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Editorial

Disaster Mental Health *vs* Psychosocial Well Being: The Need for a True Paradigm Change

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Editorial

Mental health is presently a multidimensional concept which is much beyond distress, a bunch of symptoms, illness or disorders. The concept of psychological or psychosocial well being emerged to counter the stigma attached to the term "Mental Health" and to place greater emphasis on the non biological determinants of Mental Health. It encompasses various dimensions like material, physical, cultural, spiritual, biological, mental, social, emotional and psychological. The debate over the inadequacies of the bio-medical model of approaching mental health and value of its counterpart the bio-psycho-social model of approaching psychosocial well being, have been in the field of mental health since its inception. Though heavily contested there is a general consensus with regard to the bio - psychosocial model of approaching Mental Health/Well Being among professionals in the sector.

There is much research and progress in establishing an exclusive bio medical model for understanding certain symptom clusters like the mood disorders. But an exclusive psycho-social explanation of mental health outcomes in individuals, groups and communities has never gained the kind of prominence, which its presumed scientific counterpart the bio medical model has achieved. The reasons being many especially those related to the political economy of the field (professionalization of care and support functions, institution centric approaches, pharma politics among others), the difference in the approach and methods pursued by the biological sciences and the social sciences and the very nature of the subject being explored – the human thoughts and emotions. The secondary status of psychosocial dimension in the understanding of mental health/explanation of causality has had serious implications for research, practice and more so with regard to developing a comprehensive understanding of mental health in itself. Thus the psychosocial interventions emerging from the bio-psychosocial approaches have only acted as an adjunct to the bio medical treatment. Often psychological interventions targeting the individual or the family have become the only form of psychosocial intervention ever made available. In the name of specialization these interventions have become very narrow in its focus namely cognitive and behavioural therapies. Interventions that target other dimensions of psychosocial well being namely the material, physical, spiritual, cultural, biological etc were close to nonexistent. The researchers who studied the social dimensions (sociology of emotions/mental health) too missed out in comprehensively integrating it with the mainstream mental health field, especially in practice. Thus the research on psychosocial dimensions and interventions had touched a point of no progress or were heavily subsumed by the medical model, thus putting forth the need for a true paradigm change.

Disaster mental health and psychosocial support that has gained prominence in the past two and half decades have opened up new spaces and opportunities to the exploration of psychosocial dimensions in relation to well being. The conceptualization of disaster mental health and approaches to target the same has seen a sea change since these two and half decades. It has moved from a bio medical understanding to a bio-psycho social approach which has been much more comprehensive than that of the conventional sector of mental health interventions. The traumatic nature of disasters, the attention that it draws on psychological suffering and the non suitability of conventional ways of addressing distress among a large population has made the shift true to its nature, beyond just the use of terminologies and jargons. More over since disasters warrant a whole range of basic support services such as safety, protection, relief, housing, livelihood etc it becomes practically possible to comprehensively address all dimensions of well being and thus evolve, research and document comprehensive mental health and psychosocial support interventions.

Though the recognition of psychosocial consequences along with the mental health consequences [1] has been a significant milestone, there is ambiguity with regard to the understanding of disaster mental health and psychosocial consequences, conceptually and in the field. Though conceptually there is a broad recognition for disaster mental health outcomes as normal reactions to abnormal circumstances, there is ambiguity with regard to distinguishing the emotional outcomes of psychosocial consequences in the context of disasters from that of symptoms of mental ill health, and it largely depends on the lens through which the consequences are looked at. When one attempts to comprehensively look at the psychosocial and mental health consequences of disasters one has to look at both everyday feelings and expressive behavior in response to disasters (emotions per se) and symptoms of emotional distress/ problems which are considered to be moods or affective states rather than emotions per se.

In the field though there are symptoms checklist and diagnostic criterions, the use of same in different cultural context and without much focus on the larger post disaster social context in which the respondent expresses the symptom list, further complicates the artificial differentiation arrived at by professionals from different disciplines. The cultural and larger social context becomes crucial as every day expressions of feelings of sadness, loneliness, hopelessness, anxiety, worry and fear are key components of symptoms scales and

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psychiatric diagnoses of emotional problems {defining features of 45.7% of a total of 210 disorders and are associated features of 64.8% of the 210 disorders mentioned in DSM – III diagnostic criteria – Thoits [1]}. Thus the possibility of misrepresentation or differential understanding by helping professionals is very high. Moreover, the possibility that the experience of frequent and persistent distressing emotions underlie the development of milder mental health problems has not been established otherwise. Hence the distinction between psychosocial and disaster mental health services is more of an artificial divide based on disciplinary distinctions and not empirically worked out.

The ambiguities pertaining to the conceptualization of psychosocial well being and the interventions emerging from this conceptualization has led to the narrow focus on disaster specific trauma and its impact on surviours [2,3]. Stress induced psychopathology including traumatic stress syndromes are viewed as aberrant individual response to unusual circumstances. The role of diverse interrelated factors like individual social status, the context of their daily lives (including the post disaster context of displacement, loss, compensation etc), prior exposure to stressors, secondary stressors emanating from the disaster exposure, resources available to cope with stressors and varied norms of physical and psychological expressions of distress, that converge on people's well-being are often ignored. Though social theories and subsequent research have identified social factors contributing to community distress and individual expressions of distress, interventions to address these distresses in the disaster context have been primarily limited to individual/household centric approaches, largely rooted in the medical model.

Moreover the recognition granted to the study of traumatic stress in the context of war and conflict has led to an increasing volume of research and clinical work that uses models with established efficacy in resource-rich contexts and focuses primarily on traumatized individuals or families. Trauma and refugee rehabilitation centres delivering individualized or family-based therapeutic interventions with proven efficacy in a resource-rich context, are nevertheless critiqued for their limited reach and cultural inappropriateness in LMIC context [4,5].

As a response to the above critiques, the mental health interventions that focus on providing 'helpful services' to address acute stress and not 'therapeutic' or clinical treatments [6] have been the key focus of research literature and organizations in recent years. Two such popular mental health interventions are: Psychological First Aid and Critical Incident Stress Management (CISM)/Debriefing (CISD) [7]. The literature on the effectiveness of CISM/CISD (sometimes referred to as Psychological Debriefing, despite being different) and PFA are mixed, however PFA is identified as "evidence informed" [6,8] and preferred over the much critiqued CISM/CISD [9-12]. Thus several organizations like WHO, American Red Cross and US Veteran Associations have expressed reservations in the use of psychological debriefing [6,13,14] and have endorsed PFA among several other key organizations like FEMA, Department of Homeland Security [7,14]. Though PFA is preferred over CISM, both are traumatic stress focused interventions targeting the prevention of prolonged stress reactions like Post Traumatic Stress Disorders (PTSD) among individuals and groups "exhibiting stress reactions" [13]. In spite of limited "evidence base [8] PFA's use in response to recent emergencies like Ebola and Nepal Earthquake are witness to its wide spread universal application during different disasters in varied context including LMIC.

Even if we set aside the debates on differing cultural context in the expression, assessment and management of distress, the sheer magnitude of the problem, combined with the inadequacy of resources (infrastructure, personnel and funding) to meet general mental health needs, asserts the need for re-considering the approach to traumatic stress and mental health in the context of LMIC [15].

A more relativistic "anthropological" position presents itself as a pragmatic alternative to the traumatic stress approach. This considers the reactions to disasters, displacement, violence and traumatization as "normal", with grief, stress and trauma as shared, normative experiences that are effectively dealt with within indigenous support systems. The therapies introduced by outsiders are hence regarded as alien and intrusive. This approach shifts the focus of interventions to the repair of the social environment, which is the primary focus of humanitarian relief operations [16]. Studies have also highlighted the significance of an enabling environment in facilitating the prevention and early recovery from traumatic stress syndromes among refugees and internally displaced persons [17-20].

The much boasted paradigm change in the context of disaster mental health and psychosocial support would be possible only if: Disasters and its mental health/psychosocial consequences are not considered as mere discrete happenings involving a traumatic event followed by a response, but as social stress emerging from difficult and threatening circumstances confronted by collectivities having similar social and economic background, and as outcomes shaped by many factors pre and post disasters, that over time changes depending on the larger context of disaster recovery. The Trauma/distress need to be conceptualized in terms of an interaction between individuals, families, communities, and the society-at-large, and not as an entity to be located and addressed within the individual. Interventions evolved need use a contextual approach, linking and addressing each of the levels while taking account of its effect on other levels.

Research and interventions to address psychosocial well-being should be multidisciplinary working across a range of disciplines such as social work, public mental health, psychology, psychiatry, anthropology, and epidemiology. And will encompass the social, economic, political, biological, and cultural determinants of mental illness/health.

Interventions should be based on a multifaceted approach engaging several sectors such as health, education, rural development (for income generating activities), social welfare, jurisdiction (for human–rights legislation), gender-related organizations (for specific risk groups such as women who have been raped or men being idle) etc.

Context specifc Interventions that address social factors beyond an individual in working towards empowerment of local resources in increasing sustainability, equity, and the use of natural support systems such as healers, mourning, cleansing, and reconciliation rituals, is an urgent need in the sector of disaster mental health and psychosocial support.

Thus for a paradigm shift to be true to its claim, it will have to start with addressing the ambiguities both conceptually and at the level of practice in the field.

References

1. Thoits PA. Social support and psychological well-being: Theoretical possibilities. In Social support: Theory, research, and applications (ed GI Sarason & BR Sarason); 51-72). Dordrecht, the Netherlands: Martinus Nijhof. 1985.
2. Jaswal S, Joseph, J. Psychosocial Support and Mental Health Services in Disasters [Working paper No. 7]. Mumbai: JTCDM, TISS. 2008.
3. Johnson RJ, Hobfall SE. Mental Health and Terrorism. In T.L. Scheid and T.N. Brown (Eds.), A Handbook for the Study of Mental Health: Social Context, Theories and Systems (2nd ed.). New York: Cambridge University Press. 2010.
4. Yehuda R. Post-traumatic stress disorder. New England Journal of Medicine. 2002; 346: 108-114.
5. Raphael B, Wilson J. Introduction and overview: Key issues in the conceptualization of debriefing. In: Raphael B, Wilson J (eds), Psychological Debriefing Theory, practice and evidence. United Kingdom: Cambridge University Press. 2000; 1-17.
6. Fox JH, Burkle FM, Bass J, Pia FA, Epstein JL, Markenson D. The effectiveness of psychological first aid as a disaster intervention tool: research analysis of peer-reviewed literature from 1990-2010. Disaster medicine and public health preparedness. 2012; 6: 247-252.
7. NIEHS/WETP. Literature summary and review of disaster mental health. 2013.
8. Hobfoll SE, Watson P, Bell CC, Bryant RA, Brymer MJ, Friedman MJ, Maguen S. Five essential elements of immediate and mid–term mass trauma intervention: empirical evidence. Psychiatry. 2007; 70: 283-315.
9. Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database Syst Rev. 2002; 2.
10. Regel S. Post-trauma support in the workplace: the current status and practice of critical incident stress management (CISM) and psychological debriefing (PD) within organizations in the UK. Occupational Medicine. 2007; 57: 411-416.
11. Bisson JI, Deahl MP. Psychological debriefing and prevention of post-traumatic stress. British Journal of Psychiatry. 1994; 165: 717-720.
12. Devilly GJ, Gist R, Cotton P. Ready! Fire! Aim! The status of psychological debriefing and therapeutic interventions: In the work place and after disasters. Review of General Psychology. 2006; 10: 318.
13. Nash WP, Watson PJ. Review of VA/DOD clinical practice guideline on management of acute stress and interventions to prevent posttraumatic stress disorder. Journal of rehabilitation research and development. 2012; 49: 637.
14. WHO. Psychological First Aid: Guide for Field Workers. 2011.
15. Silove D. The psychosocial effects of torture, mass human rights violations, and refugee trauma. Journal of Nervous and Mental Disease. 1999; 187: 200-207.
16. Silove D, FRANZCP. The challenges facing mental health programs for post-conflict and refugee communities. Pre-hospital and Disaster Medicine. 2004; 19: 90-96.
17. Silove D, Steel Z, Watters C. Policies of deterrence and the mental health of asylum-seekers. JAMA. 2000; 284: 604-611.
18. Silove D, Ekblad S, Mollica R. The rights of the severely mentally ill in post conflict societies. Lancet. 2000; 355: 1548-1549.
19. Silove D. The asylum debacle in Australia: A challenge for psychiatry. Australian & New Zealand Journal of Psychiatry. 2002; 36: 290-296.
20. Steel Z, Silove D, Bird K. Pathways from war trauma to post-traumatic stress symptoms among Tamil asylum-seekers, refugees, and immigrants. Journal of Traumatic Stress. 1999; 12: 421-435.

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