BRIEFING

Centre for Mental Health

# 56: Trauma, mental health and coronavirus

## Supporting healing and recovery


## Summary

The current coronavirus pandemic will affect us all in different ways. While many will come through it without lasting negative effects on their mental health, this is an extremely testing time. Those of us who have already suffered distressing experiences, such as abuse, neglect, discrimination and oppression, are at higher risk of psychological harm and trauma from the adversity it is bringing to our lives.

We know that the pandemic will not affect everyone equally. This period may be especially distressing for people who have lost a loved one or been very unwell themselves, those experiencing abuse or neglect at home, those who have lost their livelihood, and those who have a chronic health condition that puts them at greater risk from the virus. Furthermore, the burden of these widely recognised risk factors falls most heavily on groups who are already marginalised, disadvantaged or isolated, including people from racial and ethnic minorities, people living in poverty, and people living with physical disabilities and mental illness.

There is evidence that quarantine conditions can have several negative psychological effects, including post-traumatic stress symptoms, in some people. When the acute phase of the physical health crisis has passed, addressing these social and psychological consequences of coronavirus must be made a priority. Careful thought needs to be given to how we can repair the social fabric and support those who have experienced the most distress. A trauma-informed approach to both collective and individual recovery will be needed.

This briefing explores the ideas of collective trauma and healing, and what the process of recovery may look like.

## Trauma, agency and connection

*"The core experiences of psychological trauma are disempowerment and disconnection from others."*

(Herman, 1997)

*"Being able to move and do something is a critical factor in determining whether or not a horrible experience will leave long-lasting scars."*

(van der Kolk, 2014)

*"The universal experience of living through a great shock is the feeling of being completely powerless [...]. The best way to recover from helplessness turns out to be helping – having the right to be part of a communal recovery."*

(Woolf, 2007)

*"Sharing the traumatic experience with others is a precondition for the restitution of a sense of a meaningful world."*

(Herman, 1997)

When faced with a threat, we need to be able to act to protect ourselves. This is essential not only for our bodily survival but also for our mental wellbeing. It is when we feel helpless and alone in the face of danger that the risk of psychological trauma is highest.

By the same token, being able to take action against the threat lowers this risk and being able to take communal action lowers it still further. It changes a potentially traumatising experience of vulnerability and isolation into one of agency and connection.

## Collective trauma

*"by collective trauma [...] I mean a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality."*

(Erikson, 1995)

*"...being part of a crowd makes individuals adopt a new social identity, a sense of togetherness, which in turn favours collective resilience."*

(Dezecache, 2015)

*"effective social reconstruction may be the best therapy for most trauma reactions"*

(Silove & Zwi, 2005)

Taking communal action lowers the risk not only of individual trauma but also of collective trauma. Faced with a disaster, we tend to respond cooperatively, creating a sense of togetherness (Dezecache, 2015). This is especially true when we are physically together in a shared space where we can literally reach out to others, mutually giving and receiving support (Drury, Cocking & Reicher, 2009).

But sometimes communal coping is not enough to protect the social fabric from damage. Collective trauma results from a shock so violent that a group – a family, a community, a nation – can no longer function as it did before the event. This could be because the disaster has exposed divisions within the group, damaged or destroyed its institutions, affected the availability of resources, or otherwise caused significant loss and disruption.

Just as collective trauma is a shared experience, so too is recovery. Healing takes the form of social processes such as rebuilding relationships, reconfiguring systems of power, and redefining the group's identity and values. It is in coming together as a community to create shared meaning from the event, provide mutual support and restore social bonds that it becomes possible for the group to begin to recover (Shapiro, 2002).

## Trauma, inequalities and institutional betrayal

*"...the impact of institutional failure to prevent or respond supportively to traumatic experiences, what we call institutional betrayal"*

(Smith & Freyd, 2014)

*"Natural disasters have inherently social dimensions because they exacerbate preexisting inequalities and disrupt social norms and longstanding institutions"*

(Weitzman & Behrman, 2016)

*"...socially excluded groups have depleted social, economic and psychological resources by virtue of their social position which present additional challenges during times of trauma where available resources are stretched."*

(Muldoon *et al.*, 2017)

*"Although no population is immune to experiencing trauma, some types of trauma are disproportionately experienced by certain groups because of deeply entrenched structural inequalities."*

(Bowen & Murshid, 2016)

*"...when I was told that I'd contracted the virus it didn't take me long to realise that I'd contracted a diseased society as well."*

(Wojnarowicz, 1991)

Not everyone is equally vulnerable to harm from the same traumatic event. One reason is that, in the absence of protective factors, the effects of trauma can be cumulative. As a result, those of us who have already suffered distressing experiences, such as abuse, neglect, discrimination and oppression, are at higher risk of psychological harm from further adversity.

Another reason is that people who belong to marginalised or disadvantaged groups are less likely to have buffers, such as secure housing, stable employment and strong social support, to shield them from the full force of the traumatic event and its aftershocks. In these ways trauma can magnify inequality and injustice, with vulnerable groups in society exposed to the most severe effects (Hatch & Dohrewend, 2007; Seng *et al.*, 2012; Goldmann & Galea, 2014; Bowen & Murshid, 2016; Bolin, 2017; SAMHSA, 2017; Arcaya, Raker & Waters, 2020).

And injustice and inequality, in their turn, can magnify trauma. Often when we are at our most powerless we look to social institutions, such as government agencies, health care services and the criminal justice system, for support. There is evidence that, when we have faith that these institutions are acting in our best interests – that they are doing everything they can to prevent the crisis or that they responded to our needs during and after the event – we are at lower risk of psychological harm from a traumatic event; but, when we feel that they failed to protect us – when we perceive their response to be unjust or inadequate – we are at higher risk (Rhodes & Tran, 2012; Smith & Freyd, 2014). Betrayal by those who should have helped us amounts to a "second injury" that adds to the pain of the original trauma (Symonds, 1980).

## Trauma, coronavirus and lockdown Britain

While it is important to note that many will come through the lockdown without negative effects on their mental wellbeing, for others this is an extremely testing time. The paradox of the current situation is the action people are being asked to take – to stay home and do as little as possible – looks and feels like inaction. In addition, by definition, social distancing decreases connection with others. Hearing through the media about people who are having similar experiences to your own doesn't have the same impact as literally standing shoulder to shoulder with them in terms of its ability to create a sense of community and combat feelings of isolation.

As discussed above, experiences of being powerless and alone may cause significant distress, and they are risk factors for social and mental health problems. More specifically, there is evidence that quarantine conditions can have several negative psychological effects, including post-traumatic stress symptoms, and these effects may be long-lasting (Brooks *et al.,* 2020).

While it is difficult to predict who will be affected most severely, we know the more adversity a person has experienced in the past, the more easily feelings of being powerless and alone will trigger further trauma in the present (Breslau *et al.,* 1999; Brewin, Andrews & Valentine, 2000; Briere, Agee & Dietrich, 2016; Matheson *et al.,* 2019). We also know that some people will be experiencing more distress than others, such as those who are confined to a house with an abusive partner, those who have lost their employment, and those who have a chronic health condition that increases the danger of complications from coronavirus. Furthermore, the burden of these widely recognised risk factors falls most heavily on groups who are marginalised, disadvantaged or isolated, including people from racial and ethnic minorities, people living in poverty, and people living with physical disabilities and mental illness.

In addition to its effects of mental health, coronavirus is having far-reaching effects on the social fabric. All communities have been affected by losses and significant changes and, faced with this collective trauma, our natural response has been to strengthen our social ties. This need for togetherness has been expressed through the rainbows that have appeared in windows up and down the UK, the Thursday night 'Clap for Carers' and the overwhelming response to the call for volunteers to support the NHS. However, this last is emblematic of the problem that lockdown poses: so many people volunteered that the scheme had to temporarily close to new applications; our need to feel connected to others is greater than the opportunities available to do this while the lockdown is in force.

When the acute phase of the physical health crisis has passed, addressing these social and psychological consequences of coronavirus must be made a priority. Careful thought needs to be given to how we to repair the social fabric and support those who have experienced the most distress. A trauma-informed approach to both collective and individual recovery will be needed.

## Healing from trauma

A trauma-informed approach can help individuals and communities to recover following a crisis. Being trauma-informed means, at its most basic level, using knowledge of the ways in which traumatic experiences and traumatic stress affect people to make sure that the support they receive helps them to recover, instead of doing further harm.

What will this look like in the current situation? In many ways, coronavirus is unprecedented: we haven't experienced a crisis of this nature on this level before, at least in our lifetimes. However, although they are different in type and magnitude, examples of large-scale traumatic events are offered by the past. While it is unclear the extent to which lessons from these disasters will generalise to the current situation, there are some common themes in the literature that might guide our thinking in useful directions in planning a trauma-informed approach to recovery from the psychological and social impact of coronavirus.

### Trauma is normal in the wake of a crisis

Just as grief is an understandable reaction to a bereavement, traumatic stress symptoms are a normal reaction to a crisis. Moreover, just as few who experience grief go on to develop major depression, not everyone who experiences traumatic stress symptoms goes on to develop post-traumatic stress disorder (PTSD) (Neria, Nandi & Galea, 2008). As a result, instead of medicalising people's reactions, it can be more valuable to help them make sense of their thoughts, feelings and behaviours by sharing information about some typical post-traumatic symptoms (Silove & Zwi, 2005).

To illustrate the importance of this, Judith Herman, in her book *Trauma and Recovery* (1997) gives an example from a rescue at sea in Norway:

*"Survivors of a capsized offshore oil rig were briefly counselled by a mental health team after their rescue and given a one-page fact sheet on post-traumatic stress disorder. In addition to listing the most common symptoms, the fact sheet offered two practical recommendations. The survivors were advised, first, to talk with others about their experience in spite of a predictable temptation to withdraw, and second, to avoid using alcohol for control of their symptoms. One year after the disaster the survivors were contacted for follow-up interviews. Many of the men still carried in their wallets the fact sheet that they had been given on the day of the rescue, now tattered from many readings and rereadings."*

Normalising trauma symptoms and helping people to help themselves is in no way intended to deny their suffering; symptoms are no less painful for being typical. Nor is it to imply that they should cope without professional support; self-help isn't empowering when you have no other options. However, after the traumatic experiences of being helpless, alone and at the mercy of unpredictable forces, there can be great therapeutic value in knowing that traumatic stress is not an individual failing, but a natural response; in knowing that others have walked this path before; and in knowing that you have some of the tools for recovery in your own hands.

### The language of trauma will not be meaningful to everyone

Learning about common symptoms of traumatic stress will be helpful for some but not for all. Although there is evidence that traumatic stress is universal, culture shapes the ways people make sense of it and respond to it (Marsella, 2010; Michalopoulos *et al.,* 2018). For example, some cultures don't have a concept that corresponds to trauma, even though they show symptoms that Western psychiatry would label as PTSD (Kohrt & Hruschka, 2010; Khoury *et al.,* 2012; Kaiser *et al.,* 2015); and, in other cultures, the most common reactions to traumatic stress include symptoms, such as bodily complaints, that are less common in Western populations (López & Guarnaccia, 2000; Terheggen, Stroebe & Kleber, 2001;

Hinton *et al.,* 2013; Michalopoulos *et al.,* 2018; White, Manderson, Newman & Melvin, 2020). As a result, a 'one size fits all' intervention may only serve to widen inequalities, benefiting some groups, but failing to recognise or respond to the needs of others.

*"No one set of recommendations will apply to all communities cross-culturally. It is important that the activities match the cultural context and needs of the group. The best way to assure this is to involve the community in evaluating its own needs and determining which actions are most suitable."*

(Norris, Murphy, Baker & Perilla, 2004)

A trauma-informed approach is a culturally competent one. It will seek to understand the meaning the crisis has for the community; and as far as possible it will work with the strengths and resources that already exist within the group, empowering people to play an active role in their own healing (Dyregrov, Gupta, Gjestad & Raundalen, 2002; Ford, 2008; Nicolas, Wheatley & Guillaume, 2015; Womersley & Arikut-Treece, 2019). This doesn't mean the concept of trauma is disregarded – just because an idea is 'foreign' doesn't mean it is without value – however, it does mean that it is sensitively adapted and offered in a way that is respectful of the group's own traditions and systems of healing (Dyregrov, *et al.,* 2002; Schauer & Schauer, 2010; Nicolas *et al.,* 2015).

## Much healing will happen within the community

After a disaster, research indicates that relatively few people seek help for their mental health through formal channels, such as doctors and specialist services; instead, to quote Whittle *et al.* (2012), "recovery is played out through the relationships that exist within families, communities and workplaces" (see also Greenberg *et al.,* 2003; Mort *et al.,* 2005; Peck, 2005; Wessley, 2005; Goldmann & Galea, 2014). Mobilising these supportive networks has multiple benefits: it strengthens the social fabric, increasing resilience against collective trauma; it helps the recovery of the person receiving support; and it also helps the recovery of the person giving the support. An example of this last is given by Solnit (2010), writing of 9/11:

*"Many people struggled to get past security to the World Trade Centre site urgently wanting to be where they could be of use. They needed to contribute so any task, no matter how obscure or gruelling, met their own needs as well as those of others."*

In recognition of these benefits, best practice guidelines recommend strengthening family- and community-based social support (Seynaeve, 2001; Peck, 2005; Silove & Zwi, 2005; Australian Red Cross, 2018).

This indicates a primarily consultative role for mental health professionals in the immediate aftermath of a traumatic event. They may, for example, offer supervision to key figures within the community, such as faith leaders, to whom people are likely to turn to in times of distress; provide information about, for example, Psychological First Aid (see Box 1); and generally facilitate the community's own healing processes, only stepping in to provide treatment when it is essential or actively requested.

It is worth noting that such community support can only benefit those who are included in a community. Many of the most vulnerable members of society, such as children and young people in or leaving care, minority groups, non-English speakers, homeless people and migrant populations, are at risk of falling through this social safety net (Goldmann & Galea, 2014).

## Recovery is often a complex process

In the aftermath of a crisis, some people feel stuck in the moment, as if there is no way back to normality; other people try to pick up where they left off, as if the crisis never occurred. However, coming to terms with what has happened requires integrating the traumatic experience into the ongoing stream of life.

## Box 1: Psychological First Aid

Following a disaster, people have an instinctive need to give and receive support. The principles of Psychological First Aid, while lacking direct evidence for their effectiveness, are in line with what is known about trauma and, as such, can inform the ways we help one another (van Ommeren, Saxena & Saraceno, 2005; Bisson & Lewis, 2009; Bisson, 2014; Goldmann & Galea, 2014).

Psychological First Aid involves:

- Providing practical care and support, which does not intrude
- Assessing needs and concerns
- Helping people to address basic needs (for example, food and water, information)
- Listening to people, but not pressuring them to talk
- Comforting people and helping them to feel calm
- Helping people connect to information, services and social supports
- Protecting people from further harm.

(WHO, 2011)

For more information on Psychological First Aid, visit:
https://www.apa.org/practice/programs/dmhi/psychological-first-aid/resources

*"Traumatic memories need to become like memories of everyday experience; that is, they need to be modified and transformed by being placed in their proper context and reconstructed into a meaningful narrative."*

(van der Kolk, McFarlane & van der Hart, 2007)

After the disruption of a large-scale crisis, restoration of some pre-disaster routines can be deeply reassuring, but there must also be space for reflection and for coming to terms with what has changed or been lost.

The literature on disasters underlines the importance of bearing witness as a community to what has happened, grieving what has been lost and making shared meaning from the crisis (Eyre, 2007; Gasparre, Bosco & Bellelli, 2010; Hawdon & Ryan, 2011; Wlodarczky *et al.,* 2016; Australian Red Cross, 2018). In practical terms, this often takes the form of group rituals and memorials enacted within families, social institutions and workplaces.

These commemorative acts and expressions of solidarity can play a crucial role in promoting social cohesion and healing from collective trauma.

However, they are only one part of what is often a complex and drawn out process of recovery. After the acute phase of the crisis, when there is often a strong need to pull together and mutually give and receive support, and a sense of shared fate, people begin to follow very different paths to healing (Norris, Tracy & Galea, 2009). Those who were relatively unaffected by the disaster and who have strong psychosocial resources may be ready to get back to normal soon after the event, while others will be experiencing ongoing stressors, such as financial worries and health problems, long after the initial crisis has passed. Moreover, the onset of symptoms of traumatic stress may take months to develop or be noticed, and this delay may make it hard to ask for help if everyone else seems like they have 'moved on' (Beaglehole *et al.,* 2018).

Recovery from trauma is rarely linear and it does not proceed according to a fixed schedule (Arcaya *et al.,* 2020; Morganstein & Ursano, 2020). There needs to be a gradual reengagement with day-to-day life in which individuals and communities are supported to come to terms with what has happened at their own pace (Eyre, 2006; Australian Red Cross, 2018). This can be a faltering, elusive process that needs time, patience and ongoing compassion.

## Support must be well coordinated and include a long-term plan

*"There seems to be a mistaken belief that psychosocial interventions can be delivered as 'relief packages' to those affected in much the same way as hygiene kits are distributed to those displaced."*

(Wickramage, 2006)

Traumatic experiences, by their nature, shake our belief in a safe and reliable world. Poorly planned short-term interventions that start and end abruptly risk adding to these feelings of shock and loss, instead of aiding recovery. Moreover, if they are perceived as unjust or inadequate, they may undermine trust in social institutions, worsening the collective trauma. As a result, if a programme of support is to do more good than harm, it is especially important that it is carefully thought through and includes a plan for both short- and longer-term needs (Herman, 1997; Silove & Zwi, 2005; van Ommeren, Saxena & Saraceno, 2005; Eyre, 2006; Hobfoll *et al.,* 2007; IASC, 2008; Goldmann & Galea, 2014; Australian Red Cross, 2018; Jacobs *et al.,* 2019).

In the acute phase, immediately following the crisis, best practice guidelines recommend promoting a sense of safety and stability, with a focus on more active and community-based ways of coping. This includes:

- Practical help, such as financial support, to reduce the risk that people will be exposed to further stress and anxiety
- Information about some typical post-traumatic reactions and actions people can take to help themselves and others to cope with these
- Support for communities to mobilise and build on their own resources and healing systems
- More active outreach to those who may not be part of a support network and groups who are at higher risk of traumatic stress
- Provision of mental health treatment to those with the most urgent psychiatric needs
- Restoration of some pre-disaster routines and functioning.

In the medium- and longer-term, more reflective coping begins to take priority, with increasing reconnection to ordinary life and a greater role for mental health professionals in providing support to those who need it. This includes:

- Opportunities to collectively bear witness to, and make meaning from, the traumatic experience
- Time for people to make sense of what the crisis has meant to them personally and to plan for a changed future
- A gradual return to everyday life
- Engagement with different communities, especially those whose voices are often not heard, such as minority groups, to gain an understanding of their changing needs
- Ongoing practical support for those who are dealing with secondary stressors, such as financial problems, unemployment or substance use
- Provision of emotional support which is easily accessible to anyone who wants it, not only in clinical settings but also in the community, workplaces and schools
- Identification of, and treatment for, those who have ongoing mental health needs.

Following the uncertainty and sudden changes of a traumatic event, it is crucial that the agencies who are responsible for the different aspects of the programme of support work collaboratively and that their efforts are well coordinated (Boin & Bynander, 2015; Jacobs *et al.,* 2019). For many people, simply knowing that there is a dependable safety net in place, even if they don't use it, can help them to feel better able to cope.

*"What matters, apparently, is not how individuals actually cope but rather how they perceive their capacities to cope and control outcomes. The perception that one is capable of managing the specific demands related to the disaster has been strongly predictive of good psychological outcomes."*

(Norris *et al.,* 2002)

Support needs to be – and *be seen to be* – reliable, predictable, adequate and even-handed.

## Table 1: Responding to trauma

| Traumatic experience | Do the opposite | Example |
|---|---|---|
| Disempowerment | Agency and autonomy | Support people to make sense of their thoughts and feelings in response to trauma<br>Help people to understand that their reaction is normal, in light of what has happened – do not medicalise it unnecessarily<br>Give people a say in designing the programme of support<br>Make a range of options for support and recovery available<br>Give individuals and communities information that makes it possible for them to help themselves and play an active role in their own recovery |
| Widening inequalities | Equity and inclusiveness | Recognise and respond to the fact that not all individuals and communities will have been affected in the same way or with the same severity<br>Provide additional support for those who may be most vulnerable to psychological harm from traumatic stress<br>Ensure that anyone who wants help is able to access it<br>Don't assume that everyone will understand and respond to traumatic stress in the same way<br>Be respectful of the resources that already exist within communities, empowering them to play an active role in their own healing<br>Actively seek to engage with communities whose needs may not be as visible, e.g. minority groups, non-English speakers, homeless people<br>Where there have been institutional failings, acknowledge these honestly and take actions to repair the damage to trust |

| Traumatic experience | Do the opposite | Example |
|---|---|---|
| Isolation | Community and connection | Enable people to support one another<br>Create opportunities for collective rituals that validate people's experiences and create a sense of shared meaning from events<br>Restore trust in key social institutions |
| Sudden drastic changes | Gradual transitions and flexibility | Do not expect people to get back to normal immediately<br>Recognise that some people will be dealing with the aftershocks of the traumatic event long after the initial crisis has passed<br>Provide options for how quickly people reconnect with everyday routines and ordinary functioning |
| Uncertainty and disruption | Long-term planning and coordinated support | Support organisations to work collaboratively, sharing resources and expertise<br>Once a plan has been made, avoid making sudden or dramatic changes to it<br>Share information about plans so people know what to expect |

## Conclusion

On an individual level, people will be affected in different ways by the current situation. Some will come through the crisis safely, with no ill effects to their mental wellbeing; some will have experienced distress so severe that they will meet the clinical criteria for PTSD; many will be somewhere in between. And, on a collective level, every community will be coming to terms with losses and changes, and rebuilding relationships in a world that looks different and feels less secure than it did a year ago.

How we recover from the wider effects of coronavirus will be, for the most part, a path made by walking. But we can be guided by what we already know about trauma, the central tenet of which can be summed up in a single sentence:

*"Trauma-informed approaches aim to do the opposite of the original trauma."*

(RIPFA, 2019; see also, Survivors Voices, 2018)

This has been a time of abrupt changes to everyday life in which people have been cut off from others. Many will have felt isolated and disempowered at some point during the lockdown, and all will have experienced a loss – of their freedom, of their job, of their health, of a loved one.

Instead of abrupt changes, a trauma-informed approach will seek to provide long-term, reliable support; instead of isolation and disempowerment, it will seek to bring people together, rebuilding relationships, and giving all members of the community a voice in planning for recovery; and, where there has been loss, it will support people to grieve and come to terms with a changed future.

## References


Arcaya, M., Raker, E.J. and Waters, M.C., 2020. The Social Consequences of Disasters: Individual and Community Change. Annual Review of Sociology, 46.

Australian Red Cross, 2018. Review of the literature on best practices before, during and after collective trauma events. [pdf] Australian Red Cross. Available at: https://www.redcross.org.au/getmedia/ddd4a393-ba67-4ad4-96f2-40bf5be04224/ARC-CTE-Literature-review.pdf.aspx [accessed 05 April, 2020].

Beaglehole, B., Mulder, R.T., Frampton, C.M., Boden, J.M., Newton-Howes, G. and Bell, C.J., 2018. Psychological distress and psychiatric disorder after natural disasters: systematic review and meta-analysis. The British Journal of Psychiatry, 213(6), pp.716-722.

Bisson, J.I., 2014. Early responding to traumatic events. The British Journal of Psychiatry, 204(5), pp.329-330.

Bisson, J.I. and Lewis, C., 2009. Systematic review of psychological first aid commissioned by the World Health Organization. [pdf] Research Gate. Available at: https://www.researchgate.net/profile/Catrin_Lewis2/publication/265069490_Systematic_Review_of_Psychological_First_Aid/links/5450d15f0cf24e8f7375a73c/Systematic-Review-of-Psychological-First-Aid.pdf [accessed 04 May, 2020].

Boin, A. and Bynander, F., 2015. Explaining success and failure in crisis coordination. Geografiska Annaler: Series A, Physical Geography, 97(1), pp.123-135.

Bolin, B. and Kurtz, L.C., 2018. Race, class, ethnicity, and disaster vulnerability. In Handbook of disaster research (pp. 181-203). Springer, Cham.

Bowen, E.A. and Murshid, N.S., 2016. Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. American journal of public health, 106(2), pp.223-229.

Briere, J., Agee, E. and Dietrich, A., 2016. Cumulative trauma and current posttraumatic stress disorder status in general population and inmate samples. Psychological trauma: Theory, research, practice, and policy, 8(4), p.439.

Breslau, N., Chilcoat, H.D., Kessler, R.C. and Davis, G.C., 1999. Previous exposure to trauma and PTSD effects of subsequent trauma: results from the Detroit Area Survey of Trauma. American journal of Psychiatry, 156(6), pp.902-907.

Brewin, C.R., Andrews, B. and Valentine, J.D., 2000. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. Journal of consulting and clinical psychology, 68(5), p.748.

Brooks, S.K., Webster, R.K., Smith, L.E., Woodland, L., Wessely, S., Greenberg, N. and Rubin, G.J., 2020. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. Lancet (London, England), 395(10227), pp.912-920.

Dezecache, G., 2015. Human collective reactions to threat. Wiley Interdisciplinary Reviews: Cognitive Science, 6(3), pp.209-219.Dyregrov, A., Gupta, L., Gjestad, R. and Raundalen, M., 2002. Is the culture always right?. Traumatology, 8(3), pp.135-145.

Drury, J., Cocking, C. and Reicher, S., 2009. The nature of collective resilience: Survivor reactions to the 2005 London bombings. International Journal of Mass Emergencies and Disasters, 27(1), pp.66-95.

Dyregrov, A., Gupta, L., Gjestad, R. and Raundalen, M., 2002. Is the culture always right?. Traumatology, 8(3), pp.135-145.

Erikson, K. T., 1995. A new species of trouble: The human experience of modern disasters. New York: W. W. Norton & Company.

Eyre, A., 2006. Literature and best practice review and assessment: Identifying people's needs in major emergencies and best practice in humanitarian response. [pdf] HM Government. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/61224/ha_literature_review.pdf [accessed 07 April, 2020].

Eyre, A., 2007. Remembering: Community commemoration after disaster. In Handbook of disaster research (pp. 441-455). Springer, New York, NY.

Ford, J.D., 2008. Trauma, posttraumatic stress disorder, and ethnoracial minorities: Toward diversity and cultural competence in principles and practices. Clinical Psychology: Science and Practice, 15(1), pp.62-67.

Gasparre, A., Bosco, S. and Bellelli, G., 2010. Cognitive and social consequences of participation in social rites: Collective coping, social support, and post-traumatic growth in the victims of Guatemala genocide. Revista de Psicología Social, 25(1), pp.35-46.

Goldmann, E. and Galea, S., 2014. Mental health consequences of disasters. Annual review of public health, 35, pp.169-183.

Greenberg, N., Thomas, S.L., Iversen, A., Unwin, C., Hull, L. and Wessely, S., 2003. Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment. Journal of mental health, 12(6), pp.565-573.

Hatch, S.L. and Dohrenwend, B.P., 2007. Distribution of traumatic and other stressful life events by race/ethnicity, gender, SES and age: A review of the research. American journal of community psychology, 40(3-4), pp.313-332.

Herman, J., 1997. Trauma and recovery: The aftermath of violence, from domestic abuse to political terror. New York: Basic Books.

Hinton, D.E., Kredlow, M.A., Pich, V., Bui, E. and Hofmann, S.G., 2013. The relationship of PTSD to key somatic complaints and cultural syndromes among Cambodian refugees attending a psychiatric clinic: The Cambodian Somatic Symptom and Syndrome Inventory (CSSI). Transcultural Psychiatry, 50(3), pp.347-370.

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J., Friedman, M., Gersons, B.P., De Jong, J.T., Layne, C.M. and Maguen, S., 2007. Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. Psychiatry: Interpersonal and Biological Processes, 70(4), pp.283-315.

IASC, 2008. IASC guidelines on mental health and psychosocial support in emergency settings: Checklist for field use. [pdf] World Health Organisation. Available at: https://www.who.int/mental_health/emergencies/IASC_guidelines_%20checklist_%20%20for_%20field_use.pdf (accessed 30 April, 2020).

Kaiser, B.N., Haroz, E.E., Kohrt, B.A., Bolton, P.A., Bass, J.K. and Hinton, D.E., 2015. "Thinking too much": A systematic review of a common idiom of distress. Social Science & Medicine, 147, pp.170-183.

Khoury, N.M., Kaiser, B.N., Keys, H.M., Brewster, A.R.T. and Kohrt, B.A., 2012. Explanatory models and mental health treatment: is vodou an obstacle to psychiatric treatment in rural Haiti?. Culture, Medicine, and Psychiatry, 36(3), pp.514-534.

Klein, N., 2007. The shock doctrine: The rise of disaster capitalism. London: Penguin.

Jacobs, J., Oosterbeek, M., Tummers, L.G., Noordegraaf, M., Yzermans, C.J. and Dückers, M.L., 2019. The organization of post-disaster psychosocial support in the Netherlands: A meta-synthesis. European journal of psychotraumatology, 10(1), p.1544024.

Kohrt, B.A. and Hruschka, D.J., 2010. Nepali concepts of psychological trauma: the role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. Culture, Medicine, and Psychiatry, 34(2), pp.322-352.

Lopez, S.R. and Guarnaccia, P.J., 2000. Cultural psychopathology: Uncovering the social world of mental illness. Annual review of psychology, 51(1), pp.571-598.

Marsella, A.J., 2010. Ethnocultural aspects of PTSD: An overview of concepts, issues, and treatments. Traumatology, 16(4), pp.17-26.

Martin, C.G., Cromer, L.D., DePrince, A.P. and Freyd, J.J., 2013. The role of cumulative trauma, betrayal, and appraisals in understanding trauma symptomatology. Psychological Trauma: Theory, Research, Practice, and Policy, 5(2), p.110.

Matheson, K., Foster, M.D., Bombay, A., McQuaid, R.J. and Anisman, H., 2019. Traumatic experiences, perceived discrimination, and psychological distress among members of various stigmatized groups. Frontiers in psychology, 10, p.416.

Michalopoulos, L.M., Meinhart, M., Yung, J., Barton, S.M., Wang, X., Chakrabarti, U., Ritchey, M., Haroz, E., Joseph, N., Bass, J. and Bolton, P., 2020. Global posttrauma symptoms: a systematic review of qualitative literature. Trauma, Violence, & Abuse, 21(2), pp.406-420.

Morganstein, J.C. and Ursano, R.J., 2020. Ecological disasters and mental health: causes, consequences, and interventions. Frontiers in psychiatry, 11, p.1.

Mort, M., Convery, I., Baxter, J. and Bailey, C., 2005. Psychosocial effects of the 2001 UK foot and mouth disease epidemic in a rural population: qualitative diary based study. Bmj, 331(7527), p.1234.

Muldoon, O.T., Acharya, K., Jay, S., Adhikari, K., Pettigrew, J. and Lowe, R.D., 2017. Community identity and collective efficacy: A social cure for traumatic stress in post□earthquake Nepal. European Journal of Social Psychology, 47(7), pp.904-915.

Neria, Y., Nandi, A. and Galea, S., 2008. Post-traumatic stress disorder following disasters: a systematic review. Psychological medicine, 38(4), pp.467-480.

Nicolas, G., Wheatley, A. and Guillaume, C., 2015. Does one trauma fit all? Exploring the relevance of PTSD across cultures. International Journal of Culture and Mental Health, 8(1), pp.34-45.

Norris, F.H., Friedman, M.J., Watson, P.J., Byrne, C.M., Diaz, E. and Kaniasty, K., 2002. 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981–2001. Psychiatry: Interpersonal and biological processes, 65(3), pp.207-239.

Norris, F.H., Murphy, A.D., Baker, C.K. and Perilla, J.L., 2004. Postdisaster PTSD over four waves of a panel study of Mexico's 1999 flood. Journal of Traumatic Stress, 17(4), pp.283-292.

Norris, F.H., Tracy, M. and Galea, S., 2009. Looking for resilience: Understanding the longitudinal trajectories of responses to stress. Social science & medicine, 68(12), pp.2190-2198.

Peck, D.F., 2005. Foot and mouth outbreak: lessons for mental health services. Advances in Psychiatric Treatment, 11(4), pp.270-276.

Rhodes, A.M. and Tran, T.V., 2012. Predictors of posttraumatic stress and growth among black and white survivors of Hurricane Katrina: Does perceived quality of the governmental response matter?. Race and Social Problems, 4(3-4), pp.144-157.

RIPFA, 2019. Embedding trauma-informed approaches in adult social care: Frontline briefing. [pdf] Research in Practice. Available at: https://www.researchinpractice.org.uk/adults/publications/ [accessed 07 April, 2020].

SAMHSA, 2017. Greater impact: How disasters affect people of low socioeconomic status. Disaster technical assistance centre supplemental research bulletin. [pdf] SAMHSA. Available at: https://www.samhsa.gov/sites/default/files/dtac/srb-low-ses_2.pdf [accessed 22 April, 2020].

Schauer, M. and Schauer, E., 2010. Trauma-focused public mental-health interventions: a paradigm shift in humanitarian assistance and aid work. In Trauma rehabilitation after war and conflict (pp. 389-428). Springer, New York, NY.

Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Meldrum, C. D. R. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. Social Science & Medicine, 75(12), 2437-2445.

Seynaeve, 2001. Psycho-social support in situations of mass emergency: A European Policy Paper concerning different aspects of psycho-social support for people involved in major accidents and disasters. [pdf] European Federation of Psychologists' Associations.

Available at: http://disaster.efpa.eu/ddl.php/b9ba065570a8c0b647e3757a849bcea5/?dkey=b9ba065570a8c0b647e3757a849bcea5 [accessed 07 April, 2020].

Shapiro, E.R., 2002. Family bereavement after collective trauma: Private suffering, public meanings, and cultural contexts. Journal of systemic therapies, 21(3: Special issue), pp.81-92.

Silove, D. and Zwi, A.B., 2005. Translating compassion into psychosocial aid after the tsunami. The Lancet, 365(9456), pp.269-271.

Smith, C.P. and Freyd, J.J., 2014. The courage to study what we wish did not exist. Journal of trauma & dissociation: the official journal of the International Society for the Study of Dissociation (ISSD), 15(5), p.521.

Solnit, R., 2010. A paradise built in hell: The extraordinary communities that arise in disaster. London: Penguin Books.

Survivors Voices, 2018. Turning pain into power: A charter for organisations engaging abuse survivors in projects, research and service development. [pdf] Survivors Voices. Available at: https://survivorsvoices.org/ [accessed 07 April, 2020].

Symonds, M., 1980. The “second injury” to victims. Evaluation and change, 7(1), pp.36-38.

Terheggen, M.A., Stroebe, M.S. and Kleber, R.J., 2001. Western conceptualizations and Eastern experience: A cross-cultural study of traumatic stress reactions among Tibetan refugees in India. Journal of Traumatic Stress, 14(2), pp.391-403.

Van der Kolk, B.A., 2014. The body keeps the score: Mind, brain, and body in the transformation of trauma. London: Penguin.

Van der Kolk, B.A., McFarlane, A.C. and van der Hart, O., 2007. A general approach to treatment of posttraumatic stress disorder. In Van der Kolk, B.A., McFarlane, A.C. and Weisaeth, L. (eds.) Traumatic stress: The effects of overwhelming experience on mind, body and society. New York: The Guilford Press.

Van Ommeren, M., Saxena, S. and Saraceno, B., 2005. Mental and social health during and after acute emergencies: emerging consensus?. Bulletin of the World Health Organization, 83, pp.71-75.

Weitzman, A. and Behrman, J.A., 2016. Disaster, disruption to family life, and intimate partner violence: The case of the 2010 earthquake in Haiti. Sociological science, 3, pp.167-189.

Wessely, S., 2005. Don’t panic! Short and long term psychological reactions to the new terrorism: The role of information and the authorities. Journal of Mental Health, 14(1), pp.1-6.

White, J., Manderson, L., Newman, L. and Melvin, G., 2020. Understandings of trauma: contrasting Sudanese refugees and Holocaust survivors. Journal of Refugee Studies.

Whittle, R., Walker, M., Medd, W. and Mort, M., 2012. Flood of emotions: emotional work and long-term disaster recovery. Emotion, Space and Society, 5(1), pp.60-69.

WHO, 2011. Psychological First Aid: Guide for field workers. [pdf] World Health Organisation. Available at: https://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205_eng.pdf?sequence=1 [accessed 29 April, 2020].

Wickramage, K., 2006. Sri Lanka's post-tsunami psychosocial playground: lessons for future psychosocial programming and interventions following disasters. National Emergency Training Center.

Wojnarowicz, D., 1991. Close to the knives: A memoir of disintegration. New York: Vintage Books.

Wlodarczyk, A., Basabe, N., Páez, D., Amutio, A., García, F.E., Reyes, C. and Villagrán, L., 2016. Positive effects of communal coping in the aftermath of a collective trauma: The case of the 2010 Chilean earthquake. European Journal of Education and Psychology, 9(1), pp.9-19.

Womersley, G. and Arikut-Treece, Y., 2019. Collective trauma among displaced populations in Northern Iraq: A case study evaluating the therapeutic interventions of the Free Yezidi Foundation. Intervention, 17(1), p.3.

# Briefing 56: Trauma, mental health and coronavirus

Published May 2020

Written by Jo Wilton

Photograph: istockphoto.com/gb/portfolio/starcevic

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here: www.centreformentalhealth.org.uk




BRIEFING

Centre for Mental Health

56: Trauma, mental health and coronavirus

Supporting healing and recovery

Summary

The current coronavirus pandemic will affect us all in different ways. While many will come through it without lasting negative effects on their mental health, this is an extremely testing time. Those of us who have already suffered distressing experiences, such as abuse, neglect, discrimination and oppression, are at higher risk of psychological harm and trauma from the adversity it is bringing to our lives.

We know that the pandemic will not affect everyone equally. This time may be especially distressing for people who have lost a loved one or been very unwell themselves, those experiencing abuse or neglect at home, those who have lost their livelihood, and those who have a chronic health condition that puts them at greater risk from the virus. Furthermore, the burden of these widely recognised risk factors falls most heavily on groups who are already marginalised, disadvantaged or isolated, including people from racial and ethnic minorities, people living in poverty, and people living with physical disabilities and mental illness.

There is evidence that quarantine conditions can have several negative psychological effects, including post-traumatic stress symptoms, in some people. When the acute phase of the physical health crisis has passed, addressing these social and psychological consequences of coronavirus must be made a priority. Careful thought needs to be given to how we to repair the social fabric and support those who have experienced the most distress. A trauma-informed approach to both collective and individual recovery will be needed.

This briefing explores the ideas of collective trauma and healing, and what the process of recovery may look like.

Centre for Mental Health

Centre for Mental Health

Office 2D21, South Bank Technopark,

90 London Road, London SE1 6LN

Tel 020 3927 2924

www.centreformentalhealth.org.uk

Follow us on social media: @CentreforMH

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.