

SECTION 3: AN OVERVIEW OF SMID



PAHO/WHO

Despite the fact that stress management after exposure to a traumatic event has been highlighted for some time now, some people still believe that it is either not needed or that only weak and inadequate persons need such support services. Meanwhile, many people suffer through the painful reactions which they experience in silence.

What is SMID?

Stress Management in Disasters (SMID) refers to a comprehensive, peer-driven, multicomponent stress management program that is administered on a volunteer basis. It is designed to minimize the psychological dysfunction that exposure to traumatic situations like disasters may predispose emergency response personnel.

The SMID Program is based on principles of crisis intervention and critical incident stress management and it is not intended to take the place of professional therapy. Instead, it seeks to provide persons with the knowledge and skills to better understand, recognize and manage their emotional responses to traumatic situations.

While the SMID Program was developed in Caribbean countries with emergency response personnel and disaster workers as its primary target group, the principles of the program, with appropriate modification, can be readily extended for use in the broader community, including children and adolescents, to prevent and mitigate traumatic stress.

What is the rationale behind the SMID Program?

Disasters need to be viewed as longitudinal processes where different types of interventions will be needed at different phases of the disaster. After the physical damage from a disaster has been cleared, there are layers and layers of emotional devastation left behind. For this reason, you can not just treat the physical symptoms and expect the emotional ones to go away. But unfortunately, all too often instead of being proactive about managing challenging situations we tend to be reactive and suffer the consequences.

Unfamiliar disasters are more likely to be psychologically disturbing than familiar ones and those with sudden and unanticipated onset are more stressful than anticipated ones. Disasters that expose persons to life-threatening situations, major injury or death and those that have an intense impact and result in extensive damage are more likely to be associated with stress reactions. In addition, disasters that are prolonged or followed by long periods of the threat of recurrence after the initial impact may be especially stressful.

The hyperarousal that may result from exposure to traumatic stressors like disasters is thought to come about because of the dysfunction of a number of inter-related neurochemical systems in the brain, e.g., the noradrenergic system, the opiate system and the hypothalamic-pituitary-adrenal axis.

The severity of hyperarousal and its harmful effects have been found to depend on the individual's subjective response to the stressor and to how they rate their ability to deal with it. *People who generally cope successfully with stressful situations have a variety of personal attributes that minimize the levels of distress to which they are exposed. Such persons know how to approach situations for which they do not have a readily available response.* These observations have been further substantiated by recent research in the field of post-traumatic stress disorder (PTSD) which now places greater emphasis on a person's subjective response to a traumatic situation in determining their risk for developing the disorder than on the severity of the trauma itself. In addition, even though formal research in this area is lacking, it has been consistently observed that prompt interventions to minimize the intensity and the duration of the hyperarousal that follows exposure to traumatic stressors decreases the resultant neurochemical dysfunction. In other words, we do have some control over what happens to us psychologically after we have been exposed to traumatic situations.

Emergency response personnel and disaster workers are unique in that they are repeatedly exposed to very stressful situations. Even though their training prepares them to deal with such situations, the reality is that they have a higher than normal risk for developing post-traumatic stress reactions, including post-traumatic stress disorder (PTSD). It can be deduced that the repeated exposure of emergency response personnel to critical incident stress does have a potentially deleterious effect on their well-being. In addition, it has been

found that the psychological well-being of emergency response personnel dealing with emergency situations can in turn greatly affect the overall outcome of such situations, including the prognosis of the primary victims of the trauma.

It was realizations like these that led to the development of this SMID Program. Initially developed for emergency response personnel and disaster workers in the Caribbean, this program is aimed at preserving the psychological well-being of such personnel by assisting them to prevent, mitigate or better control the stress reactions they may experience after exposure to traumatic situations. Like any other stress management program, the basic strategies to be employed are avoidance of possible stressors, minimization of the resultant stress arousal and the reduction of any such arousal which does occur. For such a program to be effective, there needs to be appropriate and on-going preparation for coping with the eventualities of traumatic situations like critical incidents and disasters.

What are the goals of SMID?

1. To help persons to understand the possible responses that may follow exposure to a traumatic stressor;
2. To provide persons with the knowledge necessary to better manage stress reactions;
3. To promote worker health and well-being;
4. To prevent traumatic stress reactions; and
5. To accelerate recovery and restore functioning after a traumatic stress reaction.

How should disaster-related mental health interventions be organized?

- Give clear and concise warnings and advice;
- Buffer the news of traumatic loss and avoid grotesque details;
- Temper the media, while emphasizing that the provision of accurate disaster-related information is vital;
- Involve critical decision-makers in the community in all disaster-related interventions;
- Before deciding on the type of mental health services to be offered, seek advice from representative groups of survivors;
- Whenever possible, make use of available local expertise to provide such services;
- Stabilize crisis situations and attend to more basic needs like food, clothing, shelter and safety before embarking on trauma therapy;

- Embark on active outreach programs—persons most in need of mental health services tend not to seek them;
- Provide socially and culturally appropriate, well-coordinated mental health interventions which offer a full range of services and cater to the needs of children and adolescents as well as adults;
- Ensure that interventions are prompt and personalized;
- Provide adequate opportunity for persons to verbalize their experiences, thoughts and feelings;
- Seek to empower survivors so that they assume a state of independence and not dependence—direct them to available resources and services;
- Encourage the formation and activities of local support networks;
- Stress the importance of learning from one’s experiences and those of others and moving on;
- Elicit feedback from those persons for whom the services were intended.

When should such interventions occur?

R. Post (1992) argues that early intervention may prevent a neurologically lowered threshold for excitation from developing within the central nervous system (CNS) subsequent to exposure to intense distress. Thus, early intervention may prevent the development of a cellular “memory” of the trauma in the excitatory neural tissues.

In addition, victims of traumatic stressors usually employ psychological defences to protect themselves from further stimulation. The resultant barrier can unfortunately also stop such persons from making use of assistance being offered by others. With time, this barrier becomes less and less penetrable.

For these reasons post-trauma interventions need to be prompt if the individual is going to derive maximum benefit from them.

How do stages of managing distress reactions relate to disaster situations?

As in the phases of disaster management outlined in Section 1, managing stress reactions in disaster situations follow similar stages which can be summarized as: awareness and preparedness prior to an event and consolidation and rebuilding following the impact of a

disaster. Various aspects of how best to approach the stages of the disaster and stress management are summarized below.

It should be kept in mind that preparedness is the key to managing stress reactions. Reactions to disasters are largely influenced by the psychological well-being and coping skills of the affected individual prior to the disaster. The stability of his or her home, job, community and country are also very important factors that will influence how that person responds to the challenges of a disaster situation.

1	2	3
Pre-disaster	Impact	Post-disaster
<ul style="list-style-type: none"> • Awareness • Preparedness 		<ul style="list-style-type: none"> • Consolidation • Rebuilding

Awareness

Awareness of stress reactions in disaster situations can be accomplished through education, acceptance, self-assessment, and assessment of one's environment, as outlined below.

Education:

- Gain insight into the realities of disaster situations through word of mouth, the media, books, videos, lectures and discussions;
- Understand the nature of the stress response and its possible consequences;
- Learn about effective stress management techniques.

Acceptance:

- Acknowledge one's vulnerability to the potential consequences of exposure to chronic or traumatic stressors;
- Accept the fact that for preparedness efforts to be effective that they must be on-going;
- Acknowledge that assistance may sometimes be needed when dealing with stressful situations.

Self-assessment:

- Identify one's strengths and one's weaknesses;
- Assess the effectiveness of one's coping mechanisms;
- Learn to objectively assess one's stress levels.

Assessment of one's environment:

- Learn to recognize the stress reactions of others;
- Objectively assess the vulnerability of one's family and one's community to potential stressors;
- Identify potential sources of assistance and support in the event of a disaster situation.

Preparedness

Preparedness in terms of management of stress reactions includes physical, procedural and psychological and social aspects.

Physical preparedness:

- Build "safe" structures;
- Ensure adequate maintenance of such structures;
- Always keep reserve supplies in case of an emergency;
- Take the necessary precautions once disaster threatens.

Procedural preparedness:

- Have clear contingency plans in the event of a disaster;
- Make sure that such contingency plans are understood by all those who could possibly be affected by them;
- Organize regular group training sessions (for families, organizations, communities, etc.) and drills that include rehearsal of survival techniques;
- Have adequate insurance in place at all times.

Psychological and social preparedness:

- Keep abreast with current and accurate information about possible disaster situations;
- Routinely practice effective coping skills;
- Become part of a healthy community and social network;
- Participate earnestly in relevant community activities.

Consolidation and rebuilding

Consolidation and rebuilding are the most important post-disaster stages. Approaches to managing stress reactions for emergency response personnel during these phases are outlined below.

Consolidation

- Try to appraise the situation as accurately as possible;
- Take control of your response to the situation;
- Avoid unnecessary exposure to traumatic scenes;
- Have positive but realistic expectations of the future;
- Seek assistance as deemed necessary;
- Recognize the need to manage wisely and pool available resources.

Rebuilding

- Recognize the need for self-reliance;
- Accept that the process will take time and that assistance from outside sources will tend to decrease with time;
- Devise a plan, focus on short-term necessities and prioritize activities;
- Come up with various strategies for achieving this plan, evaluate them and choose the option which appears to be most appropriate;
- Implement the strategies chosen and carefully monitor the implementation process;
- Learn from your experiences and from those of others.

What are the techniques used in SMID?

Techniques employed in SMID in preparation for, during, and following a disaster are outlined below.

(1) Pre-Incident Measures

- (a) SMID Team formation
- (b) On-going education programs
- (c) Regular stress-relieving activities
- (d) Briefing prior to deployment at a specific incident

(2) *On-scene support:*

- (a) Rest and food
- (b) Limiting exposure and reassignment
- (c) One-to-one crisis intervention
- (d) Advice to supervisors when necessary
- (e) Peer support
- (f) Professional personnel support

(3) *Post-incident measures:*

- (a) One-to-one crisis intervention
- (b) Reassignment
- (c) Peer support
- (d) Professional personnel support
- (e) Significant-other support services
- (f) Informal group discussions
- (g) Recreational activities
- (h) Stress management education programs
- (i) Demobilizations
- (j) Defusings
- (k) Debriefings
- (l) Follow-up services
- (m) Referral options

Education programs

Education is the single most important SMID component. People who are forewarned about traumatic stress are generally able to recognize the signs and symptoms of it earlier, seek help when it is needed and cope with such reactions better. Education programs may be pre-service or in-service and they should include briefings prior to deployment.

The techniques used in such programs may range from the distribution of information leaflets to the formal training of SMID Team members.

The best stress education takes place before persons have been exposed to a traumatic event. Hence, prior to commencing active duty, all recruits, trainees, volunteers and other

personnel should receive an orientation to the possible psychological demands of their work. Prior training is not always possible, but it should be emphasized that stress education, even after the fact, can be helpful in providing useful information which can help to reduce emotional turmoil and restore a person to normal functioning.

Any education program should make use of videos, sound tracks and photographs that orient the participants in the program to the “sights and sounds” which they are likely to encounter. This technique is known as *trauma immunization*.

Discussion of some of the following topics during training may prove beneficial.

1. Understanding human behavior,
2. Family dynamics and family-life education,
3. Adaptive personality traits,
4. Adaptive social and interpersonal skills,
5. Physical and mental health promotion,
6. Social support networks,
7. Peer support,
8. General stress,
9. Occupational stress,
10. Critical incident stress,
11. Post-traumatic stress syndromes,
12. The impact of disasters,
13. Understanding grief and bereavement.

On-scene support

On-scene support refers to direct support services which are provided at the scene of a traumatic incident. This support is usually provided by trained peer support personnel but mental health professionals and the clergy may also assist. Such on-scene support services are typically offered to individuals and not to groups to minimize further disruption.

The goals and techniques of on-scene support are similar but not limited to those of crisis intervention. There are three basic types of support that may be provided at the scene:

- Brief crisis interventions with emergency response personnel who may be showing signs of distress,
- Advice and counsel for supervisory personnel, and

- Assistance to victims, survivors and family members who were directly involved with the incident.

Interventions should be brief, flexible and focus on immediate concerns only. In such situations, a 5-minute intervention is considered long, and 15 minutes extremely long. If a distressed person at a scene does not show marked improvement by the end of 15 minutes it is unlikely that such a person will recover sufficiently to return to work at that scene.

Possible signs of distress include:

- Crying,
- Screaming,
- Overall loss of emotional control,
- A shocked-like state,
- Staring,
- Wandering aimlessly,
- Isolation from the group,
- Unprovoked outbursts of anger,
- Strange behavior.

Peer support

Peer support interventions offer unique advantages over traditional mental health services especially when the peer-group views itself as being very unique, selective or otherwise “different” as compared to the general population. Peers can most effectively eradicate the myth of unique vulnerability and are in a much better position to offer advice on effective coping and appropriate stress management techniques. Well-trained peers can be very effective.

Support services for significant others

Since individuals are part of larger social groups such as families, organizations and communities, what negatively impacts on them may also indirectly impact on those around them. Consequently, it is important that stress management services be made available to groups of persons that may be indirectly affected by a traumatized individual. Children and adolescents should not be forgotten in this respect.

Support services for significant others include social activities, stress education programs, debriefings and crisis intervention counseling if necessary. On some occasions, the

emergency response personnel may need to be present. Services of this kind should be governed by the needs of the individuals involved. Specific examples of direct services to significant others include:

- Debriefings for spouses after a particularly distressing incident in the community or after a line-of-duty death in an organization;
- Bereavement counseling and follow-up care, as necessary, for the family and relatives of the deceased;
- Follow-up contact with the bereaved family for several weeks after the death;
- Grief seminars for affected families six months after the death;
- Groups for children and for adolescents after a highly traumatic incident that impacted on their parents;
- Advice about child care during times of distress in the family when such distress is directly associated with the work of an emergency services or disaster worker.

Education programs for significant others should include topics and activities such as:

- Understanding human behavior,
- Family dynamics and family-life education,
- Adaptive personality traits,
- Adaptive social and interpersonal skills,
- Physical and mental health promotion,
- Coping with anxiety and stress,
- Critical incident stress,
- Post-traumatic stress syndromes,
- Understanding grief and bereavement,
- Supporting the distressed loved one,
- Understanding children and adolescents in crisis,
- Work place tours and ride-along programs,
- Spouse support programs.

Professional support personnel

Professional support personnel include the clergy and mental health professionals. Mental health professionals are certified mental health counselors, psychiatric nurses, social workers, mental health occupational therapists, psychologists, psychoanalysts and psychia-

trists. All these persons have special knowledge and skills and have received specialized training within their professional fields. It is critical that whoever provides SMID services, whether they be peer or professional support personnel, be properly trained in SMID, counseling techniques, techniques of crisis intervention and post-traumatic stress syndromes. SMID interventions conducted by untrained persons, no matter how well intentioned, may result in significant harm to the recipients of such services.

Follow-up and referrals

Any intervention, ranging from an individual consultation to a formal debriefing, needs to be followed up. Follow-up services include telephone calls, on-the-job visits, peer visits, small group meetings, one-to-one counseling, contact with family members, chaplain contacts, discussions with senior personnel, referral to a professional contact and any other measure which may be deemed necessary in the aftermath of a traumatic event.

What should you do if you've been affected by exposure to a traumatic event?

Below are some guidelines which will assist anyone who has been exposed to and affected by a traumatic event to rapidly return to normal functioning.

- Try to live as normal a life as possible, and do the things that make you feel good;
- Keep away from mind-altering substances;
- Exercise regularly and eat a balanced diet;
- Come to grips with your feelings and be honest about them—you can write them down on a daily basis;
- No need for you to isolate yourself, but take time out for sleep, leisure, relaxation and to be alone;
- Refrain from blaming others or making major decisions, but keep in mind that only by making some decisions will you regain your confidence;
- Let go of your feelings of guilt and self-blame;
- Open up to others and spend time with them;
- Feel rotten if you need to but maintain a sense of humor;
- You can lend a helping hand to others, but overextending yourself is counterproductive;
- Utterances fuelled by anger or ignorance are best left unsaid;
- Remember that you may be accident prone, so be careful;
- Structure your time and keep busy;

- Think realistically and positively;
- Realize that your reaction is neither unique nor abnormal;
- Endeavour to accept your limitations and those of others;
- Seek professional help if necessary;
- Strive for inner peace, and above all, *don't quit*.

What should you *not* do after you or someone else has been affected by exposure to a traumatic event?

1. Don't believe that you have to care for your co-worker if you feel mentally unable to do so. *You won't be able to.*
2. Don't believe that you can't say what you're feeling. *You need to.*
3. Don't attempt to reassure yourself or others that everything is "okay". *It is not.*
4. Don't try to impose your explanation for what happened on others. *That is just your opinion.*
5. Don't blame yourself for what happened. *This is not the time for accusing anyone.*
6. Don't tell other persons that you know how they are feeling. *You don't.*
7. Don't say to the other person to simply forget about it. *It isn't that simple.*
8. Don't feel pressured to respond when someone else is talking to you. *Just being there and listening is what matters the most to that person.*
9. Don't be afraid to ask someone else how they are doing. *Your concern may be very uplifting for them.*
10. Don't try to talk someone else out of their feelings even if you don't understand their reactions to an incident. *Just listen.*

End of Section Quiz

Please circle the correct answer.

- | | | | |
|-----|--|---|---|
| 1. | One should try to live as normal a life as possible after exposure to a traumatic situation. | T | F |
| 2. | A defusing is one possible method of on-scene support which may be used in a disaster. | T | F |
| 3. | SMID is based on the principles of crisis intervention and critical incident stress management. | T | F |
| 4. | Early intervention after a stress reaction is not necessary for maximum benefit to be derived from the intervention. | T | F |
| 5. | Significant-other support services is one post-incident SMID measure. | T | F |
| 6. | When you are experiencing a stress reaction daily use of alcohol may be helpful. | T | F |
| 7. | We have some control over what happens to us psychologically after exposure to a disaster. | T | F |
| 8. | Promotion of worker health and well-being is a SMID goal. | T | F |
| 9. | After exposure to a disaster situation, don't attempt to reassure yourself or others that everything is "okay". | T | F |
| 10. | Adequate sleep and a balanced diet are essential after exposure to a traumatic situation. | T | F |

Note: Answers to questions are on page 128.

