Psychoeducation as a Response to Community Disaster

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Public education is a means of supporting trauma survivors without impeding their natural recovery process by providing accurate information about normal reactions and ways to cope in the aftermath of community disaster. It can also be used to screen for high-risk individuals who could benefit from ongoing care. Normalizing trauma reactions and eliminating the hardship of seeking mental health resources may reduce the stigma associated with obtaining this type of support. One way to accomplish this is by linking psychoeducation with concrete services, a tactic that may also attract greater numbers of participants. This article explores the literature on the subject and reports the results of psychoeducation interventions provided in response to the events of September 11, 2001. The format and outcome of the public education workshops are presented along with case material. Recommendations for implementation, including other potential applications of this methodology, are highlighted. [Brief Treatment and Crisis Intervention 4:1–10 (2004)]

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Community disaster threatens lives, evokes terror, and shatters the sense of safety that comes from a normal feeling of control, connection, and meaning in life (Herman, 1992). The majority of trauma survivors will not develop psychological disorders, but approximately 25% will become fixated upon the ordeal and develop posttraumatic stress disorder (PTSD), depression, or generalized anxiety disorder (Underwood & Spinazzola, 2003; van der Kolk, 1996). Numerous psychotherapeutic interventions have been utilized to promote recovery in the weeks and months after a traumatic event. Unfortunately treatment methodologies vary in efficacy and appropriateness. For example, debriefing is widely implemented following disasters despite scant evidence of its effectiveness (Harris, Baloglu, & Stacks, 2002; van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Furthermore, the stigma associated with seeking and receiving mental health services...
presents a barrier to attaining mental health care (Ben-Porath, 2002).

Public education is an example of an appropriate mental health intervention that may circumvent the stigma associated with receiving help. The hardship of seeking out mental health services is eliminated as information and resources are brought directly to clients. The focus of psychoeducation is on empowering clients with knowledge rather than overhelping those who are naturally recovering. It also validates normal trauma reactions while enabling practitioners to screen for high-risk clients who require more intensive treatment (Rauch, Hembree, & Foa, 2001). Public education has frequently been cited as an important component of crisis intervention and therapy, but it has rarely been conceptualized as a potentially independent entity that is useful in its own right (Lapos & Alden, 2003; Shin & Lukens, 2002).

The authors have been conducting onetime psychoeducation presentations as a component of larger sessions providing information on concrete services for those suffering from the economic fallout of the events of September 11, 2001 (9/11). Informal feedback has shown that participants are relieved to learn that their trauma reactions are normal, and they often feel supported by the resources made available to them. Psychoeducation facilitators also have the opportunity to screen for high-risk participants, many of whom have benefited from this intervention. This article will review the literature and discuss the format and outcome of public education workshops facilitated by the authors. Case material will be presented, and strategies for conducting effective workshops will be highlighted.

**Literature Review**

Human-made disasters cause survivors more distress and long-term impairment than natural disasters. Survivors experience increased anxiety in the aftermath of disasters that are sudden, life threatening, widely destructive, and continuously threatening to community members (Martino, 2002). The incidence of psychiatric disorders in disaster-affected communities usually increases by 20% over the 3 years following a traumatic event (Underwood & Spinazzola, 2003). Unfortunately trauma survivors tend to realize the full impact of loss and pain over time, as community supports begin to decline (van der Kolk, 1996; Wilson, Raphael, Meldrum, & Bedosky, 2000). Additional life stressors increase the severity of psychiatric disorders such as PTSD (Dirkzwager, Bramsen, & van der Ploeg, 2003). It has been documented that negative or minimal positive social contact exacerbates PTSD, while seeking social support and coping via active problem solving techniques alleviates PTSD severity (Dirkzwager et al., 2003).

In the case of community disasters, van der Kolk (1996) asserts, “It is widely accepted that the central issues in disaster management are the provision and restoration of social support.” Many clinicians currently endorse social support and empowerment models of intervention, often with a focus on teaching coping strategies (Dirkzwager et al., 2003; Gist, Lubin, & Redburn, 1998). Social support is especially important to communities affected by terrorism. It is generally understood that supportive interventions should be implemented within communities immediately following a disaster to prevent survivors from developing chronic difficulties (Martino, 2002). However, early intervention efforts may miss survivors’ period of greatest need because the full realization of traumatic impact is delayed (Wilson et al., 2000).

It is well known that human reactions to disaster are long lasting. Despite this knowledge, community members often encourage one another to recover as quickly as possible.
Experiencing sustained reactions to trauma can be contradictory to the Western notion that individuals are in control of their fate (van der Kolk, 1996). Moreover, mental illness, even less severe forms such as depression, is highly stigmatized in Western culture. Those who actively seek treatment for psychological distress are even more stigmatized, possibly being viewed as self-indulgent or overreacting (Ben-Porath, 2002; McFarlane, 2000). Negative attitudes toward psychological disorders and toward help-seeking behavior can prevent trauma survivors from attaining the treatment they require (Ben-Porath, 2002).

Treatment aimed at providing social support without fostering a sense of empowerment may actually impede the natural recovery process, in part by defeating survivors’ sense of self-efficacy (Gist et al., 1998; Rauch et al., 2001; van der Kolk, 1996). Critical incident stress debriefing has been shown to be less effective than no intervention at all, and this may be because it interferes with the use of avoidance as an adaptive coping strategy (Kenardy, 2001). It may also lead survivors to bypass social support (van Emmerik et al., 2002). Wilson et al. (2002) assert that mental health practitioners “may need to protect victims from those who offer help.” Many of the free crisis counseling services offered after 9/11 overlooked the fact that most disaster survivors do not need formal mental health services (Underwood & Kalafat, 2003).

**Public education** is a treatment modality that seems to bypass the stigma associated with mental illness, as well as the detriment of overhelping survivors of disaster. Public education often occurs in a community context of social support in which participants are reassured to learn about the universality of trauma reactions (Ben-Porath, 2002; Makler & Mircea, 1990). Disaster survivors often fear they are “going crazy”; psychoeducation helps dispel this myth and enable survivors to recognize their experiences as normative reactions to disaster (Hensley, 2002; Rauch et al., 2001). Psychoeducation avoids overhelping participants, instead capitalizing on personal strengths and coping strategies. Participants often experience an increased sense of self-worth as a result (Hensley, 2002). Survivors may also benefit from an early connection to mental health resources (Rauch et al., 2001).

Public education has been explored as a component of group treatment following a terrorist attack. Key aspects of the format include positive social support, normalization of trauma reactions, education about disaster, and emphasis on coping (Ottenstein, 2003). A number of mental health practitioners have determined public education a beneficial therapeutic approach (Fournier, 2002; Makler & Mircea, 1990; Ottenstein, 2003). For example, results of a 6-week psychoeducational intervention that screens for traumatized individuals indicated that participants experienced relief when they realized that their reactions were normative and they were not “crazy” (Fournier, 2002). However, Hensley (2002) states that psychoeducation does not reduce symptoms by itself; it is most effective when paired with exposure therapy, cognitive treatment, or anxiety management. This is affirmed by a study in which two treatment modalities for schizophrenics were compared and it was found that the treatment containing a psychoeducation component was more effective in reducing symptom severity and perception of stigma (Shin & Lukens, 2002). The authors were unable to locate literature pairing psychoeducation with concrete services.

Underwood and Kalafat’s (2002) case study of a 1-day psychoeducation workshop targeting 9/11 mental health practitioners shows that the sole provision of information can be a beneficial intervention. They maintain that education may empower trauma survivors to create new methods of coping by focusing on resilience and that a supportive context is critical in
facilitating an understanding of normal responses to disaster. Informal feedback shows that participants valued the opportunity to process their reactions in a structured format (Underwood & Kalafat, 2002).

Public education workshops also provide mental health practitioners the opportunity to identify people at high risk for posttraumatic stress disorder symptomatology (Rauch et al., 2001). Screening high-risk individuals is possible based upon characteristics such as the nature and severity of the trauma, as well as physiological considerations and social stressors (Norris, Murphy, Baker, & Perilla, 2003). However, PTSD does not have high predictive power (Bryant, 2003). The area of screening for high-risk individuals requires further exploration, as there is great potential to benefit disaster survivors (McFarlane, 2000).

**Methods**

Project Liberty is a federally sponsored post-9/11 support program administered by the New York State Office of Mental Health. The authors are members of a team of Project Liberty counselors for Safe Horizon, a nonprofit agency based in New York City whose mission is to provide support to victims of crime. The psychoeducation workshop is a segment of a 3-hour informational seminar conducted by Safe Horizon. Members of Safe Horizon’s Ongoing Recovery Program (ORP) conduct the larger seminar, which targets individuals who are unemployed or underemployed due to the economic fallout of September 11, 2001. Clients must meet criteria to be eligible for the ORP: They must have worked within a specific proximity to the World Trade Center, lost a certain percentage of wages, and lost those wages within a specific time frame. Those who qualify for the ORP are notarized and certified at the end of the seminar. They are eligible for free job training and health insurance, as well as information about other resources available to them.

The psychoeducation workshop is based upon the response and renewal model (R & R) of group crisis response adapted by Florrie Burke and David Mensah at Safe Horizon. The R & R was designed to create a safe space for participants to learn about trauma and its symptoms, and to validate and normalize participants’ experiences of trauma while staying in the present rather than reliving the traumatic event. The R & R emphasizes existing coping skills and aims to develop additional self-help skills. Project Liberty counselors present an adapted version of the R & R in teams of two, often with a third, backup counselor to talk with participants needing individual attention. The length and content of the psychoeducation segment is flexible, usually lasting 20 to 30 minutes and focusing on information most pertinent to the group.

The counselors are introduced at the beginning of the informational seminar by the ORP staff, and the psychoeducation segment occurs about 2 hours into the seminar. Clients are sometimes given a break just before the psychoeducation piece. After the ORP staff briefly discusses various mental health resources, the counselors are reintroduced and they inform participants that the psychoeducation segment is voluntary. An outline of the major components of the psychoeducation model is provided in the Appendix. Counselors begin by clearly stating the purpose of their piece of the seminar, which is to acknowledge the challenges participants are facing and to provide information regarding trauma and ongoing stress, as well as to facilitate a discussion on coping skills. Clients are reassured that the session is not a “group therapy” session, and they will not be asked to relive their experience of September 11. In fact, participants are discouraged from bringing up details of the disaster because it can be extremely upsetting to other participants, and the
group is not designed to contain a cathartic
group process.

After the introduction, counselors distribute
a worksheet containing information about com-
mon reactions to disaster and helpful methods
of coping. Counselors state that the list of com-
mon reactions applies to both excessive stress
and traumatic events. This point has been in-
creasingly significant as time passes and par-
ticipants describe their distress as more related
to prolonged unemployment rather than 9/11.
Reactions are divided into four categories:
emotional, behavioral, cognitive, and physical.
Participants are invited to spend a few minutes
looking over the list of reactions in each cate-
gory. Counselors emphasize that these are nor-
mal reactions to an extremely abnormal event
that nonetheless are quite uncomfortable. They
also inform participants that the experience of
multiple traumas/stressors often intensifies
reactions, and that certain experiences, sights,
or sounds may trigger reactions. After receiv-
ing this information the group is invited to
briefly share any of the reactions listed to which
participants can relate. Counselors validate their
sharing and highlight the individual nature of
the trauma and/or stress response. Facilitators
may acknowledge that recovery time varies
in length, and while it may seem that life will
never be the same again, participants can look
forward to better understanding and dealing
with their own reactions to stress, anxiety,
and alarming events in the world. Facilitators
use the group discussion as an opportunity to
screen for high-risk participants by noting clients who report
difficulty coping and observing individuals’
general body language.

Participants are informed that counseling
may be appropriate if their reactions are not
improving or have worsened with time, if they
are struggling to cope, if they are unable to
engage in their usual life tasks, or if they would
like additional support. The group is then given
the opportunity to sign up for group or
individual counseling without indicating a com-
mmitment. A sign-up sheet is distributed around
the group and is left on the table until the end of
the seminar. This allows participants to indicate
an interest in counseling more discretely at the
end of the seminar during the notarization and
certification process. Counselors also provide
information about free self-care resources,
such as massages, acupuncture, and art therapy.
They inform the group that the informational
seminar will end in approximately another half
hour and that counselors will be available for
individual discussions at that time. Facilitators
use this opportunity to seek out high-risk
participants.
Results

As of the writing of this article, Safe Horizon has held at least three information seminars a week for over a year. Most of these, which are attended by about 15 participants each, have included the psychoeducation presentations described by the authors. Although there has been no formal evaluation, clinical results seem to show that this type of intervention has merit. Mental health services and related resources were made available without stigma to a population that included many who would not normally seek them out and who, informal feedback showed, felt supported as a result. Participants reported feeling relief as they learned about trauma and realized that what they were experiencing was normal. At the same time, many individuals were screened, determined to be psychologically at risk, and referred for subsequent ongoing care including psychiatric evaluation and psychotherapy. All participants left the sessions knowing how to receive further support should they feel the need for it at a later date.

Unlike most therapeutic interventions, which tend to attract a more select audience, the concrete services offered at the information sessions drew a diverse crowd which included unskilled and often undocumented workers, the semiskilled, and professionals, of all ages and cultures. Individuals whose fears of deportation, cultural beliefs, or gender biases may have discouraged seeking out or even learning about mental health services got help they might not otherwise have received. Anecdotal evidence showed that many either asked for and obtained mental health services as a result or received information that normalized their reactions to the September 11 tragedy. The presentations also seemed to help reduce the stigma of mental health services as participants shared their reactions since that time with peers.

Since participants knew they could leave at any time during the information seminar, the fact that most did stay for the psychoeducation segment could have been a sign that the information provided was helpful. A few did leave or, when there was a break prior to the presentation, did not come back until it was complete. Those who stayed may have done so out of convenience or because they did not want to appear rude. However, audience participation in the presentations was another indicator of efficacy. Generally most participated, either by sharing verbally with the group or through body language, for example by nodding or smiling as others spoke. This was true even with groups that had been unresponsive during the concrete services portion of the session.

Appreciation for the workshops was expressed in a variety of ways that demonstrated value to participants. First there was the relief people felt when they learned that the changes they were experiencing in their sleep, thinking patterns, and other aspects of their lives were a normal effect of 9/11 and the resulting economic fallout. One man’s comment, “Wow, you really do understand,” was a common response, as were other indicators of relief such as relaxed body posture, laughter, smiles, and sighs. When told that it was common for people not to feel like themselves after such traumas, one woman said, “That’s how I’ve been feeling.” Many others agreed. It also seemed to help that they learned this in the company of people like themselves who were having similar reactions. People frequently stayed after, talking with each other, and at times even exchanged telephone numbers so that they could stay in touch. The coping strategies provided, both by the facilitators and by the participants who shared what helped them, seemed to add to the benefit of the experience. One man reported that it made him feel better to walk a neighbor’s dog. Others commented on why this was helpful for him, providing such explanations as the simple
pleasure of animal love, going outside and getting exercise, and giving life meaning and structure, the latter being two components frequently missing due to most being out of work. Many shared about their spiritual beliefs, with one reading an uplifting and faith-filled poem about his experience of the 9/11 disaster.

During the information sessions and in particular the mental health presentation, it often became evident that certain members of the group might be psychologically at risk. Counselors at times invited distraught individuals to leave the room or followed them out when they left to offer support in private rooms nearby. Other participants remained in the room but displayed signs of their distress with angry outbursts, tears, agitation, or lack of affect and/or responsiveness. Some expressed their feelings directly by reporting that they were angry, sad, scared, or feeling overwhelmed. Others talked about issues such as substance abuse, caring for a sick relative, a recent death of someone close either related to the World Trade Center or not, divorce or other significant loss of relationship, and unwanted conflict in existing relationships.

Counselors took time to meet with these individuals either during the session if warranted (i.e., in cases where the individuals seemed too upset to stay in the room) or less formally after the session ended. Some examples of the types of interventions include the case of a young man who asked to speak to a counselor after a session and talked about his problem finding a place to live. The resulting assessment revealed that he was in an abusive relationship, suffering from depression, and considering suicide. There was also a prior occurrence of sexual trauma when he was a teenager. This case was immediately referred to a mental health clinic, where he began ongoing therapy and was evaluated by a psychiatrist. A young woman who did not want to leave the session but cried throughout much of it confessed to a counselor afterward that she had started drinking excessively since 9/11 and did not know how to stop. She felt so hopeless that she sometimes thought about suicide. She also reported a strong desire to get her life back on track and to get help with the process. This client was hesitant about being referred for ongoing psychotherapy and did not seem to be imminently at risk for suicide. She had several sessions of crisis counseling that included assistance filling out forms for the September 11 Fund Mental Health Benefit, forms she had been carrying around for months unable to complete on her own, and she then requested referrals for ongoing psychotherapy.

Not all the participants were able to share during and after the presentations, but many contacted the counselors later to ask questions, get referrals, or receive counseling. In one such case, a young man realized after several sessions with a counselor that watching the Iraq war coverage was causing him and his family anxiety. He limited his viewing, and the anxiety abated. In another, a mother, who ran from the disaster with her small child in her arms, found that the combination of counseling and yoga classes she started in the course of the short-term therapy helped her to find ways to get in touch with feelings she had cut off. She chose to continue counseling with another therapist when this short-term treatment ended. Of course, not every session participant had a personal interchange with a counselor. However, all participants left the information sessions with names and phone numbers of counselors they could reach at a later date.

Discussion

The economic fallout of 9/11 and the ongoing terrorist threat make this community disaster unique. Constant triggers promote a pervasive sense of insecurity, which undoubtedly
exacerbates normative trauma reactions. Still, the results seem to show that psychoeducation has been a beneficial therapeutic intervention in the aftermath of this community disaster. Participants were visibly relieved to learn that their emotional, behavioral, cognitive, and physical reactions were normal responses to abnormal events. Providing information in a community context was crucial because participants seemed reassured to see others going through similar predicaments. Public education respects participants’ competence to make appropriate mental health decisions when properly informed, thereby empowering participants to access desired resources. In doing so, psychoeducation allows the natural recovery process to unfold without overhelping the approximately 75% of the population that does not require formalized mental health care (Underwood & Spinazzola, 2003; van der Kolk, 1996). Public education also enables the acquisition of mental health resources in an arena less marred by stigma.

The psychoeducation workshop presented may have been especially well received due in part to its coupling with concrete service providers. Mental anguish is often viewed as secondary to needs more directly associated with survival, i.e., financial stability and health care. Perhaps clients could attend to mental health needs because these primary concerns were addressed first. Moreover, this coupling makes it possible to reach many individuals who would not otherwise attend a psychoeducation workshop because seeking mental health information is often highly stigmatized.

To run effective groups, facilitators must be prepared to contain and regulate the strong emotional displays that occur in the course of the workshops. Sufficient staff should be available to tend to participants who become upset, and staff should be prepared to stay afterward for individual conversations. At Safe Horizon, some participants were not eligible for or had difficulty accessing the concrete services and/or resources offered during the seminar. This may prevent participants from seeking mental health services if they link their rejection with mental health resources. There were so many participants at Safe Horizon that this issue could not be easily remedied. Following up with participants several weeks after the information sessions could help alleviate this potential problem.

Conclusion

The results of this initial effort seem to establish psychoeducation as a viable means of both providing support and screening for individuals at risk in the aftermath of community disaster. To do this effectively and reach the broadest possible audience, the authors recommend linking psychoeducation presentations with concrete services. In addition to the information seminars discussed in this article, Project Liberty at Safe Horizon successfully facilitated numerous psychoeducation workshops on topics of interest to this population. These included parenting workshops, anger management, conflict resolution, stress management, and financial planning. Judging from the response received at Safe Horizon, similar public education workshops would be beneficial not only to those affected by community disaster but to survivors of other traumas and individuals with high levels of stress.

Appendix

Public Education Session: The Months Following September 11, 2001

Introduction

Facilitators clearly state the purpose of the session: to acknowledge the challenges
participants are facing and to provide information regarding trauma and ongoing stress.

Clients are reassured that the session is not "group therapy" and that no one will be asked to relive his or her experience of September 11.

Describe Normal Experiences After Trauma and Ongoing Stress

Four categories of reactions are explained and normalized: emotional, behavioral, cognitive, and physical. These reactions are described as normal reactions to an extremely abnormal event, but nonetheless are often quite uncomfortable. Participants learn that the experience of multiple traumas and/or stressors intensifies reactions. Participants also learn that certain experiences, sights, or sounds may trigger reactions.

The group is invited to briefly share how they can relate to the material that has been discussed.

The nature of trauma recovery is explained as an individual process that varies in length. Facilitators may acknowledge that things will never be the same again but participants can look forward to a better understanding and dealing with their own reactions to anxiety, stress, and world events.

Facilitators may use the opportunity to screen for high-risk participants via reactions described or general body language of those who choose not to interact.

Describe Positive Coping Strategies

Facilitators convey the importance of self-care, such as maintaining routine sleeping and eating schedules. Participants are also encouraged to take credit for small achievements made in the recovery process and to seek positive social supports. Techniques for staying in the present, such as holding an ice cube, stomping one’s feet, etc., are discussed as methods to manage emotional triggers.

Participants are invited to briefly share methods of coping they have found particularly useful.

Again facilitators have the opportunity to screen for high-risk participants.

Resources and Referrals

Participants are informed that counseling may be appropriate if their reactions have not improved or have worsened with time, if they are struggling to cope, if they are unable to engage in their usual life tasks, or if they would like additional support.

Participants have the opportunity to sign up without a commitment for individual or group counseling during this portion of the session.

Information about free self-care resources is provided.

Facilitators inform participants that they will be available for individual discussions at the completion of the larger information session. Facilitators can use this opportunity to seek out high-risk participants.

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References


