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MODERN APPROACHES TO DEVELOPING PSYCHOLOGICAL RESILIENCE IN EMERGENCY SITUATIONS

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Abstract. This article examines contemporary approaches to strengthening psychological resilience among people exposed to emergencies, including natural hazards, technological accidents, displacement, and other disruptive events. A narrative comparative review of international guidance and peer-reviewed research considers psychological first aid, preparedness education, social connectedness, stress-management skills, and digitally supported interventions. The analysis distinguishes resilience as a dynamic adaptation process from the absence of distress and proposes a multi-level framework connecting individual skills, family and community resources, and institutional readiness. The findings suggest that preparedness programs should combine practical rehearsal, accessible communication, supportive social environments, and pathways to professional care. The paper is a literature-based analytical study; no original survey, intervention, or clinical outcomes are claimed.

Keywords: psychological resilience, emergency situations, disaster mental health, psychological first aid, coping, preparedness, social support, community resilience, digital mental health.

INTRODUCTION

Emergencies disrupt everyday routines, threaten physical safety and livelihoods, and may generate uncertainty, grief, fear, and prolonged stress. Psychological responses are heterogeneous: some people recover with ordinary social support, others experience persistent difficulties, and many show fluctuating patterns over time. Consequently, psychological resilience should not be understood as invulnerability or an obligation to remain calm. Rather, it refers to processes and capacities that support adaptation in the presence of adversity [1, 2].

The relevance of this issue is growing as populations face interacting natural, technological, and public-health hazards. The Sendai Framework for Disaster Risk Reduction 2015–2030 emphasizes preparedness, inclusive risk governance, and the reduction of disaster impacts [3]. The Inter-Agency Standing Committee (IASC) similarly places mental health and psychosocial support within coordinated humanitarian response rather than treating psychological wellbeing as a purely individual responsibility [4].

Although emergency preparedness often emphasizes evacuation routes and physical supplies, behavioral readiness and psychosocial resources also affect how people interpret warnings, seek assistance, cooperate with others, and recover after disruption. The purpose of this article is to synthesize evidence-based approaches to developing psychological resilience and to outline an integrated framework suitable for educational, community, and emergency-management settings.

MATERIALS AND METHODS

A structured narrative review and comparative thematic analysis were employed. The source base comprised foundational peer-reviewed studies of resilience and disaster mental health [1, 2, 5], consensus guidance on mass-trauma intervention principles [6], WHO guidance on psychological first aid [7], IASC humanitarian mental health guidance [4], WHO recommendations on stress-related conditions [8], and

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the Sendai Framework [3]. Sources were selected for conceptual relevance, institutional authority, and applicability to emergency settings. This was not a systematic review or meta-analysis; no claim of exhaustive database retrieval is made.

The analysis used five domains: (1) understanding stress responses; (2) personal coping and perceived efficacy; (3) family and community support; (4) institutional preparedness and service referral; and (5) accessibility, ethics, and digital delivery. Recommendations were differentiated from established evidence where effectiveness depends on local conditions, implementation quality, or further evaluation.

RESULTS

1. Resilience as a dynamic and socially embedded process

Bonanno's work on responses to potentially traumatic events describes multiple adjustment trajectories and cautions against assuming that all exposed individuals will develop long-term pathology [1]. Norris and colleagues' disaster research likewise demonstrates that consequences vary with exposure, resources, social context, and time [5]. These findings support a flexible model in which resilience can be reinforced through both individual competencies and external support systems rather than by a single personality trait.

2. Psychological first aid and early supportive response

WHO, War Trauma Foundation, and World Vision International describe psychological first aid as humane, supportive, and practical assistance that respects dignity, culture, and abilities [7]. Its core orientation is to assess immediate needs, listen without pressuring disclosure, help people access basic services and social supports, and protect safety. Psychological first aid is not psychotherapy, compulsory emotional debriefing, or a substitute for clinical assessment when serious symptoms or risks are present. Its usefulness depends on appropriate training, safeguarding, and clear referral routes.

3. Practical preparedness, self-efficacy, and coping skills

Preparedness programs can connect knowledge of hazards with achievable protective actions: recognizing official alerts, planning family communication, identifying safe meeting arrangements, and rehearsing responses through realistic exercises. Such activities may reduce uncertainty and strengthen perceived ability to act, although their psychological effects should be measured rather than assumed. The five essential elements identified by Hobfoll and colleagues—safety, calming, individual and collective efficacy, connectedness, and hope—offer a useful organizing framework for emergency psychosocial support [6].

4. Community relationships and institutional coordination

Resilience is also shaped by trusted relationships, accessible services, and functioning institutions. The IASC guidelines recommend layered supports ranging from basic services and security through family and community assistance to focused non-specialized and specialized care [4]. Community-level preparedness therefore requires coordination among emergency responders, schools, health workers, social services, and local organizations. Support must be inclusive of children, older adults, people with disabilities, displaced persons, and people with limited access to digital information.

5. Digital and blended approaches

Mobile messaging, online psychoeducation, remote consultations, and simulation-based training can expand access to preparedness information and support continuity during disruption. However, digital delivery should be regarded as a complement to—not a replacement for—face-to-face support, accessible offline channels, and professional care. Privacy, data security, connectivity, accessibility, misinformation, and unequal access are essential implementation considerations. Claims that any specific app or simulation reliably improves resilience require evaluation in the intended population.

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Table 1. Comparative framework for psychological resilience interventions in emergencies

Approach	Expected contribution	Implementation and evaluation considerations
Psychological first aid	Immediate humane support and linkage to practical help	Train responders; avoid forced disclosure; monitor referral pathways [7]
Preparedness drills and scenario learning	Action familiarity and perceived capacity to respond	Assess actual task performance and accessibility, not attendance alone [3, 6]
Coping and stress-management education	Recognition of stress reactions and adaptive self-regulation	Avoid one-size-fits-all claims; refer persistent or severe symptoms [8]
Family and community support	Social connection, mutual assistance, shared resources	Include vulnerable groups; evaluate participation and service reach [4, 5]
Digital and blended support	Wider distribution of information and remote contact	Check privacy, accessibility, misinformation and offline alternatives

The approaches are complementary rather than interchangeable. Immediate support addresses urgent practical and emotional needs; drills build procedural familiarity; coping education supports self-management; community structures maintain connection; and digital tools may improve reach. Their success cannot be inferred from adoption alone. Appropriate evaluation would examine the accessibility and quality of support, protective-action competence, referral uptake, and wellbeing over time, using ethically appropriate measures.

DISCUSSION

The reviewed evidence challenges a narrow interpretation of resilience as individual toughness. A person may demonstrate adaptive coping while still needing material assistance, social protection, or treatment. In addition, the absence of visible distress does not establish that support is unnecessary, just as an immediate stress reaction does not by itself indicate a mental disorder [1, 4, 7]. Preparedness should therefore avoid stigmatizing help-seeking and should communicate that different responses to emergencies are common.

For education and emergency-management practice, a staged program is proposed. Before an emergency, organizations can teach risk literacy, build inclusive communication plans, and rehearse practical decisions. During an event, trained personnel should prioritize safety, basic needs, clear information, supportive contact, and appropriate referrals. After the acute phase, follow-up should support reconnection with routines and services, identify those requiring further assistance, and evaluate lessons from the response. These stages align with the broader preparedness and recovery logic of the Sendai Framework and the IASC layered-support model [3, 4].

Psychological interventions must also be proportionate to evidence. WHO guidance for stress-related conditions supports context-sensitive assessment and care, while the literature on mass-trauma interventions warns against treating a single universal technique as suitable for everyone [6, 8]. Training programs should be supervised, culturally appropriate, and evaluated for unintended effects as well as benefits. Digital innovations are promising for dissemination and coordination but cannot compensate for missing basic services, unsafe environments, or a shortage of qualified professionals.

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This article has limitations. Its narrative review design does not permit pooled effect-size estimates or causal conclusions about particular programs. The literature includes studies conducted in different disaster types and cultural contexts, so transferability to specific communities—including those in Uzbekistan—requires local needs assessment and pilot evaluation. Future empirical work could compare training formats using validated measures of perceived efficacy, observed protective behavior, social support, and follow-up wellbeing.

CONCLUSION

Developing psychological resilience in emergencies requires a coordinated, multi-level approach rather than isolated motivational training. International evidence and guidance point to the combined importance of safety, practical preparedness, perceived efficacy, social connectedness, accessible psychological first aid, and pathways to specialized support. Educational institutions and emergency agencies can strengthen preparedness by integrating scenario-based exercises, inclusive risk communication, community participation, and carefully governed digital tools. The effectiveness of these measures should be assessed through local, ethically designed research instead of assumed from their novelty or popularity.

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