Responding to a Major Disaster: The Trauma Assessment and Support Clinic in Beirut

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The Beirut port explosion on August 4, 2020, traumatized the Lebanese population. It also revealed a lack of disaster mental health preparedness in a country subject to significant political, economic, and security challenges. The Trauma Assessment and Support Clinic at the American University of Beirut Medical Center was one of many initiatives set up nationally as a dedicated emergency benevolent service. The authors recommend anticipating the psychiatric consequences of such rare events at a professional and systemic level. The experiences of clinicians and the challenges faced in Lebanon can guide the improvement of disaster mental health care on a global level.

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On the evening of August 4, 2020, the Lebanese capital, Beirut, was struck by the third-most-powerful nonnuclear explosion in history. The blast caused devastation to the harbor area and neighborhoods within a 3-mile radius, killing, injuring, and displacing thousands of citizens. The explosion came in the wake of political unrest, deplorable socioeconomic conditions, and a health care system challenged by the COVID-19 pandemic (1)—a perfect storm heralding a national mental health crisis (2).

An effort led by international agencies was set in motion to support physical restoration and provide primary resources and psychosocial care to a population still in shock. A local response was also established by nongovernmental organizations and university hospitals. This column describes the experience of the improvised emergency response team at the Department of Psychiatry at the American University of Beirut Medical Center (AUBMC).

Adapting Services to a National Emergency

In the earliest days after the explosion, the Lebanese population drowned in a "psychological shockwave." The impact was experienced directly by survivors, first responders, and citizens of areas surrounding the explosion and indirectly through relentless and ruthless media exposure. Mental health professionals were not spared. Nevertheless, many of these professionals took part in establishing and volunteering in mental health responses while also processing and managing their own experiences.

At AUBMC, the Department of Psychiatry developed the Trauma Assessment and Support Clinic (TASC), a rapid, specialized, and free clinic to address acute mental health needs in the community and provide an alternative to potentially unvetted pop-up mental health care initiatives.

The clinic brought together professionals with diverse clinical expertise, including two psychiatrists, two senior psychiatry trainees, three adult psychotherapists and one child and adolescent psychotherapist, a neuropsychologist, a social worker, and a specialized psychiatric nurse. Clinicians maintained their regular responsibilities and clinics while volunteering at the trauma clinic. The service was advertised on the hospital's social media platforms and by word of mouth. Patients calling the service's direct line and those referred by clinicians were first assessed by a psychiatric nurse and triaged to either a psychiatry or psychotherapy appointment,

HIGHLIGHTS

- The tragic explosion of the Beirut port uncovered enormous gaps in disaster mental health preparedness and trauma response training.
- Adopting a multilayered and integrated support system that encourages collaboration among all active governmental and nongovernmental taskforces and fosters the buildout of local capacities is essential to improve disaster preparedness and mental health response.
- The creation of a mental health response committee that coordinates national and international clinical, research, and funding resources can advance the field of disaster mental health.

based on the severity of symptoms and the potential need for a pharmacological intervention. Suicidal patients were redirected to the emergency department. The triage nurse followed up on patients who canceled or did not attend their appointment. Trainees received regular supervision. Additionally, team members consulted and coordinated with each other for the duration of the service.

The clinic, in its emergency response format, ran for 6 consecutive weeks. A total of 43 individuals contacted the TASC inquiring about its services and requesting an appointment. Nearly 30% (N=12) of these individuals did not show up for their appointments. Reasons for missing appointments included "feeling better," spontaneous symptom reduction, and the belief that the service would be better used for needier patients. Among those who were seen in the clinic, women outnumbered men by a 2:1 ratio. Children and adolescents constituted 42% (N=18) of service users. Adults who presented to TASC had a variety of symptoms that fell under three major intertwined clusters: trauma, mood, and anxiety. Most parents seeking help for their children did so because they observed changes in their children's behavior, ranging from internalizing symptoms, such as separation anxiety, to externalizing symptoms, such as aggressive behavior. Psychological first aid, support, stabilization, and psychoeducation were the most commonly implemented interventions.

Hurdles Faced and Lessons Learned

Help-seeking behaviors and psychiatric backgrounds. Despite the free cost, advertisement, and abundant public calls for mental health support, the utilization rate for the clinic was lower than expected, especially in terms of adult mental health care. Requests for consultations with children were relatively more common, possibly because there is less stigma related to children receiving psychological care or because of a tendency to prioritize the well-being of children in a time of crisis. The service could have benefited from advertisement beyond social media, given that many victims may have lost access to phones, Internet, or the means to present to the hospital. Although it is possible that women have been disproportionately affected, their overrepresentation in our sample is in line with studies showing that women are more likely than men to seek formal mental health support (3). Moreover, most individuals who presented to the TASC were aware of the sudden change in their mental health status and were familiar with symptoms suggestive of deterioration; however, they were minimally equipped to independently address these issues. This challenging situation can stem from several factors: the unprecedented nature and scale of the trauma in question, a lack of knowledge about mental distress, and the social stigma regarding seeking help. These factors are unsurprising in a nation where mental health has commonly been perceived as a taboo topic. Since the blast, however, extensive efforts have aimed to raise awareness and encourage help seeking. These are joint efforts with contributions from private academic centers and task forces, such as the TASC; government-affiliated initiatives via the National Mental Health Program; and activities mediated by nongovernmental organizations.

Clinicians' perspective: shared trauma or shared resilience. It is well documented that trauma workers can suffer from compassion fatigue and secondary traumatization (4–6). In the context of Beirut's blast, to further complicate matters, mental health professionals involved in the TASC were themselves residents of the Beirut area and shared the same traumatic reality as patients. Clinicians' personal experiences of the blast included severe damage to homes, traumatic endangerment of self and loved ones, witnessing death and serious injury in the city and the emergency room, and death of loved ones. Therefore, clinicians were managing their traumatic reactions and emotional responses (grief, anxiety, anger, and uncertainty) while providing treatment to distressed fellow citizens.

While the shared traumatic reality translated into strong motivation for creating the TASC and improved capacity for compassionate patient care, it also presented novel challenges to therapeutic boundaries and self-disclosure, with clinicians trying to balance relating to patients as fellow citizens with containing their own emotionality in the service of patient care. Although the dual role of mental health provider and citizen was, at times, tiring because of "double-exposure" to the traumatic event, it was nevertheless healing, as providers experienced compassion satisfaction (6, 7) and shared resilience in a traumatic reality (SRTR) (6). Indeed, SRTR is a concept that points to the positive effects of shared direct or indirect exposure to trauma between clinicians and patients (6). It is essentially mediated through empathic connectedness with patients, given the exposure to the same collective trauma. SRTR also allows for adequate functioning while navigating available resources for coping (6). This concept is relevant because SRTR can ultimately generate a sense of meaning and purpose for mental health practitioners in Lebanon, promoting their personal growth and that of the community. While many people have been driven to find a productive way to contribute to the reconstruction and healing of affected areas and individuals (e.g., the hordes of citizens participating in street cleaning), it was a relief for TASC mental health professionals to have professional contributory roles, in addition to being part of other civilian-led initiatives, including street cleaning and food and clothing drives.

Disaster preparedness: improving mental health response and clinician readiness, resilience, and competence. In the aftermath of the Beirut explosion, outreach initiatives worked to reestablish basic safety, physical, and social needs for the community. Mental health and psychosocial support (MHPSS) was often mentioned as a component in these initiatives, despite conflicting information on the numbers of individuals reached and the quality of the intervention delivered.

Paradoxically, mental health specialists, such as those involved in our trauma clinic, found it more difficult to access the population in the most affected areas. With the hospital-based model, not only geographical location but also the stigma associated with these centers can be major hurdles for attendance by those not already familiar with the setting. The early integration of specialized mental health services with preexisting, well-established forms of support in the community, such as nongovernmental, charitable, and religious organizations, can minimize stigma and improve services uptake while ensuring the quality and sustainability of these services (8). Additionally, encouraging collaboration between various activated taskforces facilitates the implementation of a multilayered support system endorsed by the Inter-Agency Standing Committee in emergency settings (8). Local frontline professionals and volunteers, through their experience of SRTR and their familiarity with local cultures and traditions, can spearhead the MHPSS response with international backup that will invariably still be required in low-resource health economies.

The Beirut port explosion was reminiscent of the 9/11 terrorist attack in New York City in terms of the emergence of urgent and unprecedented community needs, which uncovered gaps in disaster mental health and trauma response training (9). The situation also presented challenges to the dual identity of mental health provider and citizen. These challenges included applying self-compassion and self-care while maintaining regular clinical duties and responding to acute community needs. TASC clinicians reached out for support and consultation from supervisors and colleagues in the Department of Psychiatry. Others also took advantage of professional support offered by other organizations to frontline professionals working in Beirut. The role of national associations, such as the Lebanese Psychiatric Society (LPS) and the Lebanese Psychological Association, proved essential in providing the backbone for rapid coordination, needs assessment, and capacity building.

Psychiatry trainees, including those who volunteered at their respective university hospitals, relied on established networks such as the Early Career Psychiatrists Section of the LPS, which was already active in national awareness, education, and mental health advocacy initiatives. Although training programs cannot anticipate adversities of this scale, a greater emphasis on the core competencies of disaster mental health in psychiatric curricula is recommended to enhance personal and professional preparedness for involvement in postdisaster psychosocial relief. This step is of particular relevance to programs concerned with community and global mental health.

Moving from institutional initiatives toward national collaboration. The TASC was established as a spontaneous emergency clinic in the wake of a national disaster. More than 9 months after the blast, the shift in the needs of the community is compelling a shift in the mission and delivery model. Evolution toward a sustainable service needs to recognize the limitations and opportunities provided by the setting of an academic psychiatric department, in contrast with other organizations providing outreach MHPSS in directly affected areas. For more people to benefit and for clinicians to optimize their volunteering potential, these initiatives should be integrated in a larger response framework. Emergency mental health preparedness should become a priority at a national and international level, with a view toward addressing the immediate postshock effects of disasters, mitigating the longer-term mental health impacts, and extending access to basic and specialist care to the largest number of affected individuals. Although caused by an unfortunate event, the momentum for reform created by the Beirut blast should serve as a catalyst for reviewing the way society and institutions respond to major disasters—an objective that can be achieved only through the proactive leadership of public health authorities, international organizations, and all major stakeholders in the field of mental health. Lebanon already has a disaster relief authority, which was established a decade ago with the financial and logistical support of United Nations agencies (10). The project was hailed as a model for countries in the region. It unfortunately made no provisions for mental health response. Since it is expected that most developments in terms of formal evidence-based response to disasters are likely to include international sponsorship, mandating that mental health response preparedness is included in any future plan would be a strong incentive for local cooperation on this front. The creation of a dedicated mental health response steering committee that would be responsible for evaluating resources, developing protocols, and maintaining regular coordination can lead to more effective coordinated mobilization at short notice. Experience sharing among countries affected by disaster should also be encouraged, whether through disseminating research findings, developing training modules, or building practically oriented regional networks. These principles, adapted to each country's social and health ecosystem, would advance the field of disaster response in the Global South while reducing reliance on direct foreign intervention.

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REFERENCES

1. Devi S: Lebanon faces humanitarian emergency after blast. Lancet 2020; 396:456
2. Massena F: After Beirut Blast, Mental Health Is Lebanon's Next Crisis. London, The New Arab, 2020. https://english.alaraby.co.uk/analysis/after-beirut-blast-mental-health-lebanons-next-crisis

3. Oliver MI, Pearson N, Coe N, et al: Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. Br J Psychiatry 2005; 186:297–301
4. Tosone C, Lee M, Bialkin L, et al: Shared trauma. Psychoanal Soc Work 2003; 10:57–77
5. Saakvitne KW: Shared trauma: the therapist's increased vulnerability. Psychoanal Dialogues 2002; 12:443–449
6. Nuttman-Shwartz O: Shared resilience in a traumatic reality: a new concept for trauma workers exposed personally and professionally to collective disaster. Trauma Violence Abuse 2015; 16:466–475
7. Ungar M: Resilience, trauma, context, and culture. Trauma Violence Abuse 2013; 14:255–266
8. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva, Inter-Agency Standing Committee, 2006
9. Bender E: NY Residency Programs Expand Training in Disaster Psychiatry. Washington, DC, Psychiatric News, 2002. https://psychnews.psychiatryonline.org/doi/full/10.1176/pn.37.17.0016a
10. Making Lebanon Resilient: Achieving Disaster Risk Reduction in the Arab States—Good Practice Country Brief. Geneva, United Nations Office for Disaster Risk Reduction, 2012

Lived Experience Inclusion & Leadership Column Seeks Submissions

Coeditors: Nev Jones, M.A., Ph.D., and Keris Jän Myrick, M.B.A., M.S.

This column aims to publish critical analyses, case studies, and reports on the involvement and leadership of mental health service users (peers and consumers) and caregivers in mental and behavioral health service delivery. Specific topics include novel or innovative peer support and peer-led interventions, case studies of the lived experience leadership roles, participatory research efforts that center meaningful involvement (or leadership), and empirically informed lived-experience perspectives on topics related to the ethics and sociopolitics of interventions and services. We have a strong interest in intersectionality and the perspectives of individuals with multiple historically underrepresented or marginalized identities and encourage all submissions to include lived-experience lead authors or coauthors.

Submissions (via mc.manuscriptcentral.com/appi-ps) are limited to 2,400 total words, inclusive of a 100-word abstract, two or three one-sentence Highlights, and up to 10 references.