peek's (2011) work with Muslim Americans in the backlash they faced after 9/11. Muslim Americans were already a marginalized group pre-9/11, however, after the tragedy, they faced a much different kind of collective trauma than the majority of Americans. Not only did they experience the devastating loss and horror after the terrorist attacks, but they also faced the compounded fear of being discriminated against in retaliation (Peek, 2011). They were excluded from many of the interventions designed to help communities, especially those in New York, grieve for those they lost in the attacks. Thus, when designing an intervention, it is important to recognize who, if anyone, may be left out due to social, political, economic, or cultural factors.

Another vulnerable population that has recently received increased attention from the disaster research community is children. Psychologist, William Steele is a leading expert in training mental health providers, school personnel, and communities in

developing interventions that address the needs of this unique population (i.e. schools and children in general). He takes into account many of the recovery lessons that schools and communities have learned regarding disaster preparedness in the domain of mental health and psychosocial interventions (Steele, 2015). He stresses the importance of, particularly when dealing with children who have experienced disasters, employing interventions that match the developmental needs of the disaster survivors. Lori Peek also explains the significance of addressing particular developmental needs through her work with children and young adults after Hurricane Katrina (Fothergill and Peek, 2015). For example, cognitive approaches may be better suited for young adults or older teenagers, whereas non-verbal, sensory-based interventions may be better for younger children.

Therefore, not only is it important to address the needs of all members of a community, but it is also crucial to design psychosocial interventions to fit with the specific goals, needs, abilities, and cultural norms of that population. Campbell (2016) demonstrates the importance of considering the cultural context in figuring out how best to approach communities with psychosocial interventions and to ensure that services are even wanted. She looks at what happened in one small mountain community outside of Boulder, Colorado after the 2013 floods when one organization went door to door in an attempt to directly offer mental health services to the community. In failing to consider the cultural norms and attitudes such communities held regarding outsiders, this door to door approach did not inspire trust among the community. This failed approach for an intervention actually prohibited many people from taking advantage of the services that were offered. Thus, while it is important to have protocols and to be prepared to ensure that people will have the resources they need, it is also essential to be flexible. There is no

one size fits all solution, and responders and mental health providers in particular must constantly remain culturally aware and inclusive, recognizing the needs of all groups, especially those that have historically been marginalized and may already be more vulnerable.

Collective Recovery

Along the lines of remaining culturally sensitive, it is clear that psychosocial interventions must be centered on the community's voice and values. Oftentimes, organizations attempt to force unwanted and unwarranted interventions on a community in an effort to "help" (Jordan, 2012). Thus, the goal of any intervention should be built around what is most important to that community, while also strengthening the inherent resilience of that community. Interventions that emphasize and strengthen the adaptive capacities of communities will promote collective recovery after a traumatic event (Saul, 2013). This process of enhancing a community's adaptive capacities can be inspired from both within and outside a community, recalling the ways in which multi-level and multi-organizational collaborative taskforces can be quite successful. Saul (2013) explains how, "collective recovery is a creative and emergent process; its content and form are constructed over time through cycles of collective action, reflection, and narration" (p. 2). This can be done in a way that takes into account research-supported guidelines while also considering the cultural and social context of a specific community.

Psychological interventions to address community-level disaster recovery can take many forms. As mentioned before, collective recovery is best addressed with multi-level interventions. Sometimes, outside entities can contribute to collective recovery by coming into a community to collaborate and share research on effective recovery interventions and

best practices. Other times, members within a community recognize where and when such interventions may be able to best inspire resilience and a collective sense of support in their own community (Saul, 2015). It is sometimes as simple as recognizing the need to mobilize and contribute in order to rebuild and repair the physical as well as mental and social damage a disaster can leave behind. Steele (2015) explains that, "in the midst of crisis people will do best when they are actively engaged in doing something " (p. 17). At an individual level, this can allow people to recapture some sense of control and can help regulate emotional reactions and stress. However, it is also through this shared mobilization and collective recovery that relationships and social networks are strengthened. After all, "it is in the doing that people in crisis begin to heal" (Steele, 2015, p. 17).

Therefore, in designing interventions, Saul (2013) points out how effective collective narration can be in helping communities come together in order to integrate meaning into such a traumatic event. Additionally, creating meaningful understandings of the disaster-event can contribute to stronger recovery regarding risk reduction and mitigation for future disasters. Saul (2013) presents two different examples of projects that were led by the Downtown Community Resource Center in New York City after 9/11 that encouraged a wide array of voices and experiences within the community to be expressed (Saul, 2013). One project was a narrative video while the other was a theater project, and both incorporated the stories of people within the community allowing for conversation. This type of collective expression creates a sense of identity for a community and allows members to rebuild social capital and while also working through much of the shared grief, trauma, and fear that traditional psychological interventions may not be able to address,

thus strengthening a community's adaptive resilience in the process. Peek (2011) expands on this notion of collective grief, explaining that the sharing of grief emotions among loved ones and strangers within an affected community is a key step in the recovery process. However, it is important to recognize when certain marginalized subgroups within a community may be excluded from the collective narrative, and, subsequently, the collective grief. For example, during 9/11, Muslim Americans were excluded from the collective grieving process that the rest of America was able to take part in and their trauma was invalidated (Peek, 2011). Muslim Americans often felt their experiences were not part of the collective narrative that was supposed to encompass the experiences of all Americans. Recognizing these cultural, social, and political barriers in the recovery process, particularly through inclusive psychosocial interventions that allow for collective recovery and conversation, can be a useful way to address many of the inequalities that are often exacerbated by traumatic events.

Along those lines, any attempt at memorializing the event should also include the input and desires of stakeholder from across the community. This process of memorializing an event and finding long-lasting meaning within tragedy can help communities collectively grieve and move forward in the recovery process (Saul, 2013). However, the design of a memorial, whose careful creation and the conversation surrounding it can act as a psychosocial intervention in and of itself, must be done with great care, as the ultimate placement of such a reminder can serve to either help create meaning or serve to re-traumatize those that must remember the day of the event (Steele, 2015). For example, Steele (2015) emphasizes how important it is to carefully consider the appropriateness of the type of memorial and its placement. Placing a memorial commemorating the victims of

a school shooting right in the middle of the school may not be helpful for the students, and may actually serve to re-traumatize any survivors of the event rather than aiding in the healing process (Steele, 2015). Additionally, it is essential that a general cultural awareness surrounds the creation process of a memorial because, as mentioned before, sometimes certain experiences are excluded from the collective narrative and the collective memorialization of an event. For example, after 9/11, many Muslim Americans did not feel welcome at the memorials or community events that were designed to help people heal and promote resilience (Peek, 2011). This speaks to the need to ensure that, in any psychosocial intervention, all members of the community have an outlet for collective recovery and can come back even stronger, as interventions involving multilayered psychosocial support can provide an opportunity to address existing inequalities within the community.

Discussion and Conclusion

This paper is meant to serve as a preliminary guide based on interdisciplinary research regarding the best practices and considerations to keep in mind when developing psychosocial interventions that promote community resilience and recovery. While a significant amount of disaster literature exists around many of the social inequalities and vulnerabilities mentioned in this paper, research regarding practical solutions for addressing these factors seems to be lacking. Thus, the aim of this paper is to present a promising option in the form of psychosocial solutions that not only have the potential to, if designed carefully, promote collective recovery and resilience, but also provide an opportunity to address existing vulnerabilities within a community. There is still a need for more research regarding effective outcomes and lessons learned from the implementation

of such interventions; however, existing literature indicates that an approach that emphasizes social connections after a large-scale disaster can yield extremely positive outcomes in terms of unifying communities and allowing for collective recovery to ensue. Yet, there is still a need for research on how collective trauma and recovery are experienced by different subgroups within communities and how psychosocial interventions may provide a useful opportunity to address social inequalities both before and after disasters. Ultimately, disaster research could benefit from a much more comprehensive and interdisciplinary approach to mental health, putting the treatment of individual psychopathologies within a social and cultural context and drawing from the fields of sociology and anthropology.

Taking an interdisciplinary approach will help garner a more holistic understanding of disasters in order to better promote resilience and ensure that everyone is included in the recovery process. However, while understanding the broader context is critical, that is not to say that the treatment of individuals should be forgotten. Individuals that are struggling significantly after a traumatic event must still have access to and be directed towards more individualized care if they do not seem to be getting better. Thus, the understanding of all experiences of trauma—individual, collective, and vicarious—can help responders and communities include everyone in the mitigation, response, and recovery processes. As such, it is crucial to remain open to uncovering and incorporating the lessons that others have learned and to critically evaluate the strengths and weaknesses of various interventions. This research is critically important because disaster literature too often focuses only on the immediate economic and material consequences of disasters without considering the human cost that survivors and communities continue to

experience long after the event has ended. Therefore, I recommend that a new emphasis should be placed on psychosocial interventions and that the implementation of such interventions be considered as an essential step in the preparedness, response, and recovery stages of a disaster. The physical rebuilding of a community is important, but so is the mental, social, and collective rebuilding and enhancement of the relationships and social networks that ultimately make a community a community.

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