

COPING WITH DISASTERS

A GUIDEBOOK TO PSYCHOSOCIAL INTERVENTION

(Revised Edition)

by

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INTRODUCTION AND OVERVIEW

People all over the world know the destruction produced by weather, the devastation of geological disaster, the havoc of industrial and transportation accidents. Many know, as well, the misery of terrorism, chronic political violence, and war. Over the last quarter of a century, more than 150 million people a year have been seriously affected by disasters.

The physical effects of a disaster are usually obvious. Tens or hundreds or thousands of people lose their lives. The survivors suffer pain and disability. Homes, workplaces, livestock, and equipment are damaged or destroyed. The short-term emotional effects of disaster -- fear, acute anxiety, feelings of emotional numbness, and grief -- may also be obvious. For many victims, these effects fade with time. But for many others, there may be longer-term emotional effects, both obvious and subtle.

Some of the emotional effects are direct responses to the trauma of disaster. Other effects are longer-term responses to the interpersonal, societal, and economic effects of the disaster. In any case, in the absence of well-designed interventions, up to fifty per cent or more of the victims of a disaster may develop lasting depression, pervasive anxiety, post-traumatic stress disorder, and other emotional disturbances. *Even more than the physical effects of disasters, the emotional effects cause long-lasting suffering, disability, and loss of income.*

There is no single, universally applicable recipe for responding to disasters. Disasters come in many forms. Some, like earthquakes, hurricanes, and tidal waves, are natural; others, like wars and terrorist attacks, are made by humans. Some, like a rape or a fire in a home, immediately affect only one person or one family; others, like a bomb blast or a tornado may affect hundreds of people or, like an earthquake or a war, may affect entire communities and nations. Some, like personal assaults and ethnic cleansing, are inflicted intentionally on their victims; others, like airplane crashes or industrial accidents, though the result of human or technological error, are unintended. Disasters may be relatively short lived, although devastating, or, as is the case with famine and war, may last for years.

Perhaps the greatest source of variability, both in the effects of disaster and in the most appropriate responses, stem from differences between the countries and cultures in which a disaster occurs. There are two major components of this variability.

First, the level and patterns of economic development vary from country to country. Wealthy countries face disasters with a wealth of human and material resources, a well-developed medical and mental health infrastructure, highly structured emergency planning, and efficient transportation and communication systems. While these are no protection against the direct effects of a disaster, they greatly facilitate responses to disaster. By contrast, poor countries lack these resources.

Second, many characteristics of poorer countries make their people more vulnerable to the effects of a disaster. Substandard housing is more easily destroyed by the high winds of hurricanes and cyclones. The dwellings of the poor, crowded onto flood plains and unstable hillsides, are especially vulnerable to floods. Deforestation destabilizes hillsides and contributes to the devastation of floods. Chronic malnutrition and poor health status reduces resistance to infectious diseases in shelters and refugee camps. Inefficient, understaffed, and unprepared government bureaucracies mismanage relief efforts.

For these reasons, although disasters are no more likely to strike poor countries than rich ones, the poor countries of the world share the overwhelming burden of the human consequences of disaster. Africa and Europe have about the same total population. But from 1992 to 1996, in the relatively wealthy countries of Europe, an average of 2352 people were killed and 54,820 made homeless by disasters each year. During the same period, in the much poorer countries of Africa, an average of 7595 people were killed and 555,858 were made homeless each year. In this manual, we will not assume that extensive pre-existing resources are available. To the extent they are available, the task of response is made simpler and easier, but many of the same underlying principles of response to disaster apply, everywhere in the world.

Cultural variations from one country to another and even within a given country may also alter the course and consequences of disaster. They certainly are important in planning responses to disaster. Communities in areas that are regularly struck by disaster (e.g., villages in flood plains or in areas frequently hit by hurricanes) often evolve traditional ways of understanding and responding to disaster. Patterns of family structure in a community and social divisions along class, ethnic, religious, or racial lines may affect patterns of mutual aid (or of mutual recrimination). Different cultural groups have various beliefs about death and injury and about health and mental health and may respond in unexpected ways to outside medical and mental health professionals. Antagonistic relationships between local communities and central authorities affect the ways in which outside warnings of impending disaster and outside offers of assistance are experienced.

Disasters affect not only individuals, but can tear the fabric of social life in larger communities, even whole countries. They threaten the bonds attaching people to each other and to a sense of community. Because both disaster and responses to disaster affect different social strata differently, they can exacerbate social tensions (or, conversely, may temporarily, at least, draw communities together).

It would be both impossible and inappropriate to give suggestions as to how to respond to every possible variation of these. The ability to engage communities in a process of mutual learning, to allow people to define their own needs, and to respect local beliefs and traditions are as essential as specific mental health skills. Fortunately, *the principles involved in planning interventions appear widely applicable and, with imagination and sensitivity, can be adapted for use in a wide variety of situations.*

Because disasters affect communities and societies, because they affect different countries and different cultures differently, and because many of the psychological effects of disaster are created or affected by the direct social and economic effects of disaster, we will conceptualize both the effects of disaster and appropriate responses to disaster not as purely psychological and not as purely social/economic, but as *psychosocial*.

* * * *

This manual outlines a variety of psychosocial interventions aimed at helping people cope with the emotional effects of disasters. It is intended for use by mental health workers (psychiatrists, psychologists, social workers, and other counselors), by primary medical care workers (doctors, nurses, and other community health providers), by disaster relief workers, by teachers, religious leaders, and community leaders, and by governmental and organizational officials concerned with responses to disasters. It is intended as a field guide or as the basis for brief or extended training programs in how to respond to the psychosocial effects of disasters.

Chapter I of the manual outlines the *effects* of disasters on mental health, including the several stages of responses to disaster. Chapter II focuses on the particular needs of several specific groups of people – children, women, the disabled, the elderly, rescue and relief workers, and those investigating disasters, such as journalists and human rights workers. Chapter III explores issues related to assessing the responses and needs of disaster victims. Chapter IV focuses on the broad *principles* underlying a wide range of psychosocial interventions. Chapter V describes several *specific techniques* for responding to the mental health effects of disaster which have been found helpful in a variety of situations. The Appendices at the end of the manual include a variety of *materials* that may be useful and information on additional *resources*.

In order to keep this manual to a manageable size, I had to make a number of decisions:

1. Throughout the manual, the focus is on short term psychosocial interventions aimed at reducing distress, improving adaptive functioning in the face of the practical and emotional demands created by the disaster, and preventing longer-term disability. The interventions described can be carried out not only by mental health workers, but, with brief training, by teachers, priests, social workers, nurses and other health workers. The manual does not address intensive treatment of established post traumatic stress disorder, depression, and other long term emotional consequences of disasters, which requires more extensive training and/or long term organization of mental health services.

It could be argued that measures to prevent disaster (e.g., early warning of storms), measures to lessen the effects of disaster (e.g., building codes to lessen the likelihood homes will be destroyed), and sustainable economic development are more effective

than psychosocial interventions with individuals or groups as ways of reducing the toll of disasters. I have no argument with this position. Nevertheless, disasters do happen (even when preventive measures, mitigative measures, and sustainable development have occurred). The victims of disaster, in rich and poor countries alike, cannot be ignored in the name of what could have been or should have been.

2. The term “disaster” can be interpreted very broadly to include a wide variety of incidents. At one extreme are individual traumatic events – single episodes affecting only a single person (e.g., a personal assault, a car accident). At the other extreme are mass calamities affecting thousands or even millions of people over a period of many years (e.g., the Chernobyl nuclear plant meltdown, the genocide in Rwanda, the 1999 hurricane and floods in Central America and their aftermath). This manual focuses most directly on the middle part of this range, on what might be called a “typical” disaster: disasters affecting at least a few dozens of people (e.g., a bus accident killing or injuring dozens of people; an apartment fire making a number of families homeless) up through events that are very calamitous indeed but which represent a single episode of disaster (e.g., an earthquake killing tens of thousands of people, a chemical plant explosion killing and injuring thousands). Although the observations and techniques in this manual apply most directly to this “middle level” of disasters, many of them can be applied, with modifications, to the individual traumas and the prolonged and complex humanitarian disasters as well.
3. Since this manual is intended as a practical guide, a list of additional resources is appended instead of a comprehensive set of references. These contain a wealth of additional information as well as reference lists for anyone wishing to pursue particular issues in greater depth.
4. I use a number of terms to indicate the people directly and indirectly affected by the disaster and responding to the disaster. Those who provide rescue services, post disaster medical care, and a wide variety of relief and reconstruction services (including running shelters and refugee camps, distributing food, arranging for communications with loved ones, helping plan rebuilding, and many, many other services) I will call “relief workers,” regardless of their specific roles. I will suggest later in the manual that people providing psychosocial services (i.e., the people at whom this manual is directed) should be called “human service workers,” “community counselors,” or some other term that does not imply that emotional responses to disaster represent mental illness. I will often use the term “disaster counselors” (or simply “counselors”) as a label for this group of people, regardless of their professional specialization (or lack of it) or their precise roles in providing psychosocial assistance. When I discuss interventions to assist survivors, I will refer to the recipients of services as “clients.”

Throughout the manual, I have used the terms “victim” and “survivor” interchangeably to indicate the individuals whose lives the disaster has devastated. Despite my somewhat careless use of the two terms, the distinction made by Lourdes Ladrigo-Ignacio and Antonio P. Perlas, describing the response to a series of earthquakes,

typhoons, and volcanic eruptions in the Philippines in the early 1990s, serves as the underlying theme of this manual:

The most basic issue in psychosocial intervention following disasters is to transform those affected from being victims to survivors. What differentiates a victim from a survivor is that the former feels himself [sic] subject to a situation over which he has no control over his environment or himself, whereas a survivor has regained a sense of control and is able to meet the demands of whatever difficulty confronts him. A victim is passive and dependent upon others; a survivor is not – he is able to take an active role in efforts to help his community and himself recover from the disaster.

CHAPTER I

PSYCHOSOCIAL CONSEQUENCES OF DISASTER

AN OVERVIEW OF THE PSYCHOLOGICAL CONSEQUENCES OF DISASTER

On Thursday, March 5, 1987, two earthquakes occurred in Ecuador, about 85 kilometers from the capital city, Quito. Heavy rains over the preceding weeks had softened the soil in the surrounding area and the earthquake caused massive landslides in the mountainsides. Debris dammed up the rivers, causing flashfloods and destroying villages along the banks and polluting the water supply throughout the region. The main highway linking the region with the rest of Ecuador, as well as the secondary roads were destroyed. The oil pipelines linking the country's main oil fields with ports was shut off, cutting the nation's oil revenue by 50%. Thousands of people were put out of work. Rivers, a primary source of water, transportation, and food, and agricultural land, the source of livelihood for thousands of people, became unusable. Over 70,000 homes, as well as schools, hospitals, and public buildings were leveled. A thousand people were killed and another five thousand made homeless.

* * *

On the night of December 2/3, 1984, the city of Bhopal in central India was covered by a cloud of methyl isocyanate, a poisonous gas which had leaked from a tank at the Union Carbide India Ltd. factory. Around midnight, people downwind of the factory woke up with feelings of suffocation, intense irritation, and vomiting. Panic spread. People ran desperately to escape the gas. Many died on the spot; others fell while running to escape. Still others reached safety only after hours of running. About 300,000 people were exposed to the deadly gas. About 2500 died.

* * *

Hundreds of squatters make their living by picking through the main dump for the ten thousand tons of garbage produced in Manila, the Philippines, each day. On July 17, 2000, after a week of monsoon rains, the huge garbage mountain, fifty feet high and covering more than seventy-four acres, collapsed. Although the complete toll may never be known, at least eight hundred of them died, smothered to death. Complicating the rescue effort were the poisonous fumes emitted by the rotting garbage and the stench of decaying bodies.¹

Imagine yourself and your family the victim of a disaster: an earthquake, a tornado, a flood, an airplane crash in your community, the threatened meltdown of a

¹ The brief accounts of the Ecuador and Bhopal disasters are drawn from articles by L.K. Comfort and by R.S. Murthy in the *International Journal of Mental Health*, 1990. The account of the Manila disaster is from the *New York Times*, July 18, 2000.

nearby nuclear plant, a terrorist attack. What happens to us when we go through a disaster? What do we feel and experience under such circumstances?

Almost instantly, in response to the sights and sounds of the event itself, our hearts pound, our mouths go dry, our muscles tense, our nerves go on alert, we feel intense anxiety or fear or terror. If there has been little or no warning, we may not understand what is happening to us. Shock, a sense of unreality, and fear dominate. Long after the event the sights, sounds, smells, and feelings of the event persist as indelible images in our memories.

As the immediate shock and terror dissipates, longer-term effects appear. The disaster challenges our basic assumptions and beliefs. Most of us, most of the time, believe that our personal world is predictable, benevolent, and meaningful. We assume we can trust in ourselves and in other people and that we can cope with adversity. Disaster destroys these beliefs. We become aware of our vulnerability. We feel helpless and hopeless. We despair in our inability to make decisions and to act in ways that would make any difference to our families and ourselves.

In the wake of the disaster, we grieve for the death of loved ones and we marvel at own survival (and we may feel unworthy or guilty for having survived). We also grieve for our home, for treasured personal memorabilia, for lost documents, lost familiar neighborhoods. If the disaster has disrupted our community's traditional subsistence activities or our community itself, we may feel intense feelings of loss tied to our cultural and social identity, as well. The loss of our personal world, of a sense of safety, of belief in ourselves, in the trustworthiness of others or even in the benevolence of God are not just thoughts; they trigger deep feelings of loss and grief.

In the days and weeks following the disaster, we may experience a wide variety of emotional disturbances. For some, chronic grief, depression, anxiety, or guilt dominate. For others, difficulties controlling anger, suspiciousness, irritability and hostility prevail. Yet others avoid or withdraw from other people. For many, sleep is disturbed by nightmares, the waking hours by flashbacks in which they feel as if the disaster is happening all over again. Not a few begin to abuse drugs or alcohol.

There may be cultural variations in the precise patterns in which disaster-related symptoms appear, but reports from countries as diverse as China, Japan, Sri Lanka, Mexico, Colombia, Armenia, Rwanda, South Africa, the Philippines, Fiji, Bosnia, England, Australia, and the United States, among others, show that the emotional responses to disaster are broadly similar everywhere in the world.

Secondary Traumatization: It is not only those who directly experience the disaster (the "primary" victims) who feel its emotional effects. "Secondary victims" – the families of those directly affected, onlookers and observers, and relief workers (both paid and volunteer) who seek to rescue the primary victims also may experience serious emotional effects. Medical and mental health workers and relief officials who subsequently work with the primary and secondary victims are constantly exposed to the

physical and emotional effects of the disaster on others and may themselves be victims of “vicarious traumatization.” Even those investigating the disaster – journalists, relief organization workers doing needs assessments, human rights workers – may be traumatized.

The “Second Disaster”: The primary source of emotional trauma is, of course, the disaster itself. But the sources of traumatization do not end when the disaster is over (in a literal sense) and when the victims have been rescued. After the disaster comes “the second disaster”-- the effects of the response to the disaster.

The rapid influx of well-meaning helpers, who must be fed and sheltered, adds to the confusion and the competition for scarce resources. In some instances, poor people from outside the disaster area have flooded into a disaster area seeking their own share of the food and other supplies relief agencies are providing to disaster victims. This still further increases the burden on disaster workers and on the already stricken community.

Those forced to take refuge in a shelter or a refugee camp for shorter or longer periods of time are forced to confront the consequences of the disaster in an ongoing, unrelenting way. To personal and material losses, we now add loss of privacy, loss of community, loss of independence, loss of familiarity with the environment, and loss of certainty with respect to the future. Family roles and ordinary work roles are disrupted. Poor sanitation, inadequate shelter, and contaminated water and food may produce epidemics, with widespread illness and death resulting. In the shelter, personal assaults and rapes may endanger women, the elderly, and other vulnerable people.

As the weeks and months go by, anger at the slowness of reconstruction or at corruption that prevents relief supplies from getting to victims may add to distress. In some instances, such as Nicaragua after the 1972 earthquake and Mexico after the 1985 earthquake, such dissatisfaction produced widespread political unrest.

Delayed Effects of Disaster: Some emotional effects of the disaster may not appear until after a considerable delay. For some victims, initial relief at having been rescued and initial optimism about the prospects of recovery may produce a “honeymoon stage.” Over a period of months or even years, this may give way to a realization that personal and material losses are irreversible. Loved ones who died will not return. Disruptions in the family are permanent. Old jobs will not reappear. A long-term reduction in standard of living has occurred. Depression and anxiety may now appear for the first time in some victims, and the suicide rate may actually rise.

Other victims of disaster appear initially to be “doing well.” This may be illusory, however. To protect themselves, they may suppress or inhibit the processing of the impact of the disaster upon them. After a delay (considerable at times), stimuli associated with the disaster may trigger memories, pulling previously suppressed material back into consciousness. As a result, psychological responses to the disaster may “suddenly” appear, months or even years afterward.

The Prevalence of Adverse Psychological Effects Following Disaster

Although the precise figures vary from situation to situation, up to ninety per cent or even more of victims can be expected to exhibit at least some untoward psychological effects in the hours immediately following a disaster. In most instances, symptoms gradually subside over the weeks following. By twelve weeks after the disaster, however, twenty to fifty per cent or even more may still show significant signs of distress. The number showing symptoms generally continues to drop, but delayed responses and responses to the later consequences of disaster continue to appear. *While most victims of disasters are usually relatively free of distress by a year or two after the event, a quarter or more of the victims may still show significant symptoms while others, who had previously been free of symptoms, may first show distress a year or two after the disaster.* Anniversaries of the disaster may be especially difficult times for many survivors, with temporary but unexpected reappearance of symptoms which they had thought were safely in the past. Reports of widespread emotional distress ten years and more after disasters such as the 1972 flood at Buffalo Creek (USA) and internment in Nazi concentration camps have been well substantiated.

The extraordinary prevalence of such strong physiological, cognitive, and emotional responses to disasters indicates that these are *normal* responses to an *extreme situation*, not a sign of “mental illness” or of “moral weakness.” Nevertheless, the symptoms experienced by many victims in the days and weeks following a disaster are a source of significant distress and may interfere with their ability to reconstruct their lives. If not addressed and resolved relatively quickly, such reactions can become ongoing sources of distress and dysfunction, with devastating effects for the individual, their family, and their society.

Factors Affecting Vulnerability to Adverse Psychological Effects

Not everyone is equally affected by a disaster, and not all disasters are equally devastating in psychological terms. Several factors may increase the risk of adverse psychological consequences:

- The more severe the disaster and the more terrifying or extreme the experiences of the individual, the greater the likelihood widespread and lasting psychological effects. In extreme cases (e.g., the Nazi concentration camps, the Rwandan genocide, the Cambodian “killing fields”), virtually everybody exposed to the traumatic events suffers lasting effects.
- Some types of disaster may be more likely to produce adverse effects than others. In general, the psychological consequences of disasters which are intentionally inflicted by others (e.g., assaults, terrorist attack, war) are likely to be greater than those of disasters which may have been produced by human activities but which are unintentional (e.g., airplane crashes, industrial explosions). These in turn have a greater likelihood of producing adverse effects than purely natural disasters (e.g., hurricanes, tornadoes).

- Women (especially mothers of young children), children aged five to ten, and people with a prior history of mental illness or poor social adjustment appear to be more vulnerable than other groups. (See Chapter II for an extended discussion of the impact of disaster on women, children, and several other specific groups). Those with a prior personal experience of trauma, whether individual (e.g., rape) or collective (e.g., earthquake, genocide) are also usually more vulnerable.
- Several specific kinds of disaster experience are especially traumatic. These include witnessing the death of a loved one, losing an adolescent or young adult child, being entombed or trapped or seriously injured as a result of the disaster, and being seriously injured or hospitalized as a result of the disaster.
- In addition to the “psychological” effects of disasters, some of the *physical* effects (e.g., head injuries, burns, crush injuries, exposure to toxins, prolonged pain) can directly produce, through physiological processes, adverse psychological effects such as difficulty concentrating, memory difficulties, depression, and emotional instability.
- Refugees from war, political oppression, or political violence are also at high risk of adverse effects. In addition to the effect of the events that may have driven them from their homes, negative experiences in shelters and refugee camps (e.g., malnutrition, widespread infectious disease, rape and other physical assaults) may themselves produce adverse psychological effects and psychological disorders.
- “Stigmatization” of the victims of a disaster makes healing more difficult. One unfortunately common situation in which this occurs is when part of the traumatizing experience has been rape. In many modern wars, rape has been used as a weapon of war. Rape is also a major hazard for women in refugee camps. Victims may be unable to tell their families and friends what happened, for fear of being blamed or even punished.
- Conversely, the availability of social support networks – supportive families, friends, and communities – reduces the likelihood of lasting adverse effects. And those who have successfully coped with trauma in the past may withstand subsequent disasters better, as if they had been “inoculated” against stress. For a minority of victims, the challenge of disaster may actually be positive and may lead to increased ability to deal with future life challenges.
- The more severe the disaster, the less the characteristics of individuals matter. In very severe disasters, virtually everybody shows adverse emotional responses. In relatively mild disasters, differences in vulnerability of different individuals may be of greater importance.

THE STAGES OF PSYCHOLOGICAL RESPONSE TO DISASTERS

It is customary to conceptualize the aftermath of disaster in terms of a series of stages or phases, each of which has its own characteristics. The phases, we hasten to say, are not rigid. There is much variation at each stage and the stages overlap.

The “Rescue” Stage

In the first hours or days after the disaster, most relief activity is focused on rescuing victims and seeking to stabilize the situation. Victims must be housed, clothed, given medical attention, provided with food and water.

During the rescue stage, various types of emotional response may be seen. Victims may shift from one kind of response to another or may not show a “typical” response of any evident response at all.

- **Psychic “numbing”:** Victims may seem stunned, dazed, confused, apathetic. Superficial calmness is followed by denial or attempts to isolate themselves. Victims may report feelings of unreality: “This is not happening.” They may respond to helpers in a passive, docile way, or may be rebellious and antagonistic as they try to regain a sense of personal control. There may be an automaton-like carrying on of daily activities. This response pattern is usually transient and may be followed by (or preceded by) heightened arousal (see below).
- **Heightened arousal:** Victims may experience intense feelings of fear, accompanied by physiological arousal: heart pounding, muscle tension, muscular pains, gastrointestinal disturbances. They may engage in excessive activity and may express a variety of rational or irrational fears. This response pattern is likely to be transient and may be followed by (or preceded by) psychic numbing (see above).
- **Diffuse anxiety:** Victims may show diffuse signs of anxiety: an exaggerated startle response, inability to relax, inability to make decisions. They may express feelings of abandonment, anxiety about separation from loved ones, a loss of a sense of safety, and yearning for relief.
- **Survivor guilt:** Victims may blame themselves or feel shame at having survived, when others didn’t. There may be a pre-occupation with thoughts about the disaster and rumination over their own activities: Could they have acted differently? They may feel responsible for the unfortunate fate of others.
- **Conflicts over nurturance:** Victims may be dependent on others, yet suspicious, and may feel no one can understand what they have been through. Some victims may feel a need to distance themselves emotionally from others and to keep a “stiff upper lip;” they may be irritable in the face of sympathy. Others may feel a strong desire to be with others at all times.

- **Ambivalence:** Some victims may show ambivalence about learning what happened to their families or possessions.
- **Affective and cognitive instability:** Some victims may show sudden anger and aggressiveness, or, conversely, apathy and lack of energy and ability to mobilize themselves. They may be forgetful or cry easily. Feelings of vulnerability and illusions about what happened are common.
- Occasionally, victims appear in an acutely confusional state. Hysterical reactions and psychotic symptoms such as delusions, hallucinations, disorganized speech, and grossly disorganized behavior may also appear. These may be isolated and very short lived or may constitute a “Brief Reactive Psychosis.”
- Most victims act appropriately, to protect themselves and their loved ones. In most disasters, despite mythology to the contrary, victims show little panic and may engage in heroic or altruistic acts.

Many of these behaviors have an adaptive quality. The behaviors of the majority of those affected by disaster, even when they seem abnormally intense or entirely unfamiliar, should be understood as normal reactions to abnormal or devastating conditions or events. They ensure short term survival and permit the victim to take in information at a controllable rate. But the symptoms themselves may be perceived by the victims as socially inappropriate, as a source of shame, guilt, and failure, as an evidence of inadequacy. Caregivers and rescue workers, in turn, may respond with irritation or withdrawal from the victims.

The “Inventory” Stage

Once the situation has been stabilized, attention turns to longer-term solutions. Heroic rescue efforts give way to bureaucratized forms of help. Over the next year or eighteen months, organized assistance from outside gradually diminishes and the reality of their losses dawn on victims.

In the first weeks after the disaster, victims may go through a “honeymoon” phase, characterized by relief at being safe and optimism about the future. But in the weeks that follow, they must make a more realistic appraisal of the lasting consequences of the disaster. Disillusionment may set in. The effects of the “second disaster” are felt.

During this phase, any of a wide variety of post-traumatic symptoms appear. Any of these symptoms may appear in isolation, but frequently victims show a number of these symptoms. Several distinct clusters of symptoms are common. Several of these -- “Post Traumatic Stress Disorder,” “Generalized Anxiety Disorder,” “Abnormal Bereavement,” “Post Traumatic Depression” -- deserve special attention. In addition, many patterns restricted to particular cultures may appear.

Post-traumatic Symptoms

- grief, mourning, depression, despair, hopelessness
- anxiety, nervousness, being frightened easily, worrying
- disorientation, confusion
- rigidity and obsessiveness, or vacillation and ambivalence
- feelings of helplessness and vulnerability
- dependency, clinging; or, alternately, social withdrawal
- suspiciousness, hypervigilance, fear of harm, paranoia
- sleep disturbances: insomnia, bad dreams, nightmares
- irritability, hostility, anger
- moodiness, sudden outbursts of emotion
- restlessness
- difficulties concentrating; memory loss
- somatic complaints: headaches, gastrointestinal symptoms, sweats and chills, tremors, fatigue, hair loss, changes in menstrual cycle, loss of sexual desire, changes in hearing or vision, diffuse muscular pain
- intrusive thoughts: flashbacks, feeling one is “re-living” the experience, often accompanied by anxiety
- avoidance of thoughts about the disaster and avoidance of places, pictures, sounds reminding the victim of the disaster; avoidance of discussion about it
- problems in interpersonal functioning; increased marital conflict
- increased drug and alcohol use
- cognitive complaints: difficulty concentrating, remembering; slowness of thinking;
- difficulty making decisions and planning
- feeling isolated, abandoned
- “dissociative” experiences: feelings of being detached from one’s body or from one’s experiences, as if they are not happening to you; feeling things seem “unreal;” feeling as if one is “living in a dream”
- feelings of ineffectiveness, shame, despair
- self-destructive and impulsive behavior
- suicidal ideation or attempts
- the “death imprint”: pre-occupation with images of death

Post Traumatic Stress Disorder: The characteristic symptoms of Post Traumatic Stress Disorder include:

- (a) Persistent re-experiencing of the traumatic event: recurrent and intrusive recollections of the events of the disaster; recurrent distressing dreams in which the disaster is replayed; intense psychological distress or physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of

the traumatic event; or experiences in which the victim acts or feels as if the event is actually re-occurring. (in children, repetitive play in which themes or aspects of the trauma are expressed may occur; trauma-specific re-enactments of the events may take place, and there may be frightening dreams without recognizable content).

(b) Persistent avoidance of stimuli associated with the trauma and continued numbing of general responsiveness: efforts to avoid thoughts or feelings or conversations about the disaster; efforts to avoid activities, places, or people that remind the victim of the trauma; inability to recall important parts of the disaster experience; markedly diminished interest or participation in significant activities; feelings of detachment or estrangement from others; restricted range of affect; or a sense of a foreshortened future, without expectations of a normal life span or life.

(c) Persistent symptoms of increased arousal: difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; exaggerated startle response.

This general cluster of symptoms has been reported in every part of the world. In less industrialized parts of the world and among people coming from these areas, the avoidance and numbing symptoms have been reported to be less common and dissociative and trance-like states, in which components of the event are relived and the person behaves as though experiencing the events at that moment, may be more common.

Generalized Anxiety Disorder: The characteristic symptoms of Generalized Anxiety Disorder include:

(a) Persistent and excessive anxiety and worry about a variety of events or activities (not exclusively about the disaster and its consequences

(b) The person finds it difficult to control the worry and the worry is far out of proportion to reality. It interferes with attention to tasks at hand.

(c) The anxiety and worry are associated with symptoms such as restlessness or feeling on edge; being easily fatigued; difficulty concentrating or the mind going blank; irritability; muscle tension; and difficulty falling asleep or staying asleep

Although individuals with Generalized Anxiety Disorder may not always identify their worries as “excessive,” they report subjective distress due to their constant worry and it may affect them in social, occupational, marital, or other areas of function. Somatic symptoms (e.g., cold clammy hands, dry mouth, nausea or diarrhea, urinary frequency) and depressive symptoms are also commonly present.

There is considerable cultural variation in how anxiety is expressed. In some cultures, it may be expressed more through somatic symptoms, in others through cognitive

symptoms. Children may reveal their anxieties through concern about their competence, (e.g., at school), excessive concerns about punctuality, over-zealousness in seeking approval, and a conforming, perfectionistic personal style.

Abnormal Bereavement: Normally, after the death of a loved one, a sequence of stages of bereavement are expected. Often the first response is disbelief and denial. Feelings of numbness may give respite and allow the realization to seep in slowly. Then, as we begin to realize the reality and significance of the loss, feeling of distress, yearning for the lost person, anger at the loss, and anxiety at one's ability to cope without them may appear. A period of mourning ensues, as we review our memories of the lost loved one, and then gradually let go of the psychological bonds and free ourselves for life without the departed person. All cultures have rituals that, however much they vary, seem intended to facilitate this process.

Trauma may interfere with the ability to go through this process normally, however. The victim's own injuries, the loss of social supports and familiar communities, survivor guilt, and the victim's own psychological trauma may interfere with both expected rituals and internal grieving processes. Memories of the deceased may trigger the victim's own memories of the disaster. Post-traumatic rumination may block the victim from confronting the memories and thoughts that are central to grieving. Post-traumatic numbing may interfere with the victim's engaging in supportive social interactions.

There may be other, practical obstacles to saying goodbye, as well. For instance, legal processes may delay funeral proceedings or concerns about the bereaved seeing the body of the deceased due to injuries it may have sustained in the disaster may lead to the bereaved not having the opportunity to view the body. Most studies have indicated that not seeing the body of the deceased may contribute to abnormal bereavement and that seeing the body, even when it is disfigured, is not inherently damaging. Few victims who have been allowed to see the remains and have accepted the offer regret doing so.

These psychological and practical obstacles to a "normal" response to the death of a loved one may contribute to a feeling of lack of closure or permit magical fantasies that the deceased person has not, in fact, died. Any of several abnormal bereavement syndromes may appear. *(Note: Different cultures vary widely with respect to what is "expected" after the death of a loved one. Among some peoples, open expression of emotion is frowned upon. Among others, public displays of emotion are expected and lack of overtly expressed emotion is suspect. In some cultures, people are expected to publicly grieve only briefly and then to return to normal activities. In others, a prolonged grieving period is expected. Evaluation of the significance of the following patterns depends on an awareness of what the cultural norms are in the particular culture).*

- (a) Inhibited grief: The bereaved exhibits a pattern characterized by psychic numbing, over-control and containment of emotions, little display of affect. They may be seen as "coping well," yet this pattern is associated with later depression and anxiety.

(b) Distorted grief: The bereaved shows intense anger and hostility which dominate over their sadness and guilt. This anger may be directed at anyone the bereaved associates with the deceased's death (e.g., relief workers).

(c) Chronic grief: The feelings of sadness and loss do not dissipate. Frequent crying, pre-occupation with the loss are unremitting.

d) Depression: The bereaved lapses into depression, with prolonged grief, despair, and a sense that life is not worth continuing. Sleep and appetite disturbances may appear. The bereaved may have active fantasies of being reunited with the deceased and suicidal ideation or attempts may occur.

(e) Excessive guilt: The bereaved may show excessive self-recrimination and guilty pre-occupations, which eclipse their sadness. Self destructive, yet not overtly suicidal behaviors, such as frequent accidents or excessive drinking may occur.

Post Traumatic Depression: Protracted depression is one of the most common findings in studies of acutely or chronically traumatized people. It often occurs in combination with Post Traumatic Stress Disorder. Trauma can produce or exacerbate already existing depression.

Common symptoms of depression include sadness, slowness of movement, insomnia (or hypersomnia), fatigue or loss of energy, diminished appetite (or excessive appetite), difficulties with concentration, apathy and feelings of helplessness, anhedonia (markedly diminished interest or pleasure in life activities), social withdrawal, guilty ruminations, feelings of hopelessness, abandonment, and irrevocable life change, preoccupations with loss, and irritability. In some cases, the person may deny being sad or may complain, instead, of feeling "blah" or having "no feelings." Some individuals report somatic complaints, including widespread aches and pains, rather than sadness. Suicidal ideation or attempts may appear. With children, somatic complaints, irritability, social withdrawal are particularly common.

In some cultures, depression may be experienced largely in somatic terms, rather than in the form of sadness or guilt. Complaints of "nerves", headaches, generalized chronic pain, weakness, tiredness, "imbalance," problems of the "heart," feelings of "heat," or concerns about being hexed or bewitched may appear.

Culture-specific disorders: The boundaries between anxiety, depression, dissociation, and emotional disorders that have predominantly somatic symptoms are very porous. Victims often have symptoms running across these categories. In many societies and cultural groups, traditional patterns of expression of emotional distress take the form of combinations of symptoms that have no exact equivalent in standard international categories of mental illness. The intermediate term response to disaster may take the form of one of these "culture-specific disorders." These may include, for example, *susto* and

ataques de nervios (Latin America and the Caribbean), *amok* (the South Pacific), *dhat* (India), *latah* (Southeast Asia and the South Pacific), and *khoucheraug* (Cambodia).²

In many parts of the world, the conventional idiom for expressing emotion may be somatic (e.g., chronic fatigue, generalized aches and pains, gastrointestinal disturbances, feelings of “heat”) or fears of somatic illness (e.g. hypochondriasis, fears of infection). In some cultural groups, the distress of a disaster may also take the form of a “trance disorder.” A “trance” is a temporary, marked alteration in the state of consciousness or a loss of the customary sense of personal identity, associated with either stereotyped behaviors or movements that are experienced as beyond one’s control or by a narrowing of awareness of one’s immediate surroundings.

The “Reconstruction” stage

A year or more after the disaster, the focus shifts again. A new, stable pattern of life may have emerged. In any event, the distinction between disaster relief and the larger pattern of national social and economic development begins to diminish and eventually disappears.

During this phase, although many victims may have recovered on their own, a substantial number continue to show symptoms much like those of the preceding (“inventory”) stage. A significant number who were not symptomatic earlier may now exhibit serious symptoms of anxiety and depression, as the reality and permanence of their losses becomes evident. The risk of suicide may actually increase at this time. Other characteristic late-appearing symptoms include chronic fatigue, chronic gastrointestinal symptoms, inability to work, loss of interest in daily activities, and difficulty thinking clearly.

The notion of “post traumatic stress disorder” described earlier derives mainly from observations of the symptoms of survivors of relatively circumscribed traumatic events. A number of studies suggest that more complex syndromes may appear in survivors of prolonged, repeated, intense trauma, such as those who have been held

² *Susto* is prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, lack of motivation, feelings of low self-worth, and somatic symptoms. *Ataques de nervios* is recognized among many Latin American, Latin Mediterranean, and Caribbean Latinos. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, verbal and physical aggression, a sense of being out of control, and sometimes dissociative experiences, seizure-like or fainting episodes, and suicidal gestures. *Amok* is recognized in Malaysia and, under varying names, in the Philippines, Puerto Rico, and elsewhere. It is described as a dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects, ending with exhaustion. *Dhat* is a term used in India to describe a syndrome of severe anxiety, headaches and body aches, loss of appetite, hypochondriacal concerns associated with the discharge of semen, and feelings of weakness and exhaustion. *Latah*, found under various names in the South Pacific and Southeast Asia, involves hypersensitivity to sudden fright, often with an apparently senseless and automatic repetition of the words or actions of others and dissociative or trance-like behavior. *Khoucheraug*, found in Cambodia, includes excessive worry and rumination over past events.

hostage, who have been repeatedly tortured or exposed to chronic personal physical or sexual abuse, who have been interned in a concentration camp, or who have lived for months or years in a society in a chronic state of civil war.

Among victims of such disasters, a “survivor syndrome” may appear. People showing this syndrome have been described as walking though life “without a spark.” Chronic depression, anxiety, and survivor guilt appear, or, alternately, chronic aggression and an “addiction to hate.” Social withdrawal, sleep disturbances, somatic complaints, chronic fatigue, emotional lability, loss of initiative, and general social, personal, and sexual maladaptatian are present. The “joy of life” is gone, replaced by a “pervasive pattern of sluggish despair.” Relationships with spouses and children are disturbed, often creating significant disturbances in later generations.

Other victims of prolonged or repeated and severe traumas have been described as exhibiting “complex post-traumatic stress disorder.” Symptoms of “complex post-traumatic stress disorder” include:

- difficulties in regulating affect (e.g., persistent depression, suicidal preoccupation, self-injury, explosive anger)
- alternations in self perception (e.g., shame, guilt, sense of defilement, a sense of difference from others or helplessness)
- alterations in consciousness (e.g., amnesia, transient dissociative states, intrusive thoughts, ruminative preoccupations)
- difficulties in relations with others (e.g., isolation, disruption in intimate relationships, persistent distrust)
- disruptions in systems of meaning (e.g., loss of faith, a sense of hopelessness and despair)
- alterations in perceptions of the perpetrator of the atrocities (e.g., a preoccupation with revenge, unrealistic attributions of total power to the perpetrator, or, paradoxically, gratitude toward the perpetrator).

COMMUNITY AND SOCIAL IMPACTS OF DISASTERS

Disasters directly affect their individual victims. But beyond that disasters create tears in the tissue of social life. Sometimes this is direct and total, as when, as a result of disaster, people are forced to leave their land and migrate elsewhere. In other cases, the rapid influx of helpers, the presence of government officials, press, and other outsiders (including mere curiosity seekers), the flood of poor people from outside the disaster area into a disaster area seeking their own share of the food and other supplies relief agencies are providing to disaster victims, combine to further disrupt the community.

Even when the formal structure of a community is maintained, the disaster can disrupt the bonds holding people together, in families, communities, work groups, and whole societies. When those bonds are destroyed, the individuals comprising the affected groups lose friends, neighbors, a community, a social identity. These collective effects of

disaster may ultimately be as devastating as the individual effects. The consequences of disaster for families, neighborhoods, communities, and societies are many:

Family dynamics may be altered. Disaster-produced deaths or disabilities, family separations, and dependency on aid givers may undercut the authority of the traditional breadwinners, supplant traditional activities in the home, and force people out of traditional roles or into new ones. Symptoms of individual family members affect their interactions with other family members. The intimate penetration of a community by outsiders may upset or challenge traditional child rearing practices and traditional patterns of male-female relationships. In the wake of disaster, marital conflict and distress rises; increases in the divorce rate in the months following disasters may occur. Parent-child conflicts also increase. Increases in intra-family violence (child abuse, spouse abuse) have been reported.

Disasters may physically destroy important community institutions, such as schools and churches, or may disrupt their functioning due to the direct effects of the disaster on people responsible for these institutions, such as teachers or priests. Traditional patterns of authority are disrupted along with customary social controls on individual behavior. Several studies have shown an increase in the rates of community violence, aggression, drug and alcohol abuse, and rate of legal convictions in the wake of disaster.

Disasters disrupt the ability of communities to carry out customary or traditional activities central to people's individual, community, and social identity, ranging from work and recreational activities to accustomed rituals. Some of these disruptions are temporary, but others are hard to reverse. For example, a flood may permanently damage farm land, making a return to traditional farming untenable, or an oil spill off the coast may permanently alter traditional fishing grounds. With people forced away from their homes and land for shorter or longer periods and with personal and community records lost due to a disaster, opportunities appear for looting. This may be limited to personal possessions or may lead to permanent loss of tools, animals, and land. The community whose members can no longer farm their traditional land, carry out traditional craft production activities, or hunt or fish in traditional ways is disrupted and its sense of identity attacked.

Disasters place a strain on traditional community social roles, patterns of social status, and leadership. Police, local housing agencies, local health facilities are overwhelmed and face a new task of integrating their work with that of volunteers, often from outside the community. There may be anger at inequities in the distribution of post-disaster aid. These inequities may exacerbate the gap between rich and poor. Outside aid agencies may threaten the traditional roles of local agencies and institutions. Outside experts may pose a threat to local professionals. In the wake of disaster, new leaders may emerge in a community, due to the role of these people in responding to the disaster. Conflicts between these new leaders and traditional community leaders may appear.

Outside assistance may be necessary in the wake of a disaster, but it can also promote a sense of community dependency. Insofar as the necessities of life are supplied from outside, incentives to resume traditional work activities are reduced. This is not just a matter of psychological “dependency.” Provision of food and other supplies may compete with local production, disrupting traditional pricing and wages and damaging attempts to recreate the old productive patterns. Added to this, the disaster itself may have destroyed the tools, workshops, animals, or other necessities of production.

Disaster may lead, directly or indirectly, to permanent changes in productive patterns, especially patterns of land ownership and use. Shifts from subsistence agriculture to wage labor, land looting, migration and uprooting and resettlement play a role.

Schisms may appear in a community, as cohesion is lost. One danger is that of scapegoating, either of individuals or using traditional divisions in the community (e.g., along religious or ethnic lines).

In communities with a history of past disaster, whether naturally caused or man-made, the trauma produced by a new disaster may re-arouse old feelings. Memories of genocide, civil war, social oppression, or racial or ethnic division and of the feelings they produced, and feelings of marginalization and helplessness may be exacerbated.

In some communities that have had to deal with repeated natural disasters such as flooding, on a more or less regular basis, disaster and the response to it may be integrated into community rituals and belief systems, as well as into community structure and people may ascribe cultural meaning to disasters. Communities may have traditional rituals for dealing with the effects of disaster. Not only the disaster, but outside intervention may interfere with these traditional rituals, responses, and attributions of meaning and may be experienced as an ambiguous blessing or even as a source of additional stress.

Disasters have impacts on individuals, families and communities. These are not distinct, separable effects. The devastating effects of disaster on the individuals making up a family or a community play a major role in creating the family and community effects. Even more important, social support systems play an extremely important role in protecting individuals from the impact of the disaster and from the impact of stress in general. Social disruption both reduces and interferes with the healing effects of the family and the community and is itself an enormous source of stress on the individuals who make up the family or community. Disruption of the family or community may be more psychologically devastating, both in the short run and especially in the long run, than the disaster itself.

CHAPTER II

EFFECTS OF DISASTER ON SPECIFIC GROUPS

Disasters do not affect everyone in the same way. At an individual level, some may experience a disaster with few or no psychological consequences, while others will go through the same disaster and be emotionally devastated. Beyond individual variation, certain *categories* of people are especially vulnerable or vulnerable in specific ways.

People's responses to emergencies are grounded in their on-going relationships with their community. Differences in power or access to power and different pre-disaster stressors and pre-disaster social roles affect how individuals experience a disaster. In general, those with the least power and resources are most exposed to the adverse effects of the disaster and its aftermath and have a harder time recovering from it. Pre-disaster high levels of stress, lack of resources, lack of information, lack of access to power, lack of access to transportation, lack of marketable skills, lack of literacy, all take their toll.

For example, structural changes in the world economy have adversely affected women in many societies, reducing their standard of living, undermining their household-based security, and intensifying their load of paid and/or unpaid work. For impoverished, uprooted peasants, urbanization may mean less substantial housing, relocation to more environmentally dangerous locales (e.g., flood plains, mudslide-prone hillsides), and exposure to toxic materials. Ethnic tensions, manageable before a disaster, may become the source of scapegoating and acute ethnic conflict in the wake of disaster. To the degree that inequality in the impact of disaster is rooted in the unresolved dilemmas of global political, economic, and social development, issues of social justice and sustainable development can be understood as disaster preparedness and response issues.

In this chapter, we focus on practical issues specific to each of several groups – their health care needs, legal rights, compensation issues, employment and self-employment issues, and the like, as well as psychological issues. This discussion should not be understood in too rigid a fashion. Not everyone in a given category has the experiences described, and an individual may fall into more than one group (e.g., be female *and* aged). They are intended to alert the reader to some issues that *may* apply. Goals, experience, and needs must be assessed on an individual basis.

CHILDREN

Two myths are potential barriers to recognizing children's responses to disaster and must be rejected: (1) that children are innately resilient and will recover rapidly, even from severe trauma; and (2) that children, especially young children, are not affected by disaster unless they are disturbed by their parents' responses. Both of these beliefs are false. A wealth of evidence indicates that children experience the effects of disaster doubly. Even very young children are directly affected by experiences of death,

destruction, terror, personal physical assault, and by experiencing the absence or powerlessness of their parents. They are also indirectly affected through identification with the effects of the disaster on their parents and other trusted adults (such as teachers) and by their parents' reactions to the disaster.

Another barrier to recognizing children's responses to disaster is the tendency of parents to misinterpret their children's reactions. To parents who are already under stress, a child's withdrawal, regression, or misconduct may be understood as willful. Or, parents may not wish to be reminded of their own trauma or, seeking some small evidences that their life is again back in control, may have a need to see everything as "all right." In either case, they may ignore or deny evidence of their children's distress. The child, in turn, may feel ignored, not validated, not nurtured. This may have long term consequences for the child's development. In the short run, feeling insecure, the child may inhibit expression of his or her own feelings, lest he or she distress and drive away the parents even more.

Most children respond sensibly and appropriately to disaster, especially if they experience the protection, support, and stability of their parents and other trusted adults. However, like adults, they may respond to disaster with a wide range of symptoms. Their responses are generally similar to those of adults, although they may appear in more direct, less disguised form.

Among pre-school children (ages 1-5), anxiety symptoms may appear in generalized form as fears about separation, fears of strangers, fears of "monsters" or animals, or sleep disturbances. The child may also avoid specific situations or environments, which may or may not have obvious links to the disaster. The child may appear pre-occupied with words or symbols that may or may not be associated with the disaster in obvious ways or may engage in compulsively repetitive play which represents part of the disaster experience. The child may show a limited expression of emotion or a constricted pattern of play may appear. He or she may withdraw socially or may lose previously acquired developmental skills (e.g., toilet training).

Older children (ages 6-11 or so) may engage in repetitious play in which the child reenacts parts of the disaster or in repeated retelling of the story of the disaster. The child may express (openly or subtly) concerns about safety and preoccupation with danger. Sleep disturbances, irritability, or aggressive behavior and angry outbursts may appear. The child may pay close attention to his or her parents' worries or seem to worry excessively about family members and friends. School avoidance (possibly in the form of somatic symptoms) may appear. The child may show separation anxiety with primary caretakers, "magical" explanations to fill in gaps in understanding, and other behaviors usually characteristic of much younger children. Other changes in behavior, mood, and personality, obvious anxiety and fearfulness, withdrawal, loss of interest in activities, and "spacey" or distractible behavior may appear.

As children approach adolescence, their responses become increasingly like adult responses. Greater levels of aggressive behaviors, defiance of parents, delinquency,

substance abuse, and risk-taking behaviors may be evident. School performance may decline. Wishes for revenge may be expressed. Adolescents are especially unlikely to seek out counseling.

Children of all ages are strongly affected by the responses of their parents or other caretakers to disaster. Children are especially vulnerable to feeling abandoned when they are separated from or lose their parents. “Protecting” children by sending them away from the scene of the disaster, thus separating them from their loved ones, adds the trauma of separation to the trauma of disaster.

Symptoms Shown by School-Aged Children

- depression
- withdrawal
- generalized fear, including nightmares, highly specific phobias of stimuli associated with the disaster
- defiance
- aggressiveness, “acting out”
- resentfulness, suspiciousness, irritability
- disorganized, “agitated” behavior
- somatic complaints: headaches, gastrointestinal disturbances, general aches and pains. These may be revealed by a pattern of repeated school absences.
- difficulties with concentration
- intrusive memories and thoughts and sensations, which may be especially likely to appear when the child is bored or at rest or when falling asleep
- repetitive dreams
- loss of a sense of control and of responsibility
- loss of a sense of a future
- loss of a sense of individuality and identity
- loss of a sense of reasonable expectations with respect to interpersonal interactions
- loss of a realistic sense of when he or she is vulnerable or in danger
- feelings of shame
- ritual re-enactments of aspects of the disaster in play or drawing or story telling. In part, this can be understood as an attempt at mastery. Drawings may have images of trauma and bizarre expressions of unconscious imagery, with many elaborations and repetitions.
- Kinesthetic (bodily) re-enactments of aspects of the disaster; repetitive gestures or responses to stress reenacting those of the disaster
- omen formation: the child comes to believe that certain “signs” preceding the disaster were warnings and that he or she should be alert for future signs of disaster
- regression: bed wetting, soiling, clinging, heightened separation anxiety.
- Post Traumatic Stress Disorder syndromes much like those of adults, although possibly with less amnesia, avoidance, and numbing evident.

For an adult, although the effects of disaster may be profound and lasting, they take place in an already formed personality. For children, the effects are magnified by the fact that the child's personality is still developing. The child has to construct his or her identity within a framework of the psychological damage done by the disaster. When the symptoms produced by disaster are not treated, or when the disaster is ongoing, either because of the destruction wrought (e.g., by an earthquake) or because the source of trauma is itself chronic (e.g., war or relocation to a refugee camp), the consequences are even more grave. The child grows up with fear and anxiety, with the experience of destruction or cruelty or violence, with separations from home and family. Childhood itself, with its normal play, love, and affection, is lost. Longer-term responses of children who have been chronically traumatized may include a defensive desensitization. They seem cold, insensitive, lacking in emotion in daily life. Violence may come to be seen as the norm, legitimate. A sense of a meaningful future is lost.

WOMEN

Women's roles and experiences create special vulnerability in the face of disaster. In poorer countries, women are more likely to die in disasters than men are. In richer countries, as well, women often show higher rates of post disaster psychological distress – depression, PTSD, and anxiety. Several aspects of women's experience of disaster may contribute to these results:

Women are often assigned the role of family caregivers. As such, they must stay with and assist other family members. This may affect their willingness to leave their homes when a disaster (such as a storm) threatens. While their own threshold for leaving may actually be lower than men's, their actual willingness to go may depend on their being able to leave with their children.

Women may be more isolated and home-bound, due to their traditional roles and occupations. As a result, they may have less access to information (both before a disaster and after). They may also be more vulnerable to the physical effects of a disaster on their house itself, both with respect to their physical safety and to the integrity of their work areas.

In the aftermath of disaster, women may face another threat: violence. This threat may take several forms. Within the immediate family, disaster may initially lead all members of the family to unite in their efforts to deal with the crisis. Over the course of weeks or months, however, the continued strain may be divisive. As family stress mounts, women may become more exposed to physical or emotional abuse from their spouse. Other women, who have previously fled their marriage to avoid beatings, may be inadvertently re-exposed to their abusers (e.g., in shelters). Women may also be exposed to rape and other forms of violence in shelters or refugee camps. In war situations, women and girls may be specifically targeted.

Post-disaster, women often get less assistance. Their husband, as "head" of the household, often becomes the conduit for assistance to the family, which may or may not

be equitably shared within the family. In some instances of food shortage, women have been given the lowest priority for getting a portion of what food is available. Discrimination with respect to food and medical attention in shelters has also been a problem in some instances. Health care facilities in shelters and refugee camps often do not attend to women's needs with regard to reproductive health, and providing for relief of other sources of strain on women, such as responsibilities for childcare, often get a low priority.

In the aftermath of disaster, women who have been widowed by the disaster may find it harder to remarry than men. Lacking skills that are saleable in the paid job market, they may be left destitute. Alternately, husbands may leave the disaster community, seeking paid work elsewhere, leaving their wives more dependent on outside assistance and more isolated.

The experience of women in disaster, it should be emphasized, can create opportunities for women, as well. Women may have better social networks and hence, more social support than men. They may emerge as the leaders of grass-roots level organizations. They may be able to use disaster aid to develop skills and acquire tools and take on non-traditional roles. These changes are not without risk, however, since they may lead to intrafamily conflict.

THE ELDERLY

Reports on the responses of the elderly to disaster are inconsistent. In some disasters, they seem no more vulnerable than younger people. In others, they appear more vulnerable. Despite the inconsistency in formal research studies, there are reasons to believe that the elderly are at increased risk for adverse emotional effects in the wake of disaster. They may live alone and lack help and other resources. Depression and other forms of distress among the elderly are readily overlooked, in part because they may not take on exactly the same symptom pattern as among younger people. For instance, disorientation, memory loss, and distractibility may be signs of depression in the elderly. The elderly are also more vulnerable to being victimized. In the context of increased stress on the family and community, meeting their special needs may take on a lowered priority. One particular issue that may appear is feelings that they have lost their entire life (loss of children, homes, memorabilia) and that, due to their age, there is not enough time left in their life to rebuild and recreate. The elderly are also more likely to be physically disabled (see below).

THE PHYSICALLY, MENTALLY, OR DEVELOPMENTALLY DISABLED

Although people who are physically disabled, mentally ill, or mentally retarded have distinct needs from one another, all three groups are at especially high risk in disasters. For those in each group, the normal patterns of care or assistance that they receive and their own normal adaptations to produce acceptable levels of functioning are disrupted by disasters. For instance, supplies of medication, assistive devices such as wheelchairs, familiar caretakers, and previously effective programs of treatment may

become unavailable. This has both direct effects and increases anxiety and stress. Stress, in turn, may exacerbate pre-existing mental illness. There may also be special needs with regard to housing or food.

Those who were mentally ill or developmentally delayed may also have fewer or less adaptable coping resources available and less ability to mobilize help for themselves. The ongoing problems of the disabled may seem to the other victims of the disaster to be of only minor importance in comparison to their own acute and unaccustomed suffering. Their disabilities may even seem like an obstacle to dealing with the disaster itself. The disabled are especially vulnerable to marginalization, isolation, and to “secondary victimization.” They are at greater risk of post-disaster malnutrition, infectious disease (e.g., in a shelter situation), and of the effects of lack of adequate health care.

REFUGEES FROM WAR AND OTHER FORMS OF POLITICAL VIOLENCE

Most of the discussion in this manual focuses on victims of “disasters” in the usual sense. The experience of refugees from war and political violence (and even from famine and other economic hardship) bears many similarities to the experience of the victims of natural disasters, however. Those who have been tortured or the victims of systematic violent political terrorization are especially vulnerable to adverse psychological effects (as well as lasting physical effects) from their experience.

Many of the comments in this manual apply directly to refugees. In addition, even when “former” refugees have been “resettled” in host countries far from home, although they may no longer be physically separated out from others as identifiable “refugees,” they may continue to bear the emotional consequences of their history. When new disasters (earthquakes, hurricanes, etc.) hit, their previous experiences may complicate their responses.

At any given time in the last decade, some fifteen million people were refugees. Another twenty million were “internally displaced persons,” refugees who have left their homes but have not crossed international boundaries.

Refugees have, typically, experienced personal terror or witnessed the physical abuse or death of loved ones. They have suffered the destruction of their homes and communities, the loss of their traditional livelihoods and of material possessions. They may have been forcibly detained or spent periods in concentration camps and may, prior to arrival in the refugee camp, have been tortured, raped, or otherwise physically abused. Their personal status, belief in themselves, trust in others, and hopes for the future have been shattered. They feel vulnerable and mistrustful. They have become dependent on others for the physical necessities of life. In refugee camps, they may experience poor housing, disruption of personal networks, lack of medical care, interruption of their children’s schooling, uncertainty regarding their rights and legal status and future. The refugee camp itself is likely to be a source of ongoing stress, with overcrowding, lack of privacy, poor sanitation, long periods of inactivity, noise, disrupted sleep, and dangers of assault or rape.

Many of these experiences are especially problematic for women. Since they are often the ones responsible for preserving their home and their family, disruption of home and family may be especially distressing. As “little” a thing as not being able to cook for their family may be a source of stress. They may also suffer from changes in family relationships. If their husband is dead, missing, injured, traumatized, or separated from the family, the woman becomes the “head” of the family and must take on unfamiliar and traditionally male roles. This may confuse the children or lead to intrafamily conflict. Alternately, an immature son may be forced to take on age-inappropriate roles. There may not be any socially accepted role for a female single parent or widow. The woman may find herself victimized by relatives. Lack of education or marketable skills may make reintegration into a new social environment especially difficult.

Another danger for women, while fleeing and in refugee camps and shelters, is rape. Rape may be a source of shame, guilt, denial of the woman’s own needs. She may “escape” into illness or become socially isolated. In war settings, rape may take the form of mass or repeated rape. This may be a form of torture, aimed at extracting information from the woman or from her family, or it may be part of a systematic program of terrorization of a civilian population.

Children, especially those who have been separated from their families are also especially vulnerable. One unique group is children who have served as soldiers. In addition to being traumatized and brutalized by their experiences at a developmentally sensitive time in their lives, they are a stigmatized group, isolated from their former communities.

For men and for women, being a “refugee” may prolong the trauma and prevents self-healing. The usual model of response to disaster assumes that once the disaster is “over,” the victim is in a safe, peaceful, “post-traumatic” environment. For refugees, this is not true. They remain in a highly stressful, even repeatedly traumatic situation, and may have little prospect of escaping it.

Just as with other forms of trauma, responses may vary from person to person. A central theme that may emerge is *mistrust*. The experience of many refugees has been that their trust has been repeatedly and violently violated. They have been exposed to death, danger, and fear, often at the hands of neighbors or government officials. Initially, the refugee camp may seem like a haven, but after several weeks, with no permanent refuge in sight, the refugee’s hopes seem once again to have been betrayed. In this context, feelings of anger, betrayal, skepticism, and hostility are both common and normal. Refugees may express or enact distrust of camp officials, aid givers, mental health workers, and relatives back home. Scapegoating, ostracizing others in the refugee camp, victimization of individuals or ethnic minorities may also occur. Apparently “irrational” fears for personal safety may dominate behavior. For instance, a visit to a medical facility may trigger memories of torture experiences.

Other common responses seen among refugees are prolonged mourning, homesickness, prominent fears, dissociative disorders, and prominent somatic reactions, even several years after initial flight. In refugee camps, suicide attempts are relatively common (especially among rape victims). Domestic violence, physical and sexual abuse of women and children, apathy, hopelessness, sleep disturbances, and learning difficulties may be endemic.

Being a refugee continuously distorts people's reactions. What was useful or adaptive before they became refugees (skills, beliefs, knowledge, relationships) is no longer so. This poses many problems for assessing the needs and responses of refugees. Is a child's violence, for instance, a response to traumatization? A means of assessing others in the context of the refugee camp? A pre-existing personality pattern?

RESCUE AND RELIEF WORKERS (AND JOURNALISTS, HUMAN RIGHTS

WORKERS, AND OTHER OBSERVERS)

Disaster workers, including both those involved in rescue efforts immediately following the disaster and those involved in longer term relief work, are at very high risk of adverse emotional effects. *Many of the same factors affecting direct rescue and relief workers affect human rights workers, officials of humanitarian organizations, reporters, and others who investigate disasters and their aftermaths.*

- They may themselves be primary victims of the disaster, with the same burdens as other primary victims.
- They are repeatedly exposed to grisly experiences (e.g., recovering bodies), the powerful emotions and harrowing tales of victims.
- Their tasks may be physically difficult, exhausting, or dangerous.
- The demands of their tasks may lead to lack of sleep and chronic fatigue.
- They face a variety of role stresses, including a perceived inability to ever do "enough." Even if the limits of what they can do are imposed by reality or by organizational or bureaucratic constraints beyond their control (e.g., lack of supplies, lack of manpower), they may blame themselves.
- They may feel guilt over access to food, shelter, and other resources that the primary victims do not have.
- They may identify with the victims.
- They may feel guilt over the need to "triage" their own efforts and those of others or may blame themselves when rescue efforts have failed.
- They are exposed to the anger and apparent lack of gratitude of some victims.

In addition to post traumatic responses much like those of the primary victims of the disaster, rescue and relief workers may evidence anger, rage, despair, feelings of powerlessness, guilt, terror, or longing for a safe haven. These feelings may be distressing and may make the worker feel that there is something wrong with them. Their sense of humor may wear thin, or they may use "black humor" as a way of coping.

Toleration for others' failings is reduced and the anger of other relief workers or victims may feel like a personal attack. Belief in God or other religious beliefs may be threatened by a feeling of "How could God let this happen?" After a prolonged period of time on the job, evidence of "burn-out" may appear.

Professional rescue workers, such as policemen and firemen, have some unique sources of vulnerability. Their professional identity may depend on a self-image of themselves as strong and resilient. Allowing themselves to "feel" their emotions about the situations to which they are exposed may challenge their self respect or make them feel like they are letting down co-workers or make them feel they are risking the ridicule of other workers. In addition, professional rescue workers may have been exposed to many previous traumatic situations. The new experiences may activate unresolved feelings from past traumatic events.

Symptoms of "Burnout" Among Relief Workers

- Excessive tiredness
- "Loss of spirit"
- Inability to concentrate
- Somatic symptoms (e.g., headaches, gastrointestinal disturbances)
- Sleep difficulties
- Grandiose beliefs about own importance (E.g., engaging in heroic but reckless behaviors, ostensibly in the interests of helping others; neglecting own safety and physical needs (e.g., showing a "macho" style of not needing sleep, not needing breaks)
- Cynicism
- Inefficiency
- Mistrust of co-workers or supervisors
- Excessive alcohol use, caffeine consumption, and smoking

Those providing mental health services to disaster victims and to relief workers and those investigating disasters (e.g., journalists, human rights workers, officials of humanitarian organizations doing "needs assessments") also face special stresses. Their central role is as *witness* to the sufferings of others. They may identify with their clients and share their emotions. "Vicarious traumatization" is not uncommon. In contexts of continuing conflict (e.g., civil conflict, political repression, war refugee camps), health care workers of all sorts are themselves increasingly targets of violence. Contact with survivors and providing advice and support to the local population may be seen as a threat to the state, to one or the other side in the conflict, or to powerful forces in the refugee camp. They may face harassment, arrest, detention, or assault. In some situations, they can not evoke the law for their own protection, because the police or the army are "part of the problem." The result may be a heightened sense of powerlessness, anger, fear and anxiety, and a pre-occupation with clients' safety and one's own safety. There may

be feelings of betrayal and loss, of vulnerability, of loss in a belief in an orderly or just world.

Disaster workers of all kinds face additional stress when they complete their tasks and return home, to their “regular” life. Their experience has diverged in a variety of ways from the experiences of their families and in the absence of preparation of both workers and their families, a variety of marital and parent-child conflicts and stresses may appear.

Distressing or problematic emotional responses are extremely common among relief workers. For example, in one air crash, more than eighty per cent of the rescue workers who had to deal with the bodies of victims showed some post traumatic symptoms, more than half moderately severe symptoms. Almost two years after the crash, a fifth of the rescue workers were still symptomatic.

Rescue and relief workers are rarely prepared ahead of time either for their own reactions or to deal with the reactions of primary victims. Providing psychosocial assistance to these workers and providing them with adequate shelter, food, and rest, even when these are not available to the victims themselves, is a very high priority in disasters. It may seem unfair, but if the rescue and relief workers are unable to function efficiently, they can not help any one else.

CHAPTER III

ASSESSING THE PSYCHOLOGICAL IMPACT OF DISASTERS

In the wake of large scale disasters (e.g., hurricanes, earthquakes, refugee crises), identifying which individuals are most at risk of becoming or remaining symptomatic is a high priority. Inquiries may also be undertaken to determine exactly what happened (e.g., to help prevent repetition of the disaster or to identify deficiencies in the relief efforts or, in some situations, to reveal human rights violations).

Individuals affected by a disaster exhibit a wide range of reactions. Some may require support or other services immediately and urgently, others only after a delay, and still others not at all. Some victims may experience initial relief at being safe; some refugees may go through a several-week-long or several-month-long “honeymoon.” If people are assessed too early and found not to be in need of services, it is easy to miss these later reactions. Follow-up several days, weeks, or months later may identify people in need who were initially passed by.

For the most part, victims and relief workers are unlikely to seek out assistance on their own. Do not assume that, because a person has not sought out assistance, they do not need assistance. Several approaches to identifying those in need of services may be used:

- By category: Certain groups are especially vulnerable. These include relief workers, victims who have had a family member die in the disaster, victims who were trapped or entombed in the course of the disaster, victims who were severely injured in the disaster (*including those still in hospitals*) or who continue to experience pain or physical disability, children aged five to ten, mothers of young children, and victims with a prior history of poor adaptation at work or at school or of poor coping in previous periods of high stress.
- By specific behavior patterns: Those who engage in maladaptive behaviors, such as children who stay out of school after the disaster or adults who absent themselves from work or who fail to “bounce back” may be signaling difficulty. Similarly, after the first few days following the disaster, those presenting with vague “medical” problems such as sleep disturbances, excessive fatigue, diffuse pain, unexplainable headaches or gastrointestinal symptoms may be evidencing psychological distress. Those expressing suicidal thoughts or making suicide attempts or other attempts at self-harm are a high priority. Victims who describe persistent re-experiencing of the trauma, especially if they report that they feel as if they are re-living it, or who persistently avoid sights, sounds, or locations associated with the disaster, or who show marked restlessness, irritability, or

hypervigilance, or who present the appearance of “being in a fog,” more than a day or two after the disaster, are also at risk for ongoing difficulties.

- By use of screening instruments: Symptom checklists can be distributed in schools, churches, workplaces, or shelters or refugee camps. The Symptom Report Questionnaire (SRQ) has been used in many countries and has proven successful in identifying adults and older adolescents in distress. *The SRQ, two forms of a Pediatric Symptom Checklist designed for use with children, and a questionnaire aimed at detecting signs of “burnout” among relief workers can be found in Appendix A.*
- By case finding: Outreach efforts, including distribution of leaflets, announcements on radio and television, articles in newspapers, public lectures, posters in the offices or headquarters of the relief effort may stimulate self-referrals. Teachers, religious leaders, medical workers, workplace supervisors, and other local residents who may have contact with substantial numbers of victims should be enlisted to help identify those in distress.

Some Diagnostic Issues

- Recall that there are many reactions to trauma, including anxiety, depression, somatic reactions, and culturally specific responses. Do not over-focus on whether people meet specific diagnostic categories such as Post Traumatic Stress Disorder.
- Distinguish intense but understandable responses to concrete situations from pathological responses. Intense grief should be distinguished from depression. Aches and pains resulting from injury should be distinguished from somatic symptoms expressing anxiety and depression. “Paranoia” due to loss of familiar cultural cues, miscommunications, ambiguities in personal interactions, real or fancied discrimination (among those from groups that have historically been discriminated against), or as a consequence of torture should be distinguished from psychosis. Even psychotic symptoms (hallucinations and delusions) may be a brief reactive response to trauma, which will resolve fairly quickly with support, or it may be part of a longer term pattern. Obtaining a history from the victim or their family -- when the symptoms first appeared, when they worsened and when they lessened, etc. -- is the best guide.
- Be aware that some people may minimize their suffering, recent or past, due to fear that their story will not be believed or fear that letting their suffering be known will stigmatize them or will lead to other adverse consequences. The stigmatization of victims of rape represents a common situation in which a victim’s experience may be presented in disguised form (e.g., concern with physical symptoms) or not reported.

- Note that there are many different ways of coping with trauma. Some of these ways may be adaptive. E.g.,
 - Fatalism; belief in fate or “karma;” belief it was “God’s will” or “It was meant to be”
 - Beliefs that catastrophe and suffering are a normal part of life and should be examined for their meaning (e.g., “bad precedes good” or “It is God’s way of testing me.”)
 - Use of family, community, church support
 - Focusing on new dreams or priorities or a sense of mission
 - Hard work (learning new skills, acquiring a new language; helping others; working hard) as a source of renewed self worth. Distinguish this from an flight into intense, unsustainable, and sometimes pointless activity.
 - Exerting self-control

Other coping mechanisms are less adaptive and may indicate a need for intervention. For instance,

- Expressing stress in somatic form
- Denial and silence
- Avoidance
- Projection; blaming; scapegoating
- Helplessness and dependency
- Dissociation, numbness

Distinguish an absence of marked distress that is the result of good coping from that which reflects numbing, avoidance, denial, or other less adaptive forms of coping. Absence of emotional responsivity may be one indicator of the latter.

- Psychological responses to trauma may be confused with physiological responses:
 - Head injuries can cause brain damage. The victim of a brain injury may experience headaches, dizziness, memory loss, difficulty attending or concentrating, sudden outbreaks of crying or anger or laughing, difficulties with vision or hearing or movement, and may express worry that their mind is “broken.” Any of these may occur in the absence of brain injury, as well, but treatment needs of those with physical damage to their brain are quite different from those of people without such injury. Ask the victim and their family whether they experienced an injury to the head in the disaster (usually involving at least temporary loss of consciousness). Memory loss is a good, although not perfect, indicator, as well. Ask the victim whether people say they are forgetful, whether they have been having experiences such as leaving the stove on or forgetting things. Memory can be briefly tested by asking the victim to recall three words (e.g., “orange, necktie, 1983) immediately after hearing them and after a delay of three or four minutes. Most people have no trouble with this task.

- Other disaster related injuries may also cause apparent mental disturbances. These include metabolic disturbances due to burns, exposure to toxins, crushing injuries, infection, or nutritional deficiency. The victim's history before and in the disaster (obtained from the victim or from family) is the best guide.
- Pain may mask the reporting of psychological symptoms.
- Substance abuse may also mask or exacerbate emotional responses to trauma.

Assessment can harm those being assessed

A victim of a disaster may perceive assessment as a further violation of their already tenuous sense of control over the traumatic experience. In the period immediately after the disaster, the environment may be chaotic and there may be immediate stressors and challenges to deal with. Subjects may seem fragile as they strive for control over the environment. Assessment may seem like a continuation of the traumatic experience or revive feelings. Even after a delay of days or weeks, evoking traumatic memories may lead to feelings of shame or embarrassment or may trigger emotional turmoil or may activate images of previous times in the victim's life when he or she has been victimized. It may activate defenses, including denial and avoidance. It may be resisted by victims or may lead to avoidant or hostile responses directed at the counselor or other inquirer.

- Pushing a victim to reveal what happened to them too fast or too insistently may exacerbate the victim's symptoms or even retraumatize the victim. Let the client control the pace of the assessment. Ask gentle questions and listen. Let what the client needs to tell you take precedence over predetermined notions of what information must be gathered.
- Assure the victim that the assessment process is confidential and that the interviewer will not reveal anything about the interview without the victim's consent. To ensure confidentiality, interviews should be conducted in a safe, quiet, private place. If translators are used, the same assurance of confidentiality must be extended by the translator.
- Clarify to victims the reasons for the assessment or other inquiry and give the person assessed as much control as possible over the process. It may be helpful to start by explicitly noting that the assessment may be distressing. Invite the person being assessed to communicate if they are feeling distressed. Let them know that they can stop the process at any time. Offer opportunities for respite during assessment. Warn that in the hours or days following the assessment, there may be an exacerbation of symptoms and that this is normal, part of how people resolve trauma.

Cross Cultural Issues

Usually, those providing disaster counseling in the wake of disasters are the victims' fellow countrymen and the counselors are familiar with the language and culture of the victims. At times, however, counselors from other countries are involved. (This may be the case in the wake of large-scale disasters in poorer countries).

I have already noted that symptoms may present in "culturally specific" ways (Chapter I). In the context of assessment, this implies that counselors must learn local symptom patterns and local idioms for expressing distressing or other negative feelings. They must also beware of (a) historical animosities between the national or cultural groups represented by client; and (b) potential misunderstandings of the roles to be expected of a helper (the counselor) and the one being helped (the victim); and (c) potential misunderstandings of the relationship between individual and family. (With respect to assessment, in many "Western" cultures the family is important primarily as a source of ancillary information about the individual. In many other societies, however, a problem experienced by an individual is shared by all in his or her family. The unit of assessment may be the family rather than the individual).

A few more specific examples of cultural variants:

- In some cultures, focusing on negative experiences may be seen as detrimental to your future well-being (in this life or in a future one).
- A traumatic event may be understood as due to one's own actions. The "victim" should endure it, not seek help.
- A traumatic event may be understood as a result of fate, and it may be seen as inappropriate to challenge or modify events that have happened to you.
- Revelation of victimization (especially rape) may be stigmatizing and may have serious consequences.
- In some cultures, children are protected from knowledge of death. To "see" death can lead to the spirit of the dead entering the child, and talk of death with a child is taboo.
- Cultural symbols vary in their meaning. (E.g., the owl, a symbol of wisdom in some cultures, is a symbol of evil in others).
- The meaning of dreams differs dramatically across cultures. What is a "reexperiencing of a traumatic event" in the eyes of Western psychiatry may be a bridge to the spirit world or a portent of the future in the eyes of other cultures.
- The meaning of an event may not be the same to a counselor and a victim from another culture. For instance, to a rape victim, not only the rape itself but a resulting belief that she is infertile or unmarriageable may be of central significance. Or the stigmatization resulting from rape may lead to a need to keep it secret, resulting in loss of social support and alienation from the community. In each case, an ongoing stressor (the beliefs, the alienation) may be as tormenting as the original event.

There is no simple formula to cover all the possibilities. The counselor must learn -- from books, from informants, and, most of all, from his or her clients.

One particular issue that may arise when counselors from a foreign country are involved in disaster relief is the need to use translators or to recruit local people (who may or may not have relevant prior training or experience) to function as co-counselors. Such use of co-counselors or translators may affect the assessment process. At best, it facilitates communication. In other cases, some victims may mistrust an outsider (especially if the outsider is from a nation that formerly colonized the nation where the disaster has occurred), and the use of a co-counselor or a local translator may ease the relationship. But in still other cases, victims, fearing shame or retribution, may be less likely to share their experiences with someone from their own community than with an outsider.

Even when these issues do not arise, use of translators may create some other problems. The translator may lack the ability to translate accurately. Even if there is no question of linguistic ability, other factors may interfere with the accuracy of translations, however. These include: (a) The translator's own experience of the disaster or his or her own reactions to it may interfere with his or her ability to translate accurately. (b) The relation of the translator to the victim and to the victim's community may introduce distortions into translations. (c) The translator may experience shame at what has happened to the victim and may inaccurately report their experience. (d) The translator's versions of the victim's story may be distorted by the translator's and victim's roles in ethnic or political conflicts in the disaster community.

In any case, use of children as interpreters for their families is especially problematic and should be avoided if at all possible. It may violate traditional family roles. It may make children privy to information normally considered inappropriate for them. It may violate cultural expectations about the role of children with respect to strangers.

There is no simple solution to these problems. When local counselors are not available, use of a bilingual counselor from outside the immediate community may be the best alternative.

Risks to those doing assessment

Those assessing disaster victims place themselves at risk of adverse emotional reactions. This issue has been discussed above (Chapter II) in terms of burnout and "secondary traumatization." Some of these reactions (e.g., inability to concentrate, excessive fatigue, avoidance of tasks) can lessen work efficiency. Other reactions more directly interact with assessment tasks. For instance, experiences recounted by victims may trigger recollections or reexperiences of traumatic events in their own history. This can lead to unconscious tendencies to avoid asking about some issues or may produce subtle messages to those being interviewed not to tell about certain experiences or feelings. Alternately, the interviewer may distance himself or herself from those he or she

are interviewing, interfering with the emotional connection that facilitates the assessment process. Interventions and self-help to respond to these issues is discussed below, in Chapter IV.

CHAPTER IV

PRINCIPLES OF PSYCHOSOCIAL INTERVENTION FOLLOWING DISASTERS

There are two major aspects to intervention with the direct victims of disasters: rebuilding the community affected by the disaster and intervening with individual victims. (In addition, interventions must be aimed at rescue and relief workers and others less directly affected by the disaster).

Sometimes these two aspects have been seen as being in opposition to each other. For instance, in the context of huge disasters (e.g., a major earthquake, refugee camps for victims of ethnic cleansing), some humanitarian aid workers have argued that to focus on the mental health of individuals is a hopelessly large task. In any case, to focus on individual recovery from the disaster deflects attention and resources from the more urgent task of promoting broader social and economic recovery. From this perspective, rebuilding informal networks of social support, reuniting families and communities, and supporting the physical rebuilding of the shattered community take precedence over interventions aimed at individuals or families.

The individual and community approaches are not really in opposition to one another. The healing and rebuilding of the community is an essential underpinning for the healing of individuals and families, and the healing of individuals and families is necessary for the successful reconstruction of the community. In each case, the underlying principle is to encourage healing processes, in individuals, families, and communities. In this manual, the focus is on individual and small group interventions.

A wide variety of specific techniques have been used to provide immediate relief to individuals in distress, to prevent or mitigate the longer-term emotional effects of disasters. Later in this manual (Chapter VI), a number of these specific techniques will be discussed in detail. To be useful, the techniques have to be adapted to the specific situation – the kind of disaster, the human and material resources available, the specifics of local culture and tradition. This section of the manual focuses on the core *principles* that guide both specific techniques and their adaptations.

PRINCIPLE I: SAFETY AND MATERIAL SECURITY UNDERLIE EMOTIONAL STABILITY

It is difficult for people to maintain a stable mental state, after a disaster or in any other circumstances, unless certain basic needs are met. First, they must be assured access to food, water, clothing, and shelter. Second, their need for physical safety and security must be met. In the case of disasters, this includes not only freedom from fear for one's life, due to the disaster itself, but security from banditry, from the fear of looters, from fear of rape or other assault in shelters or refugee camps, and from the fear that the

disaster will lead to the permanent loss of one's land or one's home. Third, the safety and integrity of their family must be ensured. Fourth, their long term need for stable jobs, adequate housing, and a functioning community must be met. This "hierarchy of needs" has several implications:

- In the very early stages of disaster response, the mental health of the rescue and relief workers is the highest priority. Their wellbeing is essential in enabling them to continue their rescue and relief work, which, in turn, is the basis for ensuring that the basic needs of the direct victims of the disaster are met. A secondary need is to ensure that the mental well being of the victims suffices to enable their cooperation with rescue and relief efforts. After the initial "rescue" stage is over, as relief work continues, responding to other mental health needs of victims become important, but continuing to respond to the mental health needs of relief workers remains paramount.
- Rapid physical and social reconstruction (e.g., restoring or creating housing, creating jobs, reuniting families, rebuilding communities) is essential to restoring emotional equilibrium and maintaining mental health, at all stages of the response to disaster. There is no sharp separation of physical and material needs on the one hand, psychological needs on the other. At any stage of the response to disaster, failure to maintain the momentum towards meeting physical and material needs is a direct threat to mental health.
- Failure to provide for basic needs can be a potent source of traumatization above and beyond the traumatization created by the disaster itself. In particular, unnecessary evacuation, poor conditions in a shelter or refugee camp (lack of food, water, sanitation, shelter; threats to personal safety), failure to provide adequate housing, uncertainty as to food and water supplies, and separation of family members from one another are themselves potent causes of subsequent mental health problems.

PRINCIPLE II: ASSUME EMOTIONAL RESPONSES TO DISASTER ARE NORMAL

A wide range of emotional responses to disaster are *normal* responses to overwhelming stress. They are not, in themselves, signs of "mental illness." They do not signify that the person suffering from the symptoms is "weak" or is "going crazy." They are focuses of intervention for two reasons: (1) The symptoms themselves may be distressing to the person experiencing them. (2) The symptoms may interfere with the person doing things that are important for his or her immediate safety or well being or taking part in the recovery of their community.

Many of the symptoms described earlier can be understood as adaptive mechanisms, by which people seek to protect themselves against the overwhelming physical and emotional impact of the disaster. Both individuals and communities have natural healing processes. The central task of psychosocial intervention is to elicit, facilitate, and support these healing processes and to remove the obstacles to their

operation, in order to prevent lasting dysfunction and distress. Interventions are aimed, above all, at minimizing the number of people who will require later “treatment.” One major implication is that it is essential to reassure people, to help provide short term relief of symptoms which may be alarming to them, and to act to prevent symptoms from becoming entrenched. Education as to the kinds of reactions people may experience may help people understand and “normalize” their feelings.

Victims do not usually see themselves as mentally ill and they may fear or avoid involvement with “mental health” workers and the “mental health” system. Many do not spontaneously reach out for the assistance of mental health workers. Psychosocial assistance in the wake of disaster is best presented in a form that does not require people to see themselves as “ill” or “mentally ill.”

- Use non-mental health terms to describe services and those providing them (e.g., “human service workers,” “community counselors,” “community services,” “disaster services”). Present services as “extra help for difficulties anyone would have trouble with” after being affected by a disaster.
- Aggressive outreach and case finding is necessary. Use local residents, primary care health workers, teachers, religious leaders, and community leaders as informants. Use door-to-door canvassing, mailings, television and radio announcements, leaflets distributed in schools and workplaces, and announcements in churches to alert people to the availability of services and the indications for using them. Do not neglect informal gathering places (e.g., beauty parlors, cafes, day care centers). In shelters, actively look for signs of distress (sobbing, facial expressions, body language, aggressiveness, substance abuse, etc.).

Leaflets describing common responses to disasters, signs of distress, and services available may be directed at primary victims, parents and teachers of children affected by the disaster, rescue and relief workers, and families of relief workers. Several sample pamphlets can be found in Appendix C.

- Use existing, non-mental health institutions such as schools, churches, community centers, and medical facilities as bases for psychosocial services.
- Train and use non-mental health personnel (e.g., teachers, health workers, social service workers, religious workers) to provide psychosocial services.
- It is essential to seek the cooperation and explicit support of community leaders, religious leaders, teachers, village elders, and other leaders in the community. Because of their leadership roles, it may be difficult for these people to acknowledge that they, too, could benefit from psychosocial services. Educational sessions or debriefing sessions (see Chapter V) may provide an avenue for providing information about trauma and its consequences and enlisting support for the provision of trauma services, while giving services at the same time.

- For all those who participate in delivering services, discretion, tact, respect for the confidentiality of those being helped, and ethical behavior are essential.

PRINCIPLE III. INTERVENTIONS SHOULD BE MATCHED TO THE DISASTER PHASE

The types of response that are offered should match the phase of emotional responses and the needs of disaster relief operations.

The “Rescue” Phase:

Immediately after the disaster, the highest priority for psychosocial services is rescue and relief workers, whose continued effective functioning is essential. This may involve crisis management, crisis intervention, conflict resolution, assisting with problem solving, or “defusing” (See Chapter VI). Many very small concrete services may be emotionally useful as well as practically helpful. Bring rescue workers coffee, lend a hand in helping clean up, give a hug, express interest.

Immediately after the disaster, the most urgent needs of victims are for direct, concrete relief (e.g., rescuing lives, ensuring physical safety, providing medical care, providing victims with food, water, shelter, reuniting families). Psychosocial interventions aimed at victims during this phase are primarily directed to serving these ends. In doing so, they contribute to longer-term mental health.

- Provide “psychological first aid”: i.e., assistance for those whose acute distress and difficulties functioning interfere with the victim’s cooperation with rescue and relief efforts and ability to help provide for their own safety. *Look for signs of intense anxiety or panic, continuous crying, depressive withdrawal, disorientation, incoherence, difficulty complying with requests by relief workers or with the rules of the shelter.*
- Provide short term interventions to reduce anxiety, assist the rescue and relief process, and help prevent later maladaptive responses. These include comforting and consoling victims (a word or a hug); helping people reunite with family members or get information about loved ones; helping people reconnect with neighbors, work-mates, and others who make up their personal “community;” helping defuse conflicts with other victims or between victims and relief workers; supporting victims in such “reality tasks” as identifying the dead or making decisions about animals and other property. *Let victims express feelings, but focus on reducing psychological arousal and anxiety, restoring social support systems, and helping victims regain a sense of control. Seek to elicit competence and independence from the very beginning.*
- Begin broad preventive activities and activities that set the stage for later interventions: Provide accurate information as to what is happening, using all available mechanisms (e.g., mass media, meetings, leaflets). *Reassure victims that*

acute reactions are normal and should not be sources of fear or of feelings that one has lost control.

- Interventions that are cognitively complex (e.g., “debriefing;” see Chapter V) are premature when people are still in a stunned state. However, helping to reduce anxiety may help prevent later distress, and making contact with survivors even at very early stages after the disaster may create positive feelings towards the counselor that can make later interventions more acceptable and effective. Bringing water, blankets, toys for children, food to victims (i.e., providing “primary” services” helps counselors make initial contact and establish trust and enables clients to talk about what they need.
- One problem in the early stage of response may be a rapid influx of people seeking to help, seeking to exploit the situation, or seeking to satisfy curiosity. At the level of those organizing the response to the disaster, immediate efforts to control the potentially adverse effects of this influx is part of creating a sense of safety for victims.
- People who are indirectly affected by the disaster (families or friends of victims, onlookers, even those watching repeated reports of the disaster on television) may also show signs of distress. Note that what is helpful to one person may not be needed or appreciated by another. For example, one person may find that talking about the event reduces distress, while another needs to be quiet and introspective. If one of these people depends on the other for support (as is often the case, for example, with spouses), they may feel the other’s lack of similar response to be a form of abandonment. Reassure people that there is no “correct” response and that the other person’s differing needs are not, in fact, abandonment, but the way that person needs to deal with stress.

The “Inventory” Phase

Continuing to provide services to relief workers remains a high priority during this period.

The first days or weeks following the disaster may be a “honeymoon” phase, in which people’s feelings of relief and optimism about the future dominate. A spirit of generosity and mutuality may appear, and individuals may be in a state of denial about their losses and the problems of the future. During this stage many people will not be receptive to psychosocial interventions or will feel they do not need them. Others, however, may welcome the chance to talk through their reactions within a few days of the disaster or to find someone who can help them plan how to overcome the obstacles they are facing.

The bulk of psychosocial interventions directed at victims themselves occur in this period. Discouragement and disillusionment with relief and reconstruction efforts may set in. Anxiety, sadness, irritability, frustration, and discouragement now combine with

disaster-produced losses and post-traumatic stress effects to produce a relatively high level of need. *Focusing on identification of those at risk and on interventions to reduce the longer-term impact is essential.*

- Provide broad outreach services aimed at providing education about responses to disaster and information as to the availability of services and guidance as to when to seek assistance. This may include use of newspapers, radio, and television; arranging community meetings or sending speakers to churches or schools; distributing leaflets through shelters, schools, workplaces (see Appendix C).
- Seek to identify those most at risk or most in need of services (see Chapter III) and focus services on these people. The principles of such interventions are discussed later in this chapter; some specific techniques are described in Chapter V and in Appendix A.
- Provide concrete support in specific situations. This may include helping those who have lost a family member identify the victim and make funeral arrangements; advocating for improvements in the organization of shelters or for provision of specific supplies or services; helping organize community rituals and memorial ceremonies; helping prevent or combating scapegoating in a shelter or in a community.
- Provide school-based services for all children, in addition to individual or group services to children identified as showing signs of distress. Provide services for teachers (who must interact with and support the children). Teachers may be trained to themselves provide ongoing services for children.
- Advocating for rapid progress in rebuilding homes, recreating jobs, restoring community services (e.g., schools, churches) and involving victims in themselves advocating for these both helps ensure that the essential underpinnings of psychological recovery are realized and helps restore a sense of mastery and control in victims.

In most circumstances, the number of people trained in responding to the emotional consequences of disaster will be insufficient to meet the demand. Training of auxiliary disaster counselors will, of necessity, be a high priority during this period. Primary care health workers, teachers, religious leaders, traditional healers, and others can be enlisted.

The “Reconstruction” Phase

Emotional consequences of the disaster may continue to appear for up to two years or more post-disaster. In part this represents delayed reactions, in part responses to a growing recognition of the irreversible consequences of the disaster. *The experience of several disasters suggests that mental health assistance should remain available for about two years or more after the disaster.* Such services also permit longer-term follow-up of those treated earlier. It may be helpful to establish and maintain a telephone “hot

line” or other ways for people to contact counselors if the need arises, for the period after counselors leave the site of the disaster.

Tasks at Different Stages Following a Disaster

I. The Rescue Stage (immediate post-impact):

Provide “defusing” and crisis intervention services for relief workers
 Ensure safety of victims and ensure that physical needs (housing, food, clean water, etc.) are met
 Seek to reunite families and communities
 Provide information, comfort, practical assistance, emotional “first aid”

II. The Early Inventory Stage: First month

Continue tasks of Rescue Stage
 Educate local professionals, volunteers, and community with respect to effects of trauma
 Train additional disaster counselors
 Provide short-term practical help and support to victims
 Identify those most at risk and begin crisis intervention, “debriefing,” and similar efforts
 Begin reestablishing community infrastructure: jobs, housing, community institutions and processes

III. The Late Inventory Stage: Months two on

Continue tasks of Rescue and Early Inventory Stages
 Provide community education
 Develop outreach services to identify those in need
 Provide “debriefing” and other services for disaster survivors in need
 Develop school-based services and other community institution-based services

IV. The Reconstruction Phase

Continue to provide defusing and debriefing services for relief workers and disaster survivors
 Maintain a “hot line” or other means by which survivors can contact counselors
 Follow up those survivors treated earlier

PRINCIPLE IV. INTEGRATE PSYCHOSOCIAL ASSISTANCE WITH OVERALL RELIEF PROGRAMS

It is difficult, if not impossible, to provide effective psychosocial services without the cooperation and support of those directing and providing medical and material relief efforts, at the local as well as the regional or national level. Governmental officials (at local or national level) often do not recognize or give much priority to the psychosocial effects of disasters. Rescue and relief workers, who are necessarily focussing on the urgent and concrete tasks of saving lives, protecting property, ensuring the provision of food, clothing, and shelter, and rebuilding the material infrastructure of the community may see psychosocial services as unnecessary or even as getting in their way. Educating both of these groups about the impact of psychosocial processes on the relief effort itself and on the long run consequences of not responding to the mental health effects is essential.

Early development of liaison with those directing relief work is essential. Forming a task force made up of experts in psychosocial intervention, formal community leaders (e.g., the mayors of towns), representatives of influential groups in the community (e.g., churches, unions), leaders of the relief effort, and representatives of the victims to guide and support psychosocial work may be very useful.

One potential source of contention is that preexisting social stratification (by class, caste, gender, rural vs. urban, etc.) may lead to certain groups (e.g., women, poorer people) being left out of the process. Conforming to traditional patterns of stratification in the name of efficiency or of “restoring community structure” reinforces those patterns. Implementing programs along more egalitarian and participatory lines may produce conflict and new forms of stress, but it may also ultimately result in serving a far larger group of victims and producing a more integrated, cooperative post-disaster community.

Several useful focuses of early liaison work are:

- Providing for education and training of rescue and relief workers (before they begin work, if at all possible) as to the emotional effects relief work may have *on them* and on the availability and usefulness of supportive services *for them*. Advocate with those directing the relief efforts that this should be part of the relief worker orientation program.
- Providing for training of rescue and relief workers (before they begin work, if possible) with respect to the nature of the emotional responses *of trauma victims* that they can expect.
- Informing relief workers and officials of the importance of providing adequate, accurate, and non-contradictory information to survivors.
- Educating relief officials about the importance of keeping services unfragmented.

- Educating or informing relief officials about several findings which should influence rescue and relief operations:
 - a) the importance of keeping primary groups (families, work crews, groups of people from the same neighborhood or the same village) together, if conceivably possible
 - b) the importance of not separating children from their parents, if in any way possible
 - c) the importance of having victims play a role in the relief and recovery efforts
 - d) the importance of avoiding unnecessary evacuations and of letting people return to their homes as rapidly as possible
 - e) the importance of allowing the bereaved to see the bodies of those who have died, if they desire to do so.
 - f) The importance of pet rescue and maintenance of pets in special animal shelters. This is often neglected but is very important for the emotional well-being of many people.

One effective way of encouraging integration of social assistance with overall relief programs is for those providing psychosocial assistance to thoroughly integrate *themselves* into the relief team. Go out with food distribution teams. Run a “play” center for children, which will also draw in mothers. Be part of the “briefing” or “orientation” team for newly arriving relief workers. Attend early morning or late night team meetings.

PRINCIPLE V. INTERVENTIONS MUST TAKE PEOPLE’S CULTURE INTO ACCOUNT

People from different cultural groups (including different sub-cultural groups within a larger society) may express distress in different ways and may make different assumptions about the sources of distress and how to respond to it. Techniques originally devised in industrialized countries must be applied sensitively, if they are to be used elsewhere. (Fortunately, there is a body of evidence suggesting that these techniques can be successfully adapted to a wide variety of situations.

Some of the cross-cultural differences which may need to be taken into account include the following:

- Some societies explain behavior in “rational” or “scientific terms, others in more spiritual terms. Where on this continuum is the particular culture?

- What is the extent and nature of verbal interactions expected between a person who is in distress and a person trying to help them?
- Under what conditions is it socially appropriate to express emotions such as shame, guilt, fear, and anger? How are various emotions described and expressed?
- Is revealing feelings to others socially appropriate? What issues are raised by discussing feelings or practical problems in the presence of other family members?
- What are the social expectations with respect to the roles of victim and counselor? E.g., what is the appropriate social distance between them? What deference is owed the helper?
- What are the cultural beliefs regarding the role of ritual in the treatment? Are there expectations with regard to the sequences of interactions between a person seeking help and the helper? Are specific rituals expected in treatment?
- What are the cultural expectations with regard to the use of metaphor, imagery, myth, and story telling in a helping relationship?
- Is there an expectation that a helper will provide immediate concrete or material assistance or direct advice or instructions?
- What are the traditional ways of understanding the sources of disasters (e.g., witchcraft, the will of God, fate, karma)? What does this imply about expectations and needs with regard to a sense of personal control?
- What is the culturally expected way of responding to terrible events? (E.g., it may be resignation; individual action, collective action. “depression” may or may not be seen as a problematic way of understanding events.
- What are people’s expectations regarding the use of traditional healers or rituals and regarding the role of “western medicine”?
- How are the symptoms of “mental illness” explained?
- What are people’s expectations with regard to authority figures and especially to those seen as representing the government?
- What is the role of subsistence activities which the disaster has disrupted in establishing cultural identity?

Interventions need to be sensitive to these differences and may effectively draw on them, as well. To cite several examples, in working with victims of a volcanic

eruption in the Philippines, counselors incorporated prayer into “debriefing” sessions; in working with traumatized Navaho Indian war veterans (U.S.A.), traditional healers were enlisted both to help provide services and to organize traditional rituals aimed at cleansing warriors returning from battle.

One path which helps create such sensitivity is to involve local people in every phase of psychosocial services. Local health workers, priests, traditional healers, union leaders, teachers, and local community leaders should be educated about the psychosocial consequences of disaster and enlisted to serve as psychosocial counselors. Modifications of the techniques described in Chapter III can be developed with their aid and participation.

In this context, differences between men and women in coping styles and in what is deemed socially appropriate can also be regarded as a form of “cultural difference.” Interventions need to be sensitive to the possibly differing expectations and needs of women (e.g., with respect to speaking about emotional concerns in a family meeting or a public setting).

PRINCIPLE VI. DIRECT INTERVENTIONS HAVE AN UNDERLYING LOGIC

A variety of specific intervention techniques may be useful in responding to the emotional impact of disaster on individuals, families, and other groups. In any particular disaster situation, these techniques may have to be modified or adapted, and there are many other, less formal interventions that may be useful.

In what follows, the focus is on the logic and underlying purposes of interventions, rather than the details or specific mechanics of interventions. The latter is addressed for a number of specific techniques in Chapter III.

1. **Talking:** People need to make sense of a disaster, in the context of their lives and their culture. Telling a story about what happened is a way of creating a meaning for the events. Many victims find that simply telling others about their experiences in the disaster or about their experiences in the days and weeks after the disaster is helpful. Telling what happened to another person also permits the victim to check that his or her perceptions of what happened are accurate. Telling one’s story “externalizes” thoughts and feelings, subjecting them to examination by oneself and others. Emitting feelings a little bit at a time when the experience is safely in the past, by talking to others or by crying, reduces stress. Public opportunities for mourning, celebrating, and otherwise expressing feelings can also relieve stress and may allow expression of feelings in a socially acceptable way in situations in which one-on-one discussion with a disaster counselor may be less acceptable. Note: While talking about experiences is generally healthy, “rumination” (repetitive, obsessive retelling of a story) is associated with higher levels of anxiety and depression and should be discouraged by engaging the victim in alternative activities or diversions. Helping clients to focus on decisions and actions in the present can strengthen their mechanisms for coping with their difficult emotions and behaviors.

For children, other means of communication, including playing, art work, dancing, or role playing may play the same role that talking does in an adult. For some adults talking about the events may be painful, or talking about bad events may be culturally proscribed, and similar non-verbal means of communication may provide a way to express themselves.

2. **Communication of information:** Uncertainty increases victims' level of stress. Incorrect information produces confusion, can interfere with appropriate responses, and can lead to tensions among victims or between victims and relief workers. Provide victims with accurate and full information, as quickly as possible, using both individual, direct forms of communication and general public announcements (e.g., via the mass media). Combat rumor mongering. It is essential to have a single source of information which victims can rely upon (e.g., a posted, regular, reliable schedule for information sharing by relief officials).
3. **Empowerment:** One of the most psychologically devastating aspects of a disaster is the victim's sense of having lost control over his or her life and fate. Interventions that help those affected by the disaster change from feeling themselves as "victims" (i.e., as passive, dependent, lacking control over their own lives) to "survivors" (who have a sense of control and confidence in their ability to cope) are central to preventing or mitigating subsequent emotional difficulties. Discourage passivity and a culture of dependency. Seek to engage victims in solving their own problems. Victims should be encouraged to participate in making decisions that affect their lives and to take part in implementing those decisions. They should not be denied an active role in solving problems, in the interests of "efficiency." For adults, a return to work (either their usual work or other productive or personally meaningful activity) helps increase their sense of control and of competence. For children, a return to school performs the same function. Even when people must remain in a shelter for prolonged periods, developing small scale income generating productive activities, permitting victims to help run the shelter and the relief administration, and providing skills training are useful parts of psychosocial rehabilitation.
4. **Normalization:** While unfamiliar emotional responses are normal following a disaster, victims may find their own reactions distressing. The best antidote is education. Reassure victims that their responses are not a sign that they are "going crazy." Explain the typical time course (i.e., that, in most cases, symptoms can be expected to remit over a period of weeks or months). Warn victims that the anniversary of the disaster, environmental stimuli that remind them of the disaster and other events such as funerals or legal actions growing out of the disaster may lead to a brief return of symptoms that had faded. Victims should also know that not everyone experiences the same symptoms or even any symptoms at all. They are not condemned to have symptoms.
5. **Social Support:** Recovery from disaster is inherently social. Restoring or creating networks of social support is essential in dealing with the extreme stresses created by disaster. Avoid breaking up existing communities. Combat isolation of individual

victims. Reuniting families has the highest priority. Reuniting people from the same neighborhood, work teams, and other pre-existing groupings is helpful, and separating members of such pre-existing groups (and especially members of the same family) is harmful. Only in the most extreme situations should children be separated from their parents (e.g., if the child's parents are abusive or rejecting because they are unable to cope with their own trauma or that of their child). If separation of a child from its parents is necessary (or if the parents are injured or killed), keeping the child with another trusted adult known to them (e.g., a relative, a teacher) is urgent. Sending the children away "for their own protection" is almost never advisable. Returning children to school and adults to accustomed social environments (e.g., work) is important.

In some instances, no natural support groups are available. In this situation, creating artificial networks (e.g., creation of ongoing peer or self-help groups for treatment, helping to reorganize and rebuild communities) is helpful. In most instances, group treatment modalities should be a central part of the psychosocial response to disasters. When possible, the group that is the unit for treatment should be a naturally occurring group, such as the family.

Note: While social support generally helps people deal with stress, expectations that one should support others, if excessive, and feeling too much empathy for too many people can exacerbate stress. Resistance to involvement in social networks should be evaluated on a case-by-case basis.

6. **Relief of symptoms:** Anxiety, depression, exaggerated stress responses, and other symptoms are both distressing to the individual and may lead to difficulties in adapting to what is intrinsically a stressful situation. While extensive intervention to treat entrenched psychiatric difficulties is beyond the scope of this manual, more time-limited interventions, such as brief crisis intervention or relaxation and desensitization techniques (see Chapter VI) may be useful. Screening victims for unusually intense responses, using instruments such as the SRQ (see Appendix A) if necessary, helps identify individuals in need of more intensive services. Those with pre-existing psychiatric conditions are also at risk. Such victims should be referred for more extensive individual or group counseling, or medication, if resources are available. For those with pre-existing psychiatric disabilities, efforts should be made to restore their previous treatment (e.g., therapy, medication). For those without prior histories of psychiatric disorder but who show acute distress, medication (e.g., anxiolytics for acute anxiety and panic, neuroleptics for psychotic symptoms), when available, may be a useful short term response.
7. **Build on community strengths, traditions, and resources** (without being a slave to tradition): Communities have strengths and resources. These strengths and resources can be a powerful tool for mitigating the effects of disasters in individuals.

A sense of community, a sense of social identity, and a network of social support are essential underpinnings of mental health. Interventions and advocacy to restore

community morale, traditional economic activities, pre-existing welfare and personal services, schools, leisure and recreational patterns are useful.

Communities have a wealth of traditional strengths and resources. Use indigenous healers and local residents, both drawing on their traditional skills and training them in psychosocial rehabilitation techniques. Identify traditional rituals and ceremonies, such as healing rituals and purification rituals used by the community to deal with crisis, and facilitate their use. Where traditions don't exist, new community rituals may be created, such as a day of mourning or daily bell ringing or processions.

There are potential pitfalls in efforts to rebuild the pre-disaster community. Some of these are created, directly or indirectly, by the disaster itself. For instance, conflicts may arise between emergent leaders "created" by the crisis of disaster and traditional leaders or between local leaders and outside experts and elites. Traditional elites may use their traditional positions to monopolize post-disaster resources or to further pre-disaster ambitions. The crisis created by disaster may open long-dormant faults in societies or communities and may lead to new relations within families or within a community. A crisis is an opportunity for change to emerge in a community. "Building on community strengths" does not mean automatically seeking to restore the old structure of the community in the interests of "efficient" relief efforts, nor does it mean pursuing one's own beliefs in how communities or families "ought" to be structured. It is engagement in a community, rather than a particular structure of the community, that represents an area of hope for victims.

PRINCIPLE VII. CHILDREN HAVE SPECIAL NEEDS

For the most part, the same principles that apply to adults apply to children, with appropriate adaptations for their age (i.e., use language appropriate to the child's age; be concrete). The various child-specific reactions to disaster discussed earlier suggest several additional principles for work with children:

- Children are affected both directly by the disaster and indirectly, by observing and being affected by their parents' reactions. Unless there are strong reasons to the contrary, such as an abusive parent-child relation or the physical or psychological unavailability of the parents, involving children together with their parents should be a major part of treatment. Encouraging parents to discuss what happened in the disaster with their child, to recognize and accept and understand their child's reactions, and to communicate openly about their own reactions, is helpful.
- A barrier to identifying children in need of services may be the parents' ignoring or denying signs of distress in their children or parents or attributing regressive behaviors such as bed wetting or acting out behaviors as "willful." Parents should be educated about these issues, and case finding should be pursued through other routes (e.g., schools) as well.

- Parents may benefit from education with regard to appropriate responses to particular behaviors and to the benefits of specific treatments, as well. For instance (a) Regressive behaviors, such as bed wetting, should be accepted initially. The child should be comforted without demands. He or she should not be shamed or criticized or punished. Later, normal expectations can be gradually resumed. (b) Behavioral interventions (systems of rewarding desired behaviors, with limit setting on undesirable behaviors) are the most useful responses to inappropriate behaviors. (c) Physical comforting may be useful in reducing anxiety levels among children. One study has shown that regular back and neck massages may be helpful. (d) Children need reassurance and permission to express their own feelings without fear of being judged.
- Children may have special concrete needs – toys, bedding, special foods, availability of age-appropriate activities (play groups, school, chores). Parents also benefit when these are provided, since they help the parents cope with the demands their children place on them. On-going child care services, to enable parents to return to work or to deal with the practicalities of a return to normal function, are also needed.
- Separation of children from their parents should be avoided, if at all possible. When it is absolutely necessary (for the child's safety or because of the inability of the parents to care for the child), efforts should be made to ensure that the child is accompanied by other familiar and important figures in their life, such as a grandparent, older sibling, or teacher.
- Children are especially prone to drawing inaccurate conclusions about the cause of the disaster, their own actions, and the normality of their current feelings. For example, they may believe that they are somehow to blame for what happened. Exploration and correction of these ideas is part of treatment.
- Younger children (up to ten or eleven, at least) may not be able to use language effectively to describe their feelings or to work through their reactions. Drawing, play with puppets, role playing, or writing which is not specifically focused on the disaster (e.g., poetry, stories) may be a useful way of enabling a fuller exploration of responses. These approaches are discussed in more detail in Chapter VI.
- Children should be given time to experience and express their feelings, but as soon as possible, a return to the structure of household routines should be pursued.
- Schools play a key role. They provide a safe haven for children during the day and serve as locations for case finding and for intervention and. By providing a structured environment for the child, they help the child regulate his or her reactions. A rapid return of children to school and monitoring of attendance and of unusual symptoms is helpful. (It is not unusual for children to want to be with their parents immediately following a disaster, however. Child care services may be needed). When children return to school after a disaster, they should not be immediately rushed back to ordinary school routines. Instead, they should be given time to talk about the event

and express their feelings about it (without forcing those who do not wish to talk to do so). In-school sessions with entire classes or groups of students may be helpful. The school can also hold meetings with parents to discuss children's responses and provide education for parents in how to respond to children after a disaster.

- Children, like adults, benefit from feeling a sense of control over frightening situations. Involving children in age-appropriate and situation-appropriate tasks that are relevant to relief efforts (e.g., collecting supplies for disaster victims or taking on responsibilities such as caring for younger children in a shelter) is helpful both to the child and to other victims of the disaster.
- The repetitive graphic images of the disaster shown on television can generate anxiety. Exposure to television accounts of the disaster should be limited. An adult should be present to monitor and protect the child from overwhelming graphic images and to talk about what the child is watching.

Additional suggestions on how parents can help their children in the wake of disaster can be found in Appendix C ("Children and Disasters").

VIII. WOMEN HAVE SPECIAL NEEDS

The needs of women in the wake of disaster has to be understood in the context of the roles, experience, and status of women in the pre-disaster society. At the same time, it should be stressed that not all women have the same needs. Differences in nationality, ethnicity, age, social class, marital status, as well as particular differences in personality or history of past trauma affects their needs. Elderly or disabled women may carry a double burden of vulnerability.

Women are often underrepresented in formal organizations concerned with disaster preparedness, warning, and response. As a result, their needs may not be heard, taken into account, or responded to by those making decisions about responses to disasters.

More positively, women's formal and informal organizations and networks can be a source of strength, both to individual women and to the disaster response process as a whole. Promote women's participation, empower women within the disaster response process, open opportunities to non-traditional jobs and roles, and use women's existing skills.

Information:

- Women whose work is done at home may be relatively isolated. Extra or different efforts may be needed to warn them of impending disaster.
- In poorer countries, women are more likely than men to be illiterate or to not speak the "official" language of the country. Again, different techniques must be

used to warn women of approaching disaster and to inform women of available assistance.

Providing Assistance:

- Those responsible for designing direct aid programs should consciously analyze the needs of women and direct aid specifically to these needs. For instance:
 1. Target credit specifically at women-headed families.
 2. Provide assistance and employment opportunities directly, without the woman having to go through a male (e.g., a husband or father).
 3. Programs of repairing or rebuilding homes should use designs suitable for childcare and home based occupation needs. Women should be directly involved in planning such redesigns.
 4. Beware: If aid or credit is distributed to a household or in the name of the husband, women may get less assistance than if aid is distributed to individuals.
- In shelters, relief centers, and refugee camps:
 1. Provide for child care and elder care to enable women to participate directly in reconstruction.
 2. Provide for safety against sexual assault.
 3. In designing medical services, be sure that obstetrical and gynecological services, equipment, and medications are available.
 4. In designing medical services, include reproductive health services.
 5. Provide recourse for victims of domestic abuse and violence.

Casefinding:

- To identify women in need of services, go where women gather. This may include childcare centers, playgrounds, schools, laundry facilities, rivers where women go to wash clothes, churches, etc.

Special issues:

- *Rape*: Special sensitivity is needed in addressing the needs of women who have been raped. In almost every society, *victims* of rape and other gender-

based violence are stigmatized and, in some cases, they are severely punished. The consequences of revealing a rape may be as traumatic as the event itself.

Rape also has direct consequences, possibly including physical injury, acquisition of sexually transmitted disease (including HIV), pregnancy, or loss of virginity (in settings in which this may have profound cultural meaning). Women may have difficulty talking about such assaults. Shame, fear, and anger may prevent women from revealing these events. The woman may deny the occurrence of these events (with herself as victim or with another family member, such as a daughter, as victim) to protect herself or others. She may become socially isolated.

Rape victims should be approached by same-sex counselors. Make contact with rape victims at a rate and in a manner that the client can accept. Avoid any moral judgment of the victim: Rape is never the fault of the victim. Ensure privacy for the interview and take extra measures to ensure confidentiality. Note that denial and repression may be survival mechanisms, not signs of emotional disturbance. Provide mechanisms to protect victims against stigmatization and against direct reprisal. Seek to end the isolation of the victim.

Education of victims and community and creating alliances with community and religious leaders to combat the stigmatization of rape are essential. Rape, it can be emphasized, is not primarily a sexual act. It is an act of anger or of power or of exerting control or of terrorization enacted sexually.

- *Other sex-or gender-based harassment or assault:* Women who have been the victims of physical abuse within their families also present with special needs. Loss of telephone service or impassability of roads in the wake of disaster may render them vulnerable to renewed assault. Women who have previously fled such abuse (e.g., to a battered women's shelter) may experience evacuation in the wake of an disaster as a second evacuation. In a disaster shelter, they may be re-exposed to violence from the very person from whom they had previously fled.

Self-conscious efforts to locate women isolated in their homes and to protect them from further abuse should be part of the disaster response plan.

IX. RESIDENTS OF REFUGEE CAMPS HAVE SPECIAL NEEDS

The approaches to intervention used in a wide range of post-disaster situations may require modifications for refugees, especially those in long-term refugee camps.

- Issues of physical safety, (including safety for women from sexual harassment and assault), provision of food and water and medical services remain primary.

- Combating isolation, passivity, and idleness are essential, but ensuring at least a minimal level of privacy and opportunities to escape from crowding and noise are also essential.
- Certain types of victim (e.g., unaccompanied children, single parent families, the physically disabled) may be especially vulnerable to isolation or victimization.
- Conflicts (individual or political/ethnic) from the refugees' place of origin may spill over into refugee camps and may interfere with healing or create retraumatization.
- What appear to be trivial refugee camp rules or procedures have the potential to be retraumatizing. For example:
 - In cultural environments where ritual ablution before prayer is required, limited access to washrooms first thing in the morning can be a source of distress, even if, over the course of the day, there is adequate access for maintaining normal hygiene.
 - The process of distribution of food in a shelter or refugee camp may conflict with traditional notions of who serves whom.
 - Limitations on the ability to carry out proper mortuary ceremonies (including providing food for the dead as well as for the living) may lead to fears that improperly cared for deceased family members may reappear as vengeful spirits.
 - The role played by humanitarian aid officials may threaten the authority of old leaders or seem to threaten traditional control over children.

Sensitivity to issues such as these requires involvement of camp residents in setting camp procedures.

- Refugee camps are environments which are neither short term nor permanent. This is the antithesis of a return to "normality," which is so necessary for healing. Even within the camp, keeping families and communities together, encouraging the rebuilding of family and village structures, encouraging "normal" activities such as going to school, engaging in productive work (participating in food preparation and distribution, providing camp security, engaging in small scale production), engaging in sports and other recreational activities, participating in religious ceremonies, etc. provide a sense of connection to the past and to "normal" life. Preparing camp residents for post-camp life (e.g., developing workshops focused on practical issues, such as job-finding skills, health care, legal rights, compensation issues, self-employment issues, as well as mental health issues per se.) and developing a plan for returning refugees to their homes

and/or integrating them into a new community can help provide a sense of a future.

- When refugees are fleeing political violence or war, refugees from several of the warring factions may find themselves in the same refugee center or shelter. Attention may need to be paid to promoting peace and harmony among the several groups that had been involved in the violence. While this may not be feasible in all situations, it is important both in preventing retraumatization and conflict within the camp and in creating the possibility of a "normal" future.
- For refugees from war or political violence, testimony about their shared experience plays a central role in healing. It permits victims to tie their own experience to history and community experience. It helps thwart isolation and self-blaming as the victim recognizes the commonalities of his or her own experience and that of others. Describing one's own experience to others, orally or in writing, may be helpful. In a larger arena, Truth and Reconciliation Commissions and/or trials of the perpetrators of violence may play a central role.

Victims of torture: A full treatment of the needs of refugees who have been victims of torture is beyond the scope of this manual. The World Health Organization manual, *Mental Health of Refugees*, provides a wealth of useful ideas. (See "Further Resources"). However, note the following:

- For torture victims, a pervasive theme may be a lack of safety and mistrust. A central need is to ensure the safety of the torture victim, both practically and psychologically. Reassurance, and education about the psychological effects of torture may be useful.
- Victims may need assistance in sorting out the medical, social, and other practical problems resulting from torture.
- A central need of the torture victim is to reassume control over his or her life. Take this into account in any interventions. For instance, ask permission to interview. Explain the purposes of the interview. Allow the victim to set the pace of any interviews or treatment.
- There may be many environmental "triggers" for anxiety and memory. A visit to the doctor's office or the dentist's office, an object such as a pencil or soda bottle used in torture can trigger memories. Relaxation exercises may help the victim deal with situations that trigger anxiety.
- Neuropsychological injuries from torture may interfere with cognitive processing or influence emotional reactions.
- Torture aims at silencing, isolating, terrorizing, suppressing memory. Acknowledging the suffering of the victim, supporting his or her need for justice,

enabling his or her search for a "meaning" to the experience are helpful. Opportunities to tell the story of what happened, in individual or group or public situations may be helpful.

X. RESCUE AND RELIEF WORKERS (AND JOURNALISTS AND HUMAN RIGHTS WORKERS) HAVE SPECIAL NEEDS

Rescue and relief workers are both at high risk for adverse emotional responses and a high priority for intervention. Their needs are often ignored, since their training and willingness to work makes it appear as if they have more emotional resources than the direct victims of the disaster. Their needs may be seen as "less important" than those of the primary disaster victims, and they themselves are often poorly prepared for their own emotional reactions to their experiences doing disaster relief. (*Much of what follows also applies to human rights workers, journalists, and others with prolonged or repeated exposures to disasters and their consequences*).

Relief workers (including policemen, firefighters, and soldiers who may be involved in disaster responses) often develop a culture of "defensive distancing." They may deal with stress by using "black humor," superficial callousness, and a belief that getting the job done right is more important than expressing their feelings. They do not seek out assistance and may resist being drawn into interventions.

After a period of time on the job, the accumulated stress may lead to "burnout," a syndrome in which the rescue worker loses his or her enthusiasm for the work, becomes less efficient, feels chronically fatigued, feels besieged with unfair demands, and feels chronically irritable with and critical of fellow workers and clients.

- A process in which potential rescue and relief workers are screened and only those deemed suitable are chosen may help lessen the frequency of adverse reactions. People with a sense of independence, a sense of work identity and personal strength, and prior experience of loss-related work may do better. Those with recent, personal losses that have not been worked through are at high risk of adverse reactions.
- Training and experience help prevent adverse psychological effects. To as great an extent as possible, rescue and relief workers should be prepared *beforehand* as to what to expect, both practically and psychologically, in themselves and in victims. Preparation should focus on the particular disaster to which they are responding, if possible. The closer their expectations are to the realities they will face, the greater their sense of predictability and control, the less their feelings of helplessness and uncertainty will be. Education about general responses to stress and about signs of stress and burnout in themselves and in co-workers should be part of this training.
- Training of relief workers in simple stress management and other coping skills that they can use to protect themselves emotionally is also helpful. This may include training in distancing and relaxation techniques (e.g., using pleasant images to avoid

ruminating about the horrors of the disaster and the impossibility of doing all that has to be done; breathing exercises), education in the need for adequate rest and food, education about the value of periodic “debriefings” (see Chapter V), and education in the value of simply talking informally about experiences with colleagues may be part of this training.

- A major source of stress on relief workers arises from organizational issues. The following may be helpful in reducing stress:
 - a) Reducing bureaucracy and paperwork
 - b) Promoting a sense of camaraderie and mutual support among relief workers
 - c) Interventions to defuse conflicts among workers or between workers and their supervisors
 - d) Providing adequate information about tasks and the overall disaster
 - e) Providing adequate supplies for the work demanded
 - f) Developing work rules and schedules that permit relief workers to follow through on task assignments
 - g) Maintaining communication between workers and their own families,
 - h) Providing adequate facilities for rest, sleep, washing, and eating
 - i) Providing adequate food, shelter, and rest time for relief workers
 - j) Environmental interventions to reduce noise, improve traffic flow, and provide space to take a break
 - k) Providing recognition and appreciation for the sacrifices the relief workers are making

One of the most important ways to reduce stress for relief workers is to provide adequate “break time” or “down time.” This should be provided away from the relief site (e.g., in a separate tent on the edge of the relief operation site, or in a room in the back of a shelter). Food, supplies, and napping facilities should be provided.

- Committed supervisors who are not over-controlling but who are firm about team priorities, who can accept distress in their supervisees, who provide positive feedback, and who monitor relief workers workloads help prevent burnout.
- Efforts should be made to ensure rapid detection of acute stress reactions among workers and to respond immediately. Observation of workers, informal interaction with workers even in the absence of signs of stress, and contact with supervisors may be helpful. Allowing workers who do show acute signs of distress to ventilate briefly may relieve stress. Time out to take a short walk, have a cup of coffee, or meditate may also be useful. During work shifts, it is best not to remove relief workers from the scene of their work. Communicating that strong feelings are understandable and expectable, but that rapid return to the relief tasks is also expected is helpful.
- Within a few hours of any unusual interpersonal incident (e.g., a conflict between workers or between workers and victims) or any other unusual stressful incident (e.g., an accident injuring a worker), a more extensive “defusing” session should be carried

out. It is important for workers to have a place where they can express concerns and reactions in a supportive atmosphere and to blocks destructive criticism. The “defusing” technique is described in detail in Chapter V.

- Periodic “debriefings” and especially debriefing sessions before a relief worker returns home to his or her “regular” life are essential. Seek to create an understanding with relief officials that relief workers are expected to take part in regular debriefings, regardless of whether or not they individually show active signs of distress. Relief workers, themselves, should be made aware that participation in debriefings is part of their job. The “debriefing” technique is described in detail in Chapter V. (*Note: Debriefings should be part of an overall program of stress relief, including prior training for relief and rescue workers and follow-up services. One-shot debriefings may do as much harm as good.*)
- Providing information to relief workers and to their families about what to expect when the relief worker returns home and ascertaining whether support services will be available in the workers’ home communities is helpful. Helping workers develop a “return home” support plan should be part of the final debriefing.
- Not only those who are playing a direct role in rescue or relief operations are at risk of negative emotional effects. Disaster counselors, medical workers, administrators of relief efforts, human rights workers, journalists, and community leaders involved in reconstruction are also at risk, either because of their direct experience of the disaster or because of “vicarious traumatization” as a result of working closely with so many primary and secondary victims of the disaster. Training, peer or group supervision, adequate break time and other supports, and debriefing sessions for these groups are also indicated.

CHAPTER V

SPECIFIC INTERVENTION TECHNIQUES

Crisis Intervention (Individual)

What It Is: A set of techniques for helping individuals gain control over a crisis situation

People It Is Aimed At: Individual relief workers, disaster victims

When to Use it: At any time after a disaster, when individuals present “in crisis”

A “crisis” occurs when a person is faced with a dangerous or other seriously stressful situation for which their habitual problem-solving mechanisms are unsuccessful. Anxiety, fear, guilt and shame, feelings of helplessness or hopelessness, a sense of disorganization, or anger may result. The disaster itself represents a crisis for most victims, of course. In the days and weeks and months following a disaster, additional crises may appear, for victims and for relief workers. Some unexpected incident or simply the buildup of stress over time can constitute the “crisis.”

Crisis intervention is a set of techniques aimed at helping the person in crisis gain control over the crisis situation. A little support and focused help at such a time, aimed at helping the victim to gain control over the crisis situation, may prevent later difficulties. Crisis intervention may be focused on an individual, several people together, or small groups (including a family unit).

The crisis intervention process involves, first, identifying and clarifying the elements of the crisis (the problem or issue or situation); second, developing problem-solving strategies; and third, mobilizing the person to act on these strategies.

Simply identifying the elements of the crisis may, in itself, may help the client regain a sense of mastery. Ventilation of feeling and making the client aware that intense feelings do not represent “going crazy” may be helpful, but the flow of affect should be monitored so that the client doesn’t become frightened of losing control and so that his or her thought does not become further disorganized. The subsequent task is to help the client discover solutions, access support networks and resources and concrete services. This may be a very informal process, accomplished in as little as a few minutes, or it may be more formal and may require several meetings.

Some guidelines for crisis intervention:

- Seek to open up discussion with simple, factual questions: “What happened?” “What is concerning you?” “Can you tell me about it?” Show active interest and concern.
- Follow up with specific questions. Gather specific information beyond what is spontaneously offered. What is happening (or not happening) that is producing an ongoing state of crisis at the moment?
- Respect initial needs to minimize or deny what happened (e.g., that a loved one may have died in the disaster) as self-protection, unless the person is out of touch with reality or is expressing beliefs that are detrimental to their immediate well being. Provide empathy, warmth, support, and reassurance. Gestures such as a pat on the back or an offer of a cup of coffee may help. Recognize pain, fear, suffering, worry. “It must have been terrifying.” “I can see how worried you must be.” “I can see how you must have felt.” Gently and slowly help the client understand the situation more realistically.
- Gradually seek to elicit thoughts and feelings and reactions (“How did you feel about it when it occurred? How do you feel about it now?”). Provide encouragement. Reflect back the victim’s comments to open space for elaboration. Acknowledge feelings but don’t probe deeply or seek to intensify them – this is crisis intervention, not long term therapy. Ask questions. Are there thoughts he or she can’t get out of their head? While expression of feelings or of thoughts about the crisis-producing situation may be helpful, discourage repetitive rumination.
- Be alert to what it is in the disaster or other crisis that distresses the victim. Do not assume you know the answer to this. For example, a disaster has many potentially distressing aspects. Which is it? Is it personal injury? Loss of property? Worry about loved ones? Seeing others hurt? Shame at how the victim acted?
- Focus on the immediate problems, needs, and priorities. Seek to formulate the dimensions of the problem and their meaning for the victim.
- Assess the victim’s coping skills and sources of support. What did they do at various times during and after the disaster (or other crisis-producing situation)? Is their understanding of these events accurate and realistic? Can they focus on the next tasks and those of their family? How have they coped with stress or disaster in the past? How do they deal with anger, pain, loss, failure? What helps? What doesn’t help? How are they dealing with the situation now? What supports are available to them? What resources are available?
- Screen for signs of severe mental illness (e.g., delusions, unrealistic denial, hallucinations, suicidal thoughts, violently aggressive thoughts).

- Respond to immediate reality-based needs. Help the victim generate specific alternatives, plans, actions, solutions, priorities, and determine what they need to do next (including help or support they may need).
- Encourage active management of needs on the client's part. Discourage passivity, dependency, and regression. For instance, in most instances it is better to have the client make telephone calls to arrange for meeting their own needs than for the disaster counselor to make the calls.
- Reinforce adaptive coping. Encourage actions that facilitate feelings of mastery, such as taking part in rescue and recovery activities. Encourage talking through the experience and identifying and accepting as natural their own responses. Connect the person to others responses, so that they recognize their shared problems and responses. Reinforce supportive interactions with family and friends.
- Help the victim manage his or her feelings in acceptable doses that do not produce further disorganization.
- Give permission for or even prescribe adaptive rest, but do not provide reinforcement of passivity or inactivity. Convey an expectation that the victim can make decisions, control his or her own destiny, provide for his or her own needs, with assistance.
- Be sure to get information about the person's identity and how to locate them, to enable later follow up. In some cases, it may be appropriate to follow up within a very short period (e.g. twenty minutes). In other cases, where a longer term issue is at stake, follow up a few days later.

Defusing

What It Is: An informal procedure to help groups of relief workers deal with their reactions to specific incidents

People It Is Aimed At: Relief workers

When to Use it: Within 24 hours after the incident

Defusing is a brief, informal procedure to help relief workers deal with the feelings and reactions created by a specific incident or event. It may be a response to some unexpected incident in the course of relief work (e.g., an accident or a gruesome discovery of a disfigured body during rescue operations), or to a conflict (between two relief workers, between a worker and a supervisor, or between a relief worker and a victim). Defusing provides a chance for those affected by the incident to focus on defining the problem and to develop problem-solving strategies that will preserve the productivity of the work unit.

Defusing can be conducted with a group of individuals who were involved in a single incident or situation or with an individual. When the precipitating situation involves a conflict between two or more people (e.g., between relief workers and victims), it is better to work with each party separately, at least initially. Defusing should be done with relief workers and victims separately and with relief workers and their supervisors separately.

In a defusing session, the affected individual or group meets with a disaster counselor. The session typically lasts twenty to forty minutes.

Stage 1: Lay the groundwork for the session. Let relief workers know the goal is for them to return to work as soon as possible. Find out what happened: Ask the members of the group to tell about the event that led up to the meeting.

Stage 2: Explore the thoughts and feelings and reactions of the several individuals involved: “What did you think when this happened?” “How did you feel about this event when it occurred?” “What was the worst part for you?” “How do you feel about it now?” Reassure group members about their feelings. Be supportive.

Stage 3: Explore the coping strategies the group members are using: How are they dealing with the event or incident. Do they still have needs that are unmet? What would help for them right now? What are their plans for dealing with this event (or similar events) in the future? What would help in the future?

Stage 4: In some instances, a brief rest or diversion (a cup of coffee, a short walk) or a directed relaxation exercise (e.g., breathing, visualization – see below) may suffice to enable the person to recover their own sense of competency and direction.

Stage 5: Follow up: Maintain an expectation that the person will rapidly return to the activities they need to perform. Where a relief worker's return to work after a short break is the expected result of intervention, it may be appropriate to follow up within a very short period (e.g. twenty minutes).

Critical Incident Stress Debriefing

What It Is: A structured technique to help individuals and groups process their disaster experience and bring closure to it.

People It Is Aimed At: relief workers, disaster victims (direct and indirect)

When to Use it: with relief workers, periodically and before returning to non-relief activities. With victims, several days to a year after the disaster

Debriefing was initially developed for use with emergency and relief workers, as part of a larger program of interventions aimed at forestalling the emergence of disabling symptoms or minimizing their enduring effect. Its use with direct victims of disaster is somewhat controversial. It should not be used as a "one-off" intervention (i.e., a single intervention, with no other follow-up or support offered) or if it does not include instruction on coping with stress. Its routine use with disaster victims who are not showing unusual signs of distress or who are not seen as being especially at risk is questionable. It is also inappropriate in situations in which severe stress and danger are ongoing. It has been used, with reported success, with groups of disaster victims identified as having symptoms or otherwise being at especially high risk, however.

Critical incident stress debriefing (CISD) is a structured group discussion.³ Its goal is to help people build an account of traumatic experiences so as to help prevent the intense emotions and experiences of the experiences from becoming entrenched in the form of disabling symptoms. It allows people to share powerfully charged feelings of anger, helplessness, or fear, in a way that helps diffuse them. They learn that these reactions are experienced by others, too, and are “normal.” They learn that, though they may have had different specific experiences in the disaster, they are not alone.

Debriefing is usually done in a group setting. The group may consist of a work team of relief workers, a pre-existing work team (e.g., the crew of a train, a work team in a factory), a group of neighbors, a family, or a group of survivors assembled on an ad hoc basis. The group may consist of up to fifteen or so members.

Debriefing is carried out at least a few days after the traumatic event. If it is attempted too soon after the disaster, the short-term emotional reactions (e.g., disbelief, denial, a sense of unreality, delayed reactions) and preoccupation with dealing with practical issues may interfere, and repeated retelling of the disaster story may reinforce a sense of helplessness. Other techniques to help people regain a support network, reduce anxiety, and establish a sense of mastery can be carried out in the meantime.

³ The CISD model of intervention was originally proposed by J. Mitchell in the *Journal of Emergency Medical Services*, 1983.

Debriefing may continue to be a useful technique months or even several years after the disaster. At this stage, correcting cognitive distortions and inaccurate evaluations of victims' own roles and inaccurate estimations of ongoing threat, providing knowledge of common responses, and dealing with reactions to the relief and recovery process assume greater importance.

Debriefing usually involves a single session, lasting about two to three hours. If the participants show lingering or especially intense reactions, additional sessions may be added or individual counseling may be used as a follow up activity. If necessary, a shortened version may also be carried out. (With relief workers, who continue to be exposed to trauma, multiple shorter sessions are often used).

When possible, it is helpful to have two disaster counselors meeting with the group. One plays the primary role of leading the group discussion process, questioning, listening, and giving information. The second is available to spend time with any participants who need to leave the group due to their distress as well as helping guide the overall process of the group. (As an additional benefit, the two counselors can debrief each other about their responses to the session).

Critical Incident Stress Debriefing proceeds through a series of pre-planned phases. It can be modified in a variety of ways, to take into account the needs of individual victims, cultural differences, the effects of different kinds of disasters, etc. The guidelines that follow are meant to be suggestive, rather than a rigid set of rules.

Phase 1: Introduction: *Introduce yourself and explain what the purpose of the session is.* Give an overview of the process: (i.e., it will last about two hours; people will be asked to tell their stories of the disaster and their reactions; information about normal reactions to disasters will be offered). Describe the goals (helping people understand what is happening to them and why, so that they can manage their reactions more effectively and with minimum anxiety and disruption to their lives.). Seek to normalize people's experiences: unusual emotional symptoms are to be expected, although lack of symptoms is also normal. Answer questions. Address participants' fears and possible misconceptions (e.g., it is not psychotherapy; participation does not mean they are "abnormal").

The rules for the session should be stated: (a) No one is required to speak, although they are encouraged to do so. (b) Judgement or blaming others will not be allowed. (c) Everyone must listen to the others and let them have their say. (d) Participants should speak for themselves, not for others. (e) If anyone is very upset, they should still try to stay in the group. If they have to leave to recompose themselves, they may (accompanied by one of the counselors, if two are leading the group), but they should return promptly. (f) The proceedings are confidential: no one can talk about the substance of what others said outside the group (no "gossip").

Phase 2: Narratives: *In this phase, the aim is sharing facts and collectively creating a picture of what happened.* "Tell us who you are and what happened from your

perspective. Who would like to start?" Include everyone's account of what happened to them (although, again, participants can pass if they choose to). Refrain from focusing on psychological reactions at this point. If participants begin to talk about their reactions, gently steer them back to the "facts." With relief workers, the starting point may be to ask about what their role was in the relief effort, how long they have been on the job, and whether there were any troubling situations.

Phase 3: Reactions: *In this phase, a shared inventory of thoughts and feelings is developed.* Participants learn that others share their symptoms, which lessens feelings of isolation and shame. They also learn that thoughts and feelings are related, and that changes in understanding can lead to changes in feelings.

(a) Go around the room and ask about people's cognitive reactions at the time of the incident. "What were your first thoughts? What did you think next?" "What did you do then?" Then turn to reactions in the aftermath of the events. "What did you think when the event was over?"

(b) Now shift to reports of feelings, rather than thoughts. Ask participants to describe their feelings, linking them to their thoughts and appraisals of the situation. "How did you feel then?" "What was the worst thing about the experience for you?" "What aspect of the events caused/causes you the most pain?" Ask about the reactions of the participants' family and other significant people in their lives. Look for any feelings that family members or other significant people didn't understand what had happened to them or that family members *increased* their anxiety by the way they expressed concern. Ask about subsequent reactions (e.g., "that night" or "the next day"). Ask about both physical reactions and emotional symptoms.

Emotional expressions at this stage (and possibly at others) are to be expected. This should be accepted, but contained. If a participant is unable to contain his or her feelings to a degree that it becomes hard for the group to continue, he or she should be asked to leave the room (accompanied by the co-leader of the group) until they can compose themselves. The expectation should be that they will return within a few minutes.

(c) Continue to explore the sequence of thoughts and feelings in the days or weeks following the event, moving into the present.

(d) Now begin to shift back from emotions. Explore coping strategies. "How did you deal with it? How are you dealing with it?" "What do you usually do when you feel this way?" "What has helped you at other times to cope with problems?" "What could you do to help yourself next time you feel this way?" "Were there any positive aspects of the experience?" (With relief workers, helping identify positive or hopeful memories is especially important, since it may help them return to their relief work).

Phase 4: Education: *In this phase, the focus shifts more formally to education, although educational interventions may be made throughout the process.*

(a) Summarize the session, bringing together the narratives and the responses (thoughts, actions, feelings).

(b) Warn participants that their symptoms may not subside instantly and that new symptoms may appear. Recognize the potential for some difficult times. Hold out the expectation that this will be for a limited time, however. Be realistic, though: it can take months or even a year or more for symptoms to subside. *At the same time, teach participants that symptoms are not universal and that a lack of symptoms is just as “normal” as symptoms.*

(c) *Teach techniques of stress management (e.g., relaxation exercises).* Emphasize the importance of getting rest, having a good diet, getting exercise. Encourage talking with others. Encourage identifying concrete steps they need to pursue.

(d) *Identify those who need immediate help (e.g., desensitization of phobic symptoms). Arrange for follow-up or referral.*

(e) Give information on sources of further help. Distribute and pamphlets or leaflets available on responses to disasters.

(f) *Arrange for follow-up.*

Phase 5: Follow-up: Two or more weeks later, follow up, either by a formal questionnaire or by a brief interview. Track recovery or lack of it. Identify what has been helpful. Identify problems needing further attention.

Variations and adaptations:

1. *With disaster relief workers* (assuming that they are not themselves primary victims of the disaster), debriefing is a response not to their experience of the disaster itself but to the stresses and strains of relief work. It may be useful to carry out a debriefing session periodically (e.g., once a week or even more often). In any event, a session should be scheduled before relief workers from outside the disaster community return home to their “everyday” lives.

An end-of-service debriefing session should focus on issues such as:

- How did you get involved? What was your role? Did you feel trained for it/ prepared for it? What were your initial expectations and initial reactions?
- What were your later experiences? What did you do and think at each stage?

- What was especially difficult for you? What made you feel helpless, angry, guilty? Did any of your experiences trigger memories of bad things that have happened to you?
- What went well? What parts made you feel good about the experience?
- What were your relationships like with other relief workers? How did you get along?
- What are your feelings towards the victims now?
- How has it been for your family for you to be away? What do you think their expectations are for your return? What is it like to finish? Do you anticipate difficulties in resuming your normal life? Do you have regrets at leaving?
- What did this experience mean to you? What did you learn for yourself? What did you learn that can be useful in future disaster work?

2. *Debriefing can be conducted with a variety of audiences and under a variety of constraints.*

- With a very large group (more than twenty or so), it is impossible for every person present to share their experiences and the emphasis shifts to the educational portions. (With relief workers who are about to return home, the debriefing should be set up so that everyone gets a chance to speak. In this situation, two shorter but smaller sessions is preferable to one longer, overly large session).
- Debriefing can even be done one-on-one, when necessary.
- Debriefing can be done using a family unit as the group. This may be especially useful if there is evidence that a child is in distress or at risk of future difficulties.

3. *Debriefing can be adapted to various cultural situations.* For instance, groups formed in response to a volcanic eruption in the Philippines replaced the training in relaxation exercises with prayer as part of the sessions. Other traditional healing rituals could be incorporated in a similar fashion.

Stress Reduction Techniques

What They Are: Technique for helping individuals reduce stress and anxiety

People It Is Aimed At: Relief workers, victims

When to Use it: At times of stress or on regular basis

Disasters produce a great amount of stress and anxiety, both immediately and over the weeks and months that follow. A variety of techniques may be useful in reducing stress and anxiety.

Rest and recreation: Both brief periods of rest in the course of the day's activities and adequate sleep are important, both for relief workers and survivors. Understandably, the emergency created by a disaster may interfere with these in the first hours or days after the disaster. As soon as the most urgent, life-and-death rescue needs are met, however encourage relief workers to permit themselves to take a break or a short nap and ensure that adequate facilities are available for these. Encourage those supervising relief efforts to schedule relief workers shifts so as to ensure that the workers get adequate sleep. Recreational activities, ranging from card games to watching television to participating in games may be helpful, both for adults (relief workers and primary disaster victims) and for children and adolescents. In part, these serve as a diversion, preventing "ruminating" about the disaster. They also help restore a sense of normalcy and control over one's life.

Ventilation: Allowing relief workers and survivors to talk about their experiences and feelings in both informal and formal settings relieves stress. Repetitive restatements or rumination, however, do not relieve stress and may promote depression, however, and should be discouraged. Divert the discussion on to other topics, provide diversions, or use other approaches to promoting relaxation.

Exercise: Physical activity helps dissipate stress. Provide opportunities for relief workers and primary disaster victims (e.g., in a shelter) to get exercise: taking a walk, jogging, engaging in a group exercise "class," engaging in an athletic event, dancing.

Relaxation exercises: Several types of relaxation exercise can easily be adapted for use in disaster settings to help clients reduce anxiety and stress. These include breathing exercises, visualization exercises, muscle relaxation exercises, and combinations of these.

- Breathing exercises: The client is taught to breathe in a controlled way, while attending closely to their own breathing.
- Visualization exercises: The client is asked to provide an account of a setting or situation he or she finds very relaxing (e.g., walking in the woods) and is then

asked to visualize this scene in a very detailed way. The particular scene to be visualized should be worked out in discussion with the intended user of the exercise.

- Muscle relaxation exercises: The client is asked to practice first contracting, then relaxing different muscle groups until the entire musculature is relaxed, while concentrating on the feelings of relaxation in the muscles.

First, the counselor leads an individual or a small group of individuals through these exercises. If the victims have tape cassette players available, it may be helpful to record a relaxation exercise for each client to listen to and engage in on his or her own. Individuals can also be taught how to use the procedures on their own without an auxiliary tape.

Relaxation procedures can be used on an “as needed” basis (i.e., at a time when the relief worker or survivor is feeling “stressed out”), either on their own or with the help of the counselor. A regularly scheduled relaxation event, whether consisting of relaxation exercises, prayer, stretching exercises, or other techniques, may be offered at a consistent time once or twice a day. Many people also find that following the relaxation procedure on their own two or three times a day on a routine basis increases their ability to deal with stress throughout the day.

After learning a full relaxation exercise, a shortened form can be developed. Such brief forms are especially useful for using “as needed.”

For a person to be willing to allow themselves to relax by following the directions of another person (the disaster counselor) requires some trust. Teaching relaxation exercises should be delayed until the counselor and the client have created a trusting relationship. This is especially true of disaster survivors who have developed post traumatic stress disorder. Others, who are very anxious or very depressed, may find relaxation exercises problematic. Relaxation exercises should be approached with caution with such clients. *If the client begins to become agitated, stop the exercise.*

Contraindications to the use of relaxation exercises

Relaxation exercises are not for everyone. They should be used with extreme caution or not at all in the following circumstances:

- Presence of marked dissociative symptoms
- Anger as the primary response to trauma
- State of acute grief
- State of extreme anxiety or panic
- History of severe psychopathology prior to the trauma
- Current substance abuse
- Severe depression and/or suicidal ideation
- Presence of marked on-going stressors

- Strong need of client to regain control

Also note that visualization exercises can inadvertently re-trigger traumatic experiences (e.g., using a walk through the woods as a "pleasant" image with a refugee who escaped through the woods). Similarly, breathing exercises may be frightening to those who have been buried under rubble.

Sample scripts for several types of relaxation exercise can be found in Appendix B.

Expressive Techniques

What They Are: Techniques which do not require the ability to explicitly label emotional states

People It Is Aimed At: Children; adults who have trouble responding to questions or describing feelings in verbal form

When To Use It: Several days to a year or more after the disaster

It is difficult for children to discuss their emotional problems. Their verbal abilities are relatively undeveloped and they lack facility at labeling their emotions. This is especially the case for children below the age of eleven or so, but even older children and adolescents, and not a few adults, may have difficulty or inhibitions about explicitly talking about their feelings. In these settings, techniques that permit expression and exploration of feelings in non-verbal form (e.g., play, art, dance, games) or in forms that, although they use words, do not require the person to explicitly identify and label emotional states (e.g., writing poetry, role playing, puppet play) are useful. These techniques can be collectively labeled “expressive techniques.”

Underlying these techniques is the notion that play, artistic creation, and similar activities are systems of communication and interpersonal interaction. *Through play and similar activities, the child reveals meaningful information about his or her emotional problems, inner thought processes and states, desires, and anxieties.*

As with conventional verbal techniques, the goals of expressive techniques include ventilation of feelings, creating a new narrative about terrifying events, regaining a sense of control and mastery, working through grief, finding and feeling support from peers, and normalizing unexpected and unfamiliar reactions. They also help establish a trusting relationship between the child and the counselor.

Expressive techniques are commonly used with children up to the age of eleven or so, and with children as young as two to four. They can be used with people of any age, however, In what follows, the word “child” will be used to indicate the person with whom the technique is used, with the understanding that the “child” may, in fact, be an adolescent or adult.

Expressive techniques can be used with a single child, but are also easily adapted for groups (either ad hoc or a school class). In some cases, children experience a disaster but the parents do not experience it directly. This would be the case, for example, if there were an explosion or other violent incident at a school. In these circumstances, although parents might benefit from group debriefing sessions, the children might be treated in their classes. If, however, the child’s parents were themselves also primary victims of the

disaster or if the child is especially distressed, it may be helpful to involve the whole family unit together. A mix of expressive and verbal techniques might then be used.

Expressive techniques involve an active role for the counselor. They do not just consist in letting the child play. Undirected play may be diverting and healing for the child. However, monotonous, repetitive, ritualized play by an isolated child is a sign of trauma. It does not release the child from distress. In expressive therapy, the counselor participates; limits (emphasizes rules, encourages frustration tolerance, prevents overt aggression against others); interprets (“I wonder if you felt like your doll when....”).

Just as with other techniques, the user of expressive techniques should be sensitive to the stage of response to the disaster. Immediately after the disaster, play may help children acknowledge and ventilate their feelings. This helps reduce anxiety and provides an opportunity to provide the children with accurate information and to screen for those in severe distress. Lack of expression of intense emotion at this time is not necessarily a sign of severe disturbance, requiring treatment, however. The child who has lost a parent in a disaster, for instance, may be in a state of shock and denial for a week or two after the event and may not be fully able to communicate intensively about it for several weeks beyond that. Providing repeated opportunities for the child to express him or herself, when ready, is appropriate. More extensive intervention must wait until the child is able to handle it.

Expressive therapy may, initially, at least, be either “directive” or “non-directive.” In non-directive play, the child’s free activity (e.g., with puppets, dolls, or art materials) is observed. The counselor gently interacts with the child, entering the child’s fantasy world but in doing so, seeking to help the child explore feelings and thoughts.

In directive or pre-arranged play, the child is asked to re-enact some part of his or her experience. This might take the form of a re-enactment with dolls or puppets, or it might take the form of drawing or modeling with clay. An alternative form, especially with older children, might involve the child writing poems or stories that draw on his or her experience. The goal is to help the child eventually replay the experience with a different ending or in a fashion in which the child is exhibiting mastery.

The school may be an appropriate place for some expressive techniques (e.g., story writing, role playing). In addition, the teacher can teach children about the responses to be expected after a disaster, allow for the ventilation of feelings, teach coping skills and problem-solving techniques (through role playing, games, “complete-this-story” techniques), reassure. Aside from specific activities engaged in at school, merely going to school regularly has a healing effect. School provides structure and normalcy. Just as disaster workers benefit from the expectation that, after a crisis, they should get help but then return to their job promptly, so children benefit from the clear expectation that they will return to school promptly after a disaster. If extended shelter stays or stays in refugee camps are necessary and children cannot return to their regular school, it is important to create an ad hoc school. Teachers can receive brief training as disaster counselors with a special emphasis on work with children in their schools, using

expressive techniques. In some settings, children in mid-adolescence have also been trained as peer counselors.

Some expressive techniques

Art techniques

Free drawing, painting, modeling in clay
 Drawing “a person” or drawing “your family”
 “Squiggles”: Each takes a turn making a picture from the other’s “squiggles”
 and then makes up a story about it
 Drawings, maps, clay models of disaster scene
 Creating a group or community mural

Doll play

Human or animal dolls (commercial or homemade or paper dolls)
 Other “props” – toy soldiers, trucks, etc.

Puppet Play

Free interactions with puppets
 Re-enactments of experiences (in disaster or elsewhere); role playing

Story Telling

Child tells story, adult re-tells it with a “healthier” ending/solution/attribution
 Making books of stories and poems and drawings
 Role playing; re-enactments of actual experiences in the disaster; role playing
 of coping strategies
 Mock escapes from the disaster
 Oral histories: adults tell stories about the history of the community (to adults and
 children)

Writing

Event and emotion diaries
 Poems
 Stories

Relaxation techniques

Visualization, with a “magic word” to trigger the relaxed state produced
 Exercise; active games; races
 Muscle relaxation
 Neck and back massage

Appendix A: Assessment Instruments

I. The Self Reporting Questionnaire (SRQ)⁴

The **Self Reporting Questionnaire (SRQ)** is a measure of general psychological distress developed by the World Health Organization and intended for use with adults and older adolescents (ages 15 up). If the person completing the questionnaire does not have at least five years of schooling, the questions should be read to them. This is permissible in any case.

Interpretation: No universally applicable cut off score can be used under all circumstances. In most settings, however, five to seven positive responses on items 1-20 (the “neurotic” symptoms) indicate the presence of significant psychological distress. Item 21 addresses drinking behavior, a problem in its own right and potentially a signal of distress. A single response to any of items 22-24 (the “psychotic” symptoms”) indicates serious symptoms and need for help. Items 25-29 refer to common symptoms of post traumatic stress disorder. A single response to any of these items warrants follow-up.

Translations: Translations of the **SRQ** into Arabic, French, Hindi, Portuguese, Somali, and Spanish are available upon request, together with further information, from the World Health Organization (see footnote 4). The **SRQ** has been translated into a number of other languages, including Afrikans, Bahasa Malaysia, Bengali, Filipino, Italian, Kiswahili, Njanja Lusaka, Shona, Siswati, and South Sotho. References to studies using these translations, as well as additional information about the **SRQ** can be found *in A User’s Guide to the Self Reporting Questionnaire* (see footnote 4).

⁴ The SRQ was developed by the World Health Organization. For additional details on its development and use and a bibliography, see the WHO document, *A Users’ Guide to the Self Reporting Questionnaire* (document WHO/MNH/PSF/94.8), available from the Division of Mental Health, World Health Organization, CH-1211 Geneva 27, Switzerland. I have added items 25-29 to explicitly address post traumatic symptoms.

Self Reporting Questionnaire

Name: _____ **Date:** _____

Address: _____

***Instructions:** Please read these instructions completely before you fill in the questionnaire. The following questions are related to certain pains and problems that may have bothered you in the last 30 days. If you think the question applies to you and you had the described problem in the last 30 days, put a mark on the line under **YES**. On the other hand, if the question does not apply to you and you did not have the problem in the last 30 days, put a mark on the line under **NO**. If you are unsure how to answer a question, please give the best answer you can. We would like to reassure you that the answers you provide here are confidential.*

YES NO

- | | | |
|-------|-------|--|
| _____ | _____ | 1. Do you often have headaches? |
| _____ | _____ | 2. Is your appetite poor? |
| _____ | _____ | 3. Do you sleep badly? |
| _____ | _____ | 4. Are you easily frightened? |
| _____ | _____ | 5. Do you feel nervous, tense, or worried? |
| _____ | _____ | 6. Do your hands shake? |
| _____ | _____ | 7. Is your digestion poor? |
| _____ | _____ | 8. Do you have trouble thinking clearly? |
| _____ | _____ | 9. Do you feel unhappy? |
| _____ | _____ | 10. Do you cry more than usual? |
| _____ | _____ | 11. Do you find it difficult to enjoy your daily activities? |
| _____ | _____ | 12. Do you find it difficult to make a decision? |
| _____ | _____ | 13. Is your daily work suffering? |
| _____ | _____ | 14. Are you unable to play a useful part in life? |
| _____ | _____ | 15. Have you lost interest in things? |

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- ___ ___ 16. Do you feel that you are a worthless person?
- ___ ___ 17. Has the thought of ending your life been in your mind?
- ___ ___ 18. Do you feel tired all the time?
- ___ ___ 19. Do you have uncomfortable feelings in your stomach?
- ___ ___ 20. Are you easily tired?
- ___ ___ 21. Do you drink alcohol more than usual?
- ___ ___ 22. Do you feel that somebody has been trying to harm you in some way?
- ___ ___ 23. Have you noticed any interference or anything else unusual with your thinking?
- ___ ___ 24. Do you ever hear voices without knowing where they come from or which other people cannot hear?
- ___ ___ 25. Do you have distressing dreams about the disaster or are there times when it seems like you are re-living your experiences in the disaster?
- ___ ___ 26. Do you avoid activities, places, people, or thoughts that remind you of the disaster?
- ___ ___ 27. Do you seem less interested than you used to be in your usual activities and friends?
- ___ ___ 28. Do you feel very upset when you are in a situation that reminds you of the disaster or when you think about the disaster?
- ___ ___ 29. Are you having trouble experiencing or expressing your feelings?

II. The Pediatric Symptom Checklist (PSC)⁵

The **Pediatric Symptom Checklist (PSC)** is a measure of distress in children, aged four to sixteen. There are two versions.

1. The **PSC-P** is completed by the parent (or teacher) of a child aged 4-16. If the parent's reading ability is believed to be below the fifth grade level, it should be read to them. It can be administered by reading it to the parent even if their reading level is adequate to the task. The **PSC-P** consists of items that are rated as "never" (scored 0), "sometimes" (scored 1), or "often" (scored 2). Part I (items 1-35) is a measure of general distress. Part II (items 36-50) contains additional items more specific to disaster situations. The two parts of the **PSC-P** are scored separately. The "Part I Total" is the sum of the scores on items 1-35. The "Part II Total" is the sum of the scores on items 36-45.
2. The **PSC-Y** is a self-report form, completed by the child himself or herself. It is suitable for children aged 9-14. The **PSC-Y** should be read to children younger than 12 or to any child not able to read at a fifth grade level. It can be administered by reading it to the client even if their reading level is adequate to the task. The **PSC-Y** consist of items that are rated as "never" (scored 0), "sometimes" (scored 1), or "often" (scored 2). Part I (items 1-35) is a measure of general distress. Part II (items 36-50) contains additional items more specific to disaster situations. The two parts of the **PSC-Y** are scored separately. The "Part I Total" is the sum of the scores on items 1-35. The "Part II Total" is the sum of the scores on items 36-43.

Interpretation of the PSC-P:

Part I: For four and five year old children, a score of 24 or higher suggests moderate to severe distress. For children aged six to sixteen, a score of 28 or higher suggests significant distress. These cut-off scores should be regarded as approximate. There is no universally applicable cut off score that can be used under all circumstances. In some situations, use of a slightly lower cut off may be justified.

Part II: No norms are available. Based on the content of the items, in the context of a post-disaster evaluation, a score of 4 or more suggests the need for further evaluation of the child.

Interpretation of the PSC-Y:

Part I: A score of 30 or higher suggests moderate to severe psychosocial distress. This cut-off score should be regarded as approximate. There is no universally applicable cut

⁵ The PSC was developed by Michael Jellinek, J. Michael Murphy, and associates. A detailed discussion and bibliography can be found at their website, <http://healthcare.partners.org/psc>. I have added "Part II," which addresses some common responses to disasters more specifically.

off score that can be used under all circumstances. In some situations, use of a slightly lower cut off may be justified.

Part II: No norms are available. Based on the content of the items, a score of 2 or more on items 36-38, which suggest psychotic experiences, or a score of 4 or more on items 40-43, which reflect post traumatic responses, suggest the need for further evaluation of the child.

Translations: The **PSC-P** has been translated into a number of languages, including Spanish, Chinese, Swahili, Khmer, and Haitian Creole. For further information on these, see the references at the **PSC** website, <http://healthcare.partners.org/psc>, which also contains additional details on this measure.

Pediatric Symptom Checklist- Parent Report Form (PSC-P)

Child's Name: _____

Your Name: _____ **Date:** _____

Address: _____

Instructions: *Please mark under the heading that best describes this child.*

NEVER SOMETIMES OFTEN

PART I

- | | | | |
|--|-------|-------|-------|
| 1. Complains of aches and pains..... | _____ | _____ | _____ |
| 2. Spends more time alone..... | _____ | _____ | _____ |
| 3. Tires easily, has little energy..... | _____ | _____ | _____ |
| 4. Fidgety, unable to sit still..... | _____ | _____ | _____ |
| 5. Has trouble with teacher..... | _____ | _____ | _____ |
| 6. Less interested in school..... | _____ | _____ | _____ |
| 7. Acts as if driven by a motor..... | _____ | _____ | _____ |
| 8. Daydreams too much..... | _____ | _____ | _____ |
| 9. Distracted easily..... | _____ | _____ | _____ |
| 10. Is afraid of new situations..... | _____ | _____ | _____ |
| 11. Feels sad, unhappy..... | _____ | _____ | _____ |
| 12. Is irritable, angry..... | _____ | _____ | _____ |
| 13. Feels hopeless..... | _____ | _____ | _____ |
| 14. Has trouble concentrating..... | _____ | _____ | _____ |
| 15. Less interested in friends..... | _____ | _____ | _____ |
| 16. Fights with other children..... | _____ | _____ | _____ |
| 17. Absent from school..... | _____ | _____ | _____ |
| 18. School grades dropping..... | _____ | _____ | _____ |
| 19. Is down on him or herself..... | _____ | _____ | _____ |
| 20. Visits the doctor with doctor finding nothing wrong... | _____ | _____ | _____ |
| 21. Has trouble sleeping..... | _____ | _____ | _____ |
| 22. Worries a lot..... | _____ | _____ | _____ |
| 23. Wants to be with you more than before..... | _____ | _____ | _____ |
| 24. Feels he or she is bad..... | _____ | _____ | _____ |
| 25. Takes unnecessary risks..... | _____ | _____ | _____ |
| 26. Gets hurt frequently..... | _____ | _____ | _____ |
| 27. Seems to be having less fun..... | _____ | _____ | _____ |
| 28. Acts younger than children his or her age..... | _____ | _____ | _____ |
| 29. Does not listen to rules..... | _____ | _____ | _____ |
| 30. Does not show feelings..... | _____ | _____ | _____ |

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	NEVER	SOMETIMES	OFTEN
31. Does not understand other people's feelings.....	_____	_____	_____
32. Teases others.....	_____	_____	_____
33. Blames others for his or her troubles.....	_____	_____	_____
34. Takes things that do not belong to him or her.....	_____	_____	_____
35. Refuses to share.....	_____	_____	_____

PART II

36. Gets nervous or scared or upset for no reason.....	_____	_____	_____
37. Thinks a lot about bad things that have happened.....	_____	_____	_____
38. Does special things so nothing bad will happen.....	_____	_____	_____
39. Has bad dreams or nightmares.....	_____	_____	_____
40. Says scary thoughts just pop into his or her head	_____	_____	_____
41. Fears certain animals or situations or places.....	_____	_____	_____
42. Brags or boasts a lot.....	_____	_____	_____
43. Wets bed at night.....	_____	_____	_____
44. Gets jumpy at loud noises, startles easily.....	_____	_____	_____
45. Repeats certain acts over and over.....	_____	_____	_____

PART I TOTAL: _____

PART II TOTAL: _____

Pediatric Symptom Checklist - Youth Report (PSC-Y)

Name: _____ Date: _____

Address: _____

Instructions: Please place a mark under the heading that best fits you:

NEVER SOMETIMES OFTEN

PART I

- | | | | | |
|-----|--|-------|-------|-------|
| 1. | I complain of aches or pains..... | _____ | _____ | _____ |
| 2. | I spend more time alone..... | _____ | _____ | _____ |
| 3. | I tire easily, have little energy..... | _____ | _____ | _____ |
| 4. | I am fidgety; I can't sit still..... | _____ | _____ | _____ |
| 5. | I have trouble with my teachers..... | _____ | _____ | _____ |
| 6. | I am less interested in school..... | _____ | _____ | _____ |
| 7. | I act as if I am driven by a motor..... | _____ | _____ | _____ |
| 8. | I daydream too much..... | _____ | _____ | _____ |
| 9. | I am easily distracted..... | _____ | _____ | _____ |
| 10. | I am afraid of new situations..... | _____ | _____ | _____ |
| 11. | I feel sad, unhappy..... | _____ | _____ | _____ |
| 12. | I am irritable, angry..... | _____ | _____ | _____ |
| 13. | I feel hopeless | _____ | _____ | _____ |
| 14. | I have trouble concentrating | _____ | _____ | _____ |
| 15. | I am less interested in friends | _____ | _____ | _____ |
| 16. | I fight with other children | _____ | _____ | _____ |
| 17. | I am absent from school a lot | _____ | _____ | _____ |
| 18. | My school grades are dropping | _____ | _____ | _____ |
| 19. | I am down on myself | _____ | _____ | _____ |
| 20. | I visit doctor with doctor finding nothing wrong | _____ | _____ | _____ |

Go on to next page

	<u>NEVER</u>	<u>SOMETIMES</u>	<u>OFTEN</u>
21. I have trouble sleeping.....	_____	_____	_____
22. I worry a lot.....	_____	_____	_____
23. I want to be with parent more than before.....	_____	_____	_____
24. I feel that I am bad.....	_____	_____	_____
25. I get hurt frequently.....	_____	_____	_____
27. I seem to be having less fun.....	_____	_____	_____
28. I act younger than my age.....	_____	_____	_____
29. I do not listen to rules.....	_____	_____	_____
30. I do not show feelings.....	_____	_____	_____
31. I do not understand other people's feelings.....	_____	_____	_____
32. I tease others.....	_____	_____	_____
33. I blame others for my troubles.....	_____	_____	_____
34. I take things that do not belong to me.....	_____	_____	_____
35. I refuse to share.....	_____	_____	_____

PART II

36. I feel that somebody has been trying to harm me.....	_____	_____	_____
37. I notice interference or something else unusual..... with my thinking	_____	_____	_____
38. I hear voices without knowing where they come from or which other people cannot hear	_____	_____	_____
40. I have distressing dreams about my experiences or times when it seems like I am re-living my terrible experiences	_____	_____	_____
41. I avoid activities, places, people, or thoughts that me of the disaster	_____	_____	_____
42. I seem less interested than I used to be in my usual activities and friends?	_____	_____	_____
43. I feel very upset when I am in a situation that reminds.. me of the disaster or when I think about the disaster	_____	_____	_____

TOTAL ITEMS 1-35 _____

TOTAL ITEMS 36-38 _____

TOTAL ITEMS 39-43 _____

III. The Relief Worker Burnout Questionnaire

The **Relief Worker Burnout Questionnaire** is intended to help detect burn out among relief workers. Even relief workers not showing signs of acute distress (e.g., as indicated by a high score on the Self Reporting Questionnaire) may develop burnout, with loss of efficiency and potential long term consequences.

Interpretation: No formal norms are available for this measure. Based on the content of the items, a score of 0 – 15 suggests the worker is probably coping adequately with the stress of his or her work. A score of 16-25 suggests the worker is suffering from work stress and would be wise to take preventive action. A score of 26-35 suggests possible burn out. A score above 35 indicates probable burnout.

Relief Worker Burn Out Questionnaire

Name: _____ Date: _____

Instructions: Rate each of the following items in terms of how much the symptom was true of you in the last month.

0 = Never

1 = Occasionally (less than one time per week)

2 = Somewhat often (one or two times a week)

3 = Frequently (three or four times a week)

4 = Almost always (almost every day)

- _____ 1. Do you tire easily? Do you feel fatigued a lot of the time, even when you have gotten enough sleep?
- _____ 2. Are people annoying you by their demands and stories about their daily activities? Do minor inconveniences make you irritable or impatient?
- _____ 3. Do you feel increasingly critical, cynical, and disenchanted?
- _____ 4. Are you affected by sadness you can't explain? Are you crying more than usual?
- _____ 5. Are you forgetting appointments, deadlines, personal possessions? Have you become absent-minded?
- _____ 6. Are you seeing close friends and family members less frequently? Do you find yourself wanting to be alone and avoiding even your close friends?
- _____ 7. Does doing even routine things seem like an effort?
- _____ 8. Are you suffering from physical complaints such as stomachaches, headaches, lingering colds, general aches and pains?
- _____ 9. Do you feel confused or disoriented when the activity of the day stops?
- _____ 10. Have you lost interest in activities that you previously were interested in or even enjoyed?
- _____ 11. Do you have little enthusiasm for your work? Do you feel negative, futile, or depressed about your work?
- _____ 12. Are you less efficient than you think you should be?
- _____ 13. Are you eating more or less, smoking more cigarettes, are using more alcohol or drugs to cope with your work?

_____ TOTAL SCORE (Add up scores for items 1 – 13)

Appendix B: Relaxation Scripts

I. Guided Relaxation Exercise

[The following is a script for a relaxation exercise combining breathing and muscle relaxation. It should be read to the client in a calm, slow voice, allowing time for the client to take and hold breaths, to let out their breath slowly, and to first tighten, then relax their muscles slowly, as indicated in the script.]

Close your eyes and put yourself in a comfortable position. If you need to, you can make adjustments now or as we go along. Quiet moves will not disturb your relaxation.

Help your body begin to relax by taking some slow, deep breaths. Take a deep breath now. Hold your breath and count silently to three, or five, or ten. Take the amount of time holding your breath that feels good to you. Then let your breath out in an easy, soothing way. Breathe in again and hold it a few seconds... and, when you are ready, again let it out. As you let your breath out, imagine breathing out the tension in your body, out through your nose and mouth, breathing out the tension as you breath out. Do it yet again, breathing in slowly... holding it... and out.

I will now going to teach you an easy method of relaxation. *Make a tight fist with both hands... very tight ... so tight you can feel the tension in your forearms. Now, let go suddenly ... Notice the feeling of relaxation flowing up your arms... Make a fist with both hands again... and suddenly let go. Again, notice the feeling of relaxation in your arms... Let your mind move this feeling of muscle relaxation up your arms... through your shoulders...into your chest... into your stomach... into your hips. Continue to focus on this feeling of relaxation, moving it into your upper legs... through your knees... into your lower legs... your ankles and feet... Now let this feeling of comfortable relaxation move from your shoulders into your neck... into your jaw and forehead and scalp...Take a deep breath, and as you exhale, you can become even more deeply relaxed... You can deepen your relaxation by practicing this again. *[Go back to the place above marked by the asterisk (*) and repeat this section a second time]*.

However you feel right now is just fine. As you become even more relaxed and comfortable, each time you breath out you can continue to drift even deeper into a state of comfort... safe and serene ... When you relax, as you are now, you can think more clearly or simply allow yourself to enjoy feelings of comfort, serenity, and quiet. As a result of this relaxation, you can look forward to feeling more alert and energetic later on... You can enjoy a greater feeling of personal confidence and control over how you feel, how you think, and what you believe. You can feel more calm, more comfortable, more at ease, and more in control of what's important to you....

When you're ready, you can open your eyes, You can feel alert, or calm, or have whatever feelings are meaningful to you at this time. As you open your eyes, you may want to stretch and flex gently, as though you are waking from a wonderful nap.

II. Brief Muscle Relaxation Exercise

[The following is a breathing and muscle relaxation exercise for achieving relaxation rapidly. It should not be used until the client is able to use the longer version (above) effectively. As with the lengthier script, it should be read in a slow, calm voice, allowing the client time to carry out the directions.]

Take two or three deep breaths. Each time, hold your breath for a few seconds, then let it out slowly, concentrating on the feeling of the air leaving your body... Now tighten both fists, and tighten your forearms and biceps... Hold the tension for five or six seconds...Now relax the muscles. When you relax the tension, do it suddenly, as if you are turning off a light...Concentrate on the feelings of relaxation in your arms for 15 or 20 seconds...Now tense the muscles of your face and tense your jaw... Hold it for five or six seconds... now relax and concentrate on the relaxation for fifteen or twenty seconds...Now arch your back and press out your stomach as you take a deep breath... Hold it... and relax...Now tense your thighs and calves and buttocks...Hold...and now relax. Concentrate on the feelings of relaxation throughout your body, breathing slowly and deeply.

III. Guided Visualization Exercise (Example)

What follows is intended purely as an example, not as a script. Visualization exercises are based on identifying a setting that the particular client finds relaxing. It may be a particular place to sit in a forest, a walk by the ocean, watching the sun set and the night come on from in front of your house, or some other scene. What is important is that the client identify a place where he or she feels safe and relaxed. In the example below, it is walking on a path through the woods. Again, read it to the client in a slow, calm voice.

Put yourself in a comfortable position. Close your eyes. Check whether or not your body feels well supported and ready to become more comfortable. You can help your body begin to relax by taking in an easy deep breath, holding it for a few moments and then exhaling in a soothing, calming manner. Take in a deep breath now. Hold your breath and count silently to three, or five, or ten. Take the amount of time holding your breath that feels good to you. Then let your breath out in an easy, soothing exhalation. Breathe in again and hold it a few seconds... and, when you are ready, again let it out. As you let your breath out, imagine the tension in your body being breathed out with your breath, out through your nose and mouth, breathing out the tension as you breath out. Do it yet again, breathing in slowly... holding it... and out.

Now you can go to your safe place. Imagine yourself going to the woods that you love... You walk slowly across a field, toward the line of trees... As you get closer, you can hear the wind rustling in the leaves. You see the green leaves against the blue sky, and you can see the tops of the trees swaying, in an ever-changing pattern as the breeze moves them... You come to the edge of the woods. As you enter the woods, the air gets cooler, and the fragrance of the leaves on the forest floor greets you. Along the path, the light is bright in some places, dappled in others... The air is fresh, and the breeze cools your arms and face. The leaves rustle under your feet. The smell and the sounds and the leaves rustling make you feel happy and comfortable... At the side of the path, a patch of green moss looks soft and cool ... You stop for a moment, and concentrate on the songs of the birds, and the sounds of small animals scampering through the leaves... In the distance, a dove coos... As you walk, you feel more and more relaxed and comfortable... You see a small stream, the water meandering slowly, a leaf floating slowly down the stream. Beside the stream is a patch of soft grass, and you sit on the grass, watching the leaf float down the stream, hearing the water gurgling over the pebbles. The sun flashes on the water, making jewel-like sparkles. You listen to the breeze in the leaves, the birds singing, the water gurgling... As you sit and watch the sparkling water and listening to the gentle sounds of the birds and the leaves in the breeze and breathing the cool fresh air, your body becomes more and more relaxed... Now you stand up and slowly stretch, stretching every muscle of your body ... and slowly, slowly, you retrace your path. You walk along the path, searching with your eyes for small flowers in the underbrush, recognizing a familiar bush. You pass the mossy bank and soon, the edge of the forest nears. As you leave the forest, the sun shines brightly, warming your skin, and you feel safe and rested and relaxed....

Appendix C: Leaflets and Handouts

- I. Children and Disasters**
- II. Coping With Disaster**
- III. Coping With Disaster: A Guide
for Relief Workers**

CHILDREN AND DISASTERS

A disaster is frightening for everyone. For a child, it can be especially frightening. Children have not yet learned a wide range of techniques for controlling fear. Even more than for adults, a disaster threatens a child's sense of control over his or her life.

Children experience the effects of disaster triply.

- Even very young children are directly affected by experiences of death, destruction, terror, personal physical assault, and by experiencing the absence or powerlessness of their parents.
- Children are also powerfully affected by the reactions of their parents and other trusted adults (such as teachers) to the disaster. They look to adults for clues as to how to act. If their parents and teachers react with fear, the child's fear is magnified. If they see their elders overcome with a sense of loss, they feel their own losses more strongly.
- Children's fears may also stem from their imagination. Children have less ability than adults to judge which fears are realistic and which are not. Regardless of the source, a child's responses to a disaster should be taken seriously. A child who *feels* afraid, regardless of the reason, *is* afraid.

Most children respond sensibly and appropriately to disaster, especially if they experience the protection, support, and stability of their parents and other trusted adults. However, like adults, they may respond to disaster with a wide range of symptoms.

Some Responses of Children to Disasters

- Clinging, fears about separation, fears of strangers, fears of "monsters" or animals
- Difficulty sleeping or refusing to go to bed
- Compulsive, repetitive play which represents part of the disaster experience
- Return to earlier behaviors, such as bed wetting or thumb sucking
- Crying and screaming
- Withdrawal; not wanting to be with other children
- Fears, including nightmares and fears of specific sounds, sights, or objects associated with the disaster
- Aggressiveness, defiance, "acting out"
- Resentfulness, suspiciousness, irritability
- Headaches, stomach aches, vague aches and pains.
- Problems at school (or refusal to go to school) and inability to concentrate
- Feelings of shame

Sometimes it is hard for parents and teachers to recognize children's reactions to a disaster. We all want everything to be "all right" for our children, and we come up with all kinds of explanations to explain their conduct: We call it "willful" or believe that "he (or she) will get over it." The child, in turn, may feel ignored or misunderstood or not nurtured. In the short run, feeling insecure, the child may inhibit expression of his or her own feelings, or may "misbehave" even more, to get attention and nurture. In the long term, letting the child's feelings remain unappreciated can have negative long term consequences for the child's development.

What You Can Do To Help Your Child

- ❑ Talk with your child about his or her feelings, without passing judgment. Allow the child to cry or be sad. Don't expect him or her to "be tough." Talk about your own feelings, as well. Encourage your child to draw pictures about the disaster or write stories or poems about the disaster. This will help you understand how he or she views what happened.
- ❑ Provide your child with factual information about what happened and what is (or will happen). Use simple, direct language your child can understand. Shielding a child from unpleasant information usually leads to more difficulty in the future. Correct any misunderstandings your child may have (such as that the disaster was, in some way, his or her fault).
- ❑ Reassure your child that he or she and you are safe. Hold and touch and be affectionate with your child. Spend extra time with your child, especially at bedtime. Many children are calmed by gentle back and neck massages.
- ❑ If your child returns to babyish behaviors, such as bedwetting or thumb sucking, initially try to be accepting. These are signs the child needs comforting and reassurance. Do not shame the child (e.g., by calling him or her a "baby"). Resume normal expectations only gradually.
- ❑ Children are especially vulnerable to feeling abandoned when they are separated from their parents. Avoid "protecting" your children by sending them away from the scene of the disaster if this will separate them from their loved ones.
- ❑ Children benefit from routine and structure. Initially, you may want to relax the usual rules, but maintain family structure and responsibilities. Return the child to school as soon as feasible after the disaster and expect regular attendance.

COPING WITH DISASTER

Disasters affect people in many ways. The physical effects – loss of loved ones, pain or physical disability, damage to or destruction of homes and property and cherished belongings – are usually obvious. Short-term emotional effects, such as fear, acute anxiety, feelings of emotional numbness, or grief, are very common.

Some Initial Responses to Disaster

- Fear
- Difficulty relaxing
- Difficulty making decisions
- Irritability, being startled easily
- Guilty feelings
- Feeling that “no one can understand what I’ve been through”
- Need to cling to others
- Confusion
- Difficulty believing what has happened
- Seeking information
- Seeking help for yourself and your family
- Helpfulness to other disaster victims
- Sudden anger

For most victims of disasters, these responses fade with time, but there may be longer-term emotional effects that do not fade. The emotional effects of a disaster may show up immediately or may appear months later. They may be obviously related to the disaster or their origin may go unrecognized.

Later Responses to Disaster

- Grief, depression, despair, hopelessness; crying for “no apparent reason”
- Anxiety, nervousness, being frightened easily, worrying
- Feeling disoriented or confused
- Feeling helpless and vulnerable
- Suspiciousness, constant fear of harm
- Sleep disturbances: insomnia, bad dreams, nightmares
- Irritability, moodiness, anger
- Headaches, digestive problems, diffuse muscular pains, sweats and chills, tremors, loss of sexual desire
- Flashbacks: feelings of “re-living” the experience, often accompanied by anxiety
- Avoidance of thoughts about the disaster ; avoidance of places, pictures, sounds reminding the victim of the disaster; avoidance of discussion about it
- Increased marital conflict or other interpersonal conflict

- Excessive alcohol or drug use
- Difficulty concentrating, remembering; slow thinking
- Difficulty making decisions and planning
- Feelings of being detached from your body or from your experiences, as if they are not happening to you
- Feelings of ineffectiveness, shame, despair, guilt
- Self-destructive and impulsive behavior
- Suicidal ideation or attempts

What You Can Do

- ❑ Recognize your own feelings. Strong feelings after a disaster are almost universal. It is not “abnormal” or “crazy” to have strong feelings and unanticipated reactions.
- ❑ Be tolerant of other people’s reactions – their irritability and short tempers. Disasters are a time of stress for everyone.
- ❑ Talk to others about your feelings. Talking helps relieve stress and helps you realize that your feelings are shared by other victims. You are not alone.
- ❑ Take care of yourself: Get enough rest. Eat properly. Take time off to do something you enjoy. Get as much physical activity as possible, such as running or walking.
- ❑ Learn relaxation exercises and use them regularly.
- ❑ Seek out and share accurate information about assistance being offered and possible resources, but do not spread rumors: Check out information about which you have doubts.
- ❑ Do not allow yourself to become inactive or completely dependent on others. Get involved in making decisions that affect you. Try to solve your own problems.
- ❑ Get back to work and resume your normal family role and functions as soon as possible.
- ❑ Do not allow yourself to become isolated from others. Participate in community responses to the disaster. Accept help from others, and offer help to others.

COPING WITH DISASTER

A GUIDE FOR RELIEF WORKERS

As a disaster relief worker, whether you are involved in rescue efforts immediately following the disaster and those involved in longer-term relief work, you carry out your work under difficult conditions. You may yourself be a direct victim of the disaster, and have to deal with your own losses and your own grief. You may be exposed to grisly experiences and you are certainly exposed to the powerful emotions and harrowing tales of other victims. Your tasks may be physically difficult, exhausting, or dangerous, and your work may leave little time for sleep or adequate rest. You may feel frustrated by bureaucracy or by the sense that, no matter how much you do, it isn't enough. And you are exposed to the anger and apparent lack of gratitude of some victims.

It is extremely common for disaster relief workers to experience a range of powerful emotions and reactions. For instance, you may have unexpected feelings of anger, rage, despair, powerlessness, guilt, terror, or longing for a safe haven. These feelings may distress you or make you feel that there is “something wrong” with you. Your sense of humor may be stretched beyond its limits and your toleration for others' failings becomes limited. Your religious faith may be thrown into doubt. The anger of other relief workers or victims may seem like a personal attack rather than a response to exhaustion.

After a period of time on the job, many relief workers experience “burn-out.” You may feel excessively tired (even if you have gotten enough sleep), have trouble concentrating, or have a variety of physical symptoms such as headaches, gastrointestinal disturbances, and sleep difficulties. This can lead to neglecting your own safety and physical needs or to cynicism, mistrust of co-workers or supervisors, and inefficiency. You may find yourself smoking too much, drinking too much coffee, or drinking too much.

Disaster workers face additional stress when they complete their tasks and return home, to their “regular” life. Your experience has been very different from your normal routine, while your family's routine has gone on with little change. Your family members may make demands on you for attention and for help, while you still need time to recover your balance. You may expect an unambivalent welcome, while they may be feeling some anger at your having been gone. You may feel that they can not understand what you've been through and that their experiences while you were gone were shallow or meaningless. The crises of ordinary life may seem trivial to you, important to your family. You may see or hear things at home that will remind you of your experiences in relief work, which may trigger an unexpectedly strong emotional reaction. And you may find yourself wishing, at times, for the excitement and camaraderie of the relief operation. All of these stresses can produce marital and parent-child conflict.

What You Can Do

At the Disaster Site

- ❑ Recognize, understand, and appreciate your own feelings. It is not “abnormal” or “crazy” to have strong feelings and reactions to the experiences you are having.
- ❑ Be tolerant of the reactions of other relief workers and victims – their irritability and short tempers. Disasters are a time of stress for everyone.
- ❑ Talk to other relief workers about your feelings. Talking helps relieve stress and helps you realize that others share your feelings. Not coincidentally, it helps others recognize the same thing. You are not alone.
- ❑ Take care of yourself. Taking care of yourself is not a diversion from the “more important” tasks of relief work. It is necessary to enable you to keep doing your job. Get as much sleep as you can. Take rest breaks. Eat properly. Avoid drinking large amounts of caffeine or alcohol. Take time off to do something you enjoy. Get as much physical activity as possible, such as running or walking or engaging in sports. Keep a journal. Learn relaxation exercises and use them regularly.
- ❑ If an incident occurs that has really shaken you (whether a job-related incident or a conflict with another relief worker or a victim), take a short break. Use a relaxation exercise. Talk to someone (a disaster counselor if one is available). But don’t allow yourself to ruminate about what happened. Get back to work within a few minutes.
- ❑ Take part in regular “debriefing” sessions offered by the disaster counselors at the site of the disaster. This is especially important before you return home to your “regular” life.

When You Return Home

- ❑ Give yourself a few days to make the transition. Help your family understand you need some time to yourself before beginning a full schedule of normal activities.
- ❑ Be tolerant of what others at home want to share. What has happened to them is important to them, just as your experiences were important to you.
- ❑ Anticipate mood swings and strong emotional reactions. Expect that your family’s responses to you may not be what you expected or think you “deserve.” Be aware that you may have unexpected reactions to sounds, sights, or people that remind you of experiences at the disaster site. Prepare others for this and be realistic yourself.

Appendix D: Further Resources

PRINT

Aptekar, L. (1994). Environmental disasters in global perspective. New York: G.K. Hall.

American Academy of Child and Adolescent Psychiatry (1998). Practice parameters for the assessment and treatment of children and adolescents with posttraumatic stress disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 37:10 (supplement).

Danieli, Y., Rodley, N.S., & Weisaeth, L. (Editors). (1996). International responses to traumatic stress. Amityville, NY: Baywood.

Enarson, E., & Morrow, B.H. (Editors) (1996). The gendered terrain of disaster through women's eyes. Westport, CT: Greenwood Publishing Company.

Everly, G.S., & Lating, J.M. (Editors). (1995). Psychotraumatology: Key papers and core concepts on post traumatic stress. New York and London: Routledge.

Foa, E.B., & Meadows, E.A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. Annual Reviews of Psychology, 48, 449-480.

Foeken, I. (1999). Confusing realities and lessons learned in wartime: Supporting women's projects in the former Yugoslavia. Women and Therapy 22 (1), 91-106.

Hodgkinson, P.E., & Stewart, M. (1998). Coping with catastrophe: A handbook of post-disaster psychosocial aftercare (2nd Edition). London: Routledge.

International Federation of Red Cross and Red Crescent Societies (annual). World Disaster Report. London: Oxford University Press.

Ladrado-Ignacio, L., & Perlas, A.P. (1995). From victims to survivors: Psychosocial intervention in disaster management in the Philippines. International Journal of Mental Health, 24, 3-51.

Lima, B.R., & Gittelman, M. (Eds.). (1990). Coping with Disasters: The Mental Health Component. International Journal of Mental Health, 19, No. 1 and 2 (whole issue)

Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (1996). Ethnocultural aspects of posttraumatic stress disorder. Washington, D.C.: American Psychological Association.

Middleton, N., & O'Keefe, P. (1998). Disaster and development: The politics of humanitarian aid. London: Pluto Press.

Miller, K. Manual for "Planning to Grow" Program. Program for Prevention Research, Arizona State University, Tempe, Arizona, U.S.A. (on program carried out with children in Guatemala)

Raphael, B. (1986) When disaster strikes: How individuals and communities cope with catastrophe. New York: Basic Books.

Roberts, A.R. (Editor). (1990). Crisis intervention handbook. Belmont, CA: Wadsworth

World Health Organization, (1996). Mental health of Refugees.

Walker, B. (Ed.) (1995). Women and Emergencies. Oxford: Oxfam.

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). Disaster mental health services: A guidebook for clinicians and administrators. White River Junction, VT: National Center for PTSD. (Also available on-line at <http://www.ncptsd.org>).

INTERNET

David Baldwin's Trauma Pages, <http://www.trauma-pages.com>

National Center for PTSD, <http://www.dartmouth.edu/dms/ptsd>

Disaster Mental Health Institute, <http://www.ncptsd.org>

International Society for Traumatic Stress Studies (ISTSS). <http://www.istss.org>

National Hazard Center, <http://www.colorado.edu/hazards/>

PILOTS database, <http://ncptsd.org/research/pilots/index.html>

ORGANIZATIONS

International Federation of Red Cross and Red Crescent Societies, 17, Chemin des Crets, PO Box 372, 1211 Geneva 19, Switzerland. Tel: (41)(22) 730-4222. Internet: <http://www.ifrc.org>.

UNICEF, 3 UN Plaza, New York, NY 10017, USA. Internet <http://www.unicef.org>

World Health Organization the Division of Mental Health, World Health Organization, CH-1211 Geneva 27, Switzerland. Internet <http://www.who.org>

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Mental Health Workers Without Borders is an international, not-for-profit, non-governmental network of activist psychiatrists, psychologists, social workers, mental health nurses, counselors, and other mental health workers. Members share a common interest in issues related to psychosocial assistance for natural and man-made disaster, the rights of people with mental illnesses, and the needs of developing countries in providing treatment and psychosocial rehabilitation for their citizens with mental illness. MHWWB does not provide direct services as an organization. It encourages family- and community-based, psychosocial approaches to mental health problems, respectful of cultural variation, drawing on local resources and healing traditions, and emphasizing community revitalization and empowerment as well as individual treatment. For more information about Mental Health Workers Without Borders, contact *Martin Gittelman, 100 W. 94th Street, New York, NY 10025 (Telephone: 212-663-0131)*