# Mental Health of Disaster Relief Supporters

JMAJ 56(2): 70–72, 2013

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**Key words** Great East Japan Earthquake, Critical incident stress, Trauma, Mental health, Disaster psychiatry

## Critical Incident Stress

Critical incident stress is defined as a particular kind of stress experienced by people involved in relief activities in disasters or at the scenes of catastrophic accidents. Occupations that are highly susceptible to critical incident stress include police officers, fire defense personnel, defense force personnel, health professionals, administrative officers, and volunteers. Disaster relief supporters are often forced to work on the front lines and are even said to be at even greater risk than disaster victims for strong, long-term stress-induced responses. Deepening understanding of the mental health of supporters who rush to provide assistance to disaster areas is extremely important in terms of providing appropriate support for disaster victims.

Basically, typical critical incident stress responses do not differ from the typical responses of disaster victims to traumatic events. The core symptoms are those that appear on a continuum in acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). Symptoms of *hyperarousal* include insomnia, oversensitivity, excitation, and irritability. Symptoms of *dissociation* include fragmentary memory, no sense of reality, and dazedness. Of the symptoms of *re-experiencing* traumatic events, the most well-known are flashbacks. While undertaking relief efforts, supporters encounter terrible and serious situations, and these unpleasant experiences and images are involuntarily re-experienced. Nightmares are also a symptom of trauma re-experience. *Avoidance* is behavior that avoids situations and stimulants that evoke unpleasant experiences and memories.

Another symptom that is frequently experienced with critical incident stress is feelings of guilt or wrongdoing, or helplessness or inadequacy. In the case of the Great East Japan Earthquake, too, after supporters ended their activities in the disaster zone and returned home, many had the experience of feeling “awful that [I] could do nothing useful to help” or that “perhaps this happened through some fault or wrongdoing of [mine].” When people are faced with an overwhelming reality, many respond more or less in a similar manner. Therefore, it is important for disaster relief supporters to know in advance that all supporters experience critical incident stress to a greater or lesser extent. Many of these responses are *normal responses to abnormal circumstances*, and the sufferer generally recovers naturally over time. However, it must be kept in mind that individuals differ in the way and degree to which they respond to traumatic events.

## Long-Term Effects of Critical Incident Stress

The effects of critical incident stress may occur not only while the supporter is carrying out relief activities but continue long-term as well. Supporters may develop PTSD or continue to experience certain symptoms of PTSD. In the case that a supporter loses a colleague or some-

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This article is based on the lecture presented at the Emergency Medicine Liaison Council held on July 26, 2012.

one else to whom they are close while carrying out their activities, they frequently may experience intense grief and *survivor's guilt*, asking themselves, “Why was I the one saved?” The effects of critical incident stress remain in the form of anger and distrust, which may lead to mistrust of organizations and worsening of interpersonal relationships within organizations. In addition, an increase in stress-related physical disorders or psychological disorders accompanied by symptoms such as loss of motivation to perform everyday tasks, depression, and anxiety is also possible.

With regard to the impact on relief supporters following the Great East Japan Earthquake, reports have been published on surveys of Disaster Medical Assistance Team (DMAT).[1] During and immediately following disaster response activities in the disaster zone, people who had the experience of “feeling embarrassed because [I] became very emotional” or “feeling that [I] would become extremely emotional and distraught” were four months later experiencing strong PTSD-related symptoms. In this report, the scores for PTSD were by no means high overall, and rather than experiencing continuous pathological symptoms, supporters sub-symptomatically experienced mild or subsyndromal symptoms over a relatively long period.

## Case Examples of Critical Incident Stress

**Case Example 1:** The supporter was a 40-year-old female nurse who was dispatched to provide disaster relief at shelters. Although she thought that she had prepared herself mentally, she was deeply shocked by the enormous damage in the affected area. Returning home after five days of disaster medical activities, she began to experience frequent nightmares. She cried easily when exposed to television news reports or images concerning the disaster zone, and she came to experience emotions similar to anger and guilt, saying, “I wasn't able to do anything to help” and “Surely there was much more I could have done.” These experiences gradually abated over several weeks.

**Case Example 2:** The supporter was a 30-year-old firefighter. He lost a coworker in the tsunami, but he continued to participate in searches for the bodies of victims. For more than a year, he continued to think, “I was unable to save even my workmate.” Whenever he remembered something related to the disaster, he saw images of dead bodies and he felt as if his chest were being squeezed. In addition to a feeling of personal guilt that he was unable to do anything to help, he felt anger and distrust of organizations and lost his motivation to continue working. He continues to experience chronic gastrointestinal symptoms.

## Countermeasures Against Critical Incident Stress

The basic countermeasures for critical incident stress are an extension of countermeasures for general stress responses. First of all, it is important for disaster relief supporters to obtain knowledge and information about critical incident stress in advance. It is undoubtedly useful for supporters to have not only information about the local area and nature of the duties they are to perform, which is essential for relief activities, but also an understanding of critical incident stress, including countermeasures. Management of supporters' health is especially important, and relief support plans must be formulated with consideration given to health management for individual supporters as a countermeasure to stress for not only individuals but also organizations. From this standpoint, consideration needs to be given to how much leave and rest supporters can be provided during as well as before and after their relief efforts. When a disaster occurs, *resting* may be difficult for various reasons, but supporters must acknowledge the importance of health management and think about pacing themselves while undertaking their relief activities. If relief activities are carried out when the supporter is exhausted, it becomes easier for them to be affected by stress, which could also adversely impact their activities. Taking creative measures to maintain normalcy within the abnormal surroundings of a disaster zone as well as taking time out to get refreshed are also important.

There is debate about the meaningfulness of a person talking about a traumatic events immediately after experiencing them. At the very least, having someone tell you about a traumatic event in the form of a psychological debriefing and having to listen to the experience in detail is not

only of little benefit but may actually be harmful. However, sharing experiences spontaneously amongst trusted acquaintances and companions may provide certain benefits. The basis for this is natural common sense responses—companions comforting each other and interacting in a supportive manner.

As a measure that organizations should take, *line care* is as important as a mental health care activity by senior workers for their subordinates in disasters as it is under ordinary circumstances. Senior workers, who are in a managerial position, need to have correct knowledge about critical incident stress and understand individual differences in responses to stress. It is also desirable that managers be aware of the health status of their subordinates and colleagues and the circumstances of their families. In many cases, the results of disaster relief activities can be difficult to see. We need to be careful to share information with staff operating in the disaster zone and reward people for their efforts. Moreover, it is important to reconfirm that relief activities are sustained not only by the staff carrying out support activities in the disaster zone but also through the contributions of the staff remaining in the office. Opportunities for sharing disaster relief activities in various forms with the organization overall and together confirming the meaningfulness of these activities will no doubt be useful.

Health professionals have occupations in which they frequently experience critical incident stress. I hope that understanding of critical incident stress will be improved and countermeasures prepared as part of mental health measures for normal times.

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