

**Commentary on “Five Essential Elements of Immediate and Mid-term Mass Trauma Intervention: Empirical Evidence”
by Hobfoll, Watson et al.**

A Sound Blueprint for Building a Stronger Home

Brian W. Flynn

As I train, consult, and lecture regarding disaster mental/behavioral health, I find myself relying heavily and repeatedly on several publications in the field that I find most applicable to the work I now do. It is gratifying to see the field of disaster behavioral health expand and there are certainly many important articles, chapters, and books regularly emerging that provide invaluable information and insights. I suspect that this article will stand out in the crowd and become one to which I refer regularly.

What makes this article stand out? For me, important factors include:

- The large number of authors contributing to this article represent extraordinary diversity and unquestionable credibility. It gives the text a breadth and perspective that fewer, more homogeneous individuals seldom produce.
- Few articles do as well in relying on evidence in the formulation of major findings and recommendations while, at the same time, being honest and clear about the limits of the evidence base.

- There is a “goodness of fit” among the proposed elements. It simply makes sense. In addition, care that has been taken to document the rationale for each element as well as the cautions and complexities in both understanding and applying each.

Here are several fundamental messages in the article that are worthy of highlight:

The “Less Is More” Trend

While application of the suggested elements is anything but minimalist, simple, or easy, it does continue to reinforce a trend away from more intense individual and group psychological interventions except when clearly warranted. It reinforces, with evidence, the importance of identifying and securing basic needs in the early post-event period. It reinforces the direction taken by the various emerging models of psychological first aid. It helps, in my view, legitimize (with important cautions) the natural healing and resilience process. It provides additional roles and places additional tools in the hands of

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those who assist victims. In addition to being the provider of specialized psychosocial and medical interventions, it casts the provider in the role of protector, supporter, and advocate (more about that later). While some might see this as diluting the role of the behavioral health provider, I view it as enhancing and enriching that role.

The Importance of Reality-Based Interventions

It was very gratifying to see the complexity of the notions provided in the article. It is especially helpful that the article stresses the importance of applying these elements, based on reality, not just hope or wish. As examples, the article talks about not just safety but *relative* safety; *reality*-based appraisal of efficacy, and the problems of promoting hope without resources. Well-intentioned, but less sophisticated, authors might not have included these important nuances and thus, in the application of these elements, doomed them to failure, or worse, added to the problems of survivors.

The Call to Broader Interventions and/or Expanded Partnerships

This article proposes many activities and roles that behavioral health professionals do not see as being within their traditional roles or skill sets. Stated or implied examples include advocacy and promoting community efficacy. This article is a welcome, yet perhaps unintended, call to either expand the conceptualization of our role or, failing that, partner with others in closer, more collegial ways.

The Return/Rediscovery of Community Mental Health

Intended or not, major elements of this article read like an evidence-based rationale for a return to basic principles of community mental health. Eric Lindemann would be proud.

One of the factors that attracted me to the field of disaster mental health almost 30

years ago was that it provided an opportunity to apply the principles and practice of community mental health. Little did I know then that disaster behavioral health would become one of the very few remnants of this perspective remaining in the United States today. The former community mental health system has fundamentally changed its focus (although sometimes the organization names have not changed). Today, that system primarily focuses on treatment and support of those with serious and persistent mental illness. Long gone are publicly funded entities that, in addition to clinical services, incorporate notions of population-based interventions, preventive efforts, consultation and liaison service to diverse community partners, and promotion of healthy relationships between individuals and the community context in which they live. Fundamental to concepts of community mental health are notions that individual mental health is inextricably linked to the health of the community and that each impacts the other. In my opinion, the field of disaster behavioral health is one of the few places where those concepts can find primacy. The ability to practice and promote principles of community mental health has been a significant factor in retaining my interest and commitment over decades.

In addition to discussing interventions focused at the individual level, the article promotes such concepts as:

- The importance of social interaction
- Recommendation of community-based interventions
- Acknowledgment that solutions that target large-scale problems are beyond the reach of any individual
- Collective and community efficacy
- The value of non-traditional interventions, such as support for boat rebuilding following the tsunami in Asia

The article eloquently articulates the critical nature of community context in the promotion and protection of individual mental health. Two quotes stand out:

“A community provides safety, makes resources available for rebuilding and restoring order, and shares hope for the future.”

“Competent communities promote perceptions of self-efficacy among their members, fostering the perception that others are available to provide support, and support families who, in turn, provide sustenance to their members.”

In the face of a public mental health system that is focused almost exclusively on those with serious and persistent mental illness and devotes nearly all of its tragically and shamefully inadequate resources on the treatment and community support of this group, the case for a population-based comprehensive community mental health approach is swimming against the flow of a decades-long trend. To digress, in all honesty, this trend was in part initiated by serious shortcomings of the community mental health system to adequately address the complex and legitimate needs of those most ill. In light of history and trend, the implementation of, or adaptation to, a true system based on community mental health principles has enormous implications for public policy, funding, and support by advocacy groups.

If the public mental health system were to be changed, even under the most optimistic circumstances, it would be a lengthy and uneven process. To take a more realistic (and admittedly less optimistic) view, can (or how can) the elements described and models implied by this article be developed and sustained in a context of a mental health system that continues to be seriously underfunded and narrowly focused? Are there other systems with which to link that would enhance the probability that the conclusions of this article could be realized?

NEXT STEPS

All quality articles raise many new challenges. This article both informs and raises

many exciting and difficult potential next steps. I would highlight just a few:

Models of Intervention

This article wisely states at its inception that it is not intended to promote specific models of intervention. It does however give us tantalizing glimpses of what pieces of such models might look like. In many ways, most of the newly emerging models of psychological first aid (PFA) incorporate many of the essential elements discussed here. But, in my view, the call of this article is for intervention models that go beyond what most current PFA models would include. This is especially true of the interventions that may be more community-focused.

In this context, I was especially struck by the statement that, “Lack of understanding of the link between efficacy belief, behavioral skills, practiced repertoires, and access to resources leads to serious attribution and intervention errors.” What would models that avoid those pitfalls look like? How do we promote and instill strong but accurate efficacy beliefs? What are the best ways to instill and sustain positive behavioral skills and repertoires? How do we best empower survivors in obtaining adequate resources? How does the role of the intervener change in a context where advocacy is an additional and central role and skill? Knowing what this article has told us about the importance of leadership and adequacy of resources, as behavioral health professionals, what are our public policy opportunities and obligations?

Fine Tuning for Different Circumstances

One of the appeals of the five essential elements is their seeming universality. As further writing, thinking, and evidence is developed, it will be necessary to examine in more depth how these elements play out with regard to a number of challenging variables. These variables might include culture, different event types, survivor characteristics and

history, and community characteristics and history.

It is interesting and challenging to think about, for example, how these elements might be implemented in programs and approaches leading up to and following a rapid onset Category 5 influenza pandemic. How are these elements applied in a disastrous situation that visits every community, lasts over many months or years, creates massive death and illness, massively impacts the provider community, and adversely impacts economies and geopolitical stability across many nations.

Understanding and Adoption by Leadership

Developing usable evidence-based guidance is extremely difficult in itself. Bringing that guidance to practice is, if not more, difficult. There are implications in all of the articles guidance for training, practice, research, and public policy. If the fruits of this fine work are to see the light of day, serious consideration will need to be given to assisting leaders of many types (mental health policy, practice, training, public policy, etc.) in both understanding the importance and implications of this work and adopting its content.

The Earliest Intervention

Perhaps appropriately (due to scope and evidence), the article did not address the earliest intervention–prevention. Discussions about prevention in the mental health field are scientifically, programmatically, and politically complex. However, in the field of disaster behavioral health, this discussion is far less complex and far more intuitive. Simply, if we can prevent the occurrence of, or magnitude of, physical, psychological, social, and medical events that cause fear, distress, and trauma, we can prevent and reduce psychological trauma. Period.

Unfortunately, most of our psychosocial interventions are limited to those provided during and following exposure. It seems intuitively obvious to me that those of

us with an interest in reducing the impact of traumatic events should have an equal or greater interest in preventing their occurrence in the first place. Obviously, this approach has its limitations (we are not yet at the point of being able to prevent hurricanes), but there is much that we can do if we begin to think outside the limits of our traditional roles. It means that we as behavioral health professionals must begin sitting at tables and inserting ourselves, our commitment, and our expertise in contexts that are largely unfamiliar and untraditional (except in the purest community mental health and public health traditions). It means we sit on community planning/zoning boards as they consider levee design or building in floodplains. It means we take an interest in the architecture and glass technology used in our schools and public buildings to assure that occupants can be made as safe as possible in the event of an earthquake, hurricane, or bomb blast. It means that, welcomed or not, we make decision makers aware of the potential health impacts of fires/explosions when building liquid natural gas import facilities near where people live and work. The possibilities are limited only by our imaginations.

CONCLUSION

It is both exciting and refreshing to review and comment on an article that is so well done and raises so many exciting and challenging issues. The quality of the article is a tribute to the volume and quality of the evidence base that underpins the article's findings and the scope and diversity perspective of the many authors. While most of the time it continues to be frustrating not to have enough of an evidence base in this field and to have too little effort placed on making the evidence useful for practice and policy, this article is breath of fresh air and an antidote to frustration and cynicism. What better can be said of an article than that it both educates and motivates.