Ten years after the 9/11 attacks in the US, post-disaster support groups are are still much-needed in the UK, says Jelena Watkins

Jelena Watkins is a qualified NHS counsellor working in primary care. She is planning to research the subject of those directly affected by disaster and would like to hear from other professionals and users about their experience of disaster mental health interventions. For more information email: jelena.watkins@gmail.com

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In the wake of the 10th anniversary of the 9/11 attacks, I would like to pose some questions. If it were to happen again, here or elsewhere in the world, what would the mental health response in Britain be? Would mental health care services be able meet the needs of those directly affected, or would we be faced with the result of not learning from previous disasters?

A useful point of reference is the response laid out in NHS guidance on planning for the psychosocial and mental health care of people affected by disasters. The guidance addresses interventions primarily at the level of the individual. Yet disaster, as a collective trauma, also requires a collective approach. While the document refers to community cohesion in the aftermath of a disaster, there is nothing about the potential benefits gained from support groups and self-determining action groups in relation to psychosocial support.

After a disaster, many people seek the opportunity to be put in touch with others who have had similar experiences. Such contact can bring them a unique understanding and mutual support, which is a fundamentally important aspect of an individual's recovery after such a disaster experience. It has long been recognised that psychosocial support strategies that facilitate such opportunities are an important way of enhancing self help, community resilience and longer-term recovery.

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This assessment is based on my direct experience. After September 11, 2001, I was left to cope with the fact that my brother Vladimir was officially 'missing, presumed dead'. In addition to the stress of dealing with my own loss, I encountered numerous practical difficulties in obtaining information from the USA regarding the recovery and victim identification process, and how best to access charitable funds and work through the legal processes.

I was aware that in New York there were many support groups set up for the bereaved and survivors. I knew I could benefit from meeting other people in the same situation, but such support groups were unavailable in the UK. At the time I didn't know any other affected people on home soil, so I put my energy into seeking out other 9/11 families.

After encountering ambivalence from officialdom, I met members of Disaster Action (DA), a charitable organisation established in 1991 by bereaved families and survivors who wanted to form their own mutual support groups after particular disasters. They instantly understood my need to have a group.

DA organised the first meeting of all UK-based 9/11 families six months after the tragedy. At that first meeting in a London hotel, a formal organisation, the September 11 UK Families Support Group was created. Along with three other people I had never met before, I became one of the initial trustees.

For me personally, and for many others, it was a turning point in our recovery. We worked alongside the government to organise the 1st anniversary commemoration and to create a permanent 9/11 memorial in Grosvenor Square, London. We are now a 300-plus strong organisation.

In addition to taking an active part in this organisation, I also joined a telephone support group along with a small group of women who lost their siblings in the attacks.

Groups are not a panacea for all ills though. A source of resilience, they can also be a source of injury; for example, if exclusion on the basis of difference, be it ethnicity, religion or culture, takes place. Issues of inclusion are of primary importance in the sensitive running of support groups.

So what is the way forward? Those responsible for developing psychosocial strategies should facilitate options for people to come together following a disaster, and recognise mutual support as a central principle in their psychological and social recovery. This could be offered in addition to, and not instead of, more clinical, individually-focused interventions. Different types of groups would also be beneficial, from one-off psychoeducational groups, to face-to-face or telephone/online support groups.

A good example is the Scandinavian model of collective support for those bereaved by disaster as described by Atle Dyregrov and his colleagues. This is where a structured group intervention is put in place for the bereaved following a disaster, delivered in a format of three weekends. This method has been successfully used after several disasters in Scandinavia.

Disaster is now a part of our everyday lives. As such, all guidance should address collective, group and cultural experiences as the need for support doesn't end when the disaster does. ■

Department of Health (2009) *NHS Emergency Planning Guidance: Planning for the psychosocial and mental health care of people affected by major incidents and disasters: Interim national strategic guidance*. London: DH.