

**CATEGORY:**

***HEALTH POLICY***

**PANDEMIC PLANNING:  
PREPARING FOR THE PSYCHOSOCIAL IMPACT**

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**ABSTRACT**

The anticipated psychosocial impacts of an influenza pandemic are described, and an argument is presented for the need to include a psychosocial response in pandemic preparedness plans. Concepts from the literature on Severe Acute Respiratory Disorder (SARS), disaster mental health, psychological first aid, bioterrorism, grief and resilience are brought together to make recommendations for planning activities.

“The clock is ticking. We just don’t know what time it is” (cited in Barry, 2005). These are the words of an unnamed influenza expert, ostentatiously expressing a view that the onset of an influenza pandemic is just a matter of time. While some believe that the warnings of a pandemic are a hoax (e.g., Day, 2006; Engdahl, 2005; Mercola, 2006), many members of the scientific and medical communities, along with various levels of government, are taking the threat very seriously. The projected impacts of a pandemic are enormous: human morbidity and mortality numbers in the millions; disruptions in food and supply lines; overburdened hospitals and mortuaries; strained economies; and a decrease or stoppage of international travel (Branswell, 2005; Lam & Lee, 2006; Public Health Agency of Canada, 2006). As a result, we can expect that the psychosocial burden on individuals, families, health care organizations and communities will be staggering. What can be done to prepare for such dire prospects?

Under the guidance of the World Health Organization (WHO), governments and healthcare agencies around the world are in various stages of developing emergency preparedness plans to cope with the next pandemic. In its *Checklist for Influenza Pandemic Preparedness Planning*, WHO (2005) outlines several categories demanding attention, including surveillance, case investigation and treatment, containment of the disease, maintenance of essential services, and research. Tucked away in this list, under “Maintaining Essential Health Services” is the suggestion: “Consider the provision of psychosocial support targeted at health-care workers (clinical and laboratory) who may be occupationally exposed to the new pandemic strain virus” (World Health Organization, 2005, p. 24). The only other recommendation for psychosocial response falls in the recovery phase (post-pandemic): “Define responsibilities for social, psychological and practical support to affected families and companies” (p. 26). This paucity of reference to responding to psychosocial impacts *during* a pandemic can likewise be found in the preparedness plans of Canada, the United Kingdom and Australia (although buried in an obscure annex of Canada’s plan is a recommendation to provide grief counseling). The United States Department of Health and Human Services (2005) does a little better, by including in its plan a supplement: *Workforce support - Psychosocial considerations and information needs*.

Given the unfathomable scope and severity of anticipated pandemic impacts, it is odd that the inclusion of a psychosocial response in emergency preparedness plans is little more than an afterthought. We *must* prepare for the emotional and psychological burdens a pandemic will undoubtedly bring, particularly because a pandemic will occur over a period of months, or perhaps even years. “Stress research has clearly established that we, as humans, are better suited to cope with short-term, acute stress, rather than long-term, chronic stress” (Crimando, 2006, ¶ 4). If our doctors, nurses and community leaders cannot cope with the inevitable strain that a drawn-out emergency situation like a pandemic will bring, then the potential positive effects of activities such as surveillance and infection control will be diminished. Should we not prepare our mental health professionals to respond accordingly? Should not psychosocial preparedness be considered as important as surveillance and infection control?

**ANTICIPATED PSYCHOSOCIAL IMPACTS**

“A comprehensive review of the literature yields no empirical studies addressing the behavioral or emotional consequences of a pandemic” (Crimando, 2006). This is a discouraging comment for those who are focused on response planning for the psychosocial impacts of a pandemic. However, we *can* look to the literature on an array of related topics, including disaster mental health, psychological first aid, bioterrorism, grief, and resilience. Here we can find the building blocks to develop plans for responding to pandemic impacts. A synopsis of how these areas can converge into an appropriate and effective psychosocial response will be described later. First, we must consider the issues and circumstances that may demand such a response.

An examination of the recent past may provide some useful clues. The 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) gave us a hint as to what psychosocial issues may arise during an influenza pandemic. During the SARS outbreak, healthcare workers in Toronto feared for personal safety; worried about transmitting disease to loved ones; faced stigmatization; and confronted overwork caused by quarantines and colleagues calling in sick (Maunder et al., 2003). Other negative effects included financial losses; changes to personal and familial lifestyle; and difficulties in adjusting to restrictive infection control procedures (Nickell et al., 2004). A number of other studies concluded that psychiatric morbidity rates among healthcare workers involved with the SARS crisis in various nations ranged from 20.6 to 75 percent (see for example, Nickell et al.; Maunder, 2004; Chong et al., 2004; and Sim et al., 2004). We can glean from these initial studies that similar outcomes may be seen during an influenza pandemic.

Additionally, the United States Department of Health and Human Services (2005) has identified several anticipated psychosocial impacts of an influenza pandemic on healthcare workers, including: negative feelings due to prolonged separation from family; constant stress and pressure to keep performing; domestic pressures caused by school closures, disruptions in day care, or family illness; stress of working with sick or agitated persons and their families and/or with communities under quarantine restrictions; and concern about receiving vaccines and/or antiviral drugs before other persons. Such circumstances can lead to feelings of shock, numbness, confusion, disbelief, extreme sadness, grief, anger, guilt, exhaustion, frustration, and a sense of ineffectiveness and powerlessness (United States Department of Health and Human Services).

In addition to healthcare workers, other groups were adversely affected during the SARS outbreak, and we can anticipate the same will hold true during an influenza pandemic. Maunder et al. (2003) describe the psychosocial difficulties experienced by patients with SARS, their family members, and other patients. Patients with SARS experienced feelings of boredom, loneliness, sadness about missing family and friends, guilt, anger and fear. Commonly feared was the endangered welfare of friends and family, resentment by others, stigmatization of loved ones and income loss due to quarantine. Family members experienced feelings of helplessness and despair about being unable to visit or provide care for their ailing loved ones; and faced practical

challenges such as childcare arrangements. Inpatients without SARS feared infection; experienced anxiety about cancelled procedures and delayed discharge; became frustrated with the need for quarantine post-discharge; and experienced insomnia, anxiety and interpersonal friction with staff, due to visiting restrictions that created isolation from family members (Maunder et al.). If the psychosocial concerns manifested during the SARS outbreak are an indication of what we may expect during an influenza pandemic, it is clear that we must begin planning how we will respond.

### **WHERE DO WE START?**

As indicated earlier, there is little available with regards to a “prepackaged” psychosocial plan for an influenza pandemic. However, the research literature on disaster mental health and psychological first aid, along with grief, resilience, and bioterrorism, can help us to start formulating our responses.

#### ***Disaster Mental Health and Psychological First Aid***

A primary goal of disaster mental health is mitigation, which refers to “damage control” and alleviation of the effects of a disaster (Halpern & Tramontin, 2007). Halpern and Tramontin also suggest that tangible and concrete assistance is a hallmark of disaster mental health, with helpers taking an active role in providing what “those impacted cannot provide for themselves, whether their needs are physical or emotional” (p. 11). In the event of a pandemic, mental health responders should be prepared to respond to emotional needs such as grief and anxiety, or physical needs such as a relaxing environment for overburdened staff to take breaks. Psychological first aid is a component of disaster mental health that aims to relieve physical and emotional suffering, improve short-term functioning, help individuals’ course of recovery and provide linkage to critical resources (Halpern & Tramontin). Mental health responders should be trained in these areas, and ensure that such activities are present throughout the duration of a pandemic.

#### ***Bioterrorism***

Crimando (2006) has drawn a parallel between the expected psychosocial impacts of a pandemic, and the impacts of bioterrorism. He suggests that pandemic influenza and biological, chemical or radiological hazards are “silent disasters” or “invisible threats,” as “one cannot see, hear, feel or taste their presence” (§ 2). Crimando points out that unlike other types of disasters, which are often confined to a limited area, a pandemic would be far-reaching. The potential for mutual aid would be severely limited, as areas across the globe would be struggling simultaneously with their own “disasters”. In this way, Crimando reminds us that we need to learn to be rather self-sufficient as communities and organizations during a pandemic. With regards to planning a psychosocial response for a pandemic, Crimando suggests that we need to differentiate between behavioral reactions (e.g., hoarding, looting, non-compliance with quarantine orders) and emotional reactions (e.g., anxiety, grief), and develop plans accordingly.

#### ***Grief and Resilience***

Finally, it is common sense to assume that there will be widespread grief during a pandemic, so the knowledge and skills of mental health responders should be augmented in this area. At the same time, the literature indicates that more attention is being paid to human resilience in the face of tragedy (Halpern & Tramontin, 2007). Resilience can be understood as “the process of adapting well in the face of adversity, trauma, tragedy, threats and other significant sources of stress” (American Psychological Association, 2004). Creating and sustaining resilience in our healthcare workforce will be an essential component of our pandemic preparedness. We need to recognize the significant role human resilience plays in tragedy as we move forward with response planning.

### **RECOMMENDATIONS**

Based on an extensive review of the literature on SARS, disaster mental health, psychological first aid, bioterrorism, grief, resilience, and influenza pandemic, several recommendations for psychosocial preparedness planning can be extrapolated:

- i) Partnerships should be formed between mental health professionals, clergy and pastoral care workers, and others with counseling backgrounds (e.g., Child, Youth and Family Services social workers).
- ii) Training should be provided to the above-noted groups, focusing on anticipated health, community, and psychosocial impacts of an influenza pandemic.
- iii) There should be a strong self-awareness component in training sessions: it is important to anticipate our own emotional reactions during a prolonged period of crisis.
- iv) Futuring exercises should be used in training, to help anticipate impacts and personal responses.
- v) Skill development should be concentrated in the areas of disaster mental health, psychological first aid, grief counseling and resilience-building.
- vi) Training should include a component on caregiver stress, with a focus on self care for mental health professionals and ameliorating the effects of caregiver stress.
- vii) There should be a thorough examination by mental health and related professionals of the ethical dilemmas that are likely to arise during an influenza pandemic (this can be achieved through an exploration of the document *Stand on Guard for Thee*, University of Toronto Joint Centre for Bioethics, 2005).
- viii) Training should support the development of site-specific plans for health care facilities, and include suggestions for how to manage not only those directly impacted by influenza, but for how to respond to those affected by mental illness and other mental health issues that may arise during a pandemic.
- ix) Educational sessions on psychosocial impacts should be provided to all senior and middle managers in healthcare; and all training and planning for a psychosocial response to influenza pandemic should be clearly communicated to, and supported by them.

## **CONCLUSION**

Pandemic preparedness can help to ameliorate pandemic pandemonium. More importantly, “The level of preparedness will... influence the final death toll” (World Health Organization, 2005). We must be assiduous in all of our planning efforts, and not include psychosocial preparedness as an afterthought. The intent of having a sound plan for psychosocial response is not to coddle our workforce, nor is it to pathologize normal reactions to extreme stress. It is not about building or maintaining morale; rather, it is about creating and sustaining resilience by providing health care workers with the psychological and emotional support they will need during an extended period of trauma. If our doctors, nurses, managers or support staff are succumbing to the strain and tension of pandemic trauma, hand washing and protective masks will have little effect on reducing the mortality rate. Psychosocial preparedness is also about providing basic services to those most in need of physical or emotional support. We must prepare, and we must prepare now. As for the arrival of an influenza pandemic, yes - the clock is ticking, and no - we do not know what time it is. But the time to prepare is now, so that we can respond as effectively as possible to the psychosocial burdens that a pandemic will surely bring.

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