American COUNSELING Association

ACA Practice Briefs

Published Fall 2019

Disaster Mental Health in the Age of COVID-19

Karen Roller, Palo Alto University

DESCRIPTION OF DISASTER MENTAL HEALTH

Disaster mental health (DMH) counseling, also known as disaster behavioral health, is the treatment of the immediate reaction to, and ongoing exacerbated stress born of, extreme natural or human-made crises, often bringing subsyndromal symptoms to the surface due to the extenuating circumstances that negatively impact individuals' and communities' access to internal and external coping and resources (SAMHSA, 2015; Webber & Mascari, 2018). DMH requires a systematic response to return individuals and communities to pre-event baseline functioning, expressed in the two goals of "mitigating the development of serious mental disorders...(and) providing tools that support the natural recovery process that occurs over time for the majority of the affected population" (SAMHSA, 2015, p. 2).

DMH has historically been employed in response to mass shootings, bombings, hurricanes, tornadoes, earthquakes, tsunamis, floods, wildfires, and other regionally-bound large-scale crises (Webber & Mascari, 2018) that result in trauma, which has been described as the body's natural response to an overwhelming situation (Levine, 2010). From a traumatology standpoint, the closer one is to a life-threatening event; the higher the risk of being traumatized; as layers of protection or distance are available, the risk of being traumatized is reduced (MacFarlane et al., 1996).

The COVID-19 pandemic presents the first truly global disaster with negative repercussions touching nearly every sector of public health and well-being, thus reducing the layers of protection available to the general populace, though increasingly so for those who must continue to work or live where they are exposed to the public. This pandemic affects private coping dramatically, due to the enforced social isolation, yet disproportionately due to pre-existing social and financial inequities, and widescale competition for limited support resources to address food insecurity, lost health insurance, employment, and housing and healthcare services for those of lesser means. Furthermore, similar to 9/11 first responders' unpredicted, yet devastating long-term health impacts, DMH for COVID-19 must be employed by practitioners who are themselves at ongoing risk of exposure.

The COVID-19 pandemic forced clinicians and educators in every country and setting to prioritize crisis stabilization of Maslow's (1943) survival and affiliative needs while social distancing and sheltering-in-place, often while learning to meet personal and professional needs in real-time (Shang et al., 2020). Virtually all professional and personal contacts were impacted physically, financially, emotionally, and relationally; the mental healthcare workforce had no sustainable option but to prepare and respond accordingly.

According to the World Health Organization on March 3, 2020, the COVID-19 global mortality rate was about 3.4%, with higher rates closer to hot spots (https://www.worldometers.info/coronavirus/coronavirus-death-rate/#ref-13). The high contagion risk, lack of herd immunity, and unpredictability

of health risk factors for this novel coronavirus created severe life-threatening risk for already-vulnerable populations, and the long-term health effects of contracting the virus for all populations were still unknown. Further complicating this threat assessment was the steady flow of conflictual data and behavioral guidelines, and politicization of the crisis, which interfered with confident decision-making based on individual, familial, and systemic needs and responsibilities. This ongoing unpredictability and life-threatening danger activated a widespread survival response across the globe, wreaking economic havoc, overwhelming medical systems, shutting down pathways to care, and exacerbating chronic relational stressors to increase risk of domestic violence, child abuse, depression, anxiety, insomnia, substance abuse, and post-traumatic stress disorders (https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html), replicating the impact of a regional disaster on a global scale.

Diminished options for escaping unsafe or increasingly stressful situations necessitated more considerable skill among clinicians not specializing in crisis intervention to assess for increased risk of suicide and safety needs, especially for clients already dependent on paid professionals for social contact. Similarly, counselors worked with front-line medical workers who suffered moral injuries affiliated with insufficient support to safely care for all their patients or struggled to process the exorbitant emotional demands placed upon them with little downtime (Reger et al., 2020). Increased demand for crisis intervention skills was also required for work with abuse victims, often without clinicians having proximal access, assured confidentiality, or reliably safe referral locations for their clients. Such clinical stressors increase the risk of burnout for clinicians, which can be further exacerbated into compassion fatigue when one is experiencing primary traumatic stress from the same event. This practice brief offers personal and professional resources to support counselors' work within DMH.

INTERVENTION STRATEGIES

At the time of this writing, there was no recognized national standard for DMH intervention during a global pandemic. Further, regionally-bound disaster intervention tended to produce outcomes specific to the population impacted by the particular form of disaster, delimiting its generalizability. The best available practice at the time appeared to be Psychological First Aid (PFA), delivered via telehealth whenever possible, or wearing personal protective equipment upon return to the field as an essential worker. However, a systematic literature review of PFA did not provide evidence-based guidelines across populations and disasters (Dieltjens et al., 2014).

Preliminary research suggested telehealth is useful in psychiatric emergencies (Bolle et al., 2018), so long as ethical considerations are managed effectively (Stoll et al., 2020). The American Counseling Association (ACA) offers guidelines and training for standard telehealth practice while continuing education trainings discounted during the quarantine helped strengthen DMH practice and a comparison of telehealth platforms (https://telementalhealthcomparisons.com/) helped inform decision-making about the best format for practice. The following is an overview of how to apply PFA via telehealth.

PFA is an evidence-informed intervention applied immediately following disasters, terrorism, and other emergencies, prioritizing those at highest risk by assessing factors associated with PTSD, depression, and anxiety, following simple listening and action steps to help calm, restore a sense of individual and community agency, and re-connect survivors to appropriate long-term supports (Dieltjens et al., 2014). According to the National Center for PTSD (Brymer et.al., 2006):

(PFA) is supported by disaster mental health experts as the "acute intervention of choice" when responding to the psychosocial needs of children, adults and families affected by disaster and terrorism. At the time of this writing, this model requires systematic empirical support; however, because many of

the components have been guided by research, there is consensus among experts that these components provide effective ways to help survivors manage post-disaster distress and adversities, and to identify those who may require additional services. (p. 5)

The following list comprises the "eight *PFA* Core Actions" (National Child Traumatic Stress Network, 2020, p. 1, para. 4), with this author's summarized guidelines for implementing them via telehealth italicized:

- **Contact and Engagement:** To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner. *At the beginning of each session, inquire with adult clients or minor's guardians about their physical location, access to a safe adult if they are a minor, and ensure updated emergency contacts and permission to serve via telehealth for that location before proceeding. Use strengths-based feedback to honor client's willingness to engage in session and share needs.*
- **Safety and Comfort:** To enhance immediate and ongoing safety and provide physical and emotional comfort. *Ask clients who is with them at that time, if they have access to private space for the session, and what else they need to be comfortable for the session. Use silence and mirroring to help clients pace processing between questions, and oscillate between open and closed-ended questions depending on whether clients need balance when internalizing or externalizing distress regarding unmet needs. Starting at the bottom of Maslow's hierarchy, gently inquire about survival, security, and then affiliative needs. Use clinical judgment to determine if the client is unable to be transparent due to the presence of an abuser or others they are protecting; if necessary, inquire if there might be a better time to meet. Perform a mental status exam by inquiring about current setting, mood, thought process, available supports, and skills of daily living; rule out imminent risk of death to self or other by following up on signs of suicidal or homicidal ideation, signs of hopelessness or a foreshortened future. If a client is internalizing, gently validate that it is difficult to share right now, and use empathic conjecture to guess at negative affect based on client circumstances; normalize fear, sadness, loneliness, and state your intention to help clients find their way through pain. If the client is externalizing, contain it through regulated validation and soothing, allowing the stress response to discharge through attentive witnessing and gentle guidance to ground. If immediate concerns exist, a 911 call may be needed to request a welfare check.*
- **Stabilization (if needed):** To calm and orient emotionally overwhelmed or disoriented survivors. *Ground others in the here-and-now awareness by modeling and encouraging slow exhales, finding an available anchor for client's visual, auditory, and kinesthetic attention, using a soothing and gently authoritative tone. Facilitate proprioceptive exploration with eyes open to help client shift attention inward without becoming over-activated and flooded by negative affect. Attend to the stress response and complete activation where possible through titrated, regulated exhales. Expand awareness to extremities by placing attention where the body makes contact with furniture or floor and allowing for crying or sobbing as necessary. Follow the client's rhythm of releasing the stress response and resting in between discharges, unless they escalate into dissociation (where eyes will close and too much activation won't allow you to co-regulate them); if this begins to occur, kindly strengthen your vocal tone to draw their attention back to the here-and-now, direct them to open their eyes and see you, find something soothing in room to hold, pull their sensory awareness back into the safety of the moment by explicitly noting that current physical safety, and have them keep their eyes open on you or a pleasant object in the room. Normalize the body's response to overwhelm and provide psychoeducation of "tapping on the brakes" when stress gets too big* (Porges & Dana, 2018).
- **Information Gathering on Current Needs and Concerns:** To identify immediate needs and concerns, gather additional information, and tailor PFA interventions. *Follow up on negative affect by inquiring about unmet needs starting at the bottom of Maslow's hierarchy and systematically moving up, as well as strategies being employed to meet needs. Provide strengths-based feedback for strategies that appear to be working and consider alternatives for strategies that are not working.*

- **Practical Assistance:** To offer practical help to survivors in addressing immediate needs and concerns. *Because client and clinician are not co-located in telehealth, this requires asking for help from local authorities or support systems, depending on severity of need. If clinical judgment suggests an abuser may be present and over-hearing, do not increase risk by making explicit comments related to abuse, but seek supervision immediately after the session to determine whether to call appropriate authorities. If the client is physically safe, move up Maslow's hierarchy to security needs, inquiring about food, housing, medicine, or clothing, and determine if clients need help seeking assistance from local authorities, service providers, or support programs to acquire goods or services. Determine if social support systems will help clients seek practical help, and to what degree you will likely need to facilitate this when clients or support systems cannot.*

- **Connection with Social Supports:** To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources. *Facilitate connections with support systems through signed release of information, initiating contact as approved and necessary, or as indicated in exceptions to confidentiality on informed consent. Provide psychoeducation regarding importance of initiating and maintaining regular social contacts with trustworthy loved ones, and inquire about support received by trusted others to enhance positive affect, sense of belonging, normalization of stressors, sharing of coping mechanisms, pleasant distraction, and mental engagement. Encourage ongoing engagement with spiritual/religious community, school or work community, and loved ones via videoconferencing or phone calls as possible.*

- **Information on Coping:** To provide information about stress reactions and coping to reduce distress and promote adaptive functioning. *Normalize stress reactions through trauma-informed care, provide empathic conjecture regarding the multiple stressors clients are likely facing due to the disaster, and offer age-appropriate psychoeducation on self-care through resources listed below.*

- **Linkage with Collaborative Services:** To link survivors with available services needed at the time or in the future. *Collaborate with available support systems and perform searches of necessary and available services in the geographical area. Determine what the client is able and willing to access.*

Age and developmental stage impact the ability to engage meaningfully and self-report accurately across a screen. Clinicians working with children and adolescents will need to be mindful of managing clients' affect in proximity to the family's device, and creative in using online play therapy techniques to settle minors activated by stressors they cannot control. Sensory data available to the clinician to determine mental status exam is limited to visual and auditory data from about the sternum to the top of the head and to the immediate surroundings of the client. Thus, clinicians may also need to be more explicit in asking about risks and protective factors when they determine it is safe for the client to do so. Initial assessment of new clients, and behavioral anomalies for long-standing clients, may be more difficult to interpret when not co-located. Thus, clinicians must maintain ongoing consultation, supervision, and updated information on available local referral networks in the case of escalating psychiatric emergency.

When education, training, and experience do not meet the demand of the clinical situation, risk for compassion fatigue increases (Bates et al., 2011; Burk, & van Dernoot-Lipsky, 2009; Figley, 2015; Stamm, 2010), thus it is imperative to take advantage of free and low-cost training for telehealth service provision and PFA offered for practitioners, and share resources for telehealth interventions appropriate for target populations wherever possible. Furthermore, for those now interfacing with client family members whose preferred language is not English, on-demand HIPAA-compliant interpretation services in 170 languages are available for a nominal monthly fee through AT&T.

Resources

Disaster Mental Health and Psychological First Aid

To call 911 out of your area: https://www.911.gov/frequently_asked_questions.html

For more information on DMH: https://www.counseling.org/knowledge-center/mental-health-resources/trauma-disaster/mental-health-professional-counseling-and-emergency-preparedness

For more information on DMH: https://www.samhsa.gov/sites/default/files/dtac/supplemental-research-bulletin-may-2015-disaster-behavioral-health-interventions.pdf

For disaster help: https://www.samhsa.gov/disaster-preparedness

For domestic violence help: https://www.thehotline.org/

For more information on current HIPAA guidelines: https://www.counseling.org/knowledge-center/mental-health-resources/trauma-disaster/telehealth-information-and-counselors-in-health-care?utm_source=informz&utm_medium=email&utm_campaign=covidresources

For online training and tools: https://emsa.ca.gov/wp-content/uploads/sites/71/2018/11/EOM-Disaster-Behavioral-Health-10-26-2018.pdf

PFA resources for family and neighbors: https://www.fema.gov/media-library-data/1499092051917-115ad4c12a44f04a93b4a37c17e99211/PFA(1).pdf

For information on current HIPAA accommodations: https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html

PFA training: https://learn.nctsn.org/enrol/index.php?id=38

PFA field operations guide: https://www.nctsn.org/resources/psychological-first-aid-pfa-field-operations-guide-2nd-edition

Red Cross Introduction to PFA: https://pscentre.org/?resource=pfa-a-short-introduction

For free ongoing access help and updates: https://store.samhsa.gov/product/SAMHSA-Behavioral-Health-Disaster-Response-Mobile-App/PEP13-DKAPP-1

For more information on PFA skills : https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa

For free online training in PFA: https://www.pathlms.com/naccho/courses/4592

For free online training in PFA: https://www.naadac.org/psychological-first-aid-webinar

For more PFA tools: https://www.phe.gov/Preparedness/planning/abc/Pages/behavioralhealth.aspx

PFA tools for parents and children: https://www.ready.gov/sites/default/files/documents/files/PFA_Parents.pdf

PFA tools for teachers and students: https://www.ready.gov/sites/default/files/documents/files/PFA_SchoolCrisis.pdf

Red Cross COVID-19 training: https://www.redcross.org/take-a-class/in-the-news/coronavirus-prevention-information-for-students

For more information on DMH: https://relief.unboundmedicine.com/relief/view/PTSD-National-Center-for-PTSD/1230010/all/Introduction_and_Overview

For more technical information on PFA: https://www.samhsa.gov/dtac/about

For access to support: https://www.samhsa.gov/find-help/disaster-distress-helpline

For more information on DMH: https://www.state.nj.us/humanservices/dmhas/home/disaster/credentialing/DRCC_Training_Materials/Intro_Disaster_MH_Crisis_Counseling.pdf

For more information on DMH: https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies

REFERENCES

Bates, M., Brown, D., Money, N., & Moore, M. (2011). *Mind-body skills for regulating the autonomic nervous system*. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

Bolle, S. R., Trondsen, M. V., Stensland, G. Ø., & Tjora, A. (2018). Usefulness of videoconferencing in psychiatric emergencies -- a qualitative study. *Health and Technology*, *8*(1), 111–117. https://doi.org/10.1007/s12553-017-0189-z

Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg E, & Watson P. (2006). *Psychological first aid: Field operations guide* (2nd ed.). National Child Traumatic Stress Network and National Center for PTSD.

Burk, C., & van Dernoot-Lipsky, L. (2009). *Trauma stewardship*. Berrett-Koehler.

Dieltjens, T., Moonens, I., Van Praet, K., De Buck, E., & Vandekerckhove, P. (2014). A systematic literature search on psychological first aid: Lack of evidence to develop guidelines. *PloS One*, *9*(12), e114714. https://doi.org/10.1371/journal.pone.0114714

Figley, C. R. (Ed.). (2015). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Brunner/Mazel.

Levine, P. (2010). *In an unspoken voice: How the body releases trauma and restores goodness*. North Atlantic Books.

MacFarlane, A. C., van der Kolk, B. A., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. Guildford Press.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396. https://doi.org/10.1037/h0054346

Porges, S., & Dana, D. (Eds.). (2018). *Clinical applications of the polyvagal theory*. W. W. Norton & Co.

Reger M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019—A perfect storm? *JAMA Psychiatry.* https://doi.org/10.1001/jamapsychiatry.2020.1060

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). ProQOL.org.

Stoll, J., Müller, J. A., & Trachsel, M. (2020). Ethical issues in online psychotherapy: A narrative review. *Frontiers in Psychiatry*, *10*, 993. https://doi.org/10.3389/fpsyt.2019.00993

Substance Abuse and Mental Health Services Administration. (SAMHSA). (2015). *Disaster behavioral health resources*. https://www.samhsa.gov/dtac/disaster-behavioral-health-resources

Webber, J. M., & Mascari, J. B. (Eds.). (2018). *Disaster mental health counseling: A guide to preparing and responding* (4th ed.). American Counseling Association Foundation.