ental Health Services in Disasters:

Manual for Humanitarian Workers

RAQUEL E. COHEN

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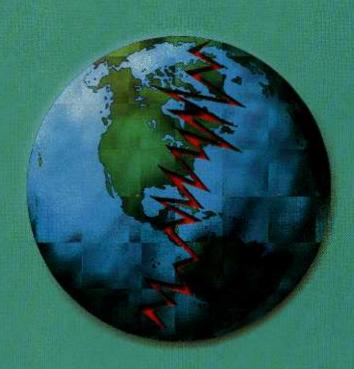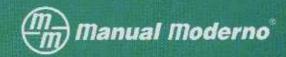# Mental Health Services in Disasters: Manual for Humanitarian Workers

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"When the center of someone's life has been blown out like the core of a building, is it any wonder if it takes so long even to find a door to close?"

Ellen Goodman
The Boston Globe
January 4, 1998

Preface

It is a privilege to provide this introduction to **Disaster Mental Health Services: Manual for Workers.** This Manual and the accompanying Training Guide, while presented in basic terms and designed for practical use, represent a remarkable compendium of state-of-the-art information.

Although the timing of individual events may be difficult to predict, natural or human-initiated disasters are tragic, but predictable, occurrences in our world. Hurricanes, earthquakes, volcanic eruptions, floods, explosions, and other such catastrophes are reported with regularity across the globe, and each takes its toll, both on those who experience the disaster directly and on others in our society.

The emerging recognition of the short- and long-term psychosocial and psychophysiologic impact of disasters is a subtle contribution to our understanding of human adaptation and illness. The opportunity to aid victims through prompt and effective intervention can play a crucial role in preventing many of the untoward short- and longer-term sequelae that we have learned to recognize.

In the aftermath of major disasters, there is often a gratifying response from persons anxious to help, which can be appropriate and effective. However, at the same time, an influx of untrained and unorganized volunteers can add to the problem. Mental health professionals who are skilled in the diagnosis and treatment of the usual forms of individual psychopathology are valuable. However, if they are untrained in the public and mental health aspects of disasters, or if their efforts are poorly coordinated, they contribute little to the needed intervention or prevention of illness.

Dr. Raquel Cohen, author of this manual and the training guide, is among the world's foremost authorities on the psychological and social consequences of disasters and on methods for rapid and effective intervention. Her contributions to the literature on the psychological and social impact of disasters put her at a level without peer. Her remarkable experiences, which range from helping individual victims to advising government leadership councils, have led her to develop a model for addressing the consequences of disasters in the populations involved. Dr. Cohen's understanding of the interplay of individual psychology, social systems, and somatic vulnerabilities are, in my opinion, of fundamental value.

I hope that this volume receives the widespread attention it deserves and that training for mental health interventions in crisis situations becomes an obligatory course of instruction for all mental health workers, and, indeed, for health care providers in general.

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Contents

Objetives

Each chapter includes learning objectives, content information, and a recommended reading list. Teaching resources to assist trainers to prepare post-disaster workers can be found in the accompanying <u>Training Guide</u>, which presents real life situations and recommended materials, such as videotapes, group work exercises, and pages that can be made into transparencies or slides.

Introduction

Disasters, whether natural or man-made, are random events creating devastation that cannot be controlled. Natural disasters like earthquakes, hurricanes, tornadoes, flooding, or volcano eruptions destroy lives, homes, and communities. For centuries, the primary response to disaster has been to assist survivors to recover the basic needs of clothing, shelter, food, and water while reorganizing the crumbled remains of their lives. Over the past twenty years, increasing awareness, understanding, and recognition of the emotional toll of disasters have led to the emergence of a mental health response for survivors. Recognizing the emotional and psychological impact of a disaster, mental health workers have developed approaches and procedures to help survivors and emergency relief workers recognize the signs of trauma and assist in the recovery from the catastrophic impact.

While each disaster has unique characteristics, the universal human response to catastrophic change and loss allows for the development of information and training that can be applied worldwide. This manual has therefore

been written to allow disaster workers to serve survivors in different regions of the world, taking into consideration differences in culture, language, traditions, religions, and public/private systems of organized response.

The content of this manual is the result of 20 years of field experience by many groups of workers who have helped disaster survivors in North American and Latin American countries. The information has been developed through amalgamation and identification of key content areas used in disaster programs, including the Red Cross program. It is the summation of research, observations, and on-site assistance in the aftermath of catastrophes in many parts of the world. Although the bibliography is mainly published in the U.S., worldwide literature on disasters can be obtained through the World Health Organization.

The manual is designed as a basic compendium of current knowledge, which will be supplemented with an accompanying **Training Guide** paralleling each chapter of the **Manual for Workers**. The **Training Guide** will be available to trainers whose responsibility is to prepare disaster assistance teams. The trainer who will train workers may develop further training resources by adding exercises, scripts and vignettes for role-playing, and reports of personal experiences in disasters in their own regions.

Key Issues in Disaster Mental Health

Goals in helping survivors:

- To increase understanding of stress so as to mitigate its effect;
- To minimize the impact of trauma by increasing coping strategies;
- To develop and improve communication and problem-solving skills in order to obtain concrete types of help;
- To restore social coping and functioning within rapidly changing systems of disaster relief resources;
- To support relationships with other survivors and staff of agencies providing health care, housing, and economic assistance;
- To work with community agencies so as to facilitate linkages between community resources and the needs of survivors;
- To continue to foster coping skills and adaptation to post-disaster changes in the community so that survivors will be able to carry on and respond normally to an abnormal traumatic event and to the changes in their lives;

■■ DISASTER SURVIVORS

The term **survivor** in this guide refers to individuals and families who have suffered from a disaster and its consequences. Disaster survivors have experienced an unexpected and stressful event that has impaired their ability to cope. Disaster survivors include persons of all ages, socioeconomic classes, and racial or ethnic groups because catastrophes affect the entire population in an impacted area.

Even though survivors may exhibit symptoms of physical or psychological stress, these symptoms should not be viewed as indications of psychopathology, but as signs that they are attempting to cope with unusual demands. Some survivors may suffer more than others, depending on several interrelated factors such as chronic illness or recent losses.

Survivors who may be particularly susceptible to physical and psychological reactions from a disaster include people who are:

• vulnerable as a result of previous traumatic life events;
• at risk due to recent ill health or chronic conditions;
• experiencing severe stress and loss due to the disaster;
• lacking in coping skills; and
• without social and psychological support.

Elderly individuals may find it especially difficult to cope with a disaster and its consequences. It is not unusual to find older survivors who live alone and are isolated from their support systems. As a result, they are often afraid to seek help. Typical post-disaster problems with this group include a feeling of depression, a sense of hopelessness, and a lack of interest in rebuilding their lives.

Children are also a special group because they usually do not have the capacity to understand and rationalize what has happened. Consequently, they may experience emotional or behavioral problems at home or school, including fears, sleep disturbance, loss of interest in school, and disruptive behavior, all as normal reactions to the abnormal situation.

Individuals with a history of mental illness may also require special attention. Under the stress of a disaster situation, coping difficulties often occur in this population due to the additional stress or difficulties in obtaining regular medication.

Individuals who were experiencing certain life crises at the time of the disaster may also require special assistance. This group might include people who have recently been widowed or divorced and those who have recently undergone major surgery. These survivors may display a special vulnerability to the stress generated by a natural disaster and loss of coping capacity.

■■■ MULTIDISCIPLINARY APPROACH

The aim of disaster mental health training is to provide disaster counselors of different disciplines (nursing, social work, paraprofessionals) with the information they need to solve the problems they will face. Because disaster mental health assistance addresses problems from the broad context of social, economic, and community development, advice from many different disciplines is required, including community demography, social systems, behavioral sciences, governmental disaster policy and management, clinical medicine, and psychology. Each of these disciplines has developed specialized approaches to post-disaster intervention programs.

Although the methodologies of post-disaster assistance can be applied to different regions of a country, the procedures and approaches to the problems will differ because of differences in cultural, social, economic, and political realities. It is expected that the content of this manual will be adapted and tailored to different world regions in such a way as to fit the realities of the population served.

■■■ ORGANIZATION OF THE MANUAL

The manual is divided into five chapters. Each chapter consists of a fundamental body of knowledge which sequentially enlarges the capacity of the disaster worker to participate in emergency and post-disaster assistance programs in unison with all other governmental agencies. The workers using the manual can choose the number and combinations of chapters to read according to the task that they will face, which in turn will be determined by their assignments.

Each chapter includes the following parts:

1. **Learning Objectives:** Identifies the knowledge, skills, and attitudes that the worker will acquire.
2. **Content:** Each chapter has been written incorporating material that will support the guidelines for assisting survivors. The intention is to provide enough material so that workers can select what they need to adapt their prior knowledge to the requirements of post-disaster assistance tasks.
3. **Reading List:** The articles have been selected to further enhance workers' knowledge, but they do not represent a complete bibliography on each subject. Additional information on topics of special interest can be obtained through a computer search or from the Documentation Center of the Pan American Health Organization, Apartado Postal 3745-1000, San José, Costa Rica, telephone: 506-296-32-52, fax: 506-231-59-73.

Historical overview and mental health role 1

 OVERVIEW OF CHAPTER

Description: Introduces the applied content of mental health participation in post-disaster programs

Purpose: To place in context the role of mental health workers within a multidisciplinary post-disaster setting

To present sociocultural guidelines for understanding post-disaster reactions in differing populations

Content:
- Historical overview in the U.S.

- The mental health worker as a disaster assistance participant/helper

- Key sociocultural variables affecting post-disaster behavior

Learning Objectives:
- To acquire knowledge of key historical developments in the field of post-disaster crisis intervention

- To identify and differentiate the role, skills, and attitudes of the mental health worker within a multidisciplinary setting

- To identify the sociocultural factors influencing post-disaster reactions in the survivor population

- To identify the cultural diversity issues that may arise during assessment, outreach, crisis counseling, and post-disaster interventions

- To recognize important similarities and differences between cultural groups

■■■ HISTORICAL DEVELOPMENT
IN THE UNITED STATES

Changes in disaster policy and training during the years between 1970 and 1990 provide a context for mental health assistance for disaster programs. In 1973, while meeting with the team of experts gathered to analyze the mental health issues that arose among survivors of the Virginia Buffalo Creek Dam disaster, professionals made observations that led to new ideas about treatment.

Additional data were added to the growing knowledge base in 1974 at a meeting organized to hear reports on the Xenia, Ohio, tornado. The data showed patterns resembling human reactions of acute loss, mourning, anxiety states, and depression. During another gathering of professionals, the author was asked to present experiences in Managua with a team of post-disaster workers after the earthquake of 1972 and exchange ideas with other workers in the field.

At that time, professionals were still seeking to organize a systematic approach to the development of mental health guidelines for disaster assistance. The exchange of knowledge between professionals in Latin America and the United States prompted the development of intervention modalities for disaster behavior. After several years, the experience gained worldwide from work in disaster situations was used to formulate guidelines for working with survivors.

■ LEGISLATIVE AUTHORITY FOR DISASTER
MENTAL HEALTH ASSISTANCE

In 1974, the enactment in the United States of the Disaster Relief Act (Public Law 93-288, Section 413) laid the foundation for systematic, organized development of this field. The Act reads as follows:

> *Crisis Counseling Assistance and Training. The President is authorized (through the National Institute of Mental Health) to provide such services or training of disaster workers to victims of major disasters in order to relieve mental health problems caused or aggravated by such major disaster or its aftermath.*

The Disaster Relief Act authorizes a program of crisis counseling for survivors of major disasters through grant support for direct services to disaster survivors, as well as training in disaster crisis counseling for crisis workers. This program was developed in cooperation with the U.S. Federal Emergency Management Agency (FEMA), which provides funding for its support.

The law was enacted in response to the recognition that disasters produce a variety of emotional and mental health disturbances which, if untreated, may become

long-term and debilitating. Crisis counseling programs funded under Section 413 are designed to provide timely relief and to prevent long-term problems from developing.

Assistance under this program is limited to presidentially declared major disasters. Moreover, the program is designed to supplement the available resources and services of states and local governments. Thus, support for crisis counseling services to disaster victims may be granted if these services cannot be provided by existing agency programs.

The passage of this legislation provided a blueprint for meeting the mental health needs of disaster survivors, a means to channel resources and structures dealing with disasters affecting community populations, and a coalescence of efforts of mental health professionals, the American Red Cross, and government agencies at all levels, including the National Institute of Mental Health (NIMH), the Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA), and FEMA.

The Disaster Relief Act solidified the position taken by many mental health professionals interested in participating in the response to catastrophic events. Massive training efforts were undertaken by NIMH through staff training programs and in collaboration with FEMA. As funds became available, NIMH organized week-long workshops for multidisciplinary professionals interested in disaster mental health services. The opportunity to network with other government disaster assistance agencies was strengthened by using representatives of these agencies as teachers and panelists. This activity also linked to the American Red Cross and evolved into national and local alliances between mental health workers and local Red Cross chapters.

■■■ CONCEPTUALIZATION OF THE MENTAL HEALTH ROLE: THE MENTAL HEALTH WORKER AS A POST-DISASTER PARTICIPANT

This section deals with the function and role shift of the mental health worker. It is essential to clarify the role of the mental health worker in providing technical expertise alongside multidisciplinary post-disaster emergency relief agency staff. That role comprises both subjective and objective aspects and is not well-defined at this time. To be more specific, mental health workers are just beginning to be incorporated into the long-standing, well-organized governmental and Red Cross programs. These programs have developed roles, functions, skills, responsibilities, and clear guidelines for dealing with individuals who are disaster survivors, not patients. To enter this field, mental health workers must shift their usual mode of work and theoretical focus to a new system of guidelines; at the same time, they must develop knowledge, skills, and attitudes for working with individuals who are traumatized but not mentally ill.

The knowledge and skills needed at each stage of a disaster change. In the immediate response phase the demands on the worker are quantitatively and qualitatively different than those in the long-term recovery phase. The nature and pace of the work change continually as a result of (1) the sequences of emotions and coping processes, (2) the rate of recovery in the community as it reorganizes post-disaster, and (3) changes in the organization of disaster agency systems and mass care shelters, Red Cross centers, and FEMA disaster application centers, which change over time in the intensity of the services and characteristics of the assistance provided. The demands for action and assistance gradually lessen in intensity and become more protracted. This slower-paced problem-solving requires more patience and perseverance on the part of workers and brings them fewer narcissistic/altruistic rewards.

The initial expectations of mental health workers participating in post-disaster situations, both of themselves and of others, can lead to discomfort and confusion regarding their role. These workers need to learn to feel comfortable performing new roles and outreach functions, such as going into homes or sitting down for a cup of coffee at the kitchen table as they obtain information on how survivors are coping with the aftermath of the disaster. Many aspects of post-disaster work incorporate non-traditional assistance roles, including helping survivors to find lost pets or obtaining phone numbers of insurance adjusters, plumbers, or roofers.

Although mental health workers are sincere in their desire to assist survivors, they are still not sure of their own and others' expectations about their activities. As they are trained, they should be better prepared to adjust to the unfamiliar situations that may occur in post-disaster emergency work and develop methods of dealing with the reality of making rapid use of information that is difficult to access and only minimally available. Experience will help them to shift their learned attitudes so that they will become comfortable and flexible in collaborating with other disaster aid professionals. When mental health workers interact with colleagues from the Red Cross, FEMA, Civil Defense, and local law enforcement and rescue agencies, they will invariably encounter problems such as confidentiality of material, shared responsibility for mutual tasks, and the need to respect other value systems and communication styles. Mental health workers may find themselves in conflict with long-standing traditions that guide the behavior of other disaster/emergency program workers. Often, the authority to make broad decisions rests with the lead government post-disaster agency. Some of these decisions may, at times, be made without consultation or consideration of the mental health implications for survivors. Such events have produced problems for mental health workers in their attempts to collaborate and cooperate within multidisciplinary teams.

Professional status and behavior norms, which form a value system and psychological school of thought within a specific cultural group, are coupled with differing methods of working among many mental health workers in post-disaster settings. Professional boundaries in a clinical setting not only define the structure

and responsibilities of clinical services in the traditional programs from where many of the team members are recruited, but they also define the domain of the workers. A very different situation exists in a post-disaster response setting, where enormous demands are placed on mental health workers as they attempt to respond to the needs of the community, and this domain has no recognizable boundaries to guide community agencies. The worker must set limits and boundaries and prioritize requirements and resources as it becomes painfully clear that all the needs encountered cannot be met. In such outreach situations, the worker will have to grapple with the conflicting roles of "active outreach mobilizer" versus "passive-receptive counselor/therapist," which is the role that many workers will have played in the past. As these role configurations develop, mental health workers must consider the continuously shifting context in which the survivors find themselves as they react to abrupt relocation, differing shelter arrangements, and daily announcements of new directives from governmental authorities and slow-evolving assistance programs.

■ SKILLS OF POST-DISASTER WORKERS

Disaster mental health workers need to adapt their previous skills to be able to help survivors realize and cope with the fact that their world has changed. To do that, survivors will need to act and make decisions to solve problems day after day. By assisting survivors emotionally and providing support and guidance, the worker legitimizes the healthy aspects of the survivors' coping capacity. This means that survivors are seen as capable individuals who will be able to reorganize their lives if they are assisted with sensitivity, knowledge, and respect.

Workers must have a clear focus in their interventions and appreciate the boundaries between post-disaster crisis counseling, mental health treatment, and advocacy. As defined by the Center for Mental Health Services, an agency of the U.S. Department of Health and Human Services, the aim of crisis counseling is to assist individuals in coping with the psychological aftermath of the disaster in order to mitigate additional stress or psychological harm and promote the development of understanding and coping strategies which the individual may be able to call upon in the future. In contrast, mental health treatment implies the existence of a diagnostic syndrome listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The method and duration of treatment may vary in length and modality, including medication and hospitalization. Advocacy implies a confrontational role vis-à-vis the agencies that provide services after a disaster. It aims to obtain services for survivors. Although helping survivors obtain resources is a goal, representing the survivor in an interview or resolving disputes between agencies and survivors is beyond the scope of the crisis counseling program.

Teams should include members who have skills in helping children, the elderly, and those with chronic physical or mental illness. Although all members should be

trained as generalists in order to ensure a common base of knowledge, specialized skills will be necessary to address the needs of different population groups. This will necessitate further specialized training to prepare workers for these tasks. Populations with special needs are discussed in Chapter 5 of this manual.

■ ATTITUDES OF POST-DISASTER WORKERS

Among the attitudes that will enable workers to provide more effective assistance to survivors are the following:

- Belief that survivors are reacting normally to very abnormal situations. Their responses are, in most cases, expressions of their attempts to cope.
- Willingness to reach out to survivors—outreach is an integral part of all efforts to find, make contact with, and assist survivors.
- Ability to avoid creating dependence on the worker and comfortable acceptance of the possibility of rejection or skepticism by the survivor.
- Willingness to accept that survivors may not consider themselves in need of mental health services and for this reason may not seek out such services.
- Ability to feel comfortable helping a survivor with practical concrete assistance to obtain resources.
- Ability to adapt the worker's usual behavior to the cultural values and beliefs of the survivor, paying attention to small details of social, traditional, or religious practice.
- Capacity to set aside usual methods of classifying emotions and behaviors according to clinical categories or mental health labels.
- Ability to resist the impulse to promise to supply all the needs of survivors, which would necessitate more resources and for a longer duration than feasible through the recovery program.
- Capacity to assist survivors in understanding the scope and limits of the post-disaster counseling program while acknowledging their impatience or anger with the slow pace of bureaucracy.
- Ability to refrain from identifying with the survivor's emotions so as not to lose objectivity and unwittingly adversely affect the survivor's perceptions of the reality stemming from the trauma.
- Ability not to lose focus or the ability to respond appropriately in an ever-changing, confused, and painful environment and take action to solve problems.
- Capacity to deal with rapid changes, edicts imposed by official governmental representatives, unclear lines of authority, and shifting agency structures.
- Realistic expectations, recognizing that individuals representing other agencies— such as FEMA, the Red Cross, the Civil Defense, the housing authority—have different goals, guidelines, approaches, and mandates.
- Acknowledgement of the need for rest and self-care.

■ POST-DISASTER CRISIS INTERVENTION BY THE MENTAL HEALTH COUNSELOR

The variations, complexity, and severity of crisis reactions encountered by post-disaster counselors present a challenge for the development of intervention approaches.

The following example illustrates the multilevel activities carried out to assist a family and highlights the shifting role of the post-disaster mental health worker:

■ CASE STUDY

A husband, 49, wife, 47, and five children had recently immigrated to the United States from Honduras when a tornado damaged their home. The woman contacted the crisis team located in a church near the disaster site to ask for help to find out "if she was crazy." She met with the crisis counselor and reported that her feelings and behavior were changing. She had heard from neighbors that behavior changes were to be expected after the trauma of a tornado. In spite of this knowledge, she thought that her experiences went beyond the normal "post-traumatic reaction." She described feelings of depression, crying spells, and inability to make up her mind about household routines. She had no interest in anything, and found it difficult to manage her children. Her drinking, normally limited to social situations, had increased, and her friends had expressed concern about it.

The family's home had been damaged, but they had already received monetary assistance from government agencies, and workers were ready to begin repairs. Although the response to this component of the upheaval was proceeding in a satisfactory manner, the family was still experiencing serious troubles. Most of the wife's complaints and expressions of difficulties centered around her husband, who suffered from multiple sclerosis that resulted in difficulty of movement and mood swings. Despite his disability, the husband wanted to control all aspects of the home's repair and the distribution of the funds received from government agencies. The woman felt her husband's attitude was adding to the complications associated with the repairs and wanted him to live with relatives while the workers were in the house. Her marital situation, already shaky, had worsened and she felt trapped. While previously she had been able to function with strong, realistic defenses and with support from her friends and relatives; she now felt that everything was falling apart because her nearest family members had also suffered in the disaster and had been forced to move to other parts of the state.

The crisis intervention counselor interviewed the husband, the couple, and the entire family to assess their psychological condition and hear their perceptions of the family's problems. The counselor was able to ascertain that the wife was using excessive control to deal with her feelings about the trauma, felt responsible for the family, and was unable to relinquish responsibility for the complex array of activities needed to deal with the bureaucracy of the disaster assistance agencies. Her inability

to cope effectively with the reality of her life and process the emotions resulting from the tornado and its effects had precipitated a crisis.

The counselor also learned that the family's cultural traditions regarded the husband as the head and controlling force in the family—a role he did not want to relinquish. The counselor, sensitive to this traditional value system, helped the wife reassess and reevaluate her situation, showing her how the mix of traumatic events, traditional values, and her need for extended family ties were exacerbating the post-disaster crisis resolution process. By enabling the wife to experience relief through verbal expression of her feelings, and then guiding her into collaboration with her husband, rather than attempting to control his dealings with the repair workers, the counselor helped her gain control of her emotions. The counselor also helped the woman to recognize her own internal feelings.

As the woman became aware of her increased efficiency, she began to feel more positive about her family. The counselor supported her in the difficult situation and commended her for the way in which she had managed the bureaucratic requirements necessary to get her home repaired, despite her unfamiliarity with the procedures.

Like many disaster survivors, this family needed more than basic assistance. They were grappling with many problems before the tornado struck; the disaster unleashed latent problems in family relations that were aggravated by the unresolved family crisis. The crisis counselor needed to identify the boundaries of post-disaster crisis assistance and then put the family in contact with a community agency that could provide additional resources to help them resolve the chronic marital problems.

Such an example highlights the types of crisis counseling for victims after the basic, concrete post-disaster assistance is rendered to normalize living conditions.

■■■ SOCIOCULTURAL ISSUES

This section highlights the need to be aware of the sociocultural diversity of populations in disaster situations. It will help mental health workers acquire the knowledge required to assist survivors from different cultural backgrounds. Content based on experience and knowledge should be incorporated into all the activities, depending on the region and the specific population affected by the disaster (Hispanic, Asian, etc.).

■ CONCEPTS FOR UNDERSTANDING BEHAVIOR WITHIN THE SOCIOCULTURAL MODEL

- Relationship of perceived behavior, expectations concerning behavior, and value level attached to it by survivors and workers.
- How behavior influences and is influenced by the perceived social status and associated role conferred on the individual by his community. Status and roles

are symbols (concepts) of culturally defined expectations regarding patterns of relationships and behavior within a particular social system. Every person occupies multiple positions and each has an associated role with an array of role behaviors (role set), which are perceived differently by different individuals.

* It is through the "operation" of the role set that the person enacts, has access to, and interacts with his culture. The operation of the role set also serves to form his cultural identity, based on an internal consistency and sense of self through which he builds a self-image. After a disaster these operations may be modified for a period of time.

* Behavior develops out of many roles modified by individual differences and molded by social situations. After a disaster, distorted community situations affect behavior.

Mental health workers bring knowledge, attitudes and skills obtained in their previous experiences, coupled with their own cultural background. These characteristics strongly influence their communication style, approach to establishing relationships, and perception of survivors' responses. They also color their approach to accepting the suffering and pain of survivors. Understanding and respect for the cultural values of survivors are part of the knowledge needed in disaster assistance intervention programs.

Characteristics of the families affected—such as ethnicity, socioeconomic levels, acculturation, religion, and traditionally accepted approaches to dealing with stressors—will influence their recovery from a disaster. A specific value system is the relationship of human beings to nature, which can be critical in understanding differences in patterns of disaster response in diverse cultures. For example, the citizens of Managua, Nicaragua, believed that the 1972 earthquake that destroyed part of their city was a punishment by Mother Nature for their "wild" behaviors.

Numerous cultural issues will influence the interaction between the worker and the survivor from the first encounter at the disaster shelter or Red Cross Center. As individuals from different backgrounds are thrown together in groups overseen by an agency staff member who needs to organize schedules according to logistics, time, and personnel, the clashes in cultural approaches become evident. An understanding of the variations and sequences of emotions and behaviors, based on cultural traditions and values, is at the heart of disaster intervention. Transcultural approaches require different ways of addressing the factors that influence crisis resolution processes, which are well known in clinical practice when dealing with the majority population but which are manifested differently after a disaster.

In disaster assistance settings, where it is difficult to personalize living arrangements, the survivors' self-esteem may be easily wounded as conflicts arise when the survivors' need for help collides with workers' own beliefs about the way help should be delivered. This conflict may be accentuated when survivors perceive themselves as dependent on agency staff from a different culture. In catastrophic

disasters, survivors who have lost most of their possessions may feel too humiliated to ask for basic necessities unless the worker uses strategies to help the survivors "save face." The worker will need to strive continually to be sensitive to the transcultural configuration of survivor-helper (dependency-authority/ power) relationships. Cultural attitudes cut across all situations, affecting the amount of help that can be accepted or offered.

■ INTEGRATING CULTURAL EXPERIENCE WITH POST-DISASTER COUNSELING SERVICE DELIVERY

The culture of a group is more than just a set of preferred behavior patterns and mazeways of social organization. Culture gives the individual a total vision of the universe, a conception and categorization of everything, as well as existential postulates regarding the nature of man and his ultimate destiny.

The worldview that individuals share with other members of a group reflects pragmatic knowledge, belief systems, attitudes, preconceived notions, and ranked value orientations. It is important for counselors to have an understanding of a survivor's culture and worldview in order to be able to plan, program, and deliver adequate and accessible services in consonance with the recipient's lifestyle. ■

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Basic mental
health content   **2**

◼️ OVERVIEW OF CHAPTER

Description: Introduces "building-block" knowledge to guide post-disaster intervention

Purpose: To present the basic content for understanding survivor reactions and formulating post-disaster interventions.

Content: Basic concepts of mental health:

- Stressor/stress reactions
- Coping and adaptation
- Loss and mourning
- Social support
- Crisis response and resolution

Learning Objectives:

- To identify theories of stressor/stress response, coping and adaptation, loss and mourning, social support systems, and crisis response and resolution.

- To identify basic building blocks of knowledge to guide post-disaster intervention.

- To acquire the knowledge needed to recognize survivors' reactions and formulate post-disaster interventions.

■■■ STRESS/STRESSOR RESPONSE

This chapter is designed to convey knowledge about stressor/stress response, coping and adaptation, loss and mourning, social support systems, and crisis response and resolution. This body of knowledge is presented in a concise and summarized manner, bearing in mind that crisis teams work in emergency situations and face time constraints, both for training and post-disaster operations.

Stressors	Events or situations that elicit physical or psychosocial reactions in a particular individual under specific conditions (trauma).
Reactions	Biological or psychosocial responses of an individual to a stressor, which vary in intensity, effectiveness, and appropriateness of responses.
Effects of Stress	Physical or psychosocial results and cumulative consequences of the reaction; some are positive or favorable.

Reactions to stressful events depend on the characteristics of the events, individuals' resources, the task required, and the characteristics of the social environment. The outcome may result in growth, temporary difficulty, and/or psychopathology, depending on the pervasiveness and persistence of the stressor. In general, the stress system may be viewed as fluctuating, open-ended, dynamic, and changing constantly.

Further, the outcome of a stressful event may be exacerbated by many life events, including:

• life timing,
• reactive resources,
• support systems,
• opportunity or ability to act on the environment,
• meaning or symbolism attached to the experience, and
• interpretation of the situation.

Stress can relate to a person's psychophysical condition at a specific point in time. A variety of environmental stimuli can produce stress, and different individuals respond differently to the same stimuli.

Some people appear immune to stressors, while others are particularly vulnerable to the conditions that produce personal disequilibrium. Stress states produce psychobiological responses of varying lengths that are determined by the number, frequency, intensity, duration, and priority of the demands placed on the coping system of an individual reacting to a traumatic event.

Specifically, an individual's reactions to stress vary, depending on the:

- context (level of trauma),
- force of the stressor (trauma),
- individual's health status,
- types of support systems in the community,
- family network, and
- habitual patterns of human interaction.

Stress responses are manifested by specific symptoms consisting of changes in the biological system that have been induced by a group of stimuli or stressors. Using the notion of life preservation as a regulatory system within the body, stress can be viewed as an outcome of the drive for self-preservation when one is impacted by external events.

The theory of equilibrium views stress as related to cognitive processes. When an individual faces a threat, he/she appraises what has happened. When an individual anticipates psychological or physical harm, the stress response increases and may immobilize the individual or cause feelings of hopelessness expressed as helplessness.

Researchers have described stress as the outcome of disrupting customary activities. The source of that disruption may be antecedent, mediating, or intervening factors. These factors, which act to increase or decrease stress, consist of prior events (stressors) that have not been fully resolved, internal and external constraints, affective cognitive processes, and the individual's social expectations and supports.

Social and psychological characteristics are modifiers that define the context in which the stressor-reaction-consequence sequence occurs and produces individual variation in the reactions sequence. Social support systems facilitate the development of coping strategies that help people keep distress within tolerable limits, maintain self-esteem, preserve interpersonal relationships, and meet the requirements of new situations by rehearsal.

■■■ COPING AND ADAPTATION

Coping	Behavior that protects the individual from internal and external stresses; coping behavior implies adaptation, defense, and mastery.

Another interrelated concept that helps to explain disaster behavior is coping and adaptation. This section will review the meaning of coping, the interrelationship of coping to stress and socioemotional support systems, and the elements of coping behavior directed toward adaptation.

Coping behavior protects us from becoming psychologically and physiologically disorganized. Coping usually incorporates action-oriented behavior responses, as well as cognitive, emotional, and perceptual appraisal processes. In coping, the individual may attempt to change the source of the stress or redefine the threat situation in terms of meaning or degree of severity. The individual also attempts to find an accommodation and compromise, such as passive acceptance, resignation, religious believe, or belief in destiny.

Protection behavior usually takes three paths:

1. Altering the conditions that are producing painful stress responses.

    Example:

    "Dr. Brown, if you insist that I remain in the hospital for a few more hours, I will follow your advice, even though I believe that I should go and check my home to see what the hurricane did to it."

2. Redefining the meaning of the stress-producing experience to downgrade its significance.

    Example:

    "We were lucky that no one in our family died and only a few members were injured when the roof fell in." Or, "It was lucky that the earthquake was at 4:30 a.m. when the highways were empty."

3. Manipulating the emotional consequences in order to place them within manageable bounds.

    Example:

    "I am ashamed to complain about my damaged home when others lost so much more."

■ COPING MECHANISMS

Coping is behavior that is designed to prevent, delay, avoid, or manage tension and stress. Coping is not unusual or rare behavior; in fact, all individuals employ coping at some time.

Most individuals learn individualized ways of dealing with stress. Although these ways vary, coping methods usually follow a pattern of:

- avoidance,
- alteration,

- management,
- prevention, and
- control of undue emotional expression.

Coping mechanisms may take three different forms:

1. The individual may attempt to change the source of strain or stress. This action presumes knowledge and perception of its causes. Attention is focused on changing the situation before strain or stress occurs. The aim of this strategy is to avoid a threatening situation.

Example:

"It is time for us to leave the house now."

2. The individual may attempt to redefine the situation so as to control the degree of stress and lessen or buffer its impact. Redefinition is a means of managing the significance and gravity of the problem situation. Cognition and perception are important in this process. Redefinition allows the individual to say that the problem situation is not important enough to be upset about. This may be done by making comparisons and then concluding that things could be worse or by selectively ignoring the negative aspects and emphasizing the positive.

Example:

"This storm appears to be diminishing in force and will not do extensive damage."

3. Coping responses may attempt to manage stress so the individual can continue to function as normally as possible. This action is essentially an effort to keep stress within controllable boundaries and bring about an adjustment to stress without being overwhelmed by it. This involves a variety of responses, including denial, withdrawal, passive acceptance, undue optimism, avoidance, or even magical thinking.

Example:

"Dr. Ross, as soon as the cast is dry, I think I can start helping other injured people. I always like to feel useful."

Coping accomplishes the following:

- Containment of the distress within limits that are personally tolerable,
- Maintenance of self-esteem,
- Preservation of interpersonal relationships, and
- Acceptance of the conditions of the new circumstances.

Positive Coping Skills

- Ability to orient oneself rapidly
- Planning of decisive action
- Mobilization of emergency problem-solving mechanisms
- Appropriate use of assistance resources
- Ability to deal simultaneously with the affective dimensions of the experience and the tasks that must be carried out
- Appropriate expression of painful emotions
- Acknowledgement of pain, without obsessing over troubled feelings
- Development of strategies to convert uncertainty into manageable risk
- Acknowledgement of increased dependency needs and seeking, receiving, and using assistance
- Tolerance of uncertainty without resorting to impulsive action
- Reaction to environmental challenges and recognition of their positive value for growth
- Use of non-destructive defenses and modes of tension relief to cope with anxiety

Coping is the behavioral response to stress and strain that serves to protect the individual from an incapacitating emotional overload.

Overwhelming stress is always associated with crisis and is the emotional discomfort felt by individuals experiencing persistent problems or undue demands. It emanates from unusual, uncommon, or unexpected pressures, such as the fear of undergoing surgery or the impact of a natural disaster. Associated with a particular event or situation, stress differs from anxiety or depression, both of which are also reactions to traumatic events.

Negative Coping Skills

- Excessive denial, withdrawal, retreat, avoidance
- Frequent use of fantasy, poor reality testing
- Impulsive behavior
- Venting rage on weaker individuals and creating scapegoats
- Over-dependent, clinging, counter-dependent behavior
- Inability to evoke caring feelings from others
- Emotional suppression, leading to "hopeless-helpless-giving up" syndrome
- Use of hyperritualistic behavior with no purpose
- Fatigue and poor regulation of rest-work cycle
- Addiction
- Inability to use support systems

Coping is intertwined with one's social and emotional resources. It is made easier, or it is hampered and prevented, by the nature of the individual's social matrix. This matrix may include the network of interpersonal relationships with family, friends, neighbors, co-workers, and small group associations. It is to this social system that the individual turns first when seeking support, understanding, or aid in problem resolution.

Coping also depends on the individual's emotional or psychological tools, including personal characteristics and individual strengths and weaknesses. These resources include the individual's ability to communicate a sense of self-esteem and a capacity for bearing discomfort without disorganization or despair.

Communication skills facilitate expression of the problem and provide the means for seeking help to resolve it. Self-esteem refers to the individual's positive feelings toward him/herself; its absence would indicate low self-image.

Coping strategies use a set of complex patterns of thinking and behavior to provide adequate responses to a situation so that the internal responses do not continue to be painful. If an individual is unable to achieve this objective, the response can be detrimental.

■■■ LOSS AND MOURNING

Loss, mourning, and grief reactions are concepts of particular use in disaster work. Although a discussion of loss usually focuses on death, losses resulting from a disaster may also include:

- property destruction,
- sudden unemployment, and
- impaired physical, social, or psychological processes.

■ THE POST-DISASTER MOURNING PROCESS

Grief is a natural, reflexive, psychological response that begins in childhood following a loss of any kind. Grief is part of the process of healing that depends on the depth and character of the loss, as well as the condition of the person.

Mourning and grieving	The reaction produced by loss, especially the death of an important individual or symbolic objects in a person's emotional life.

Barriers that impede the process of grieving and mourning include:

- Unmet basic needs during childhood;
- Multiple previous losses;

- Nature of the relationship with the person who is gone, such as ambivalence, over-dependency, or unresolved conflicts;
- Circumstances of the sudden loss, such as whether it was brutal or whether the body is unrecoverable;
- Cultural values, such as "stiff upper lip and no crying."

Many professionals have pointed out that disaster survivors go through a five-step process of mourning:

1. Denial
2. Rage/anger
3. Bargaining
4. Depression
5. Acceptance/resignation

These five stages do not always occur, nor do they always appear in a specific order. The stages and their order are strongly influenced by an individual's total personality and philosophy of life. Therapeutic intervention helps the mourner move through the process if he/she is "stuck" at one stage or has difficulty achieving resignation.

The processes of mourning, grieving, and bereavement involve cognitive elements that are frequently expressed as physical or psychological symptoms. The process begins with recognition and awareness of the loss. The individual needs to come to grips with reality in emotional as well as intellectual terms. When only an intellectual acceptance of loss occurs, the chance of emotional maladaptation increases.

The process of grieving takes a person from shock through acute distress to resignation. Along the way, the individual may suffer physical discomfort, susceptibility to illness, withdrawal into apathy, or increased hostility toward others, and he/she may become totally isolated.

A predominant reaction is a strong defense of denial; that is, survivors appear to be preoccupied with activities or conversations that do not include mentioning the loss. This delayed reaction appears to facilitate coping with uncontrollable emotions.

To understand the role of bereavement, it is important to look at the quality of the personal relationships that have been severed. A high percentage of survivors cannot move beyond the hopeless, "giving-up" stage. This, in turn, is associated with different levels of depression, including interference with all the decision-making functions necessary for survivors to reorganize their lives. Because of this inability to deal with all the human and bureaucratic interactions necessary to obtain relief resources from agencies, the crisis feelings intensify. The continuation and intensification of survivors' apprehension about the crisis stimulates a circular down-spiral, leading to a lack of energy, depression, passivity, loss of self-esteem, and helpless behavior.

Ultimately, the way a survivor deals with problems during a period of emotional stress influences whether he/she emerges from the crisis with increased susceptibility to mental distress or an increased likelihood of improved coping capacity after the disaster.

■■■ SOCIAL SUPPORT SYSTEMS

Social network/ support system	The group of individuals who influence each other's lives by fulfilling specific human needs. For the individual, the social network often provides respect, approval, and self-definition. The linkages in a social network of supports depend upon the type and quality of communication among members.
Emotional resources	The ability to draw on past experience to deal with the stress of a problem and resolve it. Emotional resources enable a person to withstand the pressures of stress, anxiety, and depressive feelings and to have the confidence to set goals and take effective action. When these resources are not sufficient to withstand tension, the individual may succumb to stress and express nonadaptive behaviors.
Social resources	The sum total of an individual's relationships, which form a network of social linkages or interrelationships with other individuals and groups and enable the individual to identify and enlist sources of emotional reassurance.

The social and emotional resources of a disaster survivor are related to past experiences of stress and crisis, loss and mourning, and coping and adaptation. The individual's emotional and social support network will greatly influence how effectively he/she overcomes a disaster experience. For this reason, the post-disaster worker must be keenly aware of the types of social and emotional resources available to survivors. This awareness allows the worker to help link the survivor to the social matrix and increase his/her ability to cope with disaster stress responses.

Traditional, stable, and structured social groups tend to promote strong bonds, and thus help protect their members against post-crisis pathological outcomes. However, this infrastructure may be impaired or disappear in major disasters. Workers who provide assistance post-disaster must be alert to the existence of social and emotional support systems and their use by disaster survivors.

Studies have shown that successful coping by disaster survivors is often directly related to the use of support systems. Immediately after a calamity, individuals who rely primarily on their linkages to relatives and close friends and less so upon neighbors and formal or volunteer organizations generally are able to deal effectively with the stresses of the catastrophe. Even years later, these disaster survivors have stronger ties to their social support system than before the catastrophe.

In dealing with a stressful event, an individual usually first calls upon a reserve of internal emotional mechanisms to resolve the problem at hand. When personal mobilization fails, the individual then uses the supports of a social network. This

coping strategy, which relies first on personal and then on social resources, is the generalized pattern for most individuals.

However, people who are overwhelmed with severe stress will often tend to rely first on social resources. If they fail, they employ their own emotional resources, limited as they may be under the circumstances; as a result, they may withdraw, express helplessness, and isolate themselves.

Clearly, the quality of one's social network and the sociocultural context of the individual acting within it are significant determinants of coping behavior. The social network may be a major force in maintaining certain forms of behavior or an important factor in determining the degree and direction of change. In either case, the network of relationships in the disaster setting may provide the support to change or not to change, and it may facilitate efforts to adapt or not to adapt, depending on the social and cultural values at work in the situation.

In times of stress, individuals may use both formal and informal support systems to help them manage their problems. Group affiliation as a means of developing one's social support network is necessary when individuals have been displaced, relocated, or have suffered severe isolation. This network provides the individual with information, advice, protection, and reinforcement of individuality and worth.

■■■ CRISIS RESPONSE AND RESOLUTION

Crisis A crucial period or turning point in a person's life that has both physical and emotional consequences. A crisis is a time-limited period of psychological disequilibrium, precipitated by a sudden and significant change in an individual's life situation. This change results in demand for internal adjustments and the use of external adaptation mechanisms that are temporarily beyond the individual's capacity.

■ CRISIS THEORY

The crisis model has considerable significance for post-disaster workers. The model conveys an understanding that certain life events produce a loss of habitual modes of behavior due to the personal turmoil, tension, and emotional upset that accompany stress response. The model also identifies crucial periods when an individual is faced with ongoing decisions that have long-term implications for subsequent life styles and levels of adjustment.

Individuals will give different meaning to an event depending on:

- their perception of what has occurred;
- their past experience with hazardous events; and
- their success or lack of success in managing its impact.

Consequently, a crisis will differ depending upon the people or society involved. Some groups will define a certain event as producing crisis, while others will not.

The final phase of crisis involves finding appropriate defenses and ways to master painful feelings during a period of turmoil. This process of reconstitution involves marshaling personal and social resources in the search for equilibrium and effective functioning. Individual activation of the skills that are necessary to cope emerge during this final phase.

In coping with a crisis, an individual may attempt to:

- change, reduce, or modify a problem;
- devalue an event by seeking satisfaction elsewhere; or
- become resigned to what has happened and then attempt to manage the resulting stress.

The individual in crisis may be seen as affected by an interplay of dynamic changes, which, in turn, are continuously influenced by natural, biopsychic mechanisms designed to bring about a state of balance and personal equilibrium. There are both inputs and outputs of energy and information into the system.

> *The essential point of crisis is that the intensity of the energy exceeds the capacity of the organism to adjust and adapt. The individual is overwhelmed and the system goes into a state of disturbed biologic rhythms and temporary disorganization.*

The severe fluctuation of an individual in the face of a crisis event is associated with the disorganization of psychological and somatic systems. The consequences of this fluctuation include severe personal tension and stress. The imbalance may be induced by such events as the death of a loved one, loss of income or property, illness, relocation, or other important personal factors.

As a secondary consequence, changes in role patterns and in usual or expected behaviors often produce problems in interpersonal relationships. As these changes occur, the individual tends to develop new patterns and behaviors to manage stress and therefore diminish discomfort and pain.

The stress response is likely to produce a pathological outcome if it is severe and/or prolonged. If the combination of events that encompass the experience of the disaster are prolonged or severe, the survivor may develop problematic psychological or behavioral mechanisms to cope with the situation.

Crisis theory is based on the following assumptions:

Assumption:

Disasters are stressors that produce an impact on survivors, resulting in a crisis situation that affects biological, psychological, social, and behavior systems.

Assumption:

Integration and synthesis of complex phenomenology data allows the development of a comprehensive formulation that conceptualizes the situation of the survivor at a specific point in time after the disaster. This clarifies the situation for the post-disaster worker and makes it possible to develop a psychological intervention.

Assumption:

At the moment of impact, a survivor's behavior will depend on prior life factors and the survivor's interpretation and definition of the threatening event.

Assumption:

To understand the individual in stress, it is necessary to look specifically at the chief complaints and the presenting problems of the survivor, the relationship of those presenting problems to precipitating factors, and a description of relevant prior life events as part of the assessment and indications for crisis intervention.

The initial impact of a stressor may produce a level of stress stimulated by:

- type and duration of the disaster;
- degree of loss;
- survivor's role, coping skills, and support systems; and
- survivor's perception and interpretation of the catastrophe.

These reactions represent different stages of the crisis resolution process and follow several developmental phases. These disaster-produced reactions may also be influenced by other random environmental events of a traumatizing nature, such as failure of bureaucratic reconstructive efforts and other disappointments, which have been called the "second disaster."

■ ORGANIZING PRINCIPLES FOR UNDERSTANDING CRISIS

Survivors whose lives have suddenly been disrupted by a disaster, and who may also be receiving help to heal physical traumas, must develop a coping behavior. Psychological observation and interviewing techniques can be used to understand this set of behaviors and to evaluate the degree of distress in order to offer assistance and support.

Through observation and interviewing, the disaster worker can identify the following:

- Individual personality traits;
- Type of historical events that have influenced the individual's level of development:

- Survivor's usual coping mechanisms and available methods to deal with the crisis when confronted with physical and psychological trauma;
- History of the disaster and how it physically impacted and personally affected the individual.
- The survivor's reactive behavior and personality skills for adapting to the new post-disaster situation.
- Social and post-disaster support system available to the survivor and use of those resources to support healing and recovery.
- Level of support of the medical/social matrix as measured by the degree of community organization versus the disorganization of both the official emergency unit and the disaster assistance agencies.
- The social balance between the availability of support systems resources and the intensity of the stressors, adding further difficulties in obtaining adequate medical and psychological aid.

All of these variables influence the balance between adaptive and non-adaptive behavior and may heighten the vulnerability of survivors and their specific needs before psychological equilibrium can be regained. They will determine the interactive set of responses that influence the course of crisis resolution as they interact with the disaster conditions.

Survivors first call on their own personality skills to adapt. If they are unable to deal with the multiple events occasioned by the catastrophe, they next try to access sources of support in an effort to gain assistance from emergency personnel. If these resources are unavailable or inadequate to meet the life event demands produced by the disaster, the survivors may turn to their culturally provided beliefs, values, and symbols. In post-disaster behavior, many survivors take advantage of all available resources simultaneously and in a complementary manner.

As hours go by in the aftermath of a disaster, some survivors are not able to cope with their problems and continue to express anxiety, apathy, anger, nightmares, insomnia, and difficulty in interpersonal relationships. At some point in the survivor's crisis resolution behavior, the worker will encounter a juncture that will lead either to a healthy or a pathological endpoint. The crisis worker needs to acquire the skills and the knowledge to assess the situation and bring to bear therapeutic intervention procedures that will support and guide the survivors toward achieving the best potential outcome in the situation. This objective necessitates planning logistics and training crisis counseling personnel.

Crisis personnel may also be exposed to post-disaster stress and express emotional problems in the aftermath of a disaster. Relatives of survivors, medical professionals, and disaster relief workers are all vulnerable to the consequences of post-disaster stress. Crisis workers may expect emotional problems from the impact of a natural catastrophe, including reactions such as fear, shock, psychic numbing, anxiety, depression and psychosomatic complaints.

■ EMOTIONAL REACTIONS

It has been recognized that several stages of crisis resolution occur following a disaster. These stages overlap, and survivors may go back and forth with no clear distinction between stages. This emotional vacillation is a normal reaction in survivors experiencing stress responses, and their emotional state may fluctuate for some time.

In the early period, the survivor may deny the reality of the situation or the physical impact of the trauma. A survivor may verbalize acceptance of what has happened or even admit being grateful that it was not worse. This lack of emotional reaction to the reality of discomfort or change signals a need to defend him/herself from fully registering the consequences of the trauma. The level of accommodation to all the manipulations necessary for medical intervention may vary from mild complaints to exaggerated complaints to feigned unconcern.

As the survivor allows the reality of the new situation to sink in, a new set of symptoms may appear:

- Episodes of strong emotional reaction that will overwhelm the denial defense;
- Restlessness, anxiety, extreme talkativeness or reluctance to talk, passive resistance to medical advice, sudden brief episodes of irritation or signs of frustration;
- A helpless, indecisive reaction to orders;
- Evidence of psychic disorganization, with the passage of time and according to the degree of somatic trauma,;
- Episodes of fear, mood swings without crying episodes, and resentment of minor demands made by the emergency professionals.

An important type of behavior described as "survivor's guilt" needs to be monitored. This behavior is defined as the ambivalent feelings of being happy to be alive, while at the same time feeling guilty about being alive when others have died or suffered worse injuries. This behavior can be antecedent to feelings of depression or paranoid ideation, and it can be the precursor of paranoid clinical depression.

Post-traumatic stress disorder

Psychic trauma is a process initiated by a catastrophic event that confronts an individual and presents an acute, overwhelming threat to survival. When the event occurs, the central nervous system loses the capacity to control the disorganizing effects of the experience and a state of disequilibrium ensues. The event propels the individual into a traumatic state lasting for as long as the brain systems need to return to an organized state. The individual has a need to make sense of the new world view— that is, the why and how of the event that has occurred and what it means.

A person's genetic, constitutional, and personality make-up, state of mind when the event occurred, psychological level of development, existing support systems, as well as the content, intensity, and duration of the event, all contribute to the severity of the traumatic effect.

The central feature of post-traumatic stress disorder is the development of characteristic symptoms after experiencing a psychologically traumatic event, or events outside what is usually considered the normal range of human experience.

The characteristic symptoms include:

• Reliving the traumatic event;
• Numbing of responsiveness to, or involvement with, the external world.
• Autonomic, dysphoric, or cognitive symptoms.

The reactions to and consequences of the disaster effects can produce varied behavioral and emotional expressions, including the following:

> • The survivor may have obsessive repeated memories of the event and become preoccupied with them. These memories may appear in dreams or nightmares.
> • The survivor may also have periods of feeling distant or detached. This detachment may intermittently disturb social relationships.
> • The survivor may experience symptoms of autonomic arousal and increased sensitivity to strong noises or unfamiliar situations that recur many months following the psychic trauma of the disaster.
> • The survivors may complain of impaired memory and difficulty in carrying out usual daily tasks.

These subtle changes in personality and sense of social effectiveness are difficult to differentiate from the preexisting emotional characteristics of the individual or the acute response to the impact of the disaster. Nevertheless, these changes in functioning should all be considered by the crisis worker in the diagnostic evaluation of the quality of the stress response, the level of psychic trauma, and the psychological sequelae of crisis resolution. If the worker notices that there is no change in the severity of behavior dysfunction after one or two months, he/she should ask for a consultation or referral to a mental health clinic.

■■■ THE BIO-PSYCHO-SOCIO-CULTURAL SYSTEM *

■ KEY CONCEPTS SUPPORTING AN UNDERSTANDING OF SURVIVORS:

• The organism is a dynamic, evolving system of information exchange and processing - A disaster stimuli.
• It exists in an ever-changing environment where information transfer occurs within and between the brain and the environment - Internal sensory processing of disaster impact.

- The interrelationship of subsystems consists of a large variety of communication signals transmitted in a regular or irregular rhythmic manner - Disorganization of usual patterns after disaster.

- The organism is an intricate communication system of information exchanged by means of signals coming from external and internal sources and affecting the rhythm of these communication signals (neurological, hormonal, endocrine) - The total biological shifts following disaster stimuli.

- Stressful experience perturbs these rhythms and affects function, at times disorganizing them - Chance of outside patterns stresses individuals.

- Function is a unifying and dynamic concept that focuses on an integrated approach of the organism in its world. The patterns of physiology and behavior are inextricable - Coordinated by outside disorganized, unfamiliar events of disaster.

- Any perturbation of one component of the organism will lead to a change in function, which forms the basis of stress response theory. - This supports the basic biological disturbance to understand post-disaster behavior.

- Specific integrated, coordinated, and appropriate responses to each stressful experience occur. At times, depending on individual characteristics, these responses may be inappropriate, excessive, or inadequate, in which case symptoms may occur which depend on predisposition and disaster characteristics - During the sequential phases post-disaster we can observe how functions change. ■

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Developmental stages of survivor behavior

3

████████ **OVERVIEW OF CHAPTER**

Description: Sets the stage for recognizing the crisis response and adaptive behavior of survivors across post-disaster time phases

Purpose: To systematically categorize behavior processes through time phases

Content: Developmental phases of individual reactions following natural disasters

Learning Objectives:
- To become aware of behavior, thinking, and feelings of survivors with the passage of time post-disaster.

- To conceptualize the sequences of changes as the survivor adapts to different stages of the disaster.

■■■ DEVELOPMENTAL PHASES OF REACTIONS TO DISASTERS

Trying to understand survivors—their suffering, what they have gone through, and the problems they face in the near future—is a unique, sobering, and challenging human experience.

Human reactions across the time frame after a catastrophic disaster can be said to fall into the following transitional phases:

- Threat Phase
- Impact Phase
- Recoil Phase
- Early Aftermath Phase
- Late Aftermath Phase

In the following section, reported human reactions during these phases are organized and described from the biological, psychological/emotional, interpersonal, and sociocultural perspectives. These reports are not inclusive, as the effects of the disaster interplay with all the adapting efforts human beings bring to bear in order to cope with unfamiliar and uncontrollable circumstances. Documented accounts of survivor responses and adaptation behavior in the late aftermath phase are especially sparse, both in the literature and anecdotal experience.

■ THREAT PHASE

Modern technology has developed the capability of forecasting many natural disasters with the use of weather satellites, radar, and radio signals that are able to track storms, hurricanes, tidal waves, and numerous other devastating disasters. The use of print and electronic media to send emergency signals and messages prepares and alerts the threatened population to the possibility of potential danger. This initiates the stage known as the threat phase. This phase is absent in cases of sudden impact such as earthquakes, which cannot be predicted.

Unfortunately, no reports or studies exist on the biological response to disaster "alerts" signaled through auditory or visual stimuli. Nevertheless, it can be inferred that an increase occurs in a variety of levels of anxiety and other physiologic responses to the fears aroused by the "alert" stimuli. These reactions vary according to the experiences of the individuals in the affected region, cultural traditions, and the level of expectation based on previous disasters in the area.

Psycho-Social Perspectives

It has been observed that following a media forecast of an impending natural disaster, people are so concerned about hearing the latest reports that they organize their daily routines to be close to a radio or television. Rumors are constant sources of distorted information that flow through informal communication networks.

Reactions to the many "bits of knowledge" passed along vary from individual to individual and are influenced by cultural and social customs. Some people respond rapidly with planned, appropriate, and responsible actions. Other individuals, who deny the possibility of the disaster occurring, postpone plans to take care of their property or themselves. Some of the behavioral responses appear to convey the individual's sense of invulnerability and belief that "it can't happen to me" or "it won't strike here." Some individuals manifest an attitude of relinquishing responsibility to the "powerful" governmental system which "should take care of us." In this case, individuals choose to react with a passive-aggressive stance. In many cases, humor prevails, and many jokes circulate among the group.

All these types of expressions among adults are influenced by cultural and social norms. There are no documented reports of how children react.

In this phase, the adaptive defenses that are predominantly used are psychological:

Denial	Affects the perception of external reality and is closely associated with sensory experiences.
Repression	Consists of excluding from conscious awareness ideas and feelings that are painful/frightening.
Reaction-Formation	Expression of feelings such as fear, manifested in paradoxical forms, such as planning and attendance at "hurricane parties."

Interpersonal Perspective

As the knowledge of imminent danger pervades the community and the intensity of emotions results in increased nervous tension, interpersonal relationships take on different patterns. This increased family agitation can be equated with "worry work," which, in moderation, is a good coping mechanism. For example, family members may contact each other and plan helpful and supportive actions. There may be increased shopping activity for essential articles. Meetings may be convened for a variety of preparatory family activities that range from anticipatory to prearranged task assignments.

Sociocultural Perspective

The sociocultural community activities that parallel the initial individual preparatory phase also begin to influence personal reactions. For example, planning of religious meetings may be influenced by the religious customs, rituals, and other characteristics of the traditional social systems in the affected community. All cultural and social environmental influences have an impact on how individuals behave and react under the threat of imminent disaster.

■ IMPACT PHASE

Biological Perspective

Little research is available on the biological reactions that occur a few hours or days after the impact of the disaster and the consequences of traumatic aftereffects. Descriptions of self-observed reactions by some individual survivors, supported by animal studies, indicate that there are changes in the neurochemical levels of the central nervous system associated with stress reactions that may affect immune responses. Complaints of constant or intermittent fatigue, exhaustion, and differing levels of restlessness have been noted, accompanied by changes in appetite and sleep patterns.

Psychological/Emotional Perspective

Disaster survivors show psychological and emotional reactions ranging through all levels of anxiety. As people's perceptions of themselves change, they experience fear, worry, shame, and guilt. Their difficulties in adapting and coping with their new situation are compounded by changes in their usual ways of reacting and behaving.

During this phase, feelings of fear, anxiety, apprehension, and demoralization "wash over" survivors like waves, sometimes stronger, sometimes weaker, but constant for a period of time. Other key psychological and emotional reactions observed during this phase include the following:

Sense of centrality: Belief that the affected person received "the brunt of the impact" and will have the worst outcome compared to others.

Cognitive clouding: Different levels of disorientation, disorganization, slowness of thinking, confusion, difficulty making decisions, inability to understand what others are saying, and time confusion; may last from a few hours to several days.

Psychic numbing: Feelings of flatness, disinterest, distance, and unresponsiveness that make it difficult to relate to individuals who previously were significant.

Shattering of the "death mantle": Inability to continue denying one's own mortality; when a person has come so near to death or has had to endure the death of a loved one, it is difficult to reinstate the denial-protection.

A group of adaptive defenses has been observed during this phase. Mechanisms such as "denial" help the individual adapt and cope with the painful and unbelievable change in his/her life.

The following dialogue between a mental health worker and a survivor shows how denial is useful to sustain control of emotions:

Mental Health Worker:

"It must have been a very frightening experience for you to see the water rising and no one available to rescue you."

Survivor:

"Well, it was quite an experience, like an adventure, like going to the movies and seeing a scary picture. I knew someone would come, though, so I waited. It wasn't too bad."

Another manifestation of the need to control emotions is the degree of docile and passive obedience exhibited by some survivors to the commands, orders, or regulations from rescue authorities. In contrast, other survivors become rebellious or antagonistic toward any rules, and demonstrate a wish to be in charge of their own routines in the disaster shelters. This behavior exemplifies the need to control situations in order to avoid being overwhelmed by feelings that are painful and intense.

Interpersonal Perspective

Observers have found that in interpersonal relations with the first group of helpers that appears on the scene, some disaster survivors behave in a helpless, docile, dependent, or indecisive way. Others make demands, complain, or express a sense of entitlement, or they use the authorities as scapegoats for the consequences of the disaster. A small percentage of survivors isolate themselves and are uncommunicative.

Some survivors express guilt feelings over the fact that others were less fortunate. For example, if their house was less damaged or they suffered fewer losses of loved ones, they appear to need to perform actions symbolizing atonement, while expressing defensive explanations for the fact that they were spared a fate as bad as that of their neighbors.

Adaptive defenses—which appear to help individuals initiate the coping activities they need to continue through the difficult days ahead—range from rigid, obsessive behavior in their interaction with other individuals to vacillation, changing their minds, and going along with any suggestions.

Some survivors form groups easily and extend individual support toward helpers or survivors. At times, the support behavior is inappropriate and is resented. All these individual efforts, either to relate to each other or to isolate themselves, seem to help people deal with the sense of crisis, emergency, and threat and with the unfamiliar world into which they have been plunged.

Sociocultural Perspective

The community is changed after the impact of a disaster. The pre-impact sociocultural characteristics of the community will continue to have an impact on individual behavior, especially in regard to support and relief operations.

Two examples illustrate this fact:

Following the Managua earthquake (1972), people fell on their knees to pray and remained like that for hours without any recovery efforts available due to the disaster's massive impact on all social resources.
Citizens in the Revere, Massachusetts, disaster (1978) used flashlights to signal to boats that survivors were on rooftops.

■ RECOIL PHASE

Biological Perspective

As time passes, disaster survivors manifest somatic reactions. Medical professionals who work with survivors report increases in psychosomatic complaints, a rise in interference with usual biologic functions, and the occurrence of acute flare-ups of chronic somatic conditions. Cardiovascular problems have been reported, and conditions that had been previously controlled, such as blood pressure and diabetes, need readjustment in medication.

Psychological/Emotional Perspective

Psychological/emotional reactions vary when survivors return to their neighborhoods for the first time and realize the consequences of the impact of the disaster. As they begin to ascertain what it will take to begin reconstructing their lives, reported reactions range through all the known manifestations of grieving, mourning, despair, and "working through" of loss that are familiar to mental health professionals.

For many survivors, life becomes a series of painful days, as they work through the task of achieving resolution and resignation. They deal with personal emotions and interpersonal relations, while at the same time taking care of daily living tasks. At times, survivors experience moments of intense feelings of helplessness.

Levels of vulnerability are manifested, which tends to strip individuals of their usual coping and adaptive defenses. At times, their usual psychological mechanisms fail, making it difficult for them to deal with the multiple demands of decision-making needed to reconstruct their lives.

Sometimes these behaviors seriously interfere with the task of dealing with disaster assistance staff. These workers, who have to clean up after the devastation has destroyed the structure of streets and houses, need to interact with citizens. They must use equipment to clean roads, haul uprooted trees, repair water pipes, and reconnect electric wires. To do this, relief workers will intrude into "living spaces" of the survivors. Emotional and violent reactions resulting from misunderstandings between survivors and workers have been reported.

In addition, decisions have to be made and negotiations have to be initiated with plumbers, architects, banks, and others whose assistance is needed to return the household to normal. These tasks require from the survivor the ability to solve problems through clear thinking and emotional stability. Both of these characteristics, however, may be impaired at these crucial moments.

In this period, feelings are easily hurt and conflict arises from survivors' need to ask for help, which means that they must suppress their sense of humiliation and pride. Their awareness of having lost a known sense of security and independence, without knowing if they will ever regain it, adds to the bitter pain of these moments.

Interpersonal Perspective

During the recoil phase, a mixture of behavioral patterns appears in interpersonal relationships, some of which are paradoxical. For example, some survivors who tended to be within groups in the early phase following the disaster will shift their behavior and isolate themselves, showing reactions of rigid independence. These individuals will have difficulty interchanging efforts and resources and sharing the materials supplied by the rescue workers.

Also in this phase, it appears to be difficult for individuals to maintain steady, predictable relationships between themselves. People get angry easily, feel hurt and discriminated against for not receiving their fair share of the "relief" resources, blame others for their fate, or feel guilty and greedy. In areas of especially scarce resources, a percentage of the population develops a "victim" response when frustration begins to accumulate, with its accompanying expression of entitlement, learned helplessness, expectations of assistance, and reactions of depression.

The increasing intrusion of the events that follow the disaster, combined with the accompanying loss suffered, makes the individual feel like a failure as he/she negotiates with others. An individual may feel that there is now "proof" that he/she is dependent on others, rather than strong, able, and in control. These reactions begin to alter and distort relationships between individuals and their support systems, and some survivors avoid getting involved with other individuals as a method of regaining control. Paradoxically, this behavior compounds their difficulties in dealing with the crisis situation, because to resolve their problems they must interact with many people. For most individuals, over time, these feelings of self-disparagement slowly disappear and characteristic personality traits and social skills reemerge.

Sociocultural Perspective

During the recoil phase, active efforts by groups or individuals emerge within the community. This aids in revitalizing the community social structure and slowly helps the affected social agencies to function more effectively. Survivors, who have regained some sense of normality, begin to take on the functions ascribed to governmental, religious, and social and human service agencies. A sense of competence is regained and continuation of functions to assist survivors takes over as the outside relief workers begin to leave the community.

Organized religious activity continues in many of the community groups, at times with increased celebration of reactivated and reestablished rituals, such as thanksgiving for the living or prayers for the dead.

■ EARLY AND LATE AFTERMATH PHASE

In the early aftermath phase, a reduction in the outpouring of community support is observed. This support reaches its height just after the impact phase, with heroic,

altruistic, and loving acts of generosity shown by the community itself and the outside world. Occasionally, this outpouring of objects and gifts adds another aspect of trouble, as officials attempt to choose the recipients of these gifts in a fair and appropriate manner.

Documentation of the events and reactions that appear in this period is spotty in the literature, and few observations have been reported. Staff of assistance and relief operations agencies leave the affected area, so few observers remain to document human reactions. Little research is available on the adaptation processes occurring in the later months or years following the disaster.

However, anecdotal evidence and newspaper articles reveal that a majority of survivors reconstruct their lives and that new buildings go up in the community. Levels of individual adjustment vary according to the resources that survivors have at their disposal. Some groups, especially the elderly, continue to manifest chronic anxiety and depression. Most seem to achieve resolution of the crisis situation through individual patterns of adaptation and resignation to the experiences and loss.

It is not known to what extent many survivors continue to carry the "scars" of the disaster experience. Some accounts have documented psychophysiological reactions to traumatic "signal" stimuli, such as the sound of rain on the roof, media announcement of tornadoes, or the rumble of a train that sounds similar to an earthquake.

Survivors appear to make increased and continuous use of their support systems for a long time. Many months after the event, there is an ongoing need to "vent," to have others acknowledge the traumatic nature of the event, and to receive acceptance of behavior that still feels alien to the individual.

As the community begins to put the trauma produced by the disaster into perspective, explanatory stories emerge. The disaster becomes a milestone that bonds individuals and allows them to share a sense of history that is unique to the survivors.

Documented accounts of survivor responses and adaptation behavior in the late aftermath phase are also limited, both in the literature and anecdotal experience. In most of the documented disasters, a large percentage of the population has returned to their normal activities, even though their neighborhoods are still in the process of reconstruction and reorganization. The first year anniversary date generally evokes traumatic memories in the survivors, who may notice a reemergence of anxiety and depression. ∎

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Post-disaster 4
intervention
programs

■■■■ OVERVIEW OF CHAPTER

Description: Introduces post-disaster intervention programs and applied and operational guidelines.

Purpose: To review the purpose, scope, and application of post-disaster assistance guidelines.

Content:
- Similarities and differences vis-à-vis other types of mental health intervention programs.
- Special characteristics of post-disaster assistance to survivors:
  — Consultation and education
  — Outreach
  — Crisis counseling

Learning Objectives:
- To acquire knowledge of the basic organizational structures needed to set up a post-disaster mental health intervention program.
- To identify existing outreach methodologies available to disaster mental health workers.

■■■ ESTABLISHING A POST-DISASTER INTERVENTION PROGRAM

Planning for mental health service in a post-disaster environment requires knowledge, patience, and, above all, flexibility. Mental health workers will encounter situations that are unique to their profession. They will also have to respond to the networks and authorities that are already established in the area.

It is the responsibility of administrators to provide post-disaster mental health services within the web of government, community, and volunteer agencies that are helping survivors cope after the disaster. Administrators are also responsible for providing methods of information-gathering, communication channels, and a system to establish accountability for all workers.

Delivery of assistance to disaster survivors requires clarity in organizing help, dividing labor, and delegating authority. In the implementation phase of planning a disaster mental health services program, the following issues arise: funding for the project; selection, orientation, and training of staff; and design of administrative and information structures. The mental health planner or project director, with the assistance of a task force, deals with each of these issues as the project progresses. Clear boundaries and responsibilities should be assigned to post-disaster workers— i.e., what they will do themselves and what services should be referred to other agencies.

Programs can either be decentralized or centralized. Decentralized programs often have centers located in affected neighborhoods, with a team assigned the responsibility of servicing that area. In these cases, a team member serves as administrator and supervisor of team activities and also reports to the project's director. Projects with a more centralized structure may have only one facility, but may assign the responsibility for doing outreach work and crisis counseling to contracted teams within a particular geographical area.

Each type of program requires a system for keeping records and collecting information. The program must have procedures to keep accurate records of funds allocated for space, equipment, materials, supplies, and payment of staff. Confidential records are also required to note workers' observations, actions, and progress in helping individuals and families.

As the project progresses, there is a need to evaluate individual and collective performance and to report to authorities on program activities. By reviewing statistical forms, authorities will have an understanding of each worker's activities and will have an overview of the survivors and their problems. The data may be used to make reassignments or to alter program strategies. In addition, this information may be compiled on a regular basis to provide interim reports for the task force, community leaders, and funding agency. Different forms of administrative organization may be instituted in different regions of the world.

■■ CONSULTATION AND EDUCATION

Disaster consultation and education is one of the newest, most challenging areas of activity for mental health workers. New strategies and tactics are being developed, novel approaches are emerging, and innovative methods are being tested. In post-disaster situations, the objective of disaster consultation is to increase the capacity of the emergency worker to assist survivors and work with multiple post-disaster agencies.

The primary objective of this modality is to educate the staff of disaster emergency assistance agencies so that they can incorporate knowledge and understanding of mental health issues into the task of assisting survivors. Mental health consultants must have background knowledge of both psychosocial theories and disaster assistance procedures to accomplish this objective.

Education is used by workers who are in close contact with the public media or have an opportunity to educate groups in their community. Consultation is used by experienced workers who assist the public and private emergency relief agencies helping the survivors. Crisis counseling training, which is operationally driven, necessitates practical role-playing and continuing supervision once the workers begin to interact with the survivors. Intervention approaches need to be adapted to the cultural characteristics of survivors and the time lapse post-impact.

Some of the typical problems in post-disaster consultation with emergency relief agencies are:

- Difficulty obtaining material and human resources;
- Bureaucratic responsibilities, regulations, methodology of multiple agencies;
- Lack of a recognized plan for interagency coordination;
- Different points of view and objectives;
- Power struggles and "turf wars";
- Interdisciplinary communication.

■ ADMINISTRATIVE ORGANIZATION

After a disaster, when large numbers of individuals have been rescued and grouped in a safe physical setting, a spontaneous, transitional, shifting community evolves. A network of disaster assistance agencies develops, composed of lay, religious, volunteer, and official government rescue personnel. The main goal of this network is to provide physical comfort, treat bodily injuries, and ultimately proceed to help reorganize the lives of affected citizens.

The following factors affect the success of a mental health consultant working within this network of assistance workers:

- The degree to which the consultant's role is sanctioned by the emergency network linking the assistance agencies;

- The knowledge, attitudes, and skills of the consultant;
- The quality and quantity of information available to the consultant.

■ CONCEPTUAL MODEL AND THEORY

With the assistance of a conceptual model to support and guide the intervention, a mental health consultant can better help in integrating psychological theories and post-disaster relief operations. The lack of such a conceptual model is one of the factors that most often leads to failure in consultation programs.

The post-disaster mental health specialist must conceptualize his/her own behavior as the mobilization of a set of forces that will, in turn, be affected by the system itself. In this case, the system is composed of all the members of the disaster assistance agencies. Acting as a collaborator, the consultant can initiate a dynamic interaction with the disaster agency staff. This dynamic interaction is an essential part of the ongoing planning process that results in the strategies for approaching disaster assistance work.

Although the mental health consultant and the disaster agency emergency staff come from different professional backgrounds, they must join their efforts and combine expertise, skills, and energy toward a common goal. Certain areas of theoretical knowledge from these professional backgrounds have proven useful in other intervention activities:

- Concepts of organization and administration for post-disaster relief programs;
- Crisis intervention and assistance;
- Principles and practices of consultation;
- Principles and practices of education.

From these broad areas of social psychology and disaster assistance operations, a philosophical framework can be developed for intervention, consultation, and education in disaster programs.

■ GUIDELINES

The following guidelines are basic to the development of this model. Awareness of these guidelines will help the mental health consultant organize intervention strategies that address the physical, biological, and/or psychosocial needs of the survivors:

- All the consultant's activities must be directed toward developing practical procedures that will be useful to the agency member who will participate as the recipient, as well as to the survivor who will be the focus of the services.
- The consultant must be aware of the traditional and cultural practices and the accepted modes of behavior in the disaster assistance setting; resulting approaches should reflect this understanding.
- All consultation and education must be directed at specific, immediate problems and/or behavior difficulties that concern the emergency relief worker. However,

potential opportunities to participate in long-range and broader planning for the agency should not be overlooked.

- The development of professional relationships should be continuously pursued at every level of organization to identify individuals who can help solve problems. However, the consultant must remain sensitive to confidentiality and the detrimental effects that a breach of trust might have on the mental health role. Sharing of data or a casual mention of something learned from the emergency relief worker has been one of the most common sources of failure for mental health activities.

- Data should be obtained, organized, and analyzed during all activities, and a continuous feedback system should be developed to share with workers and help keep the consultant focused on the objectives. A consultant can easily lose sight of the specific objectives verbally agreed upon during interagency planning meetings.

- The mental health consultant must also be aware of the resources that are available to the emergency relief workers, both individually and as a group. The consultant can then modify patterns of disaster assistance to select and support appropriate mental health approaches for crisis resolution and disaster assistance problem-solving.

- The principle of consulting and educating is based on needs identified by the emergency workers. As the scene changes, consultant and worker must reassess the worker's disaster assistance services and reconsider objectives. The emergency worker's task will change as the survivors' needs change. The mental health consultant who has current information about how the environment is changing will be best equipped to help workers evaluate their services.

- Evaluation and an organized system of data exchange will supply more than just information; it will provide the mental health consultant a broader view of the assistance effort and greater flexibility for intervention, whether through consultation techniques or educational approaches.

- The consultant must always recognize that the assistance framework exists within the context of a changing social community. There will always be gaps in even the most current reports. Interventions must focus on operations that will mobilize both the system and the individuals interacting within the disaster assistance activities. The consultant can choose either a consultation method or suggest an educational intervention.

■ INTERVENTION PLANNING

A mental health consultant in the temporary shelter or other disaster unit is not only an independent professional who responds to the needs of survivors. The consultant also assists numerous emergency relief agency staff in identifying problems and determining the best assistance procedures for traumatized individuals. To accomplish this, the consultant must articulate a plan of intervention that is harmonious with all the other efforts of the disaster assistance agencies.

Key components of an intervention plan include:

Knowledge: Conceptual knowledge of disasters, disaster behavior, and intervention approaches that is obtained prior to a catastrophe.

Information: Determination of the degree of loss suffered by the community, based on media sources, on-site surveys, and visits to places where survivors are sheltered. It is also essential to collect information that will offer a cultural appreciation of the disaster's effects.

Assessment: An assessment of how the emergency assistance agencies have organized themselves into a network and prioritized survivor needs to enable rapid identification of the cultural influences of the community and the psychological influences affecting both survivors and caregivers.

■ PROBLEMS THAT MAY ARISE DURING CONSULTATION

Problems can and do arise for mental health consultants involved in disaster program intervention. The following are examples:

Variance in Professional Training

There is often a variance in value systems, backgrounds, and training between professionals involved in post-disaster activities. The disaster agency staff's lack of familiarity with mental health methodology creates a unique problem and one which compounds the overall unfamiliarity with disaster assistance procedures. This schism between the agency staff and the mental health consultant may result in serious communication barriers.

Successful collaboration and integration of different objectives and techniques into disaster assistance will depend on how well the consultant and the relief workers can focus on the simultaneous goals of contributing to survivors' coping abilities and helping them reconstruct and reorganize their lives. This can be achieved by increasing the mental health knowledge and skills of relief workers.

Degree of Responsibility for Problem-solving

The mental health consultant must ascertain the degree of problem-solving responsibility that appears to be appropriate, based on the task at hand and the amount of professional resources and skills available. The consultant can either choose to offer expertise upon request but not become involved on an ongoing basis, or the consultant can decide to participate more actively, assuming long-range collaboration functions during all the phases of disaster assistance and interacting on many levels.

Coordination of Interventions

Procedural logistics and schedule misalignment can further complicate the coordination of interventions. In a disaster situation, where time is a critical factor,

the time that a relief worker spends with a mental health consultant competes with the intense demands from survivors for the worker's time and services. This competition produces a tension of its own, although the difficulties decrease with time as both workers find methods of saving time and energy.

■ TYPES OF CONSULTATION

Two types of consultation are most often seen in post-disaster situations:

Case Consultation (survivor-centered)

The primary task of case consultation is to develop a plan that will help a specific survivor who is having difficulties of an unusual nature. In some cases, the mental health consultant will personally investigate the survivor's psychological and social needs. The emergency agency workers will collaborate further on the case through subsequent discussions with the mental health consultant.

Survivor-centered case consultation is the type of consultation most often needed in a disaster program. The consultant advises the agency workers about the nature of the difficulties and suggests what can be done to alleviate them.

Usually, the emergency worker will present the case material to the consultant. Sometimes, the mental health professional will meet with the survivor, reach a diagnostic impression, and offer a recommendation to the emergency program worker. The program worker translates appropriate aspects of the recommendation into a plan of action that will be feasible in the disaster assistance setting.

The following is an example of a survivor-centered case consultation:

A Red Cross nurse working in the shelter asked for assistance to deal with a woman who was unable to make decisions. The woman had been offered several options for relocation, but kept changing her mind and could not decide whether to leave the shelter. This woman had been in a previous disaster and suffered some property losses. Reflecting on the past interfered with her decisions to choose options. The mental health consultant instructed the nurse about the effect of anxiety and past memories on the woman's emotions. Subsequently, the nurse decided that she would first need to spend some time helping the woman sort out her fears so the woman could understand that this relocation would not be a repetition of her previous experience. After she calmed the woman about this fear, the nurse was able to proceed with the development of housing plans.

■ ADMINISTRATIVE-CENTERED CONSULTATION

A second type of consultation focuses on the design and/or modification of relocation programs and administrative procedures for the purpose of prevention, early diagnosis and treatment, and rehabilitation of disaster-related psychological disturbance.

The kinds of problems that the consultant will be called on to address for this type of consultation include:

- program planning;
- administrative organization;
- methods of multi-service delivery;
- policy-making;
- recruitment, training, and use of disaster relief staff; and
- establishment of linkages with other services.

The recipient of the administrative-centered consultation may be an emergency agency administrator, a group of program directors from the Red Cross, or a committee such as a task force of government officials. The mental health consultant's focus would be the program in question.

The following is an example of a administrative-centered case consultation:

> After a devastating ocean storm that damaged numerous homes, survivors were housed in a large motel, where families of three or four members were assigned to one room. Fixed amounts of money were approved for meals in the motel dining room. One of the most severe problems was the lack of good communication channels between the disaster assistance agencies, the staff of the motel, and the families. The manifestation of the difficulties appeared in the behavior of the adolescents who had no means of getting around. Sporadic acts of vandalism, theft, and raucous behavior aggravated the tense relations between the motel administrators and the survivor population. Some women began to exhibit signs and symptoms of depression, insomnia, irritability, and hostility. They also made unrealistic demands of the service staff. Mental health consultants were dispatched to the motel as part of a team. After spending several days meeting with every group and obtaining the information necessary to analyze and understand the complexities of the problem, it became evident that the agency staff lacked the knowledge to understand and handle the daily problems of the group. A mental health consultant met with the agency's administrator and discussed the human dimension of the problem. To address the "burn-out" syndrome of the workers, the administration changed procedures and began to rotate staff so that there could be a "rest and relaxation" component to the staff operations schedule. The consultant contributed both knowledge and help with attitudes to remedy this identified need.

■ EDUCATION AND COLLABORATION

The mental health consultant assists other agency staff in reorganizing and reconstructing the lives of disaster survivors, as well as promoting the incorporation of mental health components in communities devastated by disaster. These components should be designed to ensure the early detection and prompt treatment of survivors who suffer psychological consequences of the calamity.

Mental health professionals will be best equipped for their role as consultants and will increase their potential as a crucial link in the disaster assistance network if the support model is based on integrated application of disaster assistance principles and theories of psychosocial behavior.

The consultant has an opportunity to carry out educational activities every time there is a request for assistance in disaster relief operations. All collaborative activities in post-disaster relief operations have an educational aspect that the consultant can address to help relief workers with the problems they are encountering, and relief workers can benefit from this assistance, which enhances their personal repertoire of skills and reduces areas of misunderstanding.

It is this educational aspect of collaboration that makes it an important survivor resettlement method. The goal is to spread the consultant's mental health knowledge to the many agencies that will continue working with survivors' resettlement across the changing developmental stages of post-disaster behavior.

To be effective in helping workers deal with the problems of a survivor, the mental health consultant needs to define, set limits, and design specific boundaries with the maximum educational carryover, given the realities of the crisis climate, time constraints, shift of personnel, and rapid changes of policy in disaster assistance programs. A direct, precise, well-defined educational component will therefore be more practical and effective than the slower, methodical, and repetitive conditions needed for the process of changing the attitudes, stereotypes, and prejudices of relief workers. The targets for such educational activities are government disaster relief agencies and their staffs, as well as the community at large and civic, social, and political groups in the area of human service.

■ EDUCATION FOR THE RELIEF WORKER

To implement educational activities, mental health consultants must have skills in community organization, verbal and written communications, crisis intervention, and supervision. Perhaps the most needed skill is that of teacher—i.e., the ability to impart to others the knowledge, methods, or confidence for understanding disaster behavior and the needs of survivors.

To accomplish the training objectives, mental health consultants must design short- and long-term programs for professionals and nonprofessionals. In the immediate aftermath of a catastrophe, both mental health and emergency relief workers require quick, flexible orientation immediately following the disaster. Later on, a planned effort to provide continued training and support for the emergency program's professional and nonprofessional staff must be devised. Training content will vary depending on the experience, the specific needs, and educational background of the relief and mental health workers.

The primary training need is the acquisition of knowledge and understanding of how survivors react after a disaster. By reviewing the time phases of a disaster (pre-

impact, impact and post-impact), the types of physical and emotional problems survivors may be expected to suffer at each phase can be examined. Training in the concepts of stress, loss, and mourning; social and emotional support; and coping and adaptation are crucial in overcoming disaster-related problems.

■ PUBLIC EDUCATION

Public education must begin immediately after the disaster strikes and should continue until the project terminates. The emphasis of the effort will vary over time. The purpose of a public education campaign associated with a disaster assistance program is to:

- gain widespread support for the program;
- reconstruct the community;
- anticipate changes in emotions and behavior as normal reactions to the consequences of the disaster;
- publicize services for survivors; and
- report to the community on activities and progress.

Community approval and support are necessary for the effective planning and implementation of programs for disaster survivors. Also, when a program begins, the dissemination of information about the program's activities and location of services is essential. This type of publicity may take several forms. It may educate the public and the survivors about the fact that physical and emotional discomfort following a calamity is a normal reaction to stress. If there is a need for help, survivors may seek assistance from the programs by calling and asking for help.

■ POST-DISASTER OUTREACH AND CRISIS COUNSELING

Crisis counseling	An intervention technique that restores survivors' capacity to cope and handle stressful situations and provides assistance for reordering and reorganizing their world; education and interpretation of the overwhelming feelings produced by post-disaster stresses are available to help restore a sense of capability and hopefulness.

■ OUTREACH OBJECTIVES

- Providing education and information about resources available to help survivors reorganize their lives.
- Helping with identification of ambivalent feelings, acknowledging needs, asking for help, and accepting support.

- Helping with prioritizing needs, obtaining resources, and increasing individual capacity to cope with specific priorities identified.
- Providing opportunities to become engaged and affiliated.
- Providing a structured method of perceiving specific problems, self-observations, behavior, and powerful emotions through help in understanding, defining, and ordering events in the larger world.

Outreach to individuals may initiate the linkage to mental health intervention. In such situations, outreach can be followed by crisis counseling.

The goal of post-disaster psychological intervention is to alleviate a survivor's emotional distress and/or cognitive disorganization and to suggest corrective action and offer appropriate information. The crisis worker can help survivors interpret their overwhelming emotions, understand the reactive nature of feelings, and recover a sense of capability and hopefulness.

Specific elements of post-disaster crisis counseling and outreach are:

- Reorientation and adaptation to a social transition period;
- Appraisal of the support network;
- Determination of thoughts, emotions, levels of anxiety, depressive reactions, fear, anger.

During the first phase of the post-disaster experience, the primary effort is the outreach process. This "first aid" technique helps survivors get reoriented and adapted to their new transitory reality. Outreach is the crucial first step in beginning to resolve a survivor's sense of being overwhelmed by the events of the disaster.

While disaster survivors need help with reality testing to determine what has happened, what is happening, and what will happen in the future, care should be taken not to interfere with the psychological defense mechanisms used by the survivor. These defense mechanisms, which give the survivor a personal sense of remaining in control, include denial of the extent of an injury, loss, or trauma, and a sense of vagueness concerning the catastrophic event.

Further, although expressions of empathy are helpful, care must be exercised not to reinforce or reward the victim role. The healthier parts of the survivor's personality must be encouraged and mobilized to enhance the ability to "hold on" for the present.

An appraisal of the survivor's emotional reactions needs to be done to determine what assistance is appropriate in the situation and appraise levels of anxiety, depression, fear, and anger. All support system resources should be mobilized. The responsibilities of daily living can be apportioned to family members.

Crisis workers themselves should seek to strike a balance between rest and work. They should also build networks to enhance their own support systems in

order to prevent "burn out." Crisis personnel should always work to facilitate the expression and understanding of painful emotions that are part of all phases of recovery.

The setting where survivors are physically located is an important variable that will affect the choice of psychological interventions. The turnover of large numbers of survivors in the shelter and the small number of trained crisis personnel make it important for crisis workers to realize the impact of their interaction. This transitory situation must, therefore, mold the type of intervention that is used.

■ GOALS AND OBJECTIVES OF CRISIS COUNSELING

To foster mastery of coping behavior, the mental health worker should promote action directed toward the "unknown" generated by change in the survivor's environment. Appropriate action includes helping survivors follow temporary shelter procedures, await news of post-disaster events, or deal with the lack of information on the whereabouts of other family members.

In addition, the crisis worker can provide guidance concerning the survivor's immediate focus of attention. Communication of reasons for hope is crucial, as is conveying an attitude of concern and confidence about the probability of an eventual successful outcome.

Specific objectives of crisis intervention include the following:

• To identify problems generated by the disaster and the difficulties posed by the need for change.

Example:

Helping survivors adjust to the possibility that they may not be able to return home and may have to stay in an emergency shelter for an extended period.

• To list alternatives and strategies for action.

Example:

Explaining to survivors that a list of options for obtaining resources and handling living situations will be provided in the next few days.

• To build a decision-making model and develop steps for implementing it.

Example:

Choosing an individual to assist the survivors on a permanent basis or introducing a team of workers that is available to them.

- To operationalize alternatives.

  Example:

  Explaining and "walking through" the many operations of the shelter with the survivors.

- To take steps toward dealing with survivors' problems and get feedback on outcome and results.

  Example:

  Talking to survivors about the problems to be addressed when they move out of the shelter and asking for reactions.

■ INTERVENTION GUIDELINES

Assessing the mental health needs of survivors in a post-disaster setting can be a delicate matter. The environment is murky, time is short, and the standard methods are not available. In this confusing setting, crisis workers need to determine the mental/emotional condition of survivors and decide how that condition will affect their abilities to deal with solving immediate problems and deciding whether to refer them for professional help.

To provide support for necessary decision-making, the worker should follow guidelines to determine the appropriate type and level of activity that the survivors can perform. Furthermore, interventions must be planned in terms of immediacy versus delay and should take into account the emotional state of survivors and the staffing conditions in the emergency setting.

To measure the level of function, the crisis worker must investigate the following risk factors to ascertain the indications of emotional reactions:

- Psychosocial maturity or immaturity of the survivor's personality;
- Role of stress in social expectations of performance, as judged by survivors and others living with them, within or outside the temporary setting;
- Continued environmental stress, both in social and physical conditions, including interventions such as surgery, relocation, lack of privacy;
- Accidental crisis events occurring in the survivor's life, either before or after the disaster, that affect them or their loved ones.

■ PRINCIPLES OF CRISIS INTERVENTION

There is a need to prepare the survivor for post-disaster crisis counseling and intervention. The mental health worker plans for crisis intervention by obtaining the

information needed to plan the intervention, establishing competence and credibility, describing the psychosocial intervention plan, and eliciting the survivor's cooperation with the plan.

The counselor must discern the survivor's attitudes and expectations about the intervention and then move forward to a collaborative decision. From this awareness, the crisis worker arrives at a tentative formulation of the problem and/or plan of action.

Crisis workers should be familiar with a wide variety of approaches and should select the combination that best fits the characteristics of the problem. The objectives are to alleviate emotional distress and/or cognitive disorganization and to offer the survivor information and suggestions for corrective action.

Survivors are potentially capable of handling their own problems after being helped to recognize barriers to solutions or redirect their behavior toward exploring new solutions. Transposed dependence may initially occur so that survivors can "borrow" confidence from the crisis workers. Advice should generally be given with caution, although survivors should be informed about relevant matters on which they are uninformed or misinformed in order to enhance the problem-solving.

Communication in the initial interview may be difficult due to distorted ways of communicating stemming from high anxiety and cognitive disorganization. Often survivors are also defensive and guarded. Success in communicating freely with survivors depends on a general ability to win their trust and confidence.

Survivors need help in resolving the present crisis produced by the disaster. Discussion of the "here and now" establishes a relationship, facilitates feedback and options in solving problems, and helps survivors analyze realistic ways of moving toward the solution of problems.

Some exploration of past methods of problem-solving will aid the counselor in understanding how survivors handle the present situation. Meaning and symbolism, including psychophysiological responses to present events, are largely determined by past experiences. Therefore, a partial review of the past may help understand how survivors perceive the problems they face and what they consider acceptable options in terms of their own value systems. Interpretation that enables survivors to see the linkages between feelings or behaviors may be therapeutic, as it will allow survivors to make sense of feelings that are not clear, and it can enhance a sense of mastery and control by putting feelings in perspective.

Reinforcing positive activities and reminding survivors of their skills and strengths in handling problems is critical. It is important to focus on personal skills that are working well rather than focusing only on weaknesses or pathological aspects of the survivor's problem-solving.

The purpose of intervention is to bring about a change in the survivor's problem-solving capabilities, which have been weakened by the disaster

conditions. Specifically, survivors experience the following psychological states:

- Feelings of diminished self-confidence and inability to remember past successes in overcoming traumatic episodes. Survivors are overwhelmed by the external circumstances in the post-disaster environment and by their own confusing feelings and thoughts in reaction to a new, unfamiliar, and uncomfortable world.
- Belief that failure will be the outcome of all their traumatic and crisis experiences. This, in turn, strengthens feelings of guilt and shame as part of adaptive regression.
- Feelings of resentment because others on whom they counted for help seem unable or unwilling to provide the needed help. The reactive behavior of these other people, who include multidisciplinary crisis personnel, may be to express irritation because crisis workers often feel that survivors should show gratitude, not feelings of entitlement. The crisis worker's own fatigue and frustration adds to this, often creating a vicious circle between survivors, families, and crisis personnel.
- Increased dependency on others causes a lack of feedback that exacerbates the survivor's low self-esteem. This creates further distance between the survivor and potential support systems.
- Loss of faith in group values and in former beliefs or peers that had, in the past, given the survivors a sense of security and significance in the world. Survivors need help in reestablishing and reordering this faith.

The main objective of crisis intervention is to help survivors develop an internal sense of order and perspective, so that they will be able to organize their own environments as they are helped to process the painful and powerful emotions accompanying the post-disaster events. Another objective is to help survivors reach out, acquire, and build upon resources from recovery agencies so that they gain help in reordering their world and develop a sense of comfort, security, and self-esteem.

■ TYPES OF INTERVENTION ACCORDING TO POST-DISASTER PHASES

First Phase: Triage and Outreach Activities

The primary objective in the first phase is to lessen stress and offer support. Psychological emergencies require immediate, rapid evaluation of the survivor's behavior. A minimum of data will be available for making decisions, and both time and human energy will be limited. The skill and knowledge required to treat multiple problems may seem overwhelming.

The emergency situation not only requires that the crisis worker play a new role, but also demands types of intervention that can be classified under the concept of outreach.

Disaster triage and outreach are the procedures used by team members and other crisis workers to assess behavior, gage the degree and level of crisis, and supply guidance, resources, and information. This knowledge is provided to the assisting team so that disaster aid planning can alleviate the immediate situation and the psychosociological reactions of the survivors by assisting them in venting feelings, sharing experiences, and receiving support.

Immediately following the disaster, survivors may temporarily become emotionally disorganized. Cognitive disorganization will affect attention and focus, level of interest and involvement, ability to stop ruminating about the catastrophe, learning capacity to absorb information given by crisis personnel, and recall of skills available to solve problems. The therapeutic objective should be to help survivors minimize the effects of the disorganization and reinforce their cognitive mastery. Procedures must be implemented to increase competence and maintain awareness by allowing survivors to tell their stories and obtain validation for their suffering.

The following areas of outreach are useful in dealing with cognitive disorganization:

- Assisting the survivors by reinforcing their knowledge of their new social world, such as demonstrating time-space scheduling and recognizing practical daily living arrangements.

- Strengthening conscious awareness of the appropriateness of social reactions and informing them of normal post-trauma reactions. Many survivors believe they are "going crazy" because they notice changes in their social behavior and they therefore need reassurance.

- Helping survivors identify realistic causal relationships between events and reactions and discussing them individually or in groups.

In dealing with emotional disorganization, the crisis worker should be able to rapidly gage the type and quality of the predominant effects through social interactions with survivors. The major effects seen in the initial phase include sadness, fear, and anger, which are manifested in many forms and with a wide range of intensity. Some expressions are pronounced, while some are subdued or defensive, such as feigned composure, calm, or passive dependence.

During the triage and outreach stage, the worker should not tamper with these sets of behavior. They offer a means of psychological first-level healing that keeps the personality functioning during the acute phase. Although these behaviors cover up emotions, the worker should not encourage expression of guarded emotions until the place and time are appropriate and the worker can stay with the survivor through the process of recuperating some emotional stability.

Intervention objectives for survivors in the shelter include helping them achieve physical comfort, increased cognitive organization, and a sense of emotional control.

These approaches will help diminish survivors' sense of helplessness, indecisive or regressive behavior, and belief that they lack coping skills. In addition, these approaches help increase competency, self-esteem, flexibility to consider alternative solutions, and ability to handle the confusion and mixed communications that are characteristic of this first phase of disaster assistance.

As the days go by, crisis workers must sort out priorities for action, such as helping survivors with a sense of orientation, reinforcing reality testing, and developing support systems. De facto support systems must also be developed within the group of survivors in shelters.

In addition, the wide array of available resources must be organized to meet the specific needs of survivors, whether physical or psychological. Crisis personnel can mobilize appropriate help by observing the way survivors behave or approach them. This requires a special type of technique that allows the crisis worker to elicit directly and personally from the survivors their perceived immediate needs. The worker can then collaborate with other emergency personnel in mobilizing resources so that the survivors feel assisted, rather than helpless, hopeless, or destitute.

Second Phase and Third Phase

As survivors are relocated from emergency shelters to temporary housing and back to their reconstructed homes, a new stage of bereavement and crisis emerges. This necessitates a broader repertoire of mental health intervention activities, including crisis counseling with the objective of achieving crisis resolution and assisting with depression reactions that emerge in response to the "second disaster."

Therapeutic activities can help achieve some of the following objectives in assisting survivors:

- Providing education and information about the help available;
- Helping to identifying ambivalent feelings about acknowledging needs and asking for and accepting worker support;
- Helping survivors interact on a cognitive level, assigning priorities to needs, accepting advice on how to obtain information, and increasing the capacity to cope with the dislocation of their lives.
- Providing a structured method of perceiving problems, self-observations, behavior patterns, and powerful emotions through help in understanding, defining, and ordering events in the new environment.

Once these objectives have been met, each categorical problem can be singled out and suggestions can be made for its management. At the same time, several areas of cognitive, emotional, behavioral, and social reality are put into perspective as a first step toward understanding what is happening.

All these activities are preparatory for further work. If the survivors need and accept the offer from the crisis worker, they are led naturally into accepted methods of crisis counseling and therapy for several weeks. If necessary, they are referred to another mental health group.

■ ANNIVERSARY REACTIONS

Families report a reemergence of memories of their emotions with the return of the date of the disaster. Generally the media reinforce these memories by publishing pictures of the event. The range of distress can go from reliving the trauma to evoking unfinished mourning. For survivors who have experienced significant losses mourning is still in progress one year later. For other survivors dealing with the abnormal situation following the disaster, the anniversary can also provide an opportunity for further healing.

■ PREVENTIVE PLANNING FOR ANNIVERSARY REACTIONS

Crisis counselors should expect and be ready for a resurgence of calls asking for help to obtain further counseling. For many survivors, all that will be needed is phone counseling and reassurance that their emotions are healthy reactions. Others will need more extensive assistance and referral.

At the time of the one-year anniversary of the disaster, the workers themselves will already have returned home, or will be preparing to do so, and they may therefore have some difficulty in separating their own feelings from the survivors' reactions. Workers will need support from senior staff and trainers.

In keeping with the guidelines presented above, mental health intervention programs can be organized along two major lines of assistance activity. The first is direct, face-to-face intervention with families that were housed in emergency shelters during the acute stage of the emergency. Guided by their knowledge of the time phases and the sequential manifestation of crisis phenomenology, the workers can identify and organize a number of approaches to help families through the anniversary phases of crisis, coping, and adaptation. The second line of activity focuses on the community as families relocate to temporary or permanent housing, which may mean a complete change of neighborhood or human support networks. This is accompanied by changing phases of crisis resolution and will necessitate different crisis counseling procedures, as well as both individual and community support organizations.

The objective of mental health assistance during the anniversary period is effective use of interventions that will assist families in (1) handling the stressful situation and (2) further strengthening their coping capacity.

Crisis counselors should consult with child welfare agencies so that they can anticipate difficulties around the anniversary date, which will help prevent problems and offer broad-based opportunities to assist families and children who have been traumatized by a disaster. School personnel are also important collaborators to help children resolve any long-term problems linked to the disaster. ■

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Populations with special needs 5

■■■■■■ **OVERVIEW OF CHAPTER**

Description: Identifies special populations at risk after a disaster and their specific assistance needs

Purpose: To describe the interventions needed to assist special populations.

Content:
- Characteristics of different populations and their needs, including:
  — Children
  — Elderly populations
  — Persons with mental illness
  — Persons with HIV/AIDS
  — Persons with substance abuse problems
  — Post-disaster caregivers and workers
- Identification and description of "burnout."

Learning Objectives:
- To identify and describe the characteristic reactions of special populations affected by a disaster.
- To describe the operations needed to assist populations at risk.

▆▆ CHILDREN

A disaster produces a variety of reactions in children that are specific for each child and depend on a group of variables. The type, extent, and proximity of the impact on a child within a family living in a geographical area has to be understood both from a child psychology and a disaster response perspective.

The following concepts are useful in understanding a child's reactions to a disaster:

- Stage of development;
- Gender, ethnicity, and economic status;
- Usual coping style;
- Intensity of the impact;
- Availability and appropriate "fit" between child's needs and support systems;
- Extent of dislocation;
- Availability of relief and community post-disaster assistance.

Based on these concepts, the post-disaster mental health intervention program can be organized along two major lines of activity. The first is direct face-to-face intervention through outreach or through contact with families housed in emergency shelters during the acute stage of the emergency. The second line of activity begins as the families relocate to temporary or permanent housing, which may mean a complete change of neighborhood or human support networks. This is accompanied by changing phases of crisis resolution that will necessitate different therapeutic procedures.

The objective of post-disaster mental health intervention is to restore the child to his/her developmental level of functioning by helping the child handle the stressful situation. The worker also assists family members in reorganizing their world so they can extend adequate parenting support to the child.

Collaboration with child welfare agencies can offer broad-based opportunities to help children that have been traumatized by a disaster. School personnel are important collaborators to help children resolve the post-disaster crisis.

▆ PSYCHIC TRAUMA PRODUCED BY A CATASTROPHIC EVENT

The following key issues are critical in helping a child deal with a disaster:

- Children's reactions will vary according to their stage of cognitive, affective, and sociobehavioral development.
- The reactive phenomena observed after a catastrophic event represent of bio-psycho-social systems reactions and early efforts to cope with the disorganization of these systems.

- Family and societal behavior toward a child are powerful influences that can enhance or impede the trauma resolution process. The child's reliance on the family for cognitive guidance and socioemotional support is influenced by the child's stage of psychosexual development and preexistent psychopathology.
- A mourning process accompanies all catastrophic psychic trauma due to loss of body configuration, interpersonal bonds, worldview and familiarity, expectations and trust.
- Reactive depression as a clinical syndrome needs to be differentiated from the expression of psychic trauma and an effective/ineffective mourning outcome.

Current intervention practices for children include the following three elements:

1. An opportunity for exposure to a disaster's frightening elements in a nonthreatening atmosphere.

Example:

Activities such as drawing pictures, sharing stories, and playing disaster games let children "relive" and deal with the disaster.

2. Development of coping skills for issues that remains difficult.

Example:

Adjustment to new surroundings helps children cope with the loss of their house.

3. Access to supportive social relationships.

Example:

Parenting support helps children adjust when a disaster has affected a parent's ability to cope.

Key Variables Influencing Post-disaster Reactions among Children

- Speed of onset
- Duration of the trauma
- Potential for recurrence
- Degree of life threat
- Degree of exposure to death, dying, and destruction
- Proportion of the family affected
- Role of caregiver in the trauma
- Degree of displacement in home continuity   (cont.)

(cont.)
- Separation from nuclear family
- Rekindling of childhood anxieties
- Communicated anxiety between parents and children
- Cultural expectations

■ POST-DISASTER ASSISTANCE MODEL FOR COUNSELING CHILDREN

A post-disaster assistance model for children who may need further assistance should include a diagnostic and treatment service for children and families who identify themselves as needing help and/or are referred for psychological assistance. The model should also provide special consultation services for social agencies that work in the post-disaster program, with direct links between the psychological teams and the agencies. In this way, special problem cases can be referred for discussion and problem-solving to assist the social agencies in obtaining resources for the family and the child.

Objectives of Post-disaster Counseling for Children

- To help the child develop an internal sense of perspective so that he/she will be able to organize the environment.

- To assist the recuperative process of sharing painful emotions provoked by the stressor events in order to help the child put events into perspective.

- To help the child reach out to both family members and the emergency teams and use available resources to develop a sense of comfort, security, and affection.

The model should also include a program of regular group discussions with professionals who work with children. The aim of these programs is to help the professionals deal with their current problems and increase their therapeutic, supportive, and healing skills. Because assisting children who are orphaned or separated from their parents following a disaster is such a new component of social welfare systems, professionals need regular help and support in their dealings with the children and in their contacts with relatives.

The following are the components of a model counseling program for traumatized children:

Relationship-building and information-gathering regarding the trauma: The mental health worker describes the purpose and process for assisting children who have been traumatized and then proceeds to gather details about the trauma from family and child.

Assessment of the child and family: The mental health worker gathers information regarding the family structure, the child's experience in the disaster, previous traumatic experiences, addiction patterns, and the presence of consequences or symptoms of post-traumatic stress reactions.

Trauma interview: The mental health worker facilitates the child's telling of the traumatic experience through drawings or through role-playing that encourages attention to specific, details including sights, sounds, smells, and accountability for the event.

Identification of post-disaster issues: The mental health worker identifies issues that need to be addressed with the child, such as difficulty coping with nightmares, physiologic reactivity, or impulse control. Issues are also identified for the family, including management of their own and their child's post-trauma consequences and parenting and communication skills.

Crisis intervention methods: Short-term play therapy, activity therapy, family therapy, or group therapy is provided, based on the age of the child and the needs of the family post-disaster. Consultations are held with other service providers, including the school system, social services, and foster parents.

Relapse prevention: The mental health worker helps the child develop skills for coping with post-trauma consequences and situations. The return of some disaster-related problems is expected and viewed as normal. The family is encouraged to return to counseling if necessary.

Variables Assisting in the Recovery of Families

- Developing structures and networks
- Establishing reliable schedules
- Choosing activities that enhance self-esteem
- Continued strengthening of social contacts
- Becoming involved in group activities
- Attending to material/personal needs
- Encouraging relationships and attachments
- Identifying risk factors
- Learning about children's reactions at home and in school
- Using all available help and resources

Direct and Indirect Impacts of a Catastrophic Event on a Child

Body trauma
- pain
- autonomic arousal
- increased tension
- loss of function

Sensory changes
- visual
- auditory
- olfactory

(cont.)

(cont.)

Emotional expressions	Cognitive changes
• fear	• language
• distress	• communication
• anxiety	

Traumatic reactions	Disorganization of social system
• parents	• school
• siblings	• religious
• friends	• parents' employment
• extended family	• housing

REACTIVE PHASE RESPONSES OF CHILDREN TO A CATASTROPHIC EVENT

Preschool Child

Somatic systems	*Affective system*
• Muscular immobilization, hyperactivity	• Constricted/flat affect
• Temper tantrums, slow movements, not goal-directed	• Detachment
• Disorganization of acquired body functions	• Rage/aggressive responses
• Autonomic nervous system signs, vomiting, crying	• Fear/worry
• Sleeping/eating disturbances, pale skin, hyperventilation	• Anxious/suspicious
• Wide pupil stare, startle reactions	

Cognitive system	*Social behavior system*
• Recurrent memories, thoughts, fantasies of event	• Avoidance, dependence, passive/ intense, energetic/impulsive
• Disturbed dream content	• Partial loss of toilet training
• Decrease of acquired performance, language	• Increased autoerotic activity
• Visual-spatial, concentration	• Abrupt, destructive play
• Distorted description of visual phenomena	

REACTIVE PHASE RESPONSES OF CHILDREN TO A CATASTROPHIC EVENT
(cont.)

School Age Child

Somatic systems
- Energy level affected
- Movements slow, low-intensity, or rapid, frenetic, impulsive
- Autonomic disorganization; appetite/sleep/ elimination

Affective system
- Lability of affect; anxious, sad, giggly, "nervous"
- Cautious; afraid to take chances or return to familiar places
- Increased fear of competition, of losing, of getting lost
- Increased dependency/decreased independence feelings
- Increased susceptibility of emotional reactions to sensory reminders of the traumatic event
- Initial process of mourning and reactions to loss

Cognitive system
- Constriction and hypervigilant alertness
- Intellectual functions affected; dull, obtuse
- Obsessive rumination and increased distractibility affecting memory loss
- Decreased associations leading to spontaneous reminder of event characteristics
- Increased fantasizing about how they could have changed events, controlled outcome of the incident
- Appearance of learning problems

Social behavior system
- Obsessive-compulsive expressive play, talk, curiosity about event and its consequences
- Inconsistent, capricious reactions to parents
- Argumentative and disobedient
- Poor impulse control
- Difficulty returning to routines
- Some loss of habits, customs, skills

ELDERLY POPULATIONS

Elderly populations have specific reactions and needs after a disaster. Many older adults, especially those who lack resources or have declining physical capacity, lose important support systems in the destroyed neighborhood. They may also have more difficulty in "navigating" the channels of the emergency system. This situation is compounded if older persons are poor, immigrants, or unskilled.

Specific problems of the elderly that aggravate the problems of coping after a disaster include:

* Relocation with family members where privacy, personal space, and daily routines are a source of stress;
* Difficulty with sleeping schedules and relying on sleep medication;
* Sense of disorganization or confusion due to loss of "cues" in daily activities.

The reaction of older individuals to a trauma will be influenced by the impact of what they saw, heard, felt, and smelled, as well as by memories of crises in their past. This revisitation of past events is not simply a product of regression or trigger reactions. It is essentially a normal attempt to ground one's reactions in the familiar.

GUIDELINES FOR HELPING OLDER PERSONS COPE WITH DISASTER

In working with elderly disaster survivors, mental health workers should place emphasis on restoring confidence and dignity. The following guidelines will help workers assist elderly survivors cope with the aftermath of a disaster:

Rebuild and reaffirm attachments and relationships: Nurturing and physical closeness is needed. Let older persons identify those to whom they want to be attached; however, do not assume family relations are friendly.

Consider their concern about safety: The elderly need to know they have options in making a choice about their safety. Evacuation is a highly controversial issue in disaster. Older adults may be less safe in evacuations than if they remain in their homes (if this is feasible).

Talk about the tragedy: Remember that older persons may be venting feelings about their lives, not about the immediate event. Do not attempt to prevent this venting, since validating past concerns is an important part of establishing trust in preparing to deal with current concerns. The elderly may also respond well to music and opportunities to paint or create art that communicates their reactions.

Anticipate communication lapses: In conversations, the elderly may go back and forth from the past to the present. Workers may be confused by an individual's discussion of past events or past relationships in terms of the present disaster experience. It is important to remember that the discussion may be entirely rational and logical from the perspective of the individual.

Understand that stress inhibits memory: If an older person forgets a name, place, or portion of an event, the worker should take great precautions to avoid placing pressure on the elderly person to remember.

Prepare for sporadic conversation: Workers should be prepared for the elderly to talk sporadically about the disaster, spending small segments of time concentrating on particular aspects of the traumatic experience as a method of defense.

Provide factual information: Older adults want factual information, but may be able to absorb the facts only in limited quantity. Often, they ask to have information about the disaster repeated a number of times. Eventually they will integrate it and gain better control over their emotions about the event.

Make short-term predictions: Specific times and places for changes should be made clear. It will help to delineate events on a calendar or clock so that the older person can more easily track the future. Workers should spend time addressing basic needs in a detailed way, such as who will help the older person, where the person will stay at night, where he/she will get clothes, and what property may be rescued from their destroyed homes.

Establish routines quickly: It is best to reinitiate old routines if possible, since routines are considered an anchor in aging.

Reassure about normal reactions: The worker should reassure the elderly that lapses of concentration, memory losses, physical ailments, and depression are normal reactions to the abnormal post-disaster situation that may have nothing to do with the aging process.

Reactions to Traumatic Events among Elderly Populations

- Fear of mortality
- Need for permanence
- Wish to reconnect with past and with friends
- Regression
  - Generally temporary state
  - May be long-term regression of severe, chronic condition
  - May move in and out of regressed state during relocation
- Multiple Losses
  - Fear of relocation to unknown neighborhood
  - Fear of losing their dignity
  - Loss of hope for the future
  - Loss of cherished mementos
- Need to integrate loss into context of life
- Disorientation as routine is interrupted
- Sense of denial as a normal defensive reaction to trauma
- Immediate fear response, followed by anger and frustration when unable to control a situation
- Physiological responses
  - Sleep disturbances
  - Appetite disturbances
  - Crisis episodes

■■■ PERSONS WITH MENTAL ILLNESS

Historical changes in the care of people with mental illness and homeless persons living in the community have resulted in at-risk populations needing special help after a disaster. Although the number of such individuals housed in shelters or in damaged dwellings may be small in comparison to the total population, each case may need skillful handling and different approaches. Most disaster survivors who have existing mental problems will need additional help beyond crisis intervention.

Individuals suffering from a diverse variety of mental illnesses will exhibit differing reactions to the many stressors following a disaster. In a post-disaster situation, these individuals will fall into three major categories:

Individuals living in hospitals in the damaged areas: For these individuals, problems in their daily living arrangements will have been disrupted by interference with the availability of electricity, water, food, medical care, and nursing staff.

Individuals living in group homes: These individuals may be affected by loss of their homes, alteration of their surroundings, or limited access to medication. The loss of a familiar setting may increase the acuteness of their emotional reactions, which may, in turn, be manifested as symptomatology.

Individuals living with their own or foster families: These individuals also may have increased symptoms due to factors similar to those for individuals living in group homes.

If individuals are accompanied by a familiar adult helper, it may not be difficult to ascertain the diagnosis and the medication needed. This is not the case if the individual is discovered alone; in such cases, the signs of disturbance in cognition, disorientation, and severe difficulty in explaining who he/she is will make it clear that this is an individual who needs special attention. Individuals who cannot follow simple, life-preserving instructions will need individual monitoring. However, during a disaster, it is always necessary to rule out any undiagnosed head injuries that might cause similar symptoms.

Individuals who manifest behavior that appears inappropriate for the situation should be given a rapid assessment. The crisis worker should ask for consultation to differentiate between individuals suffering from acute stress and those with mental illness according to whether they exhibit the following conditions:

Stress reactions	Changes in cognition-orientation, memory, thinking, and difficulty in decision-making; changes in emotions, lability, blunting, flatness; no break with reality awareness or loss of self-identify; behaves within social conventions and relates in a passive way.

(cont.)

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Acute psychotic reactions	Expressions of anxiety, affective, and thinking behaviors; subdued response to emergency; ranges from apathetic, depressed, expressing bizarre thinking or difficulty in understanding to hyperactive, manic, unrealistic, and difficult-to-control behavior.
Effect of head injuries	Signs can mimic the characteristics of many psychiatric disorders; a neurological exam may show signs of trauma.

A number of individuals with mental illness are dependent on medication, and obtaining information about their regimen should be a priority. This should be followed by an attempt to structure their schedules and remove the patients from intense stimuli situations whenever possible. Using other survivors to assist in basic daily living activities may also be beneficial.

Disaster survivors are suddenly and painfully thrown together into a desperate and unfamiliar setting. The behaviors that emerge as they try to cope and adapt could be defined as "antisocial" if they break rules, do not accept schedules, refuse to take their turn dealing with helpers, or are identified as "trouble-makers" who may also steal and lie. Diagnosing these behaviors and sorting out which are motivated by anxiety and which by character disorders can challenge the skills of disaster workers. Because diagnosis must be rapid during the emergency phase, it may be difficult to ascertain the motivating emotions driving antisocial behavior. The best approach is to increasingly set limits on disruptive actions.

Survivors who act out due to anxiety will experience relief if structure and support are provided. They will express mortification or guilt, and will verbalize some of their fears. In the case of aggressive, self-centered, and nonempathetic individuals, crisis workers need to use stronger measures, including segregation from the group, until more individual measures are available.

Except for those with severe cases, most individuals with mental retardation will not need special measures other than instructions on how to manage in the shelter or obtain resources offered by agencies. Some careful explanation of what has happened and what plans have been made for the next few months may be of great relief to them. In cases where mental retardation is severe and accompanied by physical handicaps, it may be necessary to ask another survivor to assist in daily hygiene, feeding, and sleeping activities.

■■■ PERSONS WITH HIV/AIDS

Individuals with HIV/AIDS present special challenges to the post-disaster worker. Due to the widespread myths and lack of knowledge about the transmission of HIV, survivors develop fear and anxiety when they find out that an individual who is

HIV-positive is living, sleeping, or using the toilet facilities near them in a shelter. Mental health workers can help educate survivors and other crisis workers to reduce the fear of infection.

Reliance on disaster workers with different educational and professional backgrounds results in a mix of values, attitudes, and cultural characteristics, as well as various levels of emergency preparedness.

In a disaster, there is a phenomenon of focusing on some problem, perhaps even a small one, that may provide some sense of control for disaster survivors. Experienced disaster workers are more comfortable with HIV/AIDS-related information than new, inexperienced workers.

The following is a summary of the HIV/AIDS knowledge base needed by workers in post-disaster programs:

1. Recognition that individuals with HIV/AIDS are a new at-risk population in disaster assistance planning.
2. Identification of the unique needs of HIV-infected survivors, including medical, psychosocial, and legal needs.
3. Development within emergency agencies of clear lines of responsibility for the needs of individuals with HIV/AIDS in shelters, specialized housing, and hospitals.
4. Planning in a coordinated structure to link medical and government agencies to address the needs of survivors diagnosed with HIV/AIDS.
5. Incorporation in all training and emergency manuals of emergency care guidelines for the care of disaster survivors with HIV/AIDS.
6. Development of an inventory of existing and potential resources to respond to HIV/AIDS-related problems, including availability of health and mental health personnel; capabilities of the public health system, prison system, and mental health institutions; and preparedness of existing community-based organizations and networks.
7. Development of training materials about disaster management for incorporation in all community HIV/AIDS training programs.
8. Development of a "shelter-model" process to deal with the day-to-day problems of disaster survivors living with individuals who are HIV-infected or have AIDS.
9. Development of community emergency models that focus on preplanning and prevention approaches to the care of HIV-infected disaster survivors.
10. Awareness of the legal rights of individuals with HIV/AIDS.
11. Consultation with mental health agencies and HIV/AIDS agencies regarding medical and nonmedical mental health personnel and health personnel specially trained for disaster work.
12. Specialized training in mental health management during times of disaster to encourage therapeutic attitudes for survivors with HIV/AIDS.

■■■ INDIVIDUALS WITH SUBSTANCE ABUSE PROBLEMS

Individuals who are dependent on drugs or alcohol raise difficult management issues for post-disaster programs. In the impact phase, individuals who are addicted to drugs will manifest physiological signs of withdrawal when the drug is unobtainable. Behavior and speech will identify drug users who understand the reality of not being able to obtain the needed substance. A list of the commonly observed psychophysiological manifestations of drug withdrawal should be available for all disaster personnel.

The degree of effort needed to assist an individual who is showing symptoms of drug withdrawal will depend on the life-threatening potential and the degree of pain and discomfort. The mental health worker needs to work closely with medical personnel to assist in the treatment of these survivors. After the acute phase is controlled, a psychosocial crisis intervention is the recommended method of assistance.

■ SIGNS OF DRUG ABUSE AND ADDICTION

The following signs of drug withdrawal can be expected from substance-abusing survivors when they have no access to drugs following a disaster:

- Apprehension or vague uneasiness and fear of impending catastrophe;
- Muscle weakness evident even on mildest exertion;
- Tremors that are coarse, rhythmic, nonpatterned, evident during voluntary movement and subsiding at rest.
- Psychoses and/or delirium, usually resembling delirium tremens ("DTs"); acute panic attacks may occur.

■ SIGNS OF ALCOHOL ABUSE AND ALCOHOLISM

Individuals who are addicted to alcohol will show differing signs of central nervous system irritability and general discomfort, but most will "weather" the acute stage of the post-disaster period. If the behavior and central nervous system signs are dysfunctional, the individual will pose a problem for the personnel in charge of managing the shelter. Generally, these individuals become difficult in a passive-aggressive manner, rather than actively and aggressively disrupting living areas.

The following are signs and symptoms of alcohol withdrawal:

- Mild or early symptoms (impending delirium tremens) may appear in the first week after the last drink.
- Gastrointestinal, muscular, central nervous systems are affected.

- Vegetative (sleep) and characteristic psychological and behavior patterns may emerge.
- Advanced or severe manifestations, including the emergence of increased irritability, severe tremulousness, and auditory hallucinations, may be indications of imminent delirium tremens.

■ POST-DISASTER WORKERS

Disasters bring together emergency service workers from diverse backgrounds. Some arrive immediately with clear responsibility and priority assignments. Others arrive with different levels of previous experience and skills and different assigned post-disaster jobs. All emergency workers attempt to be helpful and proceed to rescue the wounded, gather the dead, and use triage methods to determine the priority of intervention. They work long hours with little thought to food or sleep. This group of workers represents a challenge for planning and operationalizing a program of post-disaster intervention.

Each type of post-disaster worker works within different organizations that interrelate within the common goal of disaster assistance. After individuals are recruited to a site to help, there is little opportunity to identify or work out a good fit between worker and assignment. This situation generally produces role conflict, ambiguity, and discomfort. Workers generally have multiple functions. They often attend to diverse, and at times, conflicting, needs of survivors.

The mental health worker should focus on the emotional impact of these stressors on disaster workers, as well as their reactions, behavior, and feelings, as a guide for selecting the best methods of helping them do their jobs. These reactions can range from good coping and growth to pathological and chronic sequelae that leave a dysfunctional individual and persist for months after the worker has returned to his/her home and previous job.

■ BURN-OUT

"Burn-out" is the term used to describe the many aspects of the occupational stress experienced by disaster workers. Most disaster workers are not taught to look for, identify, and address their own physical and emotional needs. They often do not acknowledge that their needs are normal in these very abnormal situations. They often fail to understand that, unless they meet their needs continually, they will not be able to function in a supportive, consistent, and sensitive manner.

The following factors have been identified as barriers to the use of preventive methods to diminish burn-out:

- High professional standards and high self-expectations;
- Reluctance or discomfort in discussing feelings for fear of showing weakness and doubt about performance;

- Denial or suppression of feelings during difficult situations in order to function;
- Discomfort in acknowledging and discussing feelings as soon as they emerge;
- Fear that acknowledging the need for help will reflect negatively on job performance evaluation and opportunities for promotion;
- Difficulties in judging one's own reactions and performance when overwhelmed and distressed;
- Shame over the contrast between one's personal situation and that of survivors.

Various approaches are available to disaster planners and program directors to prevent burn-out and assist disaster workers. These methods help workers acquire techniques and skills for coping with stress. The need for exercise, diet, relaxation, and recreation is now recognized in employment conditions.

"Debriefing" focuses on the cognitive and emotional reactions of workers who are trying to cope with novel internal sensations that accumulate from their painful experiences. These debriefing interventions are done in small groups, with specific objectives and confidentiality boundaries.

The structure of the debriefing includes the following sequence of processes:

- Description of the workers' activities in interacting with survivors;
- Identification and recognition of paradoxical and unusual emotional reactions of workers;
- Recognition of ambivalent feelings in some situations;
- Linkage of feelings to disturbance of sleep and appetite, impulse control, and irritability.

The mental health "leader" summarizes the discussion, answers questions, and reinforces the message that the emergency workers' responses are normal reactions to abnormal situations. A critical incident session is generally conducted with individuals who have participated in extremely traumatic situations and are experiencing signs of psychophysiological stress. The session is confidential and nonjudgmental.

Conditions Present in Occupational Stress

- Time pressures
- Work overload
- Minimal positive reinforcement
- High probability of conflict
- Prolonged expenditure of energy and attention to survivors
- Coincidental incidents of crisis involving several survivors at the same time
- Personal crisis in the life of the post-disaster worker

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Mental Health Services in Disasters: Manual for Humanitarian Workers

RAQUEL E. COHEN

Mental Health Services in Disasters: Manual for Humanitarian Workers, is composed of a noteworthy summary of the most updated knowledge in this field, in a world in which the effects from natural disasters are increasingly more dramatic – be they hurricanes, earthquakes, volcanoes, or floods, etc. Crucial aspects in the management of different disaster victims are emphasized, with special attention to those most vulnerable: children, the aged, HIV patients, individuals with substance abuse problems and their interaction with other victims.

The manual is written in a simple and easy-to-read format for those persons who, in some way, are involved in providing relief to an affected population, as well as in the short and long-term psychosocial and psychophysiological repercussions from the disaster. It's main objective is to provide an orderly, immediate and efficient flow of relief, training public mental health elements and preventing already-identified adverse consequences.

The author, Dr. Raquel E. Cohen, a graduate of and former associate professor of Harvard Medical School, is a world-renowned authority in the field of psychological and social consequences from disasters and intervention methods. She has extensive experience in managing these situations and has been solicited by several victim relief governmental and non-governmental organizations. One of her most recent involvements was helping the inhabitants of the region affected by Hurricane Mitch in Central America.

Mental Health Services in Disasters: Manual for Humanitarian Workers is an instrument that will contribute to the greatest degree in decreasing the social and psychological consequences for all of those people affected by a disaster. Furthermore, it is complemented by the *Instructor's Guide* (published in the same collection) that serves to help those individuals who must create and execute training and orientation programs on mental health in disasters.

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