

## Psychological Crisis Intervention and Assistance after Sudden Man-Made Disasters: Postprint

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### Abstract

Sudden man-made disasters, characterized by their unpredictability, irresistibility, and devastating consequences, exert tremendous psychological impact on the public's psychological behavior. This article describes individual mental health status and social group behavioral manifestations following sudden man-made disasters, elaborates on the characteristics of psychological effects on individuals and groups, focuses on analyzing theories and implementation of psychological crisis intervention after such disasters, and explores models for conducting long-term post-disaster psychological assistance. As sudden man-made disasters have occurred frequently in China in recent years, strengthening research and application of psychological crisis intervention and assistance will effectively enhance the entire population's capacity for prevention and response to sudden man-made disasters.

### Full Text

#### Special Topic: Psychology and Social Governance

#### Crisis Intervention and Psychological Assistance After Sudden Man-made Disasters

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### Abstract

Sudden man-made disasters are characterized by their unpredictability, overwhelming destructiveness, and catastrophic consequences, generating profound psychological impacts on public behavior. This article describes the mental health status of individuals and behavioral patterns of social groups following

such disasters, elucidates the distinctive features of psychological effects on both individuals and communities, and focuses on analyzing theories and implementation of post-disaster psychological crisis intervention, as well as models for long-term psychological assistance. With frequent occurrences of sudden man-made disasters in China in recent years, strengthening research and application of psychological crisis intervention and assistance will significantly enhance national capacity for preventing and responding to such events.

**Keywords:** sudden man-made disaster, psychological crisis, post-traumatic stress disorder, psychological assistance

Disasters are events that cause significant casualties or extensive environmental changes, producing a series of economic, political, and social consequences [1]. The term emphasizes natural and human-caused events that negatively affect human life, with the World Health Organization (WHO) directly defining disasters as “severe disturbances of an ecological and psychosocial nature that substantially exceed the coping capacity of individuals and communities” [2]. Disasters are classified by severity as particularly major, major, relatively large, and general. Researchers typically categorize disasters into natural disasters and man-made disasters—essentially “acts of God” versus “acts of man.” Natural disasters result from natural events such as hurricanes, tsunamis, and earthquakes, while man-made disasters are caused by human actions, such as terrorist attacks, or result from human error or accidents, including oil spills, nuclear accidents, major traffic accidents, and food safety incidents. China’s Emergency Response Law classifies sudden man-made disaster events as accidents, public health incidents, and social security incidents [1]. Sudden man-made disasters not only cause casualties and economic losses but also inflict tremendous negative psychological impacts on survivors and society at large.

## 1. Psychological Stress Responses in Individuals and Groups After Sudden Man-made Disasters

When facing sudden man-made disasters, individuals and groups experience intense psychological stress reactions that lead to a range of mental health problems, though this issue has long been overlooked. The September 11, 2001 terrorist attacks in the United States and the Fukushima nuclear leak in Japan in 2011 increased academic and societal attention to post-disaster psychological stress responses to varying degrees. Research on the Chernobyl nuclear accident 25 years later found that mental illness represents the most prevalent public health problem caused by sudden man-made disasters, including depression, anxiety, post-traumatic stress disorder (PTSD), medically unexplained somatic symptoms, and stigmatization [3]. Numerous epidemiological surveys have found that PTSD incidence after disasters can reach as high as 33.3%, and depression incidence up to 25%. Survivors and rescuers may also experience anxiety, sleep disorders, and substance abuse (such as alcohol and tobacco) [4]. Risk factors for post-traumatic mental illness include female gender, history of mental illness, degree of trauma exposure, current stress, and lack of social

support [5]. Compared with natural disasters, survivors of man-made disasters exhibit more complex and persistently impaired psychological problems [6]. A meta-analysis of mass violence incidents indicated that the prevalence of PTSD among survivors ranged from 1.3% to 22%, with incidence rates affected by whether the disaster was intentional and the degree of personal connection to the event [7]. Due to the uncertainty of man-made disaster impacts and associated life changes and stigmatization from illness, such disasters often cause profound and lasting effects on survivors. A survey of SARS patients revealed that during the acute infection period, the incidence of mental illness was 35%; one year later, it was 64%; and in a three-year follow-up, 42% of respondents reported mental illness, with PTSD at 23.2% and depression at 16.6% [8]. This demonstrates that public health incidents leave long psychological shadows, and patients' mental health does not recover with physical health but instead shows a deteriorating trend. Studies of fire survivors found their PTSD prevalence at approximately 25%. Since fires often cause long-term damage (including disfigurement), impairing daily functioning and social interaction, symptoms are difficult to resolve over time [9].

Three to five days after the September 11 attacks, researchers used random digit dialing to interview 560 adults nationwide about their own and their children's reactions to the event. Ninety percent of respondents showed varying degrees of stress reactions, with 44% of respondents remaining in a state of stress and 35% of children exhibiting at least one stress reaction. Stress symptoms and severity correlated with the amount of related news exposure, with over one-third of parents preventing their children from watching related reports. Stress symptoms eased over time since the disaster; among non-New York residents, 17% still had post-traumatic stress symptoms two months after the attacks, and 5.8% still exhibited such symptoms after six months, with people fearing future terrorist attacks in which they or their loved ones might become victims [10]. Through media transmission, the Fukushima nuclear incident created a strong "psychological typhoon eye" effect [11], even triggering mass social movements such as panic buying of salt and vinegar across China.

Sudden man-made disasters also easily trigger rumor propagation and intensify intergroup conflict. Rumors are unverified claims that circulate widely in ambiguous, dangerous, or potentially threatening situations to help people understand and manage perceived risks [12]. The intensity of rumor transmission depends on situational uncertainty, environmental threats, and anxiety. High-risk situations created by sudden man-made disasters, particularly public safety incidents or terrorist attacks, trigger rumor outbreaks. In an information vacuum, rumors serve as alternative expressions of public shock and anger after disasters, providing a sense of control [13]. When environments are threatening or dangerous, people lose their ability to make independent judgments. Driven by a strong need for security, they generally lack the desire or motivation to verify information authenticity; simultaneously, dangerous and chaotic situations make people more sensitive and thus more willing to spread rumors [14]. Studies of fire survivors found their PTSD prevalence at approximately 25%. Since

fires often cause long-term damage (including disfigurement), impairing daily functioning and social interaction, symptoms are difficult to resolve over time [9].

## 2. Characteristics of Psychological Stress Responses After Sudden Man-made Disasters

Compared with natural disasters, sudden man-made disasters exhibit three distinctive characteristics in their psychological impact on individuals and groups.

### 2.1 Direct Assault on People' s Sense of Security

Sudden man-made disasters, due to their unpredictability, overwhelming destructiveness, and catastrophic consequences, exert enormous influence on public psychology and behavior. The massive negative information or impacts from disasters spread rapidly through interpersonal communication, particularly modern media, generating psychological shock even beyond disaster-affected areas and potentially causing nationwide panic. After the September 11 attacks, 90% of respondents showed varying degrees of stress reactions, with 44% of respondents remaining in a state of stress [10]. Even in capsizing incidents caused by extreme weather conditions, the ultimate cause lies in inadequate preparation and safety hazards—in other words, human error or accidents. Such disasters are theoretically preventable. Consequently, compared with natural disasters, society and individuals are even less psychologically and practically prepared for man-made disasters, and even when preventive measures exist, they are not at the individual level. Therefore, in addition to fear and helplessness, emotional reactions to man-made disasters include confusion, anger, distrust, and blame. These negative emotions are not only symptoms of mental illness themselves but also more likely to lead to long-term psychological problems [15].

Meanwhile, through media and interpersonal transmission, sudden man-made disasters create psychological shock and panic across entire regions or even nations within short periods, potentially causing social upheaval [10].

### 2.2 Generation of More Iterative Psychological Trauma

After natural disasters, all sectors of society immediately extend assistance, with relief supplies being collected promptly and survivors actively engaging in self-rescue and reconstruction. For sudden man-made disasters, however, rescue responses are relatively slower, as people often wait for relevant parties to assume responsibility for the incident. Disaster recovery is often not the primary (or sole) focus externally, and reconstruction work is frequently led by outside forces, leaving local residents without a voice. Since sudden man-made disasters often involve responsible parties, accountability and compensation may require greater effort, even involving legal proceedings or political resolution—a process accompanied by greater stress and psychological burden [16]. Unclear responsibility, lack of accountability, and unfair compensation are sources of injustice

perception, even leading to large-scale social group conflicts. Because the long-term consequences of man-made disasters remain unclear—especially whether chemical or biological disasters (such as pollution, nuclear leaks, or food safety issues) cause physical and mental damage, economic and ecological impacts, and whether and when such damage can be recovered—such questions create unknowns. Under high-risk, uncertain circumstances, both individual and group psychological states and decision-making performance are affected [5].

### 2.3 Typical Staged Nature of Psychological Trauma in Survivors

After natural disasters, survivors typically experience five stages: shock (fear), heroism (altruism), sorrow (internalization), anger (externalization), and reconstruction of normalcy [17]. During the shock period about two days after a disaster, affected populations show obvious physical reactions such as muscle tension and stomach discomfort; intense emotional reactions including irritability, fear, and restlessness; and behavioral manifestations like sleep difficulties and eating disorders. Heroism refers to the enthusiastic mutual assistance displayed after disasters.

After sudden man-made disasters, people more often exhibit confusion, blame, distrust, and uncertainty about long-term impacts, with mental health levels declining rapidly and remaining persistently low. Survivors of man-made disasters rarely experience the uplifting heroism stage, often moving directly into sorrow and anger [16]. In some sudden accidents, the anger period may be correspondingly extended, with any unexpected event potentially prolonging or re-triggering the anger phase.

After sudden man-made disasters, typical grief and anger emotions emerge, beginning two days to two weeks after the event. In addition to anxiety and irritability, some individuals exhibit aggression, collusion, posting slogans, and online venting. The anger period can be subdivided into three phases: (1) **Incubation phase**: Following the shock and sorrow periods, affected populations become psychologically sensitive, generally showing “temporary stability with undercurrents.” (2) **Release phase**: When people’s demands remain unanswered for a long time or external information diverges too greatly from their own wishes, some may exhibit abnormal or even extreme words and deeds, such as attacks, online venting, and group violence. (3) **Awareness phase**: As time passes, affected populations begin to receive more information about disaster event handling, such as compensation policies issued by local governments. They may calm down or continue to release emotions, beginning to think and weigh benefits consciously.

### 3. Psychological Crisis Intervention and Assistance After Sudden Man-made Disasters

#### 3.1 Timing and Content of Crisis Intervention and Psychological Assistance

After sudden man-made disasters, it is necessary to minimize impacts on human physical and mental health and provide emergency and continuous care. To minimize impact, psychological crisis intervention and management must be implemented. Typical crisis management includes four components: PPRR—Prevention and mitigation, Preparedness, Response, and Recovery. The Response and Recovery components primarily address crisis management after accidents have occurred [18]. Simultaneously, to restore the mental health of survivors and rescuers, long-term psychological assistance must be developed.

In the early post-disaster stage, the focus of psychological intervention is to enhance sense of safety, promote stability (calming down), foster individual and collective efficacy, promote interpersonal connection, and ignite hope [19]. Critical incident management refers to emergency psychological care aimed at alleviating acute psychological stress, restoring psychophysiological functional balance, and reducing potential psychological trauma for individuals in crisis situations [20]. General emergency management integrates crisis intervention, group stress debriefing, and other techniques, comprising seven core components: pre-crisis preparation (individual and organizational levels), large-scale post-disaster demobilization procedures, individual emergency crisis counseling, defusing (brief group discussions aimed at reducing acute symptoms), critical incident stress debriefing (longer group discussions aimed at psychological closure regarding the disaster and referral of severe cases), family crisis intervention, and follow-up instructions and referral for psychological assessment and treatment [21].

Crisis intervention is a temporary solution; the intervention itself is generally brief, but its effects may last long [20]. Research has found that individuals' coping methods in the short term after sudden man-made disasters can significantly predict subsequent mental health status. A survey of post-traumatic stress symptoms after the September 11 attacks showed that coping methods adopted within two weeks of the attack were second only to pre-existing mental illness in predicting PTSD symptoms six months later. Active coping after terrorist attacks can prevent subsequent psychological problems, while failure to address stress symptoms after attacks (such as denial or giving up) increases PTSD incidence. Therefore, emergency intervention immediately after sudden man-made disasters can effectively alleviate immediate symptoms, restore order, and prevent subsequent mental illness [22].

Since psychological problems caused by disasters do not disappear quickly and may still have effects many years later, individuals may develop different symptom trajectories after trauma, mainly comprising four categories: (1) The majority of people do not show high stress states or psychological problems after

events, with psychologically resilient individuals accounting for approximately 35%-65%. (2) Another 15%-25% of people show high post-traumatic stress levels that disappear as the event fades, representing a recovery group. (3) A third group shows long-term impairment (5%-30%) with persistent symptoms. (4) The final group does not show strong stress reactions initially but develops symptoms later, representing delayed impairment (0%-15%) [15,23].

Therefore, a considerable number of groups require long-term psychological assistance after man-made disasters. The Inter-Agency Standing Committee (IASC) published *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* in 2007, providing comprehensive recommendations for addressing the most urgent mental health, psychological, and social issues after disasters. The guidelines propose the following basic principles for psychological rescue in emergencies: (1) emergency planning; (2) comprehensive assessment; (3) attention to long-term development; (4) inter-agency cooperation; (5) integration of psychological assistance into basic healthcare; (6) service provision for all affected populations; (7) in-depth systematic training and supervision; and (8) monitoring using important indicators. The guidelines also clarify the importance of universally implementing long-term psychological assistance [24].

### 3.2 Psychological Crisis Intervention After Sudden Man-made Disasters

The primary goal of crisis intervention is to reduce the impact of events, facilitate normal recovery processes (normal reactions of normal people to abnormal events), and restore individuals to normal adaptive functioning. Crisis intervention generally follows these principles: simple (simple methods), rapid (minutes, maximum one hour), adaptable (must adjust to new situations), practical (any suggestions must be practical to be effective), on-site (contact nearby), timely (crisis situations require urgent handling), and expectant (need to establish reasonable positive outcomes) [25]. Japan's post-disaster mental health care guidelines emphasize that post-disaster mental health workers must first assist local mental health institutions in normal operation and contact disaster victims as early as possible after the disaster. If psychological intervention is not timely, anxiety, despair, and confusion cannot be relieved, making serious psychological problems and even group incidents more likely. In the initial stage, mental health workers mainly conduct two types of activities for affected local residents: (1) As part of overall rescue operations, promote mental health and reduce stress and psychological trauma in the general population, mainly including visiting victims to understand situations, disseminating accurate disaster information, and providing psychological education for the general public. (2) For prevention, early detection, and treatment of common post-disaster mental illnesses, including mental illness screening, encouraging people to seek counseling, providing individual psychological education, and making referrals. According to these guidelines, in the 1-2 weeks after a disaster, the first type of activity is the priority; the second type should be conducted after meeting victims' basic

needs, focusing on reducing confusion rather than making diagnoses [26].

Effective crisis intervention methods both domestically and internationally include psychological first aid, stress debriefing, eye movement desensitization and reprocessing, and stabilization techniques, which can be conducted one-on-one or in groups [20]. During this period, affected populations are in initial fear, and many reactions are normal stress responses. Psychological care should primarily focus on emergency and stabilization, respecting individuals' natural recovery processes and psychological resilience, avoiding direct and in-depth exploration of disaster scenes and processes [26]. For major emergencies with widespread impact, establishing crisis intervention hotlines or online platforms can reach more affected populations. Since major stress reactions can trigger or worsen symptoms of severe mental illnesses such as schizophrenia, the crisis intervention stage should pay special attention to individuals with mental illness or family history of mental illness, promptly intervening with medication and other methods when psychotic symptoms appear [27].

Another important task during the crisis intervention stage is needs assessment. Compared with physical pain, psychological trauma is not intuitive and requires more in-depth identification and evaluation. Psychological assessment for major emergencies includes community-level and individual-level assessments, considering different actual situations and needs. (1) **Community assessment** primarily aims to understand the incidence of mental illness and psychological problems in populations and the frequency and severity of different intervention needs. Accurate assessment is the foundation for allocating limited resources, recommending service content, and identifying intervention priorities. Community assessment requires speed and representativeness, often using visits to community leaders and rapid screening methods. Depending on assessment content, timing varies. For example, the clinical diagnostic course requirement for PTSD is four weeks—symptoms must persist for more than four weeks for diagnosis (the diagnostic standard course for depression is two weeks) [28]. Therefore, early community assessment (2–4 weeks after the event) mainly focuses on understanding community conditions, trauma exposure, damage, and identifying individuals with potential mental health problems. (2) **Individual assessment** involves relatively detailed clinical diagnosis, daily functioning, psychosocial factors, personal attitudes and beliefs, and personal and family medical history, directly providing mental health services that meet individual needs. Individual assessment often targets individuals with severe symptoms or high-risk groups identified in community assessments.

### 3.3 Long-term Psychological Assistance After Sudden Man-made Disasters

According to the social-ecological theory of psychological recovery, individuals are influenced by factors at different levels: individual, family, school/community, and sociocultural. (1) **Individual factors** include personality, coping styles, physiological factors, and genetic factors. (2) **Family**

**factors** include family socioeconomic status, parent-child relationships, and education level. (3) **School/community factors** include social support, peer relationships, community environment, and neighborhood relations. (4) **Sociocultural factors** include socioeconomic factors, social values, and cultural traditions. Mental health depends on the health and balance of the entire ecosystem [29].

After sudden man-made disasters, all affected individuals may experience psychological problems of varying degrees. IASC recommends implementing basic psychological interventions for the entire society, targeting not only individuals with needs but also those without symptoms or who do not actively seek help [24].

Providing mental health assistance and meeting public psychosocial needs after major sudden man-made disasters is an important component of human rights protection. Psychological assistance work itself represents social progress, promoting social justice, safeguarding personal dignity, and encouraging self-help and participation—all manifestations of civilized social culture [30]. Due to varying needs, assessment and identification are required in the early stage to conduct targeted psychological assistance in a coordinated and prioritized manner. Based on symptom levels and development trends, and according to the degree of need for psychological intervention, populations can be divided into four categories: (1) **Individuals with obvious symptoms**, including clinical and subclinical populations. (2) **High-risk groups**, including severely traumatized individuals, bereaved family members, and rescuers. (3) **Vulnerable populations** easily affected by disaster events with higher post-disaster mental illness prevalence, such as children, adolescents, women, and the elderly. (4) **General population**, including ordinary citizens exposed to major emergencies who may be affected.

For individuals diagnosed with mental illness meeting clinical standards or subclinical patients not meeting clinical criteria, interventions should be administered for treatment. Common intervention methods abroad mainly include medication and psychotherapy. Medication must be conducted under the diagnosis of professional psychiatrists, such as antidepressants (for PTSD, depression) and neurostimulant drugs (for depression). Currently, internationally clinically validated effective psychotherapies for PTSD include cognitive-behavioral therapy and exposure therapy; for depression, the clinically validated effective psychotherapy is primarily cognitive-behavioral therapy [4]. Additionally, China has begun research on traditional Chinese medicine treatment for PTSD in recent years, with evidence showing acupuncture's effect on PTSD is comparable to medication [31].

For high-risk groups (severely traumatized individuals, bereaved family members, rescuers, etc.), psychological interventions focusing on psychotherapy and psychological education should be conducted to prevent symptom deterioration or delayed-onset mental illness. For vulnerable populations (such as women, adolescents, children, and the elderly), psychological services can be provided

through psychological education and organized group activities to promote mental health and school/community cultural atmosphere. For the general population, public and media campaigns can disseminate information to stabilize emotions and promote positive affect, thereby improving universal mental health. Additionally, to address stigmatization accompanying man-made disasters, education is needed to help the general public understand situations and make contact with affected populations to achieve destigmatization.

Due to the long duration and broad scope of psychological assistance, post-disaster mental health services must also transition from external leadership to local self-help. Since most regions in China generally lack professional psychology and mental health teams [32], and early post-disaster crisis intervention has high professional requirements, organized external professionals must work with local personnel in early post-disaster stages. Upon arriving, crisis intervention experts should first contact incident command departments and local mental health systems to understand their needs, and connect with local medical and education systems for preliminary assessment. Based on assessment results, screening and crisis intervention should be provided for vulnerable and high-risk groups concentrated in communities and schools. Rescuers, due to long-term exposure to disaster scenes coupled with heavy workloads and lack of rest, are more prone to stress reactions [33]. Therefore, individual and group crisis intervention should be conducted for rescuers and pivotal groups (such as medical staff, teachers, and grassroots cadres) to ensure smooth rescue operations. After the emergency rescue period, communities begin recovery and reconstruction, and psychological services transition from crisis intervention to more routine, systematic psychological assistance. The success of this process depends on five aspects: government and policy, human resources and training, programs and services, research and monitoring, and funding and finance [34]. At this stage, experts should collaborate with local governments to establish psychological assistance centers in schools or communities, employing different models and methods of psychological assistance according to service targets. Simultaneously, they should cultivate local talent and teams through professional training and supervision, establishing a psychological assistance team with professional psychological assistance organizations (such as mental health education centers, psychological service NGOs) at the core and grassroots teams with basic psychology knowledge (such as teachers and grassroots cadres) as the periphery, linked with local mental health/medical departments for referral, thus forming a complete psychological service system. To ensure quality of psychological assistance, national-level standards and training content should be established with unified regular training and assessment. A unified registration system for institutions and individuals should also be created to coordinate and supervise specific psychological assistance work.

#### 4. Recommendations for Psychological Crisis Intervention and Assistance After Sudden Man-made Disasters

As China's urbanization accelerates, populations become increasingly concentrated and lifestyles highly organized, significantly increasing the risk of casualties and psychological impacts from sudden man-made disasters. To better prevent and address psychological health and social stability issues in sudden man-made disasters in China, five aspects of work should be strengthened.

- (1) **Improve laws and regulations for post-disaster psychological crisis intervention and assistance, strengthening their status in national disaster relief operations.** In recent years, China has experienced a series of sudden man-made disasters. The Chinese government and society have not only implemented efficient life rescue and material relief but also paid close attention to post-disaster psychological crisis intervention and assistance. Psychological crisis intervention and assistance are highly professional, with strict requirements for personnel knowledge, qualifications, and clinical experience. Currently, there remains a lack of professional qualification certification, training, and effectiveness evaluation. Given the abnormal social conditions after disasters, unified management and resource support are urgently needed, along with supporting laws and regulations to ensure timely, stable, and effective implementation of psychological assistance work.
- (2) **Establish scientific systems for post-disaster information release, major decision-making, aftermath handling, and problem feedback.** Progress in accident handling after sudden man-made disasters should be released or made public gradually or in real time, ensuring information openness and transparency while expressing concern for affected populations and eliminating rumors. Accurate information release not only helps increase victims' sense of security and trust in government but also facilitates smooth psychological assistance work. Expand public participation rights by absorbing citizen representatives into regional major decision-making related to post-disaster handling and reconstruction, enhancing decision-making transparency. For example, before officially releasing post-disaster housing safety appraisal methods and maintenance plans, indoor damage assessment and compensation handling methods, opinions should first be solicited from resident representatives to gradually release information and avoid major fluctuations after policy introduction. Encourage and publicize legal channels for affected populations to express their needs, such as normal petition channels, so that disaster victims can find normal, legal pathways for problem feedback and emotional venting.
- (3) **Attach great importance to the cumulative psychological impact of secondary disasters on individuals and groups.** During emergency rescue after sudden man-made disasters, immediate safety surveys and education should be conducted to prevent recurrence of such acci-

dents. If secondary accidents or negative emotional events occur during the resettlement phase, they may directly intensify conflicts and affect aftermath handling. Secondary disasters include fires, fighting injuries, etc., and necessary measures should be taken to reduce such impacts. From a probability perspective, dangerous industrial facilities will inevitably have accidents—only the timing is uncertain. Therefore, dangerous industrial facilities need scientific planning and design to keep hazardous accidents within controllable and predictable ranges. Meanwhile, multiple detection and warning systems should be installed for dangerous industrial facilities to enable early detection and early handling.

- (4) **Position social stability tasks appropriately for post-disaster conditions.** Position the two points of preventing malignant social incidents and ensuring timely response when any social incident occurs as the bottom line. Treat people's demands to higher-level departments as normal expressions of needs to ease the high-pressure states of both the public and staff, avoiding adverse incidents. For the very few individuals who spread rumors, incite others, and affect social stability, serious legal action should be taken in conjunction with public security organs. Establish rapid problem resolution and long-term service mechanisms for the public. For difficulties and problems raised by the public, those that can be solved on-site should be solved on-site; those that cannot be solved on-site should be quickly referred through green channels after explanations, with tracking and supervision. Gradually transition public work from emergency to normal status, and according to the principle of "simple first, then complex, ensuring basics," meet the basic needs of floating populations for education and medical care, gradually promoting equal citizen treatment.
- (5) **Deploy research units and major scientific tasks on post-disaster psychological trauma to provide scientific support for crisis intervention and assistance.** Focusing on the scientific question of "the mechanism of traumatic stress response based on gene-brain-behavior-society," consolidate multi-disciplinary research forces to drive solutions to mental illness problems caused by various stress events in China (traffic accidents, domestic violence, sexual assault, major diseases with various diagnoses, etc.). Cultivate professional talents in psychological crisis intervention and assistance, and establish a national professional talent reserve network to meet the enormous demand for psychological crisis intervention and assistance after various emergencies in China.

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