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

Community Resilience and the Principles of Mass Trauma Intervention

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Drawing upon literatures in several disciplines, Norris and colleagues (in press) concluded that the resilience of communities, and consequently the wellness of communities, rests upon a network of adaptive capacities, particularly Economic Development, Social Capital, Information and Communication, and Community Competence. There are numerous ways in which efforts to build community resilience might also achieve the five essential elements of mass trauma intervention explicated by Hobfoll and colleagues. Thus, it is argued here that efforts to reduce risk and resource inequities, engage local people in mitigation, create organizational linkages, boost and protect social supports, cultivate trusted and responsible information resources, and enhance decision-making skills will augment more specific intervention efforts to promote safety, calming, efficacy, hope, and connectedness in the aftermath of mass trauma. Many of these outcomes require systems and social changes that can be the target of intervention efforts before as well as after disasters.

Hobfoll and colleagues tackled the formidable challenge of developing a set of evidenced-informed principles that can guide psychosocial interventions in the aftermath of disasters and mass trauma. This intelligent paper meets a tremendous need in a field where controlled clinical trials and even less rigorous program evaluations are rare and difficult to do. It was heartening to see the authors turn to the research base on the various mediators and moderators of trauma effects to draw tentative conclusions about the essential elements of mass trauma intervention. This paper made great strides toward bridg-
ing the gap between research and practice in the field of disaster mental health. It will be read and referenced widely.

Hobfoll and colleagues touched upon various components of cognitive behavioral and other psychological interventions that have been shown to be efficacious for treating posttraumatic stress disorder or more generally for enhancing persons’ skills and assets for managing stress. The authors’ emphasis on “essential elements” rather than on particular treatments was a useful way of conceptualizing and extending the interventions evidence base. Yet, many of the strategies outlined by Hobfoll and colleagues were not traditional psychological interventions, as the authors recognized that well-functioning social systems and structures are critical for improving the lives of disaster survivors. Our commentary seeks to elaborate further on these points by exploring how the capacities thought to underlie “community resilience” likewise promote safety, calmness, efficacy, hope, and connectedness (the five essential elements of mass trauma interventions). In this commentary, our discussions of the notions of resilience and adaptive capacity are by necessity brief and incomplete. Our recent review (Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, in press) will provide interested readers with an extensive list of references and a more in-depth analysis of community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. After relating the elements of community resilience to the elements of mass trauma intervention, we conclude this commentary with a brief discussion of how current and emerging disaster mental health practices align with the recommendations made by Hobfoll and his colleagues.

**Resilience Definitions and Concepts**

Building on the work of others who have explored the concept (e.g., Adger, 2000; Bonanno, 2004; Brown & Kulig, 1996/97; Pfefferbaum et al., 2007), Norris and colleagues viewed resilience as a process—a positive trajectory of adaptation after a disturbance, stress, or adversity. They concluded that community resilience emerges from four primary sets of adaptive capacities: Economic Development, Social Capital, Information and Communication, and Community Competence. Briefly, Economic Development refers to the level and diversity of economic resources, the equity of their distribution, and efforts to reduce risk and social vulnerabilities to hazards. Social Capital is the aggregate of resources linked to social networks. A variety of important capacities are included under the umbrella of Social Capital, including effective organizational linkages, social support and social influence, sense of community, place attachment, and citizen participation. Information and Communication encompasses communication skills and infrastructure, trusted sources of information, responsible media, and narratives that instill meaning and hope. The final set of capacities, Community Competence, has to do with collective action and skills for solving problems and making decisions, which stem from collective efficacy and empowerment.

**Shared Orientating Assumptions**

Before exploring how these adaptive capacities of communities may serve to promote safety, calming, efficacy, hope, and connectedness in the aftermath of mass trauma, we note several broad areas of overlap between the frameworks of Hobfoll and colleagues and Norris and colleagues. First, the elements in each framework are interrelated, making it difficult to pinpoint a hierarchy or sequence. In the Hobfoll discussion, safety and calmness were clearly interrelated, as were efficacy and hope; and connectedness played several roles in promoting the other outcomes. Likewise, the adaptive capacities of Norris and colleagues are conceptually distinct but mutually influential. As a roadmap for building community resilience, the capacities are more like a rotary than a highway, as one can enter and exit anywhere.

Second, each framework strives to go beyond a sole focus on psychopathology and has a very strong resource orientation. Norris
and colleagues viewed the end product or outcome of resilience as wellness (Cowen, 2000), defined as high levels of mental and behavioral health, functioning, and quality of life. While the prevention of psychopathology remains an important focus for research and intervention, a criterion of wellness serves to remind us that we must also attend to disaster victims’ abundant problems in living that may interfere with their quality of life. Hobfoll and colleagues were crystal clear that if intervention efforts are to yield a sense of safety, calmness, efficacy, hope, and connectedness, they must first and foremost supply the resources that people need to get their lives back in place.

Third, both frameworks begin with the assumption that some distress is a normal reaction to abnormal events (Flynn, 1994). Disaster research indicates that the most typical pattern is for distress to be nearly universal in the first weeks or months postdisaster, even though only a minority of participants experience criterion-level psychopathology (Norris et al., 2002a; 2002b). Most of the time—especially if the severity of the stressor has lessened and resources have been replenished—transient dysfunction is followed by a return to predisaster levels of functioning. Thus, as Hobfoll and colleagues observed, interventions must work to normalize and validate survivors’ emotional reactions.

Fourth, each framework recognizes that postdisaster interventions must occur at multiple levels (individual, family, community) and evolve over time, as needs change. It is useful to keep in mind that resilience is only one possible trajectory of wellness, along with resistance (no dysfunction), recovery (adaptation that occurs more slowly than resilience), and chronic dysfunction (the absence of resilience, resilience, or recovery trajectories). Whereas resistance is the hypothetical ideal, the best possible outcome of mass trauma intervention is not always resistance, nor is it always resilience. Nevertheless, appropriate interventions should increase the likelihood of resilience among people who are not resistant (the population at risk) and the likelihood of recovery among people who are not resilient (the population in need). Both secondary and tertiary prevention strategies, if efficacious and effective, have a place in the continuum of postdisaster care.

Finally, each framework noted the need for flexibility and local control in planning interventions. Longstaff (2005) argued that the capacity to acquire trusted and accurate information, to reflect on that information critically, and to solve emerging problems is far more important for community resilience than is a detailed security plan that rarely foresees all contingencies.

Safety and Calmness

The first element of mass trauma intervention in Hobfoll and colleagues’ scheme was promoting safety, both objectively and subjectively defined. They noted that on a public health level, this means getting people to a safe place and making it clear to them that they are safe. As they also noted, the media play a critical role in this process because they keep the public informed about risks, but they may also increase anxiety, especially when they sensationalize events. Another essential element of mass trauma intervention, closely related to the first, was calming. Hobfoll and colleagues noted that some anxiety is a normal and healthy response to trauma. Nonetheless, anxiety can interfere with physical and psychological well-being if it remains elevated. While anxiety is highly treatable in individual interventions, Hobfoll and his colleagues noted that tried and true strategies can be translated to group and community-based interventions, such as psycho-education and community outreach efforts that teach people about normal reactions to stress and ways of managing them. These goals, they say, can be accomplished through working with community institutions and media. Hobfoll and colleagues also make the important point that anxiety can be due to real problems and losses and therefore psychological interventions cannot be substituted for interventions that directly furnish needed resources.

We address the importance of tangible/economic/social resources later in this pa-
per and focus here on information and communication resources, which are vital from a community resilience perspective. In emergencies, people need accurate information about the danger and behavioral options, and they need it quickly (Reissman, Spencer, Tanielian, & Stein, 2005). In emergencies, when there is little time to check information, it is crucial that the sender of the information be trusted and trustworthy and treats the public as capable. Closer, local sources of information are more likely to be relied upon than unfamiliar, distant sources. In fact, Longstaff (2005) concluded, “A trusted source of information is the most important resilience asset that any individual or group can have” (emphasis in original, p. 62).

There are inherent challenges, perhaps even inconsistencies, with relying on media for both communication of risk and assurance of safety. Spurred on by advocacy and activist groups, media often force the attention of policymakers and the public to environmental dangers, infrastructure flaws, and security issues (see, for example, *Time*, August 13, 2007, “Special Report: Why New Orleans Still Isn’t Safe”). However, it is clear in past research that despite their invaluable contributions, the media can also become part of the problem in disaster response. The media’s exaggerated and extreme portrayals of looting and lawlessness in New Orleans, for example, directly influenced leadership’s decision to redirect police officers to attend to lawbreakers rather than to life-saving activities, which in turn undermined the safety of stranded citizens (Tierney, Bevc, & Kuligowski, 2006). The stories shared little from 50 years of sociological research showing that the emergency behavior of most disaster victims is orderly and prosocial. After the Columbine High School shooting, the school violence problem was framed in numerous ways in the media, including inadequate gun control laws, inadequate school security, inadequate parental involvement, and the dangers of “pop culture” (Lawrence & Birkland, 2004). Such discourse could surely have exacerbated the public’s anxieties and fears. The media may also prolong the stressfulness of mass trauma. Communities touched by mass violence often feel exploited by the extensive and intrusive media attention and may even perceive that they are being blamed for the abhorrent actions of the perpetrator (e.g., Hawkins et al., 2004; Palinkas et al., 2004). Responsible and balanced media raise awareness of issues, while keeping the threat in perspective, and they treat survivors and communities with respect.

Although information and communication are the primary community resources that influence safety and perceptions of safety, they are not the only ones to do so. In emergencies, people look to similar others to help them make decisions about appropriate behaviors. This idea, often characterized as “emergent norms,” is among the oldest to be found in the sociology of disasters. For example, the greater one’s social ties, the more likely one is to receive information about recommendations to evacuate. Evacuation is often the only available strategy to save lives and reduce personal injuries. In an analysis of evacuation decisions before Hurricanes Hugo and Andrew, Riad, Ruback, and Norris (1999) found that residents with stronger social support were twice as likely to evacuate as were residents with weaker social support. The important dimension was perceived support (e.g., ability to borrow money, get a ride, have a place to stay), not merely the number of ties.

**Efficacy and Hope**

Another essential element of mass trauma intervention was efficacy and collective efficacy. The belief that actions are likely to lead to positive outcomes is central to psychological well-being. As Hobfoll and colleagues noted, self-efficacy does not occur in a vacuum but requires partners with whom to collaborate. The problems confronted by disaster victims are huge, but there is strength in numbers. The promotion of self-sufficiency is a key principle in psychosocial responses to mass trauma worldwide. The element of hope is closely related to efficacy in our view. Hope helps survivors to overcome feelings of de-
spair, futility, and resignation. Hobfoll and colleagues noted that hope is often engendered by interventions that are outside the traditions of mental health but provide needed resources. The authors’ criticism of action-oriented conceptions of hope is thought-provoking, but from a community perspective, efforts to increase efficacy and efforts to increase hope are likely to go hand in hand.

Community competence, economic development, and communication (specifically narratives) all are likely to play roles in promoting efficacy and hope at the community level. Competent communities can effectively identify problems and needs, achieve a working consensus on goals and priorities, and collaborate effectively in the required actions (Cottrell, 1976). Brown and Kulig (1996/97, p. 30) argued that “the concept of resiliency in the context of communities needs to be grounded in a notion of human agency, understood in the sense of the capacity for meaningful, intentional action.” By taking charge of the direction of local recovery efforts, communities and individuals can regain their sense of collective and self-efficacy that may have been injured by the trauma and ensuing adversities.

Collective action is complex and challenging in the face of environmental threats. Sometimes, grass-roots groups are effective in building consensus and mobilizing political action, but other times, action is impeded by mistrust, conflict, or “dissensus” (Edelstein & Wandersman, 1987; Kaniasty & Norris, 2004). Which outcome occurs may depend on the process of gaining control over resources (empowerment) and the nature of political interaction. Empowering community settings are characterized by inspired, committed leadership and by opportunities for members to play meaningful roles (Maton & Salem, 1995).

Hobfoll and colleagues correctly noted that empowerment without resources is counterproductive. They observed that public mental health programs need to collaborate with economic development initiatives to assure better living conditions, more secure livelihoods, and greater resilience. Similarly, Norris and colleagues (in press) argued that Economic Development was a fundamental capacity for community resilience. Land and raw materials, physical capital, accessible housing, health services, schools, and employment opportunities create the essential resource base of a resilient community (Pfefferbaum et al., 2007). Previous research suggests that disasters are especially likely to engender severe psychological distress when they occur to poor people or in developing areas of the world (Norris et al., 2002a; 2002b). Community resilience depends not only on the volume of economic resources but also on their diversity, as dependency on a narrow range of natural resources can increase variance in income and decrease social resilience (Adger, 2000). Poor communities not only are at greater risk for death and severe damage in disasters, but they often are less successful in mobilizing support (Kaniasty & Norris, 1995). The capacity to distribute postdisaster resources to those who most need them seems vitally important for collective efficacy and community resilience.

Efficacy and hope may also emerge from communal narratives that give the experience shared meaning and purpose (an element of Information and Communication in our scheme). Couto (1989) described how “group formulations” (narratives and symbols) became a mechanism for empowerment in Aberfan, South Wales, after a horrific environmental disaster took the lives of 104 school-children and 20 adults. Writing about their own experiences in the aftermath of the September 11th terrorist attacks in lower Manhattan, Landau and Saul (2004) concluded that community recovery depends partly on collectively telling the story of the community’s experience and response. Abramowitz (2005) described six Guinean communities attacked by Sierra Leonean and Liberian forces. Residents of the three most resilient communities shared a belief that customs and social practices would return to normal as soon as economic conditions improved. Most importantly, they had
created a collective story that emphasized their resistance to the violence.

**Connectedness**

The final element of mass–trauma intervention was connectedness, defined as sustained attachments to loved ones. Hobfoll and colleagues observed that social connectedness creates opportunities for a range of supportive activities. From a community perspective, no element of mass trauma intervention is more far–reaching than the goal of augmenting naturally occurring social supports. The pattern of help utilization after disasters resembles a pyramid with its broad foundation being the family, followed by other primary support groups, such as friends, neighbors, and co–workers, followed by formal agencies and other persons outside of the victim’s immediate circle. Therefore, it has to be recognized that proportionately very few trauma victims turn to professionals for emotional, informational, or tangible support. While social networks are undeniably a source of stress as well as comfort in the aftermath of disasters, the weight of the evidence shows that social support is the single most powerful protective factor for trauma victims (e.g., Brewin, Andrews, & Valentine, 2000). Thus, every effort should be made to boost and protect community members’ capacity to help and care for one another. On the basis of their review, Hogan, Linden, and Najarian (2002) concluded that social support interventions are most effective when they build social skills and mutual support. Norris and Alegria (2005) argued that postdisaster interventions that address socially engaged emotions, social support, and social functioning would be especially appropriate for many ethnic minority groups.

For the most part, social support captures helping behaviors within family and friendship networks, but social capital also encompasses relationships between individuals and their larger neighborhoods and communities (e.g., Perkins, Hughey, & Speer, 2002). Three key social psychological dimensions of social capital (and connectedness) are thus sense of community (bonding with other members of one’s group), place attachment (emotional connection to one’s neighborhood or city), and citizen participation (engagement in formal organizations, such as religious congregations or school and resident associations). Place attachment may be of special note for disaster recovery because people are sometimes displaced from neighborhoods and communities in which they are deeply rooted. The social impacts of displacement have often been profoundly adverse, suggesting that, in some circumstances, place attachment could impair rather than facilitate resilience. Nonetheless, it should increase the likelihood that the community as a whole has the will to rebuild and to retain long–standing connections.

**Systems of Care**

Hobfoll and colleagues note several implications of their work for planning mental health services. These include the importance of psycho–education and outreach, recognition of the need to involve people other than traditional medical and mental health professionals in conducting interventions, tailoring interventions to fit the local ecology, remaining modest in claims, and designing multi–level systems that blend individual–level interventions for the most impaired with less costly interventions for the larger community. We agree wholeheartedly with these points (see also Norris et al., 2002a).

If there is a shortcoming in their insightful paper, it was the minimal attention to examining how well current approaches to disaster mental health care align with the recommendations drawn from their review. If we were to design, from scratch, a program that conformed to Hobfoll and colleagues’ framework in the United States, it might well resemble the Crisis Counseling Assistance and Training Program that is funded by the Federal Emergency Management Agency (FEMA), with technical assistance and administrative oversight from SAMHSA’s Center for Mental Health Services (CMHS). Crisis counseling programs aim to address the short–term mental health needs of individuals...
and communities affected by disasters (Flynn, 1994). The program relies on a mix of local (indigenous) professional and paraprofessional crisis counselors and emphasizes psycho–education and outreach in community settings. Crisis counseling services (both individual and group) are usually brief, rarely involving more than one visit or two.

The “active ingredient” of crisis counseling is difficult to pinpoint, but it is clearly a combination of emotional and informational support provided in a respectful, accepting way. Through active listening and psycho–education, trained crisis counselors aim to help their neighbors understand their current situation, reactions, and options, with the goal of normalizing distress and help–seeking. Crisis counselors help survivors to find ways to cope with stress (thereby promoting safety and calmness), to take better care of themselves and their families (thereby promoting efficacy), and to remain active in their communities (thereby promoting connectedness). They identify needs and make referrals to disaster relief services, other social services, and more intensive mental health services, as indicated (thereby promoting hope).

There has been little systematic evidence of the benefits of crisis counseling, which has left the approach somewhat vulnerable to criticism. However, a new standardized evaluation plan was implemented in fall 2005, and the results so far (Norris, 2007) reveal several clear strengths. After Hurricane Katrina, the reach of the program was large (1.3 million counseling encounters), deep (good penetration in the stricken areas), and wide (spanning the country from New Jersey to Utah). Local programs reached large numbers of ethnic minorities and older adults, in proportions no less, and sometimes more, than their population proportions. Respondents to a participant survey (n = 4,500) were overwhelmingly positive about the extent to which they were treated with respect and cultural sensitivity, made comfortable about seeking help, helped to know their own feelings were okay, made more confident in their abilities to help themselves and their families, and helped to stay and active in their communities. These counseling outcomes and experiences are similar to the five essential elements. For many people, crisis counseling may well be the “right” amount of intervention in the aftermath of disaster.

However, the program falls short in meeting the needs of survivors who have more serious mental health needs (Weisler, Barbee, & Townsend, 2006). Symptoms of depression and posttraumatic stress and functional impairment were highly prevalent in the participant survey sample, but only a very small percentage of participants were referred to more intensive psychological interventions. The policy issue of what the public sector should do for persons who need more than crisis counseling is one that recurs periodically, especially in the aftermath of extreme events. The reach and quality of the Crisis Counseling Program must be evaluated according to what the program is designed to do, and it is not charged with delivering treatment. However, leaders in disaster mental health can call attention to this gap in the federal response plan. Quality research on postdisaster clinical care is badly needed but is now beginning to appear. For example, Jessica Hamblen, the Baton Rouge Area Foundation, and local therapists are currently piloting “CBT for Postdisaster Distress,” an individual intervention that aligns very well with the essential elements outlined by Hobfoll and colleagues (see Hamblen et al., 2006). This work is in progress, but initial results are very promising, with “completers” showing dramatic reductions in symptoms and strong increases in efficacy, hope, and skills for seeking support (unpublished data). In addition to determining the effectiveness of interventions, researchers and practitioners still need to address many profound issues in accessibility, acceptability, and coordination of postdisaster care.

The other end of the continuum—programs that work directly with communities to enhance their resilience—is minimally represented in the research literature. In Hobfoll and colleagues’ paper, most of the conclusions regarding community intervention are more appropriately considered expert opinion than empirical evidence. Some studies have exam-
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ined how individual–level perceptions of community resilience, sense of community, or collective efficacy correlate with individual–level outcomes, but no study, to our knowledge, has truly examined how independently assessed community resources influence the postdisaster wellness of constituent populations. Although research is needed before they can claim an evidence base, interventions that promote community resilience appear to hold considerable promise for promoting safety, calmness, efficacy, hope, and connectedness in the aftermath of disasters. Moreover, on the basis of our review, we believe that community resilience has extraordinary value as a strategy for disaster readiness. If their aim is to build collective resilience, communities must develop economic resources, reduce risk and resource inequities, and attend conscientiously to their areas of greatest social vulnerability. They must engage local people in every step of the mitigation process, create organizational linkages, and boost naturally occurring social supports. They must develop decision–making and problem–solving skills and cultivate trusted sources of information. Hobfoll and colleagues and Norris and colleagues would surely agree that disaster readiness and recovery require social as well as individual change.

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