- five intervention principles that have empirical support to guide evolving intervention practices and programs following disaster and mass violence.

- We recommend that these practices and techniques, or their elements, should be contained within intervention and prevention efforts at the early to mid-term stages.

- particularly important to those responsible for broader public health and emergency management. These principles are:

  1. Promote sense of safety.
  2. Promote calming.
  4. Promote connectedness.
  5. Promote hope

**Instilling hope is critical because mass trauma is often accompanied by**
- "shattered worldview" (Janoff-Bulman, 1992),
- the vision of a shortened future (American Psychiatric Association, 1994),
- catastrophizing,

all of which
- undermine hope
- lead to reactions of
  - despair,
  - futility ไร้ค่า,
  - hopeless resignation ท้อแท้—that feeling that “all is lost.”

Because mass trauma is usually an experience people are not trained for or experienced with, it outstrips their learned coping repertoires. Without knowledge about how to cope, it is natural that hope is one of the first victims.
A
recently and most commonly been defined in psychology as "positive, action–oriented expectation that a positive future goal or outcome is possible" (Haase, Britt, Coward, & Leidy, 1992).

a thinking process that taps a sense of agency, or will, and the awareness of the steps necessary to achieve one’s goals (Snyder et al., 1991).

B
Hobfoll, Briggs–Phillips, and Stines (2003) challenged these perspectives, however, as overly based on “rugged individualism” ป้องกันการนิยามแบบสุดโต่ง ignoring the reality that people who experience mass trauma, lifetime poverty, and racism often face.

Such an action–oriented view of hope is decidedly อย่างไม่น่าสับสน Western, even upper–middle class and white.

Hope for most people in the world has a religious connotation and is not action–oriented (Antonovsky, 1979).

That is, although hope is

- internally experienced, and the feeling of the real circumstances in which people find themselves.

Nevertheless, what is amazing about the human spirit is that many people, who have been down so long that everything else looks like up,

- often do retain a sense of - optimism,

- self–efficacy,

- belief in both - strong others

- and a God who will intervene on their behalf


best theoretical work on hope in the face of mass trauma แบ่งปันนิยามว่าต้องมี Western = pioneering work of Antonovsky (1979) in his examination of Holocaust survivors.

The hopeful state that Antonovsky describes is termed “a sense of coherence,”

= “a pervasive, enduring though dynamic feeling of confidence that one’s internal and external environments are predictable —there is a high probability that things will work out as well as can reasonably be expected” (p. 123).

A major difference between this viewpoint and the efficacy–based views of hope is that Antonovsky’s belief is

- based on past experience

- often is the result of the belief that outside sources act benevolently on one’s behalf.

He did not emphasize self–agency, which he called an expressly upper–middle class, Western view.
Antonovsky emphasized that people, including those in the West, often find hope,
- not through internal agency or self-regulation,
- but through belief in
  - God (Smith, Pargament, Brant, & Oliver, 2000),
  - a responsive government (a belief that may be diminishing),
  - superstition belief เชื่อสิ่งแวดล้อม (e.g., “I'm always lucky; things usually work out for me”).

The danger of hinging hope on an internal sense of agency alone was made apparent after Hurricane Katrina, where a natural disaster coupled with a technological disaster in responding dealt a dual blow to poor residents of New Orleans in particular. Many did not evacuate, not because they lacked internal agency, but because they had little reason to hope for a positive outcome of evacuating due to a lack of external resources. This means that it is critical to provide services to individuals that help them get their lives back in place, such as housing, employment, relocation, replacement of household goods, and payment of insurance reimbursements.

In a study of veterans with combat-related PTSD,
- employment status was found to be the primary predictor of hope
  (Crowson, Frueh, & Snyder, 2001).

Likewise, one of the strongest predictors of PTSD for victims of Hurricane Andrew was
- the inability to secure funds to rebuild their homes (Ironson et al., 1997).

Moves by the state of Mississippi to
- force insurance companies to pay for damages following state law is a critical mental health intervention.

On a smaller scale, mental health professionals can develop
- advocacy programs to aid victims to work through
  - red tape
  - the complex processes involved in the tasks that emerge following mass disaster.

Lack of such efforts after the Exxon–Valdez oil disaster led to
- long-term psychological distress
- ongoing resource loss cycles
  (Arata, Picou, Johnson, & McNally, 2000).

Again, by joining with individuals, rather than just doing for them,
- self-efficacy can be raised in the process,
- as well as a sense of hope.

Hope can be facilitated by a broad range of interventions, from individual to group to mass media messaging. On an individual level, several studies have shown that those showing early signs of severe distress benefit from CBT that reduces individual’s exaggeration of personal responsibility, something that severely impedes hope due to the fear that one will continue to do badly because the problem is an internal, stable trait (Bryant et al., 1998; Foa et al., 1995). The Learned Optimism and Positive Psychology Model (Seligman, Steen, Park, & Peterson, 2005) adopts the goals of identifying, amplifying, and concentrating on building strengths in people at risk. They distilled therapeutic components that can be applied to strength-building and prevention in which they concentrate on enhancing hope and disputing the catastrophic and exaggerated thinking that undermines hope. Trauma-focused treatment with adolescents has similarly shown the efficacy of addressing ongoing trauma-generated expectations, beyond symptom response, with forward looking exercises that promote
developmental progression to instill hope and renewed motivation for learning and future planning (Saltzman et al., 2006). Additionally, the very act of individual intervention by a mental health professional communicates the message that, with treatment, things will get better (i.e., “I’m an expert and I believe that you can succeed”). Interventionists are encouraged to normalize people’s responses and to indicate that most people recover spontaneously (Foa & Rothbaum, 1998; Resick et al., 2002), as this in itself instills hope against distressing thoughts (e.g., “I’m going crazy,” “I’m inadequate,” “My reaction is a sign that I can’t take it.”). Early intervention can also foster hope by using such techniques as guided self-dialogue (Foa & Rothbaum, 1998; Meichenbaum, 1974) to underscore and restructure irrational fears, manage extreme avoidance behavior, control self-defeating self-statements, and encourage positive coping behaviors.

Decatastrophizing is another important intervention component that is critical to preserving and restoring hope. Many people catastrophize in order to adaptively prepare for the worst. Early CBT interventions have been found useful in counteracting these cognitive schemas (Bryant et al., 1998; Foa et al., 1995). Resick’s (Resick et al., 2002) Cognitive Processing Therapy works to correct erroneous cognitions related to catastrophizing and self-labeling with traits that spell ultimate failure in coping. Paradoxically, envisioning a realistic, yet challenging, even difficult outcome may actually reduce people’s distress, compared to envisioning an exaggerated catastrophic outcome. For instance, acknowledging that one’s home will take months to rebuild may need to be accepted, but the assertion that “I will never have a home again” is maladaptive. Hence, intervention at all levels should communicate that catastrophizing is natural, but that it should be identified and countered by more fact-based thinking.

Benefit-finding, often associated with increased hope, appears to be a common process among individuals facing a myriad of threatening events, and it has been shown to predict mental health adaptation months and even years later (Antoni et al., 2001; King & Miner, 2000; McMillen, Smith, & Fisher, 1997; Stanton, Danoff-Burg, Sworowsky, & Collins, 2001). Still undefined is whether this phenomenon is best conceived as a selective evaluation, a coping strategy, a personality characteristic, a reflection of verifiable change or growth, a manifestation of an implicit theory of change, or a temporal comparison. Caution should be taken in designing interventions that promote seeing benefit in trauma, as even well-intentioned efforts to encourage benefit-finding are frequently interpreted as an unwelcome attempt to minimize the unique burdens and challenges that need to be overcome. Moreover, some research has found benefit-finding to be related to greater PTSD, greater xenophobia, and greater support for extreme retaliatory violence (Hobfoll et al., 2006). It is suggested that interventions focus more on highlighting already exhibited strengths and benefit-finding, rather than promoting benefit-finding prior to individuals’ readiness.

On a community level, group or large-scale interventions may be more impactful and efficacious than individual interventions.

For instance, group interventions for mass trauma
  - offer the advantage that many of the problems are shared by hundreds or thousands of people,
  - and so coping worksheets that identify common problems gain efficiency that might otherwise take many sessions in individual therapy.

On a larger scale, Adger and colleagues (2005) point out that social-ecological resilience is an important determinant in recovery from disasters, particularly the ability of communities to
  - mobilize assets, networks, and social capital both to prepare for and respond to disasters.
This underscores how community processes interface with individual hope.

The media, schools and universities, and natural community leaders (e.g., churches, community centers) can enhance hope by helping people focus on
- more accurate risk assessment, positive goals, building strengths that they have as individuals and communities, and helping them tell their story, following Seligman and colleagues' (2005) learned optimism and positive psychology model.

In this regard, just as CBT directs individuals not to dwell on self-blame and to move into a problem-solving mode, this same set of directives can be recommended broadly, as so many people in such situations share these kinds of feelings and thoughts.

The advantage of a community model over the individual, in this regard, is that
- the group (e.g., mosque, school, business organization, chamber of commerce, Rotary Club) can develop hope-building interventions, such as
  helping others clean up and rebuild, making home visits, and involving members of the community who feel they cannot act individually because of the magnitude of the problem.

Broad-scale interventions for
Principle: Hope

Public Health Measures
- Provide services to individuals that help them get their lives back in place, such as:
  ° housing
  ° employment
  ° relocation
  ° replacement of household goods
  ° clean-up and rebuilding
  ° payment of insurance reimbursements
- Develop advocacy programs to help victims work through red tape and the complex processes involved in the tasks that emerge following mass disaster.
- Support rebuilding of local economies that allow individuals to resume their daily vocational activity, to prevent ongoing resource loss cycles
- The media, schools and universities, and natural community leaders (e.g., churches, community centers) should help people with:
  ° Linking with resources
  ° Establishing systems that enable those in recovery from similar traumas to share their experience and hope with those struggling with recovery
  ° Memorializing and making meaning
  ° Accepting that their lives and their environment may have changed,
  ° Making more accurate risk assessment
  ° Reducing self-blame
  ° Problem-solving
  ° Setting positive goals
- Building strengths that they have as individuals and communities
**Individual/Group Measures**

- Cognitive behavioral therapy (CBT) that:
  - Reduces exaggeration of personal responsibility and counteracts cognitive schemas, such as catastrophizing and the belief that problems are due to an internal, stable trait
  - Identifies, amplifies, and concentrates on building strengths
  - Normalizes responses
  - Indicates that most people recover spontaneously
  - Highlights already exhibited strengths and benefit-finding, rather than promoting benefit-finding prior to an individual's readiness.
  - Includes guided self-dialogue to:
    - Envision a realistic, yet challenging, even difficult outcome (e.g., accepting that one's home will take months to rebuild vs. the assertion that "I will never have a home again")
    - Underscore and restructure irrational fears
    - Manage extreme avoidance behavior
    - Control self-defeating self-statements
    - Encourage positive coping behaviors

- With children and adolescents, CBT that:
  - Addresses ongoing trauma-generated expectations, beyond symptom response
  - Includes forward-looking exercises that promote developmental progression to instill hope and renewed motivation for learning and future planning