

Disaster Psychosocial Response

Handbook for
Community Counselor Trainers

Compiled and edited by

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Introduction

More than 100,000 people have been unsettled in the tsunami hit Cuddalore district in Tamil Nadu, India. The Academy for Disaster Management Education, Planning & Training (ADEPT) coordinated with a group of major charitable hospitals from all over the country and mobilized medical relief on a war footing. It was estimated that less than 10% of the tsunami affected population had suffered physical injury or illness. Almost EVERYONE had suffered severe psychological and emotional trauma.

Psychosocial intervention has become a valued dimension of immediate and long-term disaster response. Psychological recovery is recognized as a focus for relief efforts, along with repairing homes and rebuilding bridges. As public mental health services are primarily limited to serving those with serious and persistent mental illnesses, and the affected survivors requiring attention far outnumbered the available mental health personnel, there was a need to train a special group in dealing with the general population who were struggling to cope with loss, disruption, and, in some cases, tragedy.

The concept of Community Counselors was developed as a potential tool for dealing with the complex task of identifying those displaying the effects of psychological trauma from within the community, taking into account the needs of special groups such as children and the elderly, and providing “psychological first-aid” and counsel to them at the community level in a culturally appropriate manner. The community counselor concept, overcomes the geographic and resource hurdle by training members from the affected community to identify and counsel those suffering from psychological trauma within that

community. These same counselors can then be utilized to help the community to regain their socio-economic independence.

Personnel from the affected communities can be highly effective to outreach community counselors as they represent the groups they are serving, and can readily gain access. Examples of community counselor groups are community leaders, youth groups, human service volunteers, teachers, municipal inspectors, public health workers, anganwadi workers, veterinary and agricultural extension employees etc.

Although these individuals may be “natural helpers” or “peer counselors” with other groups, working with survivors following the loss of loved ones, homes, property or community requires special skills and specific training on disaster and psychosocial issues combined with basic counseling techniques, to facilitate their integration into the program. Besides meeting the basic needs of the affected individuals, the counselor needs to understand the grieving process, which may extend for a prolonged period of time. Also counseling of disaster survivors may require to be undertaken in informal settings. A supportive conversation or a focused problem-solving session at a noon-meal center, during a health responder’s visit, or at a parent-teacher meeting could turn into a counseling session.

One of the challenges of the program is that the Community Counselor Program model differs significantly from the traditional psychosocial model. Disaster psychosocial response is a specialized service requiring skills, knowledge and attitudes that are quite different from those needed in therapeutic / clinical psychosocial services.

While each disaster and community is unique, States face similar challenges as they mobilize the resources to provide long-term psychosocial care and rehabilitation services. Disaster psychosocial response providers, program planners, and administrators must, therefore, quickly acquaint themselves with “the basics” of disaster psychosocial response to be able to design and deliver community counselor services that are effective.

This training manual aims to provide an overview of substantive concepts to assist psycho-social program administrators, planners, and trainers in developing the training component of community counseling projects, including how disasters affect children, adults and older adults, the importance of tailoring the program to fit the community, and descriptions of effective counseling interventions.

A course outline for Community Counselor Training complete with overheads and handouts is in the APPENDIX of this Manual. The overheads and handouts have been prepared for immediate use by the trainer.

It is our hope that this manual will help administrators, managers, and trainers to ensure that the most effective and appropriate community counseling services are provided to disaster survivors.

Caution

Trainers and Community Counselors should realize that they are not and should not consider themselves to be experts in the diagnosis and treatment of mental disorders. The community counselor’s role is first to identify those in need of help and then to offer verbal support, information, and advice when requested. Sometimes physical assistance, such as moving a victim’s belongings or helping to repair damage to homes and property, is most helpful in overcoming emotional distress.

Disasters

An overview

A disaster is a very complex, multi-dimensional phenomenon. From a general perspective, there are many ways of classifying disasters. Classifications vary depending on the criteria used. These may include:

- a) the magnitude of loss (deaths, number of injured)
- b) the known or unknown hazard, in the latter case with more lasting anxiety
- c) recurring risk, and degree of warning and preparedness at the community and individual level
- d) the severity of the impact and its effect on community functioning
- e) life threat - e.g. the degree to which escape was or was not possible during or immediately following the disaster
- f) destruction of property and material losses
- g) damage to community structure

'Personal disaster' is a term often used to describe an individual's experience of horror, traumatic death etc. 'Community disaster' is used to refer to an event that may impact a wider group or community. For example, in a community disaster with a high death toll, grief affects many: close family members, extended family, friends and co-community counselors. Others may suffer the loss of businesses, jobs and property. Moreover, with increased media coverage of national and international events, a larger global disaster community may also exist.

Common elements to be considered in the conceptualization of disasters include:

1. A disaster disrupts the existing social structure and makes it very difficult for the usual social mechanisms to manage the consequences. Difficulties resulting from disasters are many and are not limited just to those of a physical nature.
2. Variables that may moderate the impact of disasters include, the ability of survivors to adjust psychologically, the capacity of the community structures to adapt to the crisis and the amount of help available.
3. Within some populations, for example, areas which are subject to repeated floods, the prolonged experience of coping with these disasters may create a specific disaster 'sub-culture', and this is likely to affect patterns of psychosocial reactions to the disaster situation.

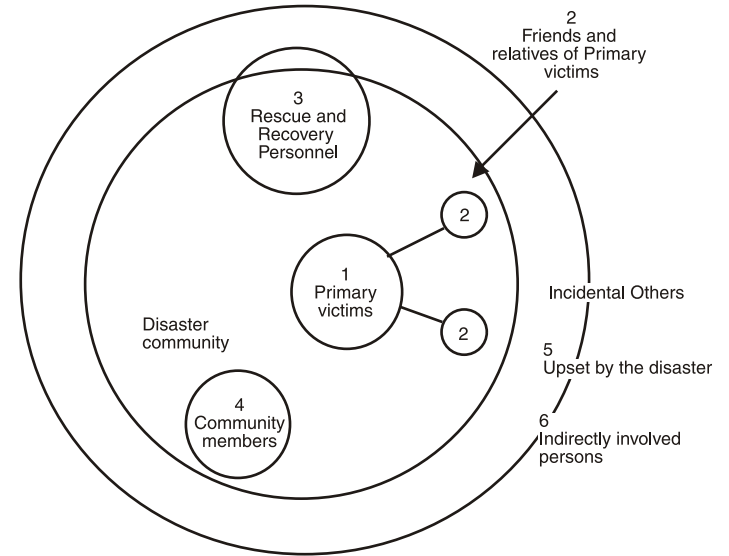
Disasters may impact on a wide range of individuals, groups and communities. Nevertheless, research shows that the majority of people cope and move on with their lives, and do not become psychologically traumatized.

Rapid communication, media coverage, shared values and group attachments serve to enlarge the consequences of destruction 'across nations and oceans'. For example, after the tsunami of Dec. 26, 2004, a wide spectrum of people were touched in geographically distant locations, due to the extensive coverage by print and television media.

Who are affected by disasters

It is often difficult to define just who is most affected by a disaster. Disasters in essence affect populations and thus call for a population approach to psychosocial and health response. i.e. linking public health and personal health cases in the response to achieve optimal effect. In any given population included are:

- those at the centre as well as at the periphery
- those whose lives were directly threatened, as well as those who were a 'near miss'
- those who have lost loved ones and who may or may not have been present in the disaster themselves



- the wider community, and so forth

One way of classifying those affected by disaster is summarized below:

- **Primary survivors:** Those in the frontline who have experienced maximum exposure to the catastrophic event.
- **Secondary survivors:** Grieving relatives and friends of the primary survivors.
- **Third-level survivors:** Rescue and recovery personnel who might 'need help to maintain their functional efficiency during any operation and to cope with traumatic psychological effects afterwards'.
- **Fourth-level survivors:** The community involved in the disaster, including those who converge, who altruistically offer help, who share the grief and loss or who are in some way responsible.
- **Fifth-level survivors:** People who, even though not directly involved with the disaster, may still experience states of distress or disturbance.
- **Sixth-level survivors:** Those who, but for chance, would have

been primary survivors themselves, who persuaded others to the course that made them survivors or who are in some way indirectly or vicariously involved.

This classification is somewhat complex and perhaps the different aspects may be best represented by a diagram.

In this manual the terms 'survivor' and 'disaster-affected person' will be used interchangeably and will refer to individuals and families who have suffered from a disaster and its consequences. Disaster survivors include all ages, socio-economic classes, and racial or ethnic groups.

The word 'victim' is used with caution as this has negative implications towards outcome. In fact, even though disaster survivors may experience symptoms of physical or psychological stress, these reactions are not viewed as psychopathology but as part of the normative coping response to disaster.

Phases of disaster

The stages of disaster begin before the actual impact.

- Preparation and planning
- Threat and warning
- Impact
- Immediate post-disaster period
- Recovery

Preparation and Planning

Disasters can be anticipated with varying degrees of accuracy. One dimension of the stress response to disaster involves anticipation and a willingness to contemplate the possibility of disaster and to see that the provision of resources in the development of disaster plans is an adaptive strategy.

Education about possible disaster experiences and how to deal with them, training through disaster exercises, and awareness of likely psychological reactions in the self and others are all helpful. This will increase the individual's and the community's capacity to respond appropriately, to recognize and deal with stress effects. It will also lessen the likelihood for adverse outcomes from these.

Threat and warning

Threat and warning refer to the time before a disaster when there may be either a general recognition that such a disaster could occur (threat) or a specific warning that a disaster is approaching (warning). Some communities may expect certain disasters because they know they are vulnerable or have experienced them before - for instance areas that have been repeatedly flooded or where there have been previous floods or cyclones. In such communities a **disaster sub-culture** may develop, with a set of beliefs about the likelihood of an episode and what should be done, or what may be effective. Several points are important with respect to the phase of threat and warning. Understanding the **background of a community** and its disaster sub-culture helps to identify likely responses to disaster threat.

- Reactions amongst those at risk of disaster may **range from active planning to prevent and mitigate** any possible catastrophe, to a **denial of the reality of threat** for this individual and this community.
- **Responses to warning** that a particular disaster is imminent may be ignored, or not responded to adequately. It may depend on who provides warning and if this source is seen as trustworthy, believable and known to give 'true' or accurate information. Technical descriptions of natural forces may not help who are those threatened to work out the likely effects for them, and what they should do. Further, if there have been false alarms, or inaccurate warnings, especially in the recent past, this may diminish the likelihood that a new warning will be responded to.
- Most Indian communities have little pre-disaster training and preparation in what to do, if a disaster occurs. Cyclone affected communities, or those that regularly experience floods may be better prepared for impact than others. As training and preparation can mitigate both impact and after-effects, it is increasingly important that vulnerability to disaster is addressed and people and communities become involved in relevant planning and training.

Specific warnings should be provided at the time of an emergency by recognized reliable and trusted authorities. They should be simple and comprehensible, and should specify appropriate actions to be followed. Television and radio are appropriate media, but also local networks of people can warn others in their neighborhood. Bearing in mind the multicultural nature of Indian society, warnings must also access ethnic groups, be provided in community languages, and address the needs of those who may not have access to mainstream sources.

Accurate information is helpful to people. It should cover what to expect and what to do. Authorities often fail to provide warnings for fear that panic will occur and lead itself to adverse consequences. Panic is rare and usually occurs only in specific circumstances. For example, if an escape route is blocked in a smoke filled building in a fire. Calm direction, accurate information and appropriate leadership can help people to take effective action in response to a disaster threat and lessen the severity of consequences.

Naturally, people are anxious when a disaster threatens, especially if they have had no previous experience with one. The above actions help to diminish anxiety. It is true to say that under-response, i.e. inadequate anxiety and failure to protect the self, is more often a problem than over-response.

Common sources of anxiety include the threat to one's own life and the safety and well being of others, such as partners and children for example. Wherever possible it is important to keep families together, especially children with parents, or to identify where they may meet after the impact is over.

Some disasters, like tsunamis, have little or no warning. The impact is virtually immediate. Those affected may not realize what has happened, and the shock and confusion may be greater in such circumstances.

Impact

The impact phase of disasters is extremely variable according to the type of event. There is also great variability within events. One house can be destroyed while the one next door is left unscathed. There is a need to compare the different types of disaster and identify the differing role of the components of threat, exposure, loss and dislocation in the patterns of adjustment.

Damage and destruction of homes and community are likely in any major disaster affecting areas of human habitation, and there may also be severe threat to human life. People's actions are usually geared to protection of the self and others, especially children, family members and those who are in any way weak and helpless. Several important issues arise with respect to impact:

- People often experience the 'illusion of centrality', especially if they are isolated from others. They may feel as though the disaster is happening just to them and may not realize that others have also been affected.
- Altruism is frequent and people often place their own lives at risk to help or save others, sometimes even people who are strangers to them.
- The shock of impact, especially if very sudden and unexpected, may temporarily paralyze the individual's response. It may also add feelings of helplessness and powerlessness, and the individual may need to come to terms with these after it has passed.
- Some people respond in a way that is disorganized, stunned or apathetic and may not be able to respond appropriately to protect themselves. Such disorganized or alternatively apathetic behavior may be transient or may extend into the post-disaster period, so that people are found wandering helpless in the devastation afterwards. Other people may be slightly disorganized or lose a sense of time, but most will act purposely and appropriately.

These reactions may reflect cognitive distortions in responses to the severe disaster stressors and may for some, indicate a level of dissociation.

Survival behaviors

Most people respond appropriately during the impact of a disaster and react to safeguard their own lives and the lives of others. This is a natural and basic reaction. A range of such behaviors can occur, and these may also need to be dealt with and understood in the post-disaster period. People may see these as not having fulfilled their own or others' expectations of themselves.

Stressors

Several stressors may occur during impact, which may have consequences for the person subsequently.

- threat to life and encounter with death
- feelings of helplessness and powerlessness
- loss (e.g. loved ones, home, possessions)
- dislocation (i.e. separation from loved ones, home, familiar settings, neighborhood, community)
- feeling responsible (e.g. feeling as though could have 'done more')
- 'inescapable horror' (e.g. being trapped)
- human malevolence (particularly difficult to cope with disaster if seen as the result of deliberate human actions)

Emergency responses may start to appear during the impact and in the immediate post-impact period. These reflect the community's and individual's initial reactions and will merge into rescue activities. Natural leaders may arise in the affected community assisting through impact, recoil, and rescue or through community leadership. When this response is spontaneously organized as it often is, this is referred to as the "emergency organization". It is self-limiting and should be distinguished from the formal emergency organizations that respond.

Immediate post-disaster period: recoil and rescue

This is the phase where there is recoil from the impact and the initial rescue activities commence. Initial psychosocial effects may appear, e.g. people may be in a state of confusion, are stunned or demonstrate high anxiety levels. During this phase there is also an attempt to build up a picture of what has occurred and to re-establish contact with family and community.

The effectiveness of the provision of basic services such as shelter, food and water by a range of authorities is a factor that can determine the stressfulness of a disaster. These activities are obviously essential for survival but also have a powerful symbolic value in which they are critical to re-establishing the individual's sense of safety with the containment of threat. This is a period when many survivors will have contact with a range of disaster rescue responders and authorities. These encounters can play an important role in containing the distress of those affected by disaster and should be documented.

It is also a time to assess the likely short and longer-term effects and to start to make provision for these. For instance:

- the numbers of deaths, injuries and destruction of the community - this will provide an indication of the degree to which the population affected has experienced personal life threat, injury, the gruesome and mutilating deaths of others
- the loss of loved ones
- the loss of home and other valued possessions
- the disruption of and dislocation from family, community life, neighbourhood and even work

These events constitute the main stressors that will contribute to adverse psychosocial impact and indicate those at risk and likely to be in need of specific psychosocial support.

Psychosocial support services should be available in readily accessible places in the community, or through outreach programs. The primary helping response at this time for **all**

community counselors should be **psychological first aid**. This aims, like other first aid, to sustain life, promote safety and survival, comfort and reassure, and provide protection. It does not involve probing those affected for their reaction but rather provides a calm, caring and supportive environment to set the scene for psychological recovery.

Other issues important to this phase include:

Rescue activities: Early rescue activities in any community affected by a major disaster are usually carried out by members of that community - who may themselves be to varying degrees directly affected by what has happened.

Congregation: People may start to gather in shelters or other neighbourhood or central places, as they come together to assist, to talk and to make meaning of what has happened. The usual social barriers may cease to exist, as people share their relief at having survived and their differing experiences. This coming together and affiliative or attachment behaviour and helping of others constitute the therapeutic community effect, which may commence during this phase and continue into the early part of recovery. This natural gathering together, sharing and mutual concern, and talking through what has happened may be helpful to some people in working through their own experiences.

Spontaneous groups: These form after disaster and often replace traditional groups at this time because of the powerful bonds of the shared experience, the crisis and the increased affiliative behaviours. Traditional groupings re-establish themselves in time but the 'special' experience of having gone through the disaster together is likely to remain important, as are friendships formed at the time and the sense of achievement.

Evacuation: In these contexts it is important to recognize that evacuation may further disrupt important social groupings that would otherwise facilitate recovery. The stereotype of evacuating women and children is unhelpful, in many instances resulting in family disruption and subsequent vulnerability.

Convergence: This phase is also characterized by the arrival or convergence of a large number of people external to the community who enter the disaster area for a number of reasons, both official and unofficial. There may be the wish to help, concern for those affected or anxiety for family members who may be at the site. There is also the natural curiosity about death and destruction. While people converging intend to be helpful, they may create further problems, for instance:

- they may congest the site
- disrupt communication
- develop problems themselves
- respond in an overly dramatic way
- exaggerate or exacerbate problems
- react angrily when their help is not needed

Managing or preventing this convergence is important in overall response at this time.

Emotional reactions: Psychological responses to the stressors of the disaster impact and aftermath may now start to appear, although these will be variable and depend on the individual's perceptions and experience of the different stressor elements noted earlier. Necessary activities of the rescue phase may mean these reactions are delayed, appearing more, as recovery processes get under way. Reactions may include:

- numbness, denial or shock
- traumatic stress reactions such as flashbacks and nightmares
- grief reactions to loss
- anger, despair, sadness and hopelessness

Conversely, relief and survival may lead to feelings of elation, which may be difficult to accept in the face of the destruction the disaster has wrought.

Activity: Active roles are very important for those affected during the disaster, as playing a part in rescue and later recovery may help to undo the feelings of powerlessness and helplessness that may have occurred during impact.

Recovery

The recovery phase is the prolonged period of return to community and individual adjustment or equilibrium. It commences as rescue is completed and individuals and communities face the task of bringing their lives and activities back to normal. Much will depend on the extent of devastation and destruction that has occurred as well as injuries and lives lost.

This period usually begins a week or two after-impact. It may be associated with a honeymoon phase deriving from the altruistic and 'therapeutic community' response in the period immediately following the disaster. A disillusionment phase may soon follow when a disaster is off the front pages, organised support starts to be withdrawn, and the realities of losses, bureaucratic constraints, and the changes wrought by the disaster must now be faced and resolved.

During the emergency, the surrounding community responds, everyone is supportive, the 'honeymoon phase' follows and many promises are made. It is as though everyone wants to make up for what has happened and return things to the way they were before the disaster. Of course this is not possible.

The extent of costs, the problem of who will pay, the time that will be required, the ongoing problems that will continue, all start to impact on those affected, bringing chronic stress which is often more difficult to deal with than the original acute experience. This period is often called the phase of **disillusionment**, or if it becomes entrenched and severe, **the post-disaster disaster**.

Recovery will inevitably take time and it is true to say things will never be quite the same again because this disaster has occurred. Several important themes emerge and continue during the recovery phase:

Active involvement in/and ownership of the recovery process is essential for members of the affected community, both as individuals and as a group. When others take over, control funds or seem to demand ongoing helplessness and gratitude, it is likely that disorganization and helplessness will predominate - continuing into a 'second disaster'.

Community organization passes from the emergency phase back to regular systems. These may need new groups and structures to cope with the additional tasks of recovery and reconstruction. Just as a spontaneous "emergency organization" may arise in a community in response to the impact, "recovery organization and organizations" may arise as specific social systems in the community. These may include self-help, advocacy, and other groups. They may contribute in very positive ways. Support for community development is essential in the recovery phase, to strengthen positive outcomes, to prevent scapegoating and splitting, and to ensure ongoing community growth in the face of the challenge.

Practical issues including resource needs may predominate. These must be dealt with, but do not by themselves meet emotional needs although their provision in supportive ways may help to facilitate recovery. People often find it difficult to ask for practical and financial assistance, especially if they have previously been very independent.

It is particularly important to remember that **emotional needs** may be very significant, especially for those who have been severely affected. They may only start to appear at this time. Delivering emotional and psychological support alongside practical assistance may increase its relevance and perceived helpfulness.

Psychosocial services will also need to be readily available during this phase of disaster. All community counselors need to be trained and aware of particular emotional reactions, so that they can behave supportively. People may also be hesitant to express distress or concern or dissatisfaction, feeling they should be grateful for the

aid given, or because they have suffered less than others have. It should be noted that sometimes emotional reactions may present as physical health symptoms, e.g. Sleep disturbance, indigestion, fatigue, as well as social effects such as relationship or work difficulties. Supportive and specialized counseling may be required if reactions are persistent and severe.

Maintaining **social networks** is also important in the recovery process. Social support plays a vital role in the recovery from adversity, and acts as a buffer against negative outcomes. Every effort needs to be made to continue networks of neighborhood, friends and confidants so that stresses may be dealt with, through such social networks and support.

Communication and information systems are central at every stage of the disaster, and continue to be so during the recovery process. They help counterbalance myths, provide feedback and promote recognition of individual and community achievements. Newsletters, television and radio are all useful, as are public meetings and forums.

Community rituals may evolve as symbolic and important steps in the recovery process. Memorial services and renewal projects, testimony of suffering and courage in art and literature all constitute ways of externalising and making meaning of the disaster. They help individuals and communities come to terms with what has happened, memorialise and pay tribute to the living and the dead, and set the experience in the past so that it may be integrated and all may move on from it.

Survivors' responses to disaster

A survivor's reactions to and recovery from a disaster are influenced by a number of factors. The disaster event itself has characteristics, such as speed of onset or geographic scope, which generates somewhat predictable survivor responses. Each survivor has a combination of personal assets and vulnerabilities that either mitigate or exacerbate disaster stress. The disaster-affected community may or may not have pre-existing structures for social support and resources for recovery. Disaster relief efforts that effectively engage with survivors and the overall community promote recovery.

Characteristics of disasters

Disasters are not uniform events. Each disaster, be it a flood, earthquake, cyclone or human-caused disaster, has intrinsic unique elements. These elements have psychological implications for survivors and communities. The disaster characteristics discussed in this section are: natural vs. human causation, degree of personal impact, size and scope, visible impact/low point, and the probability of recurrence. Each of these, individually or collectively, has the potential for shaping and influencing the nature, intensity, and duration of post-disaster stress.

Natural Vs human causation

While there are divergent findings regarding whether natural or human-caused disasters produce greater overall psychological effects, there are clearly psychological reactions unique to each. In human-caused disasters such as bombings and other acts of terrorism, technological accidents, or airline crashes, survivors

grapple with deliberate human violence and human error as causal agents. The perception that the event was preventable, the sense of betrayal by a fellow human(s), the externally focused blame and anger, and the years of prolonged litigation are associated with an extended and often volatile recovery period.

In true natural disasters, the causal agent is seen as beyond human control and without evil intent. For some, accepting mass destruction as "an act of God" is easier, whereas for others it can be more difficult. The world can temporarily seem to become unsafe with its potential for random, uncontrollable and devastating events. In reality, there is a continuum between natural and human factors. Many disasters occur or are worsened through an interaction of natural and human elements. For example, damage from the natural event of flooding may be increased due to human factors such as inadequate planning, governmental policies or faulty warning systems. An aircraft accident may result from an interaction of poor weather conditions and pilot error. Survivors experience reactions consistent with each dimension as they struggle with causal attributions.

Degree of personal impact

The more personal exposure a survivor has to the disaster's impact, the greater his or her post-disaster reactions. Death of a family member, loss of one's home and destruction of one's community exemplify high impact factors. In each of these, the intertwining of grief and trauma processes compounds the effects and extends the duration of the recovery period for many survivors. High exposure survivors experience more anxiety, depression, sadness, post-trauma symptoms, somatic symptoms, and, in some studies, alcohol abuse.

Size and scope of the disaster

When entire communities are destroyed, everything familiar is gone. Survivors become disoriented at the most basic levels. There are higher levels of anxiety, depression, post-traumatic stress, somatic symptoms and generalized distress associated

with widespread community destruction. When some fabric of community life is left intact (e.g., schools, temples, commercial areas), there is a foundation from which recovery can occur. Social support occurs more readily when community-gathering places remain. Survivors are then more able to continue some of their familiar routines. Family roles of provider, homemaker or student are more likely to be fulfilled when structures and institutions remain.

Visible impact/low point

Most disasters have a clearly defined end point that signals the beginning of the recovery period. After a cyclone or flood has passed through an area, the community sees the total extent of resulting physical destruction and begins the recovery and rebuilding process. The disaster threat is over and healing can begin.

However, in contrast, technological events like the Bhopal gas leak are "silent" disasters and do not show visual damage or have an observable "low point." The health consequences continue for decades. This prolonged impact period with no clear end impedes the recovery process. Survivors suffer the effects of chronic stress and anxiety due to the extended period of anticipation, fear, and threat.

The end point of the disaster can be ambiguous in some natural disasters as well. Although an earthquake has its major impact, the aftershocks keep survivors worrying that "the big one is yet to come." Slow moving repeat flooding and related landslides may continue for months through a period of heavy rains. While there is visual physical damage to be reckoned with, it may be weeks or months before survivors feel that the disaster is truly over.

Probability of recurrence

When the disaster has a seasonal pattern, such as cyclone or floods, survivors are concerned they will be hit again before the season ends. During the low-risk portion of the year, communities rebuild. Vegetation grows back and visual reminders of the disaster

diminish. At the one-year anniversary, the reminder that the area is potentially at-risk again causes disaster stress and hypervigilance to resurface.

The immediate probability of recurrence is perceived as high following earthquakes and floods. The aftershocks following an earthquake or the increased risk of flooding due to ground saturation and damaged flood control structures following major floods keep many survivors anxious and preoccupied. In flood plain areas prone to repeat flooding, survivors can be kept in limbo regarding governmental buyouts, re-zoning, or the rebuilding of their homes as municipal, State and Central Government agencies address jurisdictional and legislative issues. This can be especially threatening and anger inducing when the next year's flood season approaches and decisions and/or repairs have not yet been made.

Now, the discussion will shift to the survivor's characteristics that can mitigate or elevate disaster stress outcomes.

Survivor/"Person" characteristics

A major disaster indiscriminately affects all who are in its path. Some disasters, such as a tsunami or landslide, may happen disproportionately to destroy wealthy people's shoreline or cliff-top view properties; whereas, another disaster, such as an earthquake or cyclone, may destroy poor people's structurally unsound housing. The disaster may affect thousands to lakhs of people in a densely populated urban area, or affect comparatively small numbers of people in a sparsely populated rural area.

Each survivor experiences the disaster through his or her own lens. The meaning the survivor assigns to the disaster, the survivor's inherent personality and defensive style, and the survivor's world view and spiritual beliefs contribute to how that person perceives, copes with, and recovers from the disaster. Experiences with losses or disasters may enhance coping or may compromise coping due to unresolved issues associated with those past events.

Having sufficient financial resources and being able to benefit from a social support network buffer the potentially devastating effects of a disaster and greatly assist the recovery process. An additional resilience factor includes the ability to tolerate and cope with disruption and loss. In contrast, vulnerability factors include preexisting health or emotional problems and additional concurrent stressful life events. In addition, cultural experience and ethnic background may facilitate or interfere with a survivor's ability to engage with disaster relief efforts.

Disaster relief efforts

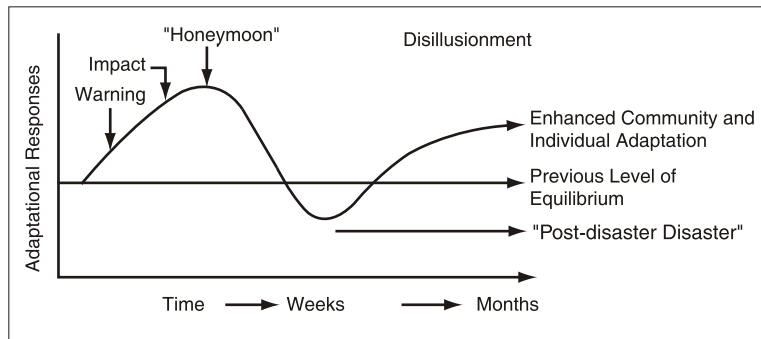
When disaster relief efforts "fit" the community being served, survivors' access to assistance is enhanced. Information is available in native languages through print media, radio, and television. Relief responders are respectful of differences and work with trusted community leaders. Barriers are identified and addressed as every effort is made to connect survivors with resources for recovery.

While the above description is a goal, relief efforts may fall short. Disaster relief responders may identify survivor groups who are not receiving services or recognize incompatibilities between the relief operation and the disaster-affected community. When individual survivors are unable to access services because of their limitations, disaster relief responders may assist the survivor with overcoming personal or institutional barriers.

The relationships shift over time. The experiences and needs of survivors and the community are different in the first week following the disaster compared with those at three months. Disaster relief efforts, including psychosocial programs, must maintain awareness of and accommodate to the time-based phases of disaster response.

Phases of disaster

Both community and individual responses to a major disaster tend to progress according to phases. An interaction of psychological processes with external events shape these phases. Examples of significant time-related external events are the closure of the emergency response phase, the damage assessment of one's personal residence or receiving financial determinations. The following diagram represents the phases that are relevant to disaster psychosocial response planners and community counselors in providing ongoing disaster recovery assistance.



Warning or threat phase

Disasters vary in the amount of warning communities receive before they occur. For example, tsunamis and earthquakes typically hit with no warning, whereas, cyclones and floods typically arrive within hours to days of warning. When there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

When people do not heed warnings and suffer losses as a result, they may experience guilt and self blame. While they may have specific plans for how they might protect themselves in the future, they can be left with a sense of guilt or responsibility for what has occurred.

Impact phase

The impact period of a disaster can vary from the slow, low-threat buildup associated with some types of floods to the violent, dangerous and destructive outcomes associated with tsunamis. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychosocial effects.

Depending on the characteristics of the incident, people's reactions range from constricted, stunned, shock-like responses to the less common overt expressions of panic or hysteria. Most typically, people respond initially with confusion and disbelief and focus on the survival and physical well-being of themselves and

their loved ones. When families are in different geographic locations during the impact of a disaster (e.g., children at school, adults at work), survivors will experience considerable anxiety until they are reunited.

Rescue or heroic phase

In the immediate aftermath, survival, rescuing others, and promoting safety are priorities. Evacuation to shelters, motels, or other homes may be necessary. For some, post-impact disorientation gives way to adrenaline induced rescue behavior to save lives and protect property. While activity level may be high, actual productivity is often low. The capacity to assess risk may be impaired and injuries can result. Altruism is prominent among both survivors and emergency responders.

The conditions associated with evacuation and relocation have psychological significance. When there are physical hazards or family separations during the evacuation process, survivors often experience post-trauma reactions. When the family unit is not together due to shelter requirements or other factors, an anxious focus on the welfare of those not present may detract from the attention necessary for immediate problem-solving.

Remedy or honeymoon phase

During the week to months following a disaster, formal governmental and volunteer assistance may be readily available. Community bonding occurs as a result of sharing the catastrophic experience and the giving and receiving of community support. Survivors may experience a short-lived sense of optimism that the help they will receive will make them whole again. When community counselors are visible and perceived as helpful during this phase, they are more readily accepted and have a foundation from which to provide assistance in the difficult phases ahead.

Inventory phase

Over time, survivors begin to recognize the limits of available disaster assistance. They become physically exhausted due to enormous multiple demands, financial pressures, and the stress of

relocation or living in a damaged home. The unrealistic optimism initially experienced can give way to discouragement and fatigue.

Disillusionment phase

As disaster assistance agencies and volunteer groups begin to pull out, survivors may feel abandoned and resentful. The reality of losses and the limits and terms of the available assistance becomes apparent. Survivors calculate the gap between the assistance they have received and what they will require to regain their former living conditions and lifestyle. Stressors abound - family discord, financial losses, bureaucratic hassles, time constraints, home reconstruction, relocation, and lack of recreation or leisure time. Health problems and exacerbations of pre-existing conditions emerge due to ongoing, unrelenting stress and fatigue.

The larger community less impacted by the disaster has often returned to business as usual, which is typically discouraging and alienating for survivors. Ill will and resentment may surface in neighborhoods as survivors receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermine community cohesion and support.

Reconstruction or recovery phase

The reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so.

With the construction of new residences, buildings, and roads comes another level of recognition of losses. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve losses. Emotional resources within the family may be exhausted and social support from friends and family may be worn thin.

When people come to see meaning, personal growth, and opportunity from their disaster experience despite their losses and pain, they are well on the road to recovery. While disasters may bring profound life-changing losses, they also bring the opportunity to recognize personal strengths and to reexamine life priorities.

Individuals and communities progress through these phases at different rates depending on the type of disaster and the degree and nature of disaster exposure. This progression may not be linear or sequential, as each person and community brings unique elements to the recovery process. Individual variables such as psychological resilience, social support, and financial resources influence a survivor's capacity to move through the phases. While there is always a risk of aligning expectations too rigidly with a developmental sequence, having an appreciation of the unfolding of psychosocial reactions to disaster is valuable.

Stages of disaster recovery

Phases	Time Frame	Emotions	Behaviors	Support
Heroic	Occurs at time of impact and period immediately afterward.	Altruism. All emotions are strong and direct at this time.	Heroic actions. Use of energy to save their own and others' lives and property.	Family groups, neighbours, and emergency teams.
Honeymoon	From 1 week to 3 to 6 months after the disaster.	Strong sense of having shared a catastrophe experience and lived through it. Expectations of great assistance from official and government resources.	Survivors clear out debris and wreckage buoyed by promises of great help in rebuilding their lives.	Pre-existing community groups and emergent community groups which develop from specific needs caused by disaster.
Disillusionment	Lasts from 2 months to 1 or even 2 years.	Strong sense of disappointment, anger, resentment and bitterness appear if there are delays, failures, or unfulfilled hopes or is lost. Promises of aid.	People concentrate on rebuilding their own lives and solving individual problems. The feeling of "shared community".	Many outside agencies may now pull out. Indigenous community agencies may weaken. Alternative resources may need to be explored.

Reconstruction	Lasts for several years following the disaster.	Survivors now realize that they need to solve problem of rebuilding their lives. Visible recovery efforts serve to reaffirm belief in themselves and the community. If recovery efforts are delayed, emotional problems, which appear, may be serious and intense.	People have assumed the responsibility for their own recovery. New construction programs and plans reaffirm belief in capabilities and ability to recover.	Community groups with the long-term investment in the community and its people become key elements in this phase.
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Principles of psychosocial intervention following disasters

There are two major aspects to intervention with the direct victims of disasters:

- a) rebuilding the community affected by the disaster and
- b) intervening with individual survivors.
- c) 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), 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 handbook, 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.

This section of the handbook 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 (described in this handbook), 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 in this handbook 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.

Survivors 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 and temples to alert people to the availability of services and the indications for using them. Do not neglect informal gathering places. 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.

- 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.
- 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, etc. Many very small concrete services may be emotionally useful as well as practically helpful.

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.*

- Counseling may be 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.

- Seek to identify those most at risk or most in need of services and focus services on these people.
- 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) 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 community counselors will, of necessity, be a high priority during this period. Primary care health workers, teachers, religious leaders, 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 followup 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 counseling 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 community 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: Month two

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 survivors 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 survivors 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.

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.

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 “psychological trauma” 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.

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.

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.

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. Such people have to be identified and referred to specialists for treatment

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.

Common needs and reactions

CAUTION

Trainers and community counselors should realize that they are not and should not consider themselves to be experts in the diagnosis and treatment of mental disorders. The community counselor's role is first to identify those in need of help and then to offer verbal support, information, and advice when requested. Sometimes physical assistance, such as moving a victim's belongings or helping to repair damage to homes and property, is most helpful in overcoming emotional distress.

The following are some thoughts, feelings, and behaviors common to all who experience a disaster:

- Concern for basic survival
- Grief over loss of loved ones and loss of valued and meaningful possessions
- Fear and anxiety about personal safety and the physical safety of loved ones
- Sleep disturbances, often including nightmares and imagery from the disaster
- Concerns about relocation and related isolation or crowded living conditions
- Need to talk about events and feelings associated with the disaster, often repeatedly
- Need to feel one is a part of the community and its disaster recovery efforts

The majority of survivors is resilient and with time, can integrate their disaster experiences and losses and move on. However, survivors who have significant concurrent psychosocial, health, or financial problems are at greater risk for depression, anxiety, post-traumatic stress symptoms or an exacerbation of their pre-existing condition. When survivors have personally sustained severe disaster losses (e.g., death of a loved one, devastation of home and community), their reactions are more intensely expressed over a longer period of time).

Symptoms of disaster caused stress will vary greatly based on an individual's prior history of personal trauma, age and ethnic background. Some of the typical symptoms experienced by both survivors and community counselors are briefly discussed below.

- Individuals may have an exaggerated startle response or hyper-vigilance. This is frequently seen after earthquakes, where people are known to jump after loud or sudden noises, such as doors slamming or trucks rumbling by.
- They may experience phobias about weather conditions or other reminders that the accident or situation could happen again.
- They may experience difficulty with memory or calculations.
- They may exhibit anger or even rage over their lack of control over the occurrence and their impotence at preventing it and protecting their families.
- Many times this may be displaced towards those who are trying to help.

Typical stress reactions to disaster trauma can be assessed by the acronym **BASIC ID**: Behavioural, Affective / Emotional, Somatic, Interpersonal Skills, Cognitive Imagery, Drugs.

Behavioral responses

- Hyper startle response
- Hyperactivity
- Workaholism
- Reckless, risk-taking behaviors
- Carelessness in tasks, leading to an increase in injuries
- Excessive use of sick leave
- Worried, rigid look, nervous activity
- Withdrawal or social isolation
- Inability to express self verbally or in writing activity
- Difficulty returning to normal
- Avoidance of places or activities that are reminders of the event
- Sexual problems

Affective / Emotional

- Initial euphoria and relief
- Survival guilt
- Anxiety, fear, insecurity
- Pervasive concern over well being of loved ones
- Feelings of helplessness, hopelessness
- Uncontrolled mood swings, periods of crying
- Apathy, isolation, detachment
- Shame or anger over vulnerability
- Irritability, restlessness, hyper-excitability, agitation
- Anger, rage, blame (often directed at those attempting to help)
- Frustration, cynicism, negativity
- Despair, grief, sadness
- Depression and withdrawal

Somatic

- Vague body complaints
- Muscle aches and pains
- Fatigue or generalized weakness
- Sleep disturbances
- Increased or decreased heart rate or blood pressure
- Feeling of pounding heart or pulse
- Trouble breathing
- Tightness in chest, throat or stomach
- Sweating
- Feelings of heaviness in arms or legs
- Numbness or tingling
- Changes in appetite or weight

- Increase in allergies, colds, flu, headaches
- Nausea or GI upsets
- Trembling, dizziness or fainting

Imagery

- Sleep Disturbances
- Nightmares
- Flashbacks and recurrent dreams of event
- Intrusive thoughts about event
- Ruminations about event

Cognitive

- Inability to concentrate
- Difficulty with calculations
- Confusion, slowness of thought
- Impaired decision making
- Amnesia
- Preoccupation with event
- Loss of judgment
- Loss of objectivity
- Rigidity
- Loss of faith
- Increased awareness of one's own and loved ones' vulnerability
- Repetitive thoughts, memories ruminations about event

Interpersonal skills

- Irritability and anger towards others
- Family and relationship problems
- Disruption of work, school or social relationships

Drugs/Alcohol

- Increased use of alcohol
- Increased use of drugs

Loss, mourning and grief

All survivors of disaster suffer loss. They suffer loss of safety and security, loss of property, loss of community, loss of status, loss of beauty, loss of health or loss of a loved one. Following a disaster, all individuals begin a natural and normal recovery process through mourning and grief.

It is normal to be upset by a major loss - and then to suffer because of it. Bereavement is always deeply painful when the connection that has been broken is of any importance. The loss, which is the reason for mourning most often, involves a person close to us. However, it can also be a familiar animal, an object to which we are very attached, or a value we have held dear. In mourning, the connection with what we have lost is more important than the nature of the lost object itself.

Grief is the process of working through all the thoughts, memories and emotions associated with that loss, until an acceptance is reached which allows the person to place the event in proper perspective. Theories of stages of grief resolution provide general guidelines about possible sequential steps a person **MAY** go through prior to reaching acceptance of the event. These stages include: **Denial, Anger, Bargaining, Depression, and Acceptance.** Whereas these theories provide general guidelines, each person must grieve according to his or her own values and time line. However, some persons will have trouble recovering emotionally and may not begin the process of mourning effectively.

This may result in troubling and painful emotional side effects. Sometimes these side effects may not appear immediately. They may remain beneath the surface until another crisis brings the emotions out into the open. Hence, many individuals may be

surprised by an increase in emotionality around the third month, sixth month, and one-year anniversaries of the event. Community counseling can assist survivors and facilitate their progress in proceeding through the predictable phases of mourning, thus avoiding surprise reactions or emotional paralysis later.

Grief is the process of working through:

All the thoughts, memories, and emotions associated with a loss, until an acceptance is reached that allows the person to place the event into the proper perspective.

Some extreme reactions might include:

- People who say they are drained of energy, purpose and faith. They feel like they are dead.
- Survivors who insist they do not have time to work through the grief with "all the other things that have to be done" and ignore their grief.
- People who insist they have "recovered" in only a few weeks after the disaster and who are probably mistaking denial for recovery.
- Survivors who focus only on the loss and are unable to take any action toward their own recovery.

Each of these extreme emotional states is very common, very counterproductive, and requires active COMMUNITY COUNSELING.

STAGES OF GRIEVING

Denial

Anger

Bargaining

Depression

Acceptance

Denial - At the news of a misfortune, tragedy or disaster, our first reaction is not to accept it, but to refuse it ("No, it's not true! No! It's not possible!"). The opposite would be abnormal. This is a sign that it is essential for our psychological organization to avoid pain without ignoring reality. This refusal is, at the same time, the beginning of an awareness of the horrible reality and is aimed at protecting us from the violence of the shock.

Anger - A feeling of anger is experienced at the fact of our powerlessness in the face of something imposed on us arbitrarily. This anger is inevitable and it must be permitted. It allows the expression of our helplessness at the situation. Therefore, it isn't surprising that survivors take out their anger on the people around them (government and municipal officials, rescue personnel, insurance companies, their families and friends, etc.). Hence, there is the need to be able to verbalize and vent this anger in post-traumatic sessions with a counselor.

Depression - The path toward the acceptance of bereavement passes through the stage of depression. At the beginning of mourning, and for a long time after during this stage of depression, the lost being is omnipresent. Of course, he or she is lost to us in reality we agree and we are trying to accept it. However, inside, we reinforce our connection to him or her, because we no longer have it in objective reality. This process of intense re-appropriation allows us, at the same time, both to lessen our pain and to console ourselves in a way by means of the temporary survival of the loved being within us. At the same time, this movement enables the work of detachment to be carried out little by little.

Generally, little by little, these movements of detachment become less frequent, the pain subsides, the sadness lessens, the lost being seems less present and his or her importance tends to decrease. The end of mourning is approaching.

Acceptance - This stage is neither happy nor unhappy. Mourning leaves a scar as does any wound. But the self once again becomes free to live, love and create. One is surprised to find

oneself looking toward the future, making plans. It is the end of mourning.

The normal process of mourning takes place over a period of several months.

Returning To Equilibrium

Every time a ***stressful event*** happens, there are certain recognized compensating factors, which can help, promote a ***return to equilibrium***. These include:

- perception of the event by the individual
- the situational reports which are available
- mechanisms of adaptation

The presence or absence of such factors will make all the difference in one's return to a state of equilibrium. The strength or weakness of one or more of these factors may be directly related to the initiation or resolution of a crisis.

When stress originates externally, ***internal changes*** occur. This is why certain events can cause a strong emotional reaction in one person and leave another indifferent.

Why do some people reach a state of equilibrium quickly while others do not?

Perception of the event:

- **When the event is perceived realistically:** There is an awareness of the relationship between the event and the sensations of stress, which in itself will reduce the tension. It is likely that the state of stress will be resolved effectively.
- **When the perception of the event is distorted:** There is no awareness of the connection between the event and the feeling of stress. Any attempt to resolve the problem will be affected accordingly.

- **Hypotheses to verify concerning the individual's perception of the event:** What meaning does the event have in the person's eyes? How will it affect his/her future? Is he/she able to look at it realistically? Or does he/she misinterpret its meaning?
- **Support by the natural network:** Support by the natural network means the support given by people in the individual's immediate circle who are ***accessible*** and who can be relied on to help at that time. In a stressful situation, the lack or inadequacy of resources can leave an individual in a vulnerable position conducive to a state of disequilibrium or crisis.
- **Mechanisms of adaptation:** These mechanisms reduce the tension and help promote adaptation to stressful situations. They can be activated ***consciously*** or ***unconsciously***. Throughout life, individuals learn to use various methods to adapt to anxiety and reduce tension. These mechanisms aim at maintaining and protecting their equilibrium. When an event happens which causes stress, and the learned mechanisms of adaptation are not effective, ***the discomfort is experienced at a conscious level.***

Psychological reactions of specific risk groups

Although there are many feelings and reactions people share in common following a disaster, there are also expressions that are more specifically influenced by the survivor's age, cultural and ethnic background, socioeconomic status, and pre-existing physical and psychosocial vulnerabilities. Disaster psychosocial response community counselors are better prepared to design effective interventions when they have an understanding of how demographic and health factors interact with disaster stress.

Each disaster-affected community has its own demographic composition, prior history with disasters or other traumatic events, and cultural representation. When disaster program planners review the groups impacted by a disaster in their community, consideration should be given to the following, as well as additional groups unique to the locale:

- Age groups
- Cultural and ethnic groups
- Socio-economic groups
- Institutionalized groups
- People with serious and persistent mental illness
- Human service responders

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 healthcare.

Children's reactions to disaster

Children in crisis present a complex challenge. Children in various age groups have specific needs and respond differently to the same crisis event. A serious problem in working with children in crisis situations is that the community counselors tend to become emotionally involved with the children they are attempting to help. Emotional involvement frequently interferes with proper crisis management.

Reactions of children to a disaster can have both short term and long-term effects. A child's view of his or her world as safe and predictable is temporarily lost. Most children have difficulty understanding the damage, injuries, or death that can result from an unexpected or uncontrollable event.

A basic principle in working with children who have experienced a disaster is relating to them as essentially normal children who have experienced a great deal of stress. Most of the problems that appear are likely to be directly related to the disaster and are transitory in nature. Relief from stress and the passage of time will help re-establish equilibrium and functioning for most children without outside help.

Children will often express anger and fear after a disaster. These will be evidenced through continuing anxieties about recurrence of the event, injury, death, or separation and loss. In dealing with children's fears and anxieties, it is best to accept them as being very real to the child. The reactions of the adults around them can also make a great deal of difference in their recovery from the shock of a disaster.

Pre-school children

Children's perceptions of a disaster are primarily determined by the reactions of their parents. Children of pre-school age believe that their parents can protect them from all danger. They believe they cannot survive without them. They fear being injured, lost or abandoned and these fears increase when they find themselves alone or among strangers.

Adults should be aware that the fertile imagination of pre-school children makes them more fearful. Three levels of anxiety in pre-school children in a disaster can be identified:

Contagious anxiety - This type of anxiety is transmitted by adults. It can be easily handled in difficult circumstances in a child who is not normally anxious by placing the child in calm surroundings.

True or objective anxiety - This is related to the child's capacity for understanding the nature of the danger threatening him/her and his/her tendency to create fantasies based on concrete events. The child is really afraid because he/she does not know the causes and dangers felt to be threatening. For example, it is useless to try to convince a child that thunder and lightning present no danger if the child does not understand their causes.

One can respond to the objective fears of children of this age by taking into account their degree of maturity and type of imagination. Adults should help them live through the event and conquer their fears to help prevent the fears from persisting into adulthood.

Profound anxiety - Different from fear, this involves separation anxiety. The child fears losing those close to him/her. Everything seems dangerous. Fear is omnipresent.

Generally, few young children express themselves verbally. It is their behavior that reveals their anxiety and fear.

Children's reactions to disaster

- Crying, depression, withdrawal and isolation
- Regressive behaviors including thumb sucking, bedwetting, clinging behaviors
- Increased fighting, anger, rages
- Nightmares and sleep disturbances, including fear of sleeping alone, night terrors, fear of falling asleep
- Loss of interest in school and routine activities
- Not wanting to attend school or other athletic or social events
- Headaches, rashes, GI upsets, nausea
- Changes in appetite
- Fears of future disasters
- Fears about death, injury and loss
- Separation anxiety or fears

Ages 6-12

The attitude of the family and the environment have great influence on the degree of anxiety experienced by the child and on what mechanisms the child uses in both the short and long term to cope with stressful situations or events.

The reaction may be immediate or delayed, brief or prolonged, intense or minimal. The child reacts with his/her present personality at a given level of biological and emotional development. The nature and intensity of the reaction will be determined by the child's temperament as well as past experiences. Faced with the same stressful situation, two children may react in entirely different ways. These reactions suggest the adaptations the child is making to assimilate, cope with, and "accept" the painful situation.

The reactions most often expressed will translate in various ways the child's anxiety and his/her defenses against it. These will vary with the age of the child. These include: fear, fright, sleep disturbances, nightmares, loss of appetite, aggressiveness, anger, refusal to go to school, behavioral problems, lack of interest in

school, inability to concentrate in school or at play. Sometimes these difficulties occur only in school. Sometimes they only occur at home with the child functioning adequately in the school environment.

Anxious children need security and, above all, love. The role of the adult consists of helping the child psychologically and trying to understand him/her.

Children can be spared much anxiety if we try to imagine their reaction to the event. Seeing through the child's eyes helps the adult to prepare the child emotionally to face events calmly and confidently as they occur.

Reactions can be prevented or lessened by clarifying the situation through open communication about the traumatic event or situation by those close to the child.

Fears and anxieties

Fear is a normal reaction to disaster, frequently expressed through continuing anxieties about recurrence of the disaster, injury, death, separation and loss. Because children's fears and anxieties after a disaster often seem strange and unconnected to anything specific in their lives, their relationship to the disaster may be difficult to determine. In dealing with children's fears and anxieties, it is generally best to accept them as being very real to the children. For example, children's fears of returning to the room or school they were in when the disaster struck should be accepted at face value. Counseling efforts should begin with talking about those experiences and reactions.

Sleep disturbances

Sleep disturbances are among the most common problems for children following a disaster. Their behavior is likely to take the form of resistance to bedtime, wakefulness, unwillingness to sleep in their own rooms or beds, refusal to sleep by themselves, desire to be in a parent's bed or to sleep with a light, insistence that the parent stay in the room until they fall asleep, and excessively early

rising. Such behaviors are disruptive to a child's well-being. They also increase stress for the parents, who may themselves be experiencing some adult counterpart of their child's disturbed sleep behavior. More persistent bedtime problems, such as night terrors, nightmares, continued awakening at night, and refusal to fall asleep may point to deep-seated fears and anxieties, which may require professional intervention.

School avoidance and school phobias

It is important for children and teenagers to attend school since, for the most part, the school is the center of life with peers. The school becomes the major source of activity, guidance, direction, and structure for the child. When a child avoids school, it may generally be assumed that a serious problem exists. One of the reasons for not going to school may be fear of leaving the family and being separated from loved ones. The fear may actually be a reflection of the family's insecurity about the child's absence from the home. Some high achieving children may be afraid of failing and, once they have missed some time at school, may have concern about returning. The low performers may find that the chaos of disaster makes it even more difficult for them to concentrate. School authorities should be flexible in the ways they encourage children to attend school.

Troubled children can be identified by their behavior in both the classroom and on the playground. Some of the signs are fighting and crying in school for no apparent reason, increased motor activity, withdrawal, inattentiveness, marked drop in school performance, school phobia, rapid mood changes, incessant talking about the disaster and marked sensitivity to weather changes.

Loss, death and mourning

It is not uncommon for children to make believe that the deceased parent is still alive. They may call the remaining parent or family a liar and deny their parent's death. Some children may go back and forth between believing and not believing that the parent has died

and may ask such questions as "When is Father coming home from being dead?" or "I know Mother's dead, but when is she going to make my supper?" Young children may not realize that there is no return from death - not even for a moment.

Many of the same issues that adults struggle with in coming to terms with death are also found in children's struggles. Magical thinking is more prevalent in childhood. Most children, when they are very young, believe that wishing for or thinking about, something can make it happen. Children who have had angry thoughts or death wishes toward the parent (as most children have at one time or another) need to be reassured that these thoughts did not cause something to happen. Children may believe that fighting with a sibling can cause a parent's death and that ceasing to fight will prevent the other parent from dying. They need reassurance that the parent's or family member's death was not their fault, that it was caused by an accident or illness. It is comforting to be told that there are some things they cannot control, such as parents getting sick or having an accident or dying. These can be contrasted with things they can control, such as the games they play, whether or not they play fairly, whether or not they do their chores and homework.

Both the child and family may suffer loss of pets, property, valuables, and treasured sentimental objects. Such losses may have as much impact on them as the loss of a loved one. A mourning process can be anticipated. When family treasures or sentimental objects are still available, they can be helpful to the mourners. They often provide something tangible as a security object. Families in disaster frequently turn to the ruins to retrieve what seem like valueless objects. This is understandable because mourning pertains to the loss of home and objects as well as to loss of loved ones.

Suicidal ideation

Threats or attempts to injure or kill oneself are rare in latency-age and younger children. However, they are not uncommon among adolescents. Any indication of suicidal feelings must be taken seriously. The most frequent motivation is loss of close family, a

sweetheart, and of significant objects such as pets, instruments or a car. Even loss of the opportunity to participate in team sports for the year may bring on serious depression.

Feelings of helplessness, hopelessness and worthlessness are strong indicators of suicide potential, expressed verbally or nonverbally through behavioral signs - withdrawal, asocial behavior, loss of interest, apathy, and agitation; physical symptoms - sleep and appetite disturbance; and cognitive process changes - loss of alternatives, poor judgment, and reasoning ability. Evidence of caring and concern are the most immediate, effective elements of help, which can be provided by all community counselors. Generally, however, any person with suicidal ideation should be referred to professional help.

Confusion

This is a sign that requires immediate attention. Confusion implies a deep-seated disturbance, which also probably requires referral to a psychosocial professional. Confusion generally refers to a disorientation in which the young person has lost the ability to sort out incoming stimuli, whether sensory or cognitive. As a result he/she is overwhelmed by a profusion of feelings and thoughts. Associations with familiar objects may be distorted or disappear, regressive behavior may reappear, and feelings displayed may be inappropriate for the occasion. In extreme cases, immobilization or uncontrolled movement may occur. The psychosocial professional can begin the process of helping to reorient the children by talking to them calmly, by providing them with specific information and by being caring and understanding.

Antisocial behavior

Behavior problems - group delinquency, vandalism, stealing, and aggressiveness - have been reported in some communities following a disaster. These behaviors may be a reaction of an adolescent with low self-esteem to community disruption. A major problem for the adolescents is the boredom and isolation from peers, which comes from disruption of their usual activities in school and on the playground.

Children with special needs

Two groups of children with special needs are briefly discussed below: those with prior developmental or physical problems; and those who have been injured or become ill as a result of the disaster. Both require more intensive attention in a disaster than normal or less seriously affected children.

The Special children

Special children are defined as those who have developmental disabilities or physical limitations, such as blindness, hearing impairment, orthopedic handicaps, mental retardation, cerebral palsy etc. Special children have special needs that require consideration when a disaster occurs. Disasters and their periods of disruption bring additional burdens upon the parents of special children. These parents have problems just in coping with their children's needs on a day-to-day basis. The emotional needs of special children are very likely to be exacerbated by a disaster of any magnitude.

Most special children live in their own homes and receive assistance from community agencies. The agencies, part of the network of human services in the community, may need to be alerted to the special needs of the children in home settings. Special children find it more difficult to function when their usual home environment is damaged or if they are moved to strange surroundings. Helping such children to understand what has occurred requires heightened sensitivity. Generally, it would be desirable to have professionals who normally are in contact with the children and assist in providing help. The professionals are able to locate and identify the children in the community and determine what special services they need, such as schooling or medical care.

Special children depend to a greater extent than other children on the consistency and predictability of their environment and the people around them. Familiarity with their surroundings is particularly important to mentally retarded children, who tend to become confused and agitated by traumatic events. One reaction is the increased levels of clinging behavior.

Adolescents

A disaster can have many repercussions on adolescents, depending on its impact on family, friends, and the environment. They show physical, emotional, cognitive and behavioral reactions similar to those of adults.

Studies have shown that the difficulties experienced by adolescents after a disaster are boredom and loneliness resulting from isolation from peers due to disturbance of their activities and re-housing of their families.

Finally, following a disaster, an adolescent may suddenly have to assume an adult role and cope with the need to become the head of the family and provide financial and emotional support to the other members of the family. The adolescent's way of envisioning his/her responsibilities depends on a variety of factors, including cultural background, age, religious views, education, personal equilibrium, and conception of life.

Adults' reactions to disaster

Adults are focused on family, home, jobs and financial security. Many are involved with caring for elderly parents as well. Pre-disaster life often involves maintaining a precarious balance between competing demands. Following a disaster, this balance is lost with the introduction of the enormous time, financial, physical and emotional demands of recovery. Children in the family are in special need of attention and familiar routines, yet parents do not have enough hours in the day to accomplish all that is before them.

Over time, this stress overload can be manifested through physical symptoms of headaches, increased blood pressure, ulcers, gastrointestinal problems and sleep disorders. Somatic reactions are especially present in those who are less able to experience and express their emotions directly. Cultural, gender-based or psychological factors may interfere with emotional expression and seeking social support.

Emotional reactions often oscillate between numbness and intense expression. Anxiety and depression are common, as adults grapple with both anxiety about future threats and grief about the loss of home, lifestyle, or community. Anger and frustration about relief efforts abound, sometimes reflecting a displacement of the "less rational" anger that the disaster happened to them and was out of their control.

Middle Age

On the face of it, middle-aged persons seem to be an unlikely special group with specific problems. However, they are, and it is helpful to be alert to these, especially for the possibility of

emotional problems arising in later, rather than immediate, post-disaster periods. Consider the family, which loses its home and most possessions in a flood. Forced to rebuild, they must do so with far more cost and highly inflated financial expenses. Prospects of an old age with adequate funds and comfortable living may have vanished. It takes a while for these conditions and the realizations of a reappraised future to sink in. They may and do, however, have any number of effects such as psychosomatic problems, relationship difficulties, and occupational dissatisfactions.

A larger proportion of older persons, as compared with younger age groups, have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. They are more likely to be taking medications that need to be replaced quickly following a disaster. While older adults may be in more need of multiple services for recovery, they are often especially reluctant to accept help and what they perceive as "handouts." Disaster psychosocial response programs can more quickly gain acceptance when they work closely with known, trusted organizations and employ older adults as outreach community counselors.

Common needs and reactions

1. Concern for basic survival
2. Grief over loss of loved ones or loss of prized possessions
3. Relocation and isolation anxieties
4. Need to express feelings about experiences during the disaster
5. Need to feel one is a part of the community and its rehabilitation efforts
6. Altruism and desire to help others
7. Psychosomatic problems, ulcers, diabetes, heart trouble
8. Withdrawal, anger, suspicion, irritability, apathy
9. Loss of appetite, sleep problems, loss of interest in everyday activities

The elderly

The elderly represent their families' memories, their special link with culture and religion. They are members of the community who are able to define their own needs and ask for the services needed to meet them. Most elderly people show strength and courage in disasters. Their life experience has enabled them to acquire the ability to recover. Their physical, emotional, cognitive and behavioral reactions are similar to those of younger adults.

The reactions of elderly people to disaster may include expressing their worries about the future and the loss of their physical health, their role in the family, social contacts and financial security.

With age, we observe greater vulnerability in persons who are alone (unmarried, widows and widowers, divorced) as well as extreme sensitivity to emotional losses and socioeconomic and cultural changes.

Lacking sufficient validation and emotional links with other generations in the community, elderly people become vulnerable to the whole range of physical, psychological and social tensions.

These older persons typically do not have highly active schedules during the day. They spend their time mostly with others of similar age and circumstances in daily routines, which have become comfortable. Others are confined to house or apartment, frequently alone. When these familiar routines are disrupted by the disaster, and particularly when residential loss and relocation occur, it would be expected that the senior citizen might exhibit some symptoms.

Many older adults fear that if their diminished physical or cognitive abilities are revealed, they risk loss of independence or being institutionalized. As a result, they may under report the full

extent of their problems and needs. They may continue living in damaged or unsanitary conditions, because they do not have the physical strength, stamina or cognitive organizational ability to undertake disaster clean up. Community counselors must carefully assess the range and full extent of problems in living faced by the older survivor. Concrete practical assistance for recovery, stabilization, and engagement with appropriate resources allows the older adult to continue living independently.

Feeling and behavior symptoms

- Depression, Withdrawal
- Apathy
- Agitation, anger
- Irritability, suspicion
- Disorientation
- Confusion
- Memory loss
- Accelerated physical decline
- Increase in number of somatic complaints

Cultural and ethnic groups in disasters

Disaster psychosocial response programs must respond specifically and sensitively to the various cultural groups affected by a disaster. In many disasters, ethnic and racial minority groups may be especially hard hit because of socioeconomic conditions that force the community to live in housing that is particularly vulnerable. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values often contribute to disaster outreach programs' difficulty in establishing access and acceptance. Communities that take pride in their self-reliance are reluctant to seek or accept help, especially from psychosocial community counselors.

Cultural sensitivity is conveyed when disaster information and application procedures are translated into primary spoken languages and available in non-written forms. Intense emotions are typically experienced and expressed in a person's language of origin, so outreach teams that include bilingual, bicultural staff, and translators are able to interact more effectively with disaster survivors. Whenever possible, it is preferable to work with community counselors rather than family members, because of the importance of preserving family roles.

Cultural groups have considerable variation regarding views on loss, death, home, spiritual practices, use of particular words, grieving, celebrating, psychosocial and helping. The role of the family, who is included in the family and who makes decisions also varies. Elders and extended family play a significant role in some cultures, whereas isolated nuclear families are the decision makers in others.

It is essential that disaster responders learn about the cultural norms, traditions, local history, and community politics from leaders and social service community counselors indigenous to the groups they are serving. Outreach program and psychosocial staff are most effective when they are bilingual and bicultural. During the program development phase, establishing working relationships with trusted organizations, service providers, and community leaders is helpful. Being respectful, nonjudgmental, well informed, and following through on stated plans dependably are especially important for outreach community counselors.

Cultural and ethnic minorities

Regardless of how many announcements may be made on radio or TV, this group may not understand what assistance is available. Cultural differences, especially of race and language, may be important. For these groups, it is essential that outreach efforts be channeled through representatives or facilities in the area. Differences in language and/or customs, if ignored, will lead to frustration by those attempting to provide services. It is important to provide education about differences in the grieving process, provide handouts on disaster related stress in appropriate languages, assist with referrals to culturally appropriate counseling services etc.

Ethnic group factors

- Previous history of trauma or stress
- Immigration status
- Level of trust or mistrust of government agencies
- Level of acculturation
- Language fluency or literacy
- Mistrust of "outsiders"
- Definition of family and individual's role in family
- Support systems
- Role of those perceived as "helpers"
- Belief system regarding disaster (e.g. fate, responsibility, punishment, guilt)

- Social status
- Economic situation and ability to recover financially
- Disaster losses may re-awaken prior losses and trauma
- Religious belief systems
- Values regarding asking for help
- Rituals and traditions, particularly relating to grieving

Socio-economic groups

Socio-economic circumstances are important influences on attitudes and reactions of people in stress situations. More importantly, these factors have a strong effect on the readiness with which individuals will seek or accept help voluntarily for emotional distress. For example, persons in lower economic circumstances are generally more inclined to seek medical rather than psychological treatment. This re-emphasizes the importance of "outreach" efforts in disaster relief work. Otherwise, these people will not be reached and may not get the help they need. By contrast, people in intermediate and upper income economic circumstances are more aware of and less likely to resist accepting all kinds of help when needed. These social groups would also be expected to be more likely to understand the possibilities of long-range benefits from early use of the services offered, i.e., heading off future problems by dealing with them now. Upper income people might be less inclined, however, to welcome outreach and "free" services as compared with lower and middle-income groups.

Many affluent, middle to upper middle class people live with a sense of security and see themselves as invulnerable to the devastation and tragedy associated with disasters. Because of their financial resources and life situations, they may have been protected from crises in the past and have purchased insurance for "protection" in the future. They are more accustomed to planning and controlling life events, rather than unexpected overwhelming events controlling them. Shock, disbelief, self-blame, and anger predominate in the hours and days following a major disaster, as the reality of losses, danger and the work that lies ahead begins to sink in.

Higher income families may never have received assistance from social service agencies before. Accepting clothing, food, money or

shelter can be difficult and sobering. While they may need emergency assistance initially, they often do have social, financial, family or other resources that engage quickly and buffer the disaster's impact.

Affluent families typically rely on known professionals for their support-their family physician, minister etc. Disaster psychosocial response programs focus on educating local healthcare professionals and religious leaders about disaster stress, because these providers are most likely to encounter upper class survivors in need.

In contrast, low-income survivors have fewer resources and greater pre-existing vulnerability when disaster strikes. While they may have developed more crisis survival skills than the more protected upper class individuals, they often lack the availability of support and housing from family and friends and do not have insurance coverage or monetary savings. Without these, the recovery process is even more arduous and prolonged and sometimes impossible. Central and State disaster assistance programs are designed to meet serious and urgent needs. The intent of these programs is not to replace all losses. Uninsured, poor families may have unmet needs and should be referred to non-profit disaster relief organizations and unmet needs committees. If they are renters, they may be faced with unaffordable increases in rent after landlords have invested money to repair their properties. They may be dislocated to temporary disaster housing that is undesirable and removed from their social supports. Relocation may make transportation and getting to appointments more difficult.

Faced with these multiple challenges and assistance that falls short of solving the problems before them, low-income disaster survivors can feel overwhelmed. For those with limited reading and writing abilities, obtaining accurate information and completing forms is difficult. Community counselors are most effective when they provide concrete problem-solving assistance that facilitates addressing priority needs. Community counselors must be knowledgeable about the full range of community resources

available to people of limited economic means and actively engage this resource network with those in need.

Feelings and behavior symptoms

- Depression
- Apathy
- Feelings of helplessness and hopelessness
- Resignation (to God's will)
- Suspicious of help offered by "outsiders"
- Ignoring or rejecting available sources of "outside" help
- Tendency to close ranks and accept assistance only from family and close friends.

Institutionalized persons in disasters

Individuals who are in institutions during a disaster are susceptible to frustration, anxiety, and panic as a consequence of their limited mobility and helpless dependence on their caretakers. The circumstances will vary widely depending on the type of institution. However, there are some common reactions which might be expected to occur in general medical hospitals, mental hospitals, adult and juvenile correctional agencies, and convalescent facilities.

Feelings and behavior symptoms

Fear

Frustration

Anxiety

Helplessness

Anger

Panic

"Escape"

People with serious and persistent mental illness

Disaster survivors with mental illness function fairly well following a disaster, if essential services have not been interrupted. People with mental illness have the same capacity to "rise to the occasion" and perform heroically as the general population during the immediate aftermath of the disaster. Many demonstrate an increased ability to handle this stress without an exacerbation of their mental illness, especially when they are able to maintain their medication regimens.

However, some survivors with mental illness have achieved only a tenuous balance before the disaster. The added stress of the disaster disrupts this balance; for some, additional psychosocial support services, medications or hospitalization may be necessary to regain stability.

Many people with mental illness are vulnerable to sudden changes in their environment and routines. Orienting to new organizations and systems for disaster relief assistance can be difficult. Program planners need to be aware of how disaster services are being perceived and build bridges that facilitate access and referrals where necessary. Disaster psychosocial response services designed for the general population are equally beneficial for those with mental illness; disaster stress affects all groups. In addition, when case managers and community counselors have a solid understanding of disaster psychosocial response issues, they are able to better provide services to this population following a disaster.

Other special groups in disasters

People in emotional crises

When a person is experiencing an emotional crisis, it is usually apparent even to the casual observer. In a disaster it might be expected that the direct and indirect effects of the catastrophe might produce severe emotional crises for some people. Precipitating causes could be death or separation from loved ones, sudden loss of contact with friends and familiar routines and settings or simply the physical force of the disaster itself. The last mentioned can in some cases bring about overwhelming feelings of inadequacy in some who are suddenly confronted with their own feelings of helplessness and mortality.

Feelings and behavior symptoms

- Emotional shock
- Apathy
- Numbness
- Agitated depression
- Disorientation and confusion
- Perseverative behavior
- Hyperactivity
- Minimal emotional control, e.g. explosive anger, uncontrollable crying
- Physical symptoms, e.g., dizziness, nausea, fainting spells, headaches, hyperventilation, rapid heartbeat.

People requiring emergency medical care

Those who are in need of immediate and surgical treatment, in addition to suffering from physical shock, may also experience anxiety caused by separation from loved ones or a lack of information about the extent of damage to home, place of business or the community itself. The degree of anxiety experienced by the injured person may aggravate his/her physical state and affect response to medical treatment. Having psychosocial services available at medical treatment facilities during and following the disaster has been found useful. The community counselor may provide invaluable relief and reassurance to the injured person by obtaining information about loved ones or about the status of property and possessions.

Stress in disaster relief responders

Disaster responders in all phases of disaster relief, whether in law enforcement, local government, emergency response or survivor support, experience considerable demands to meet the needs of the survivors and the community. Typically, disaster relief responders are altruistic, compassionate and dedicated people who occasionally have difficulty knowing when it is time to take a break from the operation. For many, the disaster response takes precedence over all other responsibilities and activities.

Relief responders may witness human tragedy and serious physical injuries, depending on the nature of the disaster and their role. This contributes to the psychological impact of their work. In disasters in which there is a high level of exposure to human suffering, injuries and fatalities, providing psychological support and interventions for relief responders is especially necessary. In addition, relief responders and first responders should be considered a target group for ongoing services during the course of the disaster psychosocial response recovery program.

As some order returns to the community, many relief responders, particularly volunteers, return to their regular jobs. However, they may attempt to continue with their disaster work. Over time, the result of this overwork can be the "burn-out" syndrome. This state of exhaustion, irritability, and fatigue creeps up unrecognized and can markedly decrease the individual's effectiveness and capability. These people may be avoiding problems at home by working constantly. Community counselors should be on the lookout for relief volunteers whose coping resources have eroded due to their personal vulnerabilities and seemingly unrelenting workload.

The most severe reactions are among those involved in post-disaster body handling. Exposure to death and dead bodies, especially those of children, has repeatedly been identified as a major stressor. The profound sensory stimulation associated with the dead, and identification with those who have died are significant stressors. Both short- and long-term disturbances are seen. Inexperienced body handlers may have more symptoms. In this group, there is a significant correlation between the number of remains handled and the level of symptoms reported. To cope with these stressors, rescue relief workers tend to avoid humanizing the remains by not looking at the face, not learning the names of victims, concentrating on the tasks at hand, and thinking of the benefits their work has on families and society. Appropriate briefing and support processes, including informal or supportive debriefing, the use of a buddy system, and recognition of the role of humour, can all lessen stressor effects.

Several variables affect the reactions of rescue responders. These include

- Age - Older people often fare better than their younger counterparts. This may be due to the fact that older relief responders have additional experience that serves as a protective factor.
- Level of exposure. This includes
 - exposure to victims remains
 - failing to save immediate survivors
 - identifying with the victims
 - physical stress and fatigue
 - life threat or other potential harm
- Lack of support, and
- Perceived threat, ethnicity and gender.
- Frustration in the ability to fulfill tasks that the community counselor wants to undertake may be an added stressor, for instance, being unable to rescue or save lives.

Symptoms :

Psychological and Emotional

- Feeling heroic, invulnerable, euphoric
- Denial
- Anxiety and fear
- Worry about safety of self and others
- Anger
- Irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost or abandoned
- Apathy
- Identification with survivors

Cognitive

- Memory problems
- Disorientation
- Confusion
- Slowness of thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Poor concentration
- Limited attention span

- Loss of objectivity
- Unable to stop thinking about the disaster
- Blaming

Behavioral

- Change in activity
- Decreased efficiency and effectiveness
- Difficulty communicating
- Increased sense of humor
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits
- Change in sleeping patterns
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, silence
- Vigilance about safety or environment
- Avoidance of activities or places that trigger memories
- Proneness to accidents

Somatic

Physical exhaustion, loss of energy, gastrointestinal distress, appetite disturbances, hypochondria, sleep disorders, tremors etc.

Psychosocial response to disaster

Key concepts

The following guiding principles form the basis for disaster psychosocial response intervention programs. Not only do these principles describe some departures and deviations from traditional psychosocial work, they also orient administrators and service providers to priority issues. The truth and wisdom reflected in these principles have been shown over and over again, from disaster to disaster.

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma-individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Disaster relief assistance may be confusing to disaster survivors. They may experience frustration, anger, and feelings of helplessness related to Central, State and non-profit agencies' disaster assistance programs.
- Most people do not see themselves as needing psychosocial services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.

- Disaster psychosocial response assistance is often more practical than psychological in nature.
- Disaster psychosocial response services must be uniquely tailored to the communities they serve.
- Community counselors need to set aside traditional methods, avoid the use of psychosocial labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest and concern.
- Interventions must be appropriate to the phase of disaster.
- Social support systems are crucial to recovery.

Community Outreach

Most people, who are coping with the aftermath of a disaster, do not see themselves as needing psychosocial services and are unlikely to request them. People reacting to disasters tend to have little patience with implications that they are in need of psychological treatment. This is why terms like "psychotherapy" or "psychological counseling" are often rejected and terms like "assistance with resources" and "talking about disaster stress" are more acceptable. Survivors who will be using program services are, for the most part, normal, well-functioning people who are under temporary emotional stress.

Outreach approaches that offer practical assistance with problem-solving and accessing resources are a key to a successful program. The concept of Community Counselors has been developed as a potential tool for dealing with the "near impossible" counseling situation in the tsunami hit fishing community.

The community counselor concept, overcomes the geographic and resource hurdle by training members from the affected community to identify and counsel those suffering from psychological trauma in that community. These same counselors can then be utilized to help the community to regain their socio-economic independence.

Community counselors are: (1) a visible symbol of local involvement (2) symbols of community control over the disaster recovery process, and (3) an expression of both cultural and regional sensitivity since they are hired in the community they serve.

It is essential that this service has the flexibility to engage with diverse individual survivors and the varied elements within the community. The program should establish a vital presence early in recovery, developing creative strategies to meet survivors where they are and bring them forward in their recovery process.

Community counselors go to the survivors and not wait and expect that the survivors will come to them. This means being visible in the disaster-affected neighborhoods, often going door-to-door to check-in with residents to see if they want assistance. Establishing relationships with community gatekeepers like corner store owners, or local cafe staff is important for referrals of survivors in need. Attending community gatherings at churches, schools or community centers is useful for connecting with local residents and providing disaster psychosocial response information. Besides these outreach approaches, educational materials that describe and emphasize the normalcy of reactions are of great benefit for disaster survivors. Educational outreach through the media-television, newspaper, radio and community newsletters reaches survivors whom other means might not contact.

Community counselors are most likely to find people struggling with the disruption and loss caused by the disaster. Disaster related psychological symptoms warranting diagnosis are rare. People vary in the ability to recognize their own needs and in comfort level with asking for help. They may, for example, feel that it is personally degrading to request clothing or to seek an emergency loan. This reluctance can usually be overcome by personal contact with a caring person, who has the correct information and encourages the seeking of assistance.

Community outreach programs must actively fit the disaster-affected community. Salient dimensions for consideration include: ethnic and cultural groups represented, languages spoken, rural or urban locales, values about giving and receiving help, and who and what the affected groups are most likely to trust. Access and acceptance is gained more quickly when disaster psychosocial response programs coordinate and collaborate with local trusted organizations.

Psychological first aid

Psychological first aid involves approaching and offering support, reassuring and ensuring safety, comforting and communicating. If the person wishes to talk about his experience this can be supported but it is inappropriate to probe for psychological reactions at this early stage. Information necessary for appropriate actions should be sought and provided. Links with families and significant others should be ensured whenever possible and support provided while there is separation.

All disaster community counselors should be familiar with the principles of psychological or emotional first aid so that all those responding to traumatized individuals can apply them.

Components of psychological first aid include the following:

The basic human responses of comforting and consoling a distressed person

Offering human comfort and support is the most important component of psychological first aid. Being with those affected, protecting them from further harm, ensuring basic needs are met, conveying compassion and recognition for what they have been through are all very important tasks.

Protecting the person from further threat or distress as far as possible

Providing a safe environment is critical. Many survivors may have experienced an overwhelming loss of safety and this needs to be restored. Reuniting individuals with family and friends is important to regaining feelings of safety. When reunion is not possible, information about family and friends should be made available, particularly if the family and friends were also in danger or affected by the trauma.

Furnishing immediate care for physical necessities, including shelter

Meeting the physical needs of the individual is extremely important and should be done immediately. This includes providing water and food, warmth and respite. Providing survivors with blankets and food helps reassure them that someone is concerned about them. Medical treatment should be given as needed. Other interventions may be experienced as an intrusion if the individual is exhausted, hungry, and cold. Care must be taken to assure physical needs as the first priority.

Providing goal orientation and support for specific reality-based tasks

Activity during the acute trauma stage can be productive or non-productive. Productive activity is oriented to the reality of the situation and involves the survivor taking an increasing and active role in his or her own return to functioning. As soon as possible disaster survivors should be encouraged to participate in simple but useful tasks.

Facilitating reunion with loved ones from whom the individual has been separated

Injured and frightened survivors should not be left alone, and parents should be reunited with their children. Ensuring the reunion of primary attachment figures may be essential to acute recovery and longer-term adaptation. It has been shown that separations of children from parents at this time may have unwanted long-term effects, even when such separations are ostensibly provided in the best interests of the children.

Sharing the experience

Once survival and the safety of loved ones is assured, people may wish to share their experience with others, particularly those who have 'been through it' with them and also those responding. Such

natural talking through of what has happened is often the beginning of a process of making meaning of the experience, a giving of testimony and ventilation of feelings. If it occurs in such natural groups or settings, eg. a shelter, it should be supported. However, it should not be expected or forced. People vary enormously in the ways they adapt to disaster, both in the immediate aftermath and subsequently. Natural talking through may be part of an adaptive process for those who have the need to do so, but having to talk in groups may be quite inappropriate for others: the timing may be wrong or different coping styles may have greater validity.

It is important to expect recovery following disaster and to acknowledge a range of reactions that are a normal response to an abnormal life situation. Validation of feelings may be very important in the acute recovery phase following trauma. This is the first stage of telling the story and if dealt with in a caring and supportive manner, may help set the person on the path of psychological recovery.

While many feelings may appear at this stage, there is now much to suggest that they will settle in the following days or weeks. Intervention should only be provided when there is evidence that these feelings are not subsiding and the person appears to be at risk as a consequence. Feelings of fear, guilt, hostility and so forth may or may not be ventilated at this time, but a more specific exploration of such issues should only occur if these reflect ongoing problems.

Linking the person to systems of support and sources of help that will be ongoing

It will be important to link survivors to support systems and services that will take over after the acute phase has passed and provide follow-up and assistance to those in need. One of the most important issues throughout all work conducted is human dignity. The loss of personal possessions, clothes and essential items such as glasses for example, the overwhelming dehumanization of the disaster experience; the subsequent dependence on others for

even the simple basics of everyday life may all be threats to the individual's personal dignity. Wherever possible those caring for survivors should be sensitive to these issues. Handouts of old clothes for which the survivors are expected to be grateful may be the sort of thing that highlights such vulnerability, making them feel ashamed, humiliated or even angry.

Facilitating the beginning of some sense of mastery

Disaster survivors frequently experience a sense of helplessness and powerlessness. Survivors of human-made trauma may feel particularly valueless and debased. It is critical to provide an opportunity for the survivor to regain a sense of self-esteem and control over their life. Assumptions about personal invulnerability, the existence of a meaningful world, and positive self-perception may have been shattered. The recovery environment should provide support, protection, containment, and structure and must avoid the further stigmatization of converting disaster survivors into 'patients' or 'permanent' survivors. Stigmatization isolates survivors at the time when they most need social support.

Identifying needs for further counseling or intervention

Identifying those who are particularly stressed or at risk and ensuring that they are followed up by community counselors is another important part of psychological first aid.

The ABC of psychological first aid

These issues can be summarized by the ABC of psychological first aid:

Arousal: This involves reducing very high arousal, comforting and consoling distressed survivors, facilitating reunion with loved ones, protecting from further threat, and ensuring physical necessities.

Behaviour: The person showing behavioral disturbances should be protected from harm resulting from these and linked to systems of support. Facilitating some sense of mastery will be important.

Cognition: Cognitive disturbances such as dissociation should be dealt with anyone through general support, information provision and good orientation to specific reality-based tasks, sharing the reality of the experience if the person wishes to talk. Mental state assessment should include potential organic factors such as head injury or toxic effects, and linking the person to ongoing systems of social support.

Provision of information

Provision of information is critical to recovery, both in practical terms and because it can diminish levels of stress. Information-giving is another critical aspect of psychological first aid.

Information needs to be simple, accurate, brief, and to the point, readily understandable and available in major community languages. It should assist with the registration of those affected,

and provide information on the whereabouts of others as soon as this is available. It will also provide a structure within a period that often seems confusing and chaotic. It is particularly important for advising what to do, and for those separated from family members. There should be one main source of information and those involved in gathering and providing it should be sensitive to its psychological as well as practical significance. Information should be repeated at regular intervals and updated. Communication of information should be clear at individual, group and community levels. It can significantly decrease anxiety, hyperarousal and panic and focus activity appropriately.

Information about when and where to get help both practical assistance and general support such as access to welfare or social aid is also necessary. Newsletters and regular news updates can provide focused information to assist survivors progressively through the recovery process.

Importance of referral

Serious problems may arise for some people after a disaster; especially if there have been particularly horrific experiences. Human-made disasters may be more likely to lead to such difficulties, particularly if human malevolence has contributed. Referral is a critical event in disaster management.

Referral is for those who are distressed or otherwise acutely affected, or demonstrated with a disturbed mental state. As with other first aid, ongoing heightened **arousal, which** does not settle; ongoing disturbed or abnormal behavior; and ongoing **cognitive** impairments, such as continuing dissociation or impact on concentration or memory, would all call for Referral. This process can link those affected into either support or protection if still on site, or if appropriate, to emergency medical/psychiatric care. It can also ensure that those likely to be at higher risk are provided with necessary intervention or care and linked to follow-up

Referral needs to take into account psychological, psychiatric and neuropsychiatric effects, for instance anxiety, depression, organic brain effects, panic, delirium, cognitive impairments and their potential sources. While this differentiation can be difficult, confusion about time or place, presence of hallucinations, extreme levels of fear and arousal all suggest potential acute organic effects.

The initial contact and assessment must encompass a compassionate and human response, the insuring of safety and survival, and the assessment and management of any physical injury or threat to life. Experience suggests that following most traumatic events, very few individuals require immediate treatment because of the severity of their behavioral decompensation. An individual may or may not be in a state in

which he or she wishes, or is prepared, to discuss what has happened. Nevertheless, some gentle querying may, if appropriate by utilized for a 'therapeutic assessment' to identify whether a traumatized person who is showing arousal, cognitive or behavioral disturbance needs emergency psychosocial care.

The aim of this process is to ensure the person's psychological safety, link them to further care if necessary, or ensure a basis for identification and follow-up if they are thought to be suffering from a disorder requiring professional treatment.

Counseling

The Basics

CAUTION:

Trainers and community counselors should realize that they are not and should not consider themselves to be experts in the diagnosis and treatment of mental disorders. The community counselor's role is first to identify those in need of help and then to offer verbal support, information and advice when requested. Sometimes physical assistance, such as moving a victim's belongings or helping to repair damage to homes and property, is most helpful in overcoming emotional distress.

People in crisis are extremely vulnerable. They are open to hurt as much as to help. The goal of community counseling should be to protect them from further harm, while providing them with immediate assistance in managing themselves and the situation. Crisis counselors provide brief, clear and gentle directions and support to distressed survivors. As soon as possible, they help the survivors take on responsibility for their own care. It is important to provide frequent reassurance and guidance when the situation is most threatening. The most important thing is to offer assistance to help the individual gain a sense of control of self and situation, and not to do everything for the survivor.

Supportive counseling can be provided to anyone acutely distressed and involves comforting and reassurance, practical advice, allowing the person to discuss their experience but only if they feel the need to do so, linking them to support networks, and identifying those at risk who may need follow-up and specialised services.

Counseling aims to help people come to terms with the disaster, loss and other distressing events they have suffered in the disaster, with emphasis on enhancing positive coping and facilitating active mastery and involvement in the recovery process. There is now evidence to suggest that more focussed or in depth counseling is not appropriate in the earliest stages, but should be available for those considered at higher risk of adverse psychosocial outcomes either through their high level of ongoing distress or other risk factors as identified above. Such specialised counseling should be provided when it is clear that the post-disaster reactions, for instance to trauma or loss are not settling, or when other factors are present, and not until about 2 weeks or more after the event.

The basic framework for post-disaster counseling is derived from several models of psychotherapy that provide for:

- (a) an alliance based on accurate empathy and continuity of care,
- (b) practical tools for the community counselor to handle emotional overload or shut-down,
- (c) practical steps through which the counselor can assist the survivor in shifting from automatic/reactive processing of traumatic stress and grief reactions to controlled/narrative processing,
- (d) recognizing and providing assistance to the survivor in addressing exacerbated pre-existing psychiatric or addictive problems, and
- (e) a practical approach to problem-solving and gaining access to resources to support recovery.

Whenever possible, it is important to help the survivor identify and focus on the problem or the most important problem if there are several. This helps the individual gain a sense of perspective and to prioritize their recovery efforts. They need to be told what is happening and why to help reduce the sense of surprise or feeling that they are being lied to.

Guidelines for community counselors

Initial interventions are primarily pragmatic, as reflected by the following stages:

Protect:

Find ways to protect survivors from further harm and from further exposure to traumatic stimuli. If possible, create a shelter or safe haven for them, even if it is only symbolic. The fewer traumatic stimuli people see, hear, smell, taste, and feel, the better off they will be. Protect survivors from onlookers and the media.

Direct:

Kind and firm direction is needed and appreciated. Survivors may be stunned, in shock, or experiencing some degree of dissociation. When possible, direct ambulatory survivors:

- Away from the site of destruction
- Away from severely injured survivors
- Away from continuing danger

Connect:

The survivors you encounter at the scene have just lost connection to the world they are familiar with. A supportive, compassionate, and nonjudgmental verbal or nonverbal exchange may help them experience a reconnection to the shared societal values of altruism and goodness. However brief the exchange, or however temporary its effects, such relationships are important elements of the recovery or adjustment process. Help survivors connect:

- with loved ones
- with accurate information and appropriate resources
- with where they will be able to receive additional support

Refer:

The majority of trauma survivors experience normal stress reactions. However, some may require immediate counseling to help them manage intense feelings of panic or grief. Signs of panic include trembling, agitation, rambling speech, and erratic behavior. Signs of intense grief may include loud wailing, rage, and catatonia. If you see these signs of panic and grief, attempt to quickly (1) establish therapeutic rapport, (2) ensure the survivor's safety, (3) acknowledge and validate the survivor's experience, and (4) offer empathy. Medication may be appropriate and necessary.

It is necessary to be aware that these are beyond the scope of community counselors and must be referred to specialists for management.

Alliance building

Introduce yourself and explain the purpose and limits of the services. "Greetings! (Vanakkam, Namaste etc). My name is _____ and I'm a community counselor. I'm one of several counselors here who are meeting with people who have been affected by this tragic disaster. Our goal is to help anyone who has been affected and would like help in sorting out what they can do to cope with stress from this disaster. If you or someone in your family needs additional services, I will help you connect with professionals who can provide continuing services".

Ask: "So tell me, what happened to you on that day?"

Help the survivor define goals that reflect his/her most immediate concerns. Be ready to just listen and nonverbally communicate openness and concern, at first. Gradually help the survivor to clarify specific goals with steps that can be addressed today, the

next week, and longer term. Goals may include:

- getting information about a missing significant other
- getting information about how to make contact with agencies that can provide assistance
- what to say to children and how to help children cope
- how to recognize, understand, and cope with post-traumatic reactions

Establishing rapport

Survivors respond when counselors offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

Active listening

Counselors listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

Allow silence - Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.

Attend nonverbally - Eye contact, head nodding, caring facial expressions, and occasional "uh-huhs". Let the survivor know that the counselor is in tune with them.

Paraphrase - When the counselor repeats portions of what the survivor has said, understanding, interest and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . ." or "I have heard you say that . . ."

Reflect feelings - The counselor may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness or fear. Possible responses are, "You sound angry, scared etc., am I correct?" This helps the survivor identify and articulate his or her emotions.

Allow expression of emotions - Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Counselors should stay relaxed, breathe easily, and let the survivor know that it is OK to feel. They should encourage the survivor to:

Talk - "Spend time with friends and family voicing opinions and expressing your feelings. Ask others how they are coping with their fears".

Pray - "If you believe in a higher power, pray for strength and well being".

Keep Active - "Take part in activities that will help keep your mind off your fears. Instead of watching and reading excessive amounts of news about terrorism, try reading a good book, seeing a movie or spending time with friends".

Keep routine and activities as close to normal as possible.

Avoid isolation.

Avoid reliance on alcohol or other substances

Rest as much as possible

Keep expectations realistic

Keep an attitude that is solution-focused rather than problem-focused

There are six **T's** to providing support to those experiencing an emotional reaction to any crisis situation:

Tears - Let the survivor know that it is normal, helpful and OK to cry.

Touch - A gentle touch on the shoulder, hand or a hug can be very supportive.

Talk - Encourage the individual to talk about the experience, not only with you, but with family and friends or support groups. Talking helps one put the incident in perspective so they can put it behind them.

Trust - You must build up a sense of trust between you and the individual. They need to know that what they share with you will be held confidential, and that you will be non-judgmental.

Toil - Be willing to work with the survivor. Don't rush them. Give them the opportunity to work through their emotions and problems.

Time - It takes time to sit with a survivor. Let them talk, and let them know that the recovery process does take time.

Things to do

Empathize: It is crucial to recognize people's strengths as well as the suffering they have experienced. While survivors' suffering must be acknowledged and compassion and empathy conveyed to them, it is also important that those who care for them believe in and support their capacity to master this experience.

Provide information: Information helps people's understanding and should be an integral part of the support and care systems. Information about what has happened, normal responses to such events, training in what to do to help etc, assist psychological recovery.

Share experiences: Many people may display a need to tell the story of their experience, to give testimony, both to externalize it and obtain emotional release, and to gain understanding and support from others. This varies enormously. It may occur spontaneously as natural groups come together after the disaster. However, there will be others who may not feel ready or who may

choose not to talk about their experience. Community counselors should be aware of these variable needs and be supportive of what the survivor wants.

Support: Support is critical. Community counselors must help the survivor rebuild and retain support networks. These networks help people in the ongoing recovery process, both through the exchange of resources and practical assistance, and through the emotional support they provide to deal with the disaster and its aftermath. Community groups may develop to facilitate support and should be encouraged. More details are provided in the Section on Self Help Groups.

Encourage: Community counselors must encourage survivors to find concrete immediate ways of solving their problems. Survivors must be made aware that it is still possible to carry on life as they did before the disaster. Address intense emotional distress by getting the person to focus on immediate problems and their solutions.

Defuse: Help the survivor to deal with emotional distress, including fear, grief, anger, guilt, shame, dissociation, depression, isolation, somatization and addiction. Help the survivor begin to reconstruct a narrative of the experience before, during and since the disaster, using the 6-step defusing protocol.

Summarize the survivor's narrative briefly, highlighting

1. critical incidents that set the context prior to the initial shock
2. the sensory-perceptual experience at the first moments of shock
3. the actions she/he took immediately, framed as "survival" responses
4. critical incidents in which she/he had moments or periods of awareness of the enormity of the disaster
5. danger or loss (often experienced as "waking up" or feeling over

whelming guilt or grief), and the specific sensory-perceptual experiences associated with these ("triggers", e.g., seeing bodies)

6. a sensitive and respectful reframing of what the person felt, thought and did, which highlights how they were addressing the concerns and values that they feel are most important even if they could not make certain crucial things happen (e.g., Preventing a death) or not happen (e.g., preventing their body from having the normal fight-flight response)
7. Summarize how the survivor has been taking positive steps to address her/his immediate goals - be creative and empathic in re-framing actions that may seem to the survivor to be ineffective, trivial or selfish as ways in which she/he is working hard to protect people by making things safer and to take care of her/himself so she/he can be available to family and friends.

Make a specific plan for how you will help the survivor meet immediate needs and manageable steps the survivor can take on her/his own. Help the survivor identify and make a commitment to contacting support persons and groups, while also taking private time to be in quiet safe places to reduce over-stimulation (recognizing that some survivors may be fearful of being flooded by fear, grief, etc. if they aren't preoccupied, and so for them the best way to recharge may be to do activities with a few select people for whom they do not have to serve as a caregiver or primary support person).

Make a plan for a next meeting or for ways the survivor can check in with you in the future if she/he prefers not to meet again. Consider the need for initiating pharmacotherapy to address debilitating anxiety, anger, sleep problems, depression, mania, psychotic symptoms or dissociative symptoms.

If the survivor has a prior history of mental illness, addiction or psychiatric or substance abuse treatment, review how she/he is using treatment/support resources currently for relapse prevention. Address any immediate risks to self or others if you

have any information or observations to suggest this is imminent, before concluding the session.

When working with the survivors of a disaster, it is important that interventions focus on the resolution of the disaster-caused problems by adapting or reinforcing the survivors' coping techniques to meet the need. Keep in mind that our goal is to decrease emotionality and increase functioning. Community Counselors can help survivors stabilize emotionally by:

- **Utilizing their available support structure (e.g. family, friends, etc.)**
- **Establishing a realistic perception of disaster recovery**
- **Predicting future problems**
- **Providing opportunities to vent their anger, fear, frustration and grief**
- **Reinforcing use of present coping strategies or developing new ones to prevent the recurrence of the same problems in the future**

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Some DO'S and DON'T'S

Do say:

- These are normal reactions to a disaster
- It is understandable that you feel this way
- You are not going crazy
- It wasn't your fault; you did the best you could
- Things may never be the same, but they will get better and you will feel better

Don't say:

- It could have been worse
- You can always get another pet/car/house
- It's best if you just stay busy
- I know just how you feel
- You need to get on with your life

Comments such as these make the survivor feel discounted, not understood or more alone. It is best when counselors allow survivors their own experiences, feelings and perspectives.

Identification of strengths and positive coping styles

Even in extreme disasters, the majority of people do not become incapable of functioning. They get back to their normal lives quickly and usually make full psychosocial recovery. Resilience and coping are probably the most common reactions seen following disaster.

There are many different coping methods and styles used by people when under stress. Active or 'action' oriented coping is an adaptive coping response often utilised following a disaster. People cope by engaging in activities such as assisting others, engaging in practical tasks, setting up support groups, rallying community support etc.

Coping helps to accomplish the following:

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

Coping is intertwined with one's social and emotional resources. It is made easier or hampered and prevented by the nature of the individual's social support system). This system may include interpersonal relationships with family, friends, neighbours, co-community counselors, and small group associations. It is to this social system that the individual typically turns first when seeking support, understanding or aid post-disaster.

Coping skills

Positive coping skills

- Orient one's self rapidly
- Plan decisive action
- Mobilise emergency problem-solving mechanisms
- Use assistance, resources appropriately
- Deal simultaneously with the affective or emotional dimensions of the experience
- Express painful emotions appropriately in manageable amounts
- Acknowledge pain, but avoid obsession over troubled feelings
- Develop strategies to convert uncertainty into manageable risk
- Acknowledge increased dependency needs and seek, receive and use assistance

Negative coping skills

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

- Tolerate uncertainty without resorting to impulsive action
- React to environmental challenges and recognise their positive value for growth
- Use non-destructive defenses and modes of tension relief to cope with anxiety (eg. humour, exercise, eating habits, time management, relaxation techniques)
- Misuse of drugs and other substances (eg. Alcohol, increasing intake of drugs by taking sleeping pills and other tranquilizing agents)
- Inability to use support systems

Providing help for children and families following disasters

A basic principle in working with problems of children in disasters is that they are essentially normal children who have experienced great stress. Most of the problems which appear are likely, therefore, to be directly related to the disaster and transitory in nature.

The intensity and duration of a child's symptoms decrease more rapidly when his or her family or other significant adults are able to indicate that they understand his or her feelings. Children are most fearful when they do not understand what is going on around them. Every effort should be made to keep them accurately informed, thereby relieving their anxieties. Talking with children, providing simple accurate information about the disaster and listening to what they have to say are probably the most important things we can do. Sharing the fact that adults were frightened too and that it is normal and natural to be afraid is also reassuring to a child. It is comforting to hear "Fear is natural. Everybody is afraid at times."

The primary goal in community counseling is to identify, respond to, and relieve the stresses developed as a result of the crisis (disaster) and then to re-establish normal functioning as quickly as possible. Sometimes the reaction is mild. Other times it is severe. Also, the community counselors must be trained to recognize when the condition is mild and can be handled by the families (with guidance) and when it is severe and needs professional help.

The general steps in the helping process include:

1. Establishing rapport

- a. Letting the children know you are interested in them and want to help them.
- b. Checking with the children to make sure that they understand what you are saying and that you understand them.
- c. Having genuine respect and regard for the children and their families.
- d. Communicating trust and promising only what you can do.
- e. Communicating acceptance of the children and their families.
- f. Communicating to the children and their families that you are an informed authority.

2. Identifying, defining and focusing on the problem

Like adults, children going through a crisis may seem confused and chaotic in their thinking. It is helpful to the children and families to identify a specific problem and to define it and focus on it first. If possible, the problem should be quickly resolved so that the children and families quickly experience a sense of success and control. Evaluating the seriousness of the problem should determine the families' capacity for dealing with it.

3. Understanding feelings

Empathy is the ability to see and feel as others do. Being empathetic with children requires patience, for children frequently are unable to express their fears and the adults need to appreciate the kind and intensity of the children's feelings. For example, adults may be required to listen to a child's account of a disaster many times while the child "works through" the disaster by talking it out.

4. Listening carefully

Frequently, the children's experiences of adults listening to them are unsatisfactory. In working with children, effort should be made to respond to them and to comment frequently. Interrupting the children should be avoided for it tends to happen often and the children may be particularly sensitive to being interrupted by adults.

5. Communicating clearly

It is important to communicate in language the children understand. The presence of the family is useful in interviews with the children for the families will be more familiar with them and their behavior. In addition, families will be able to learn how to communicate with the children better after observing the interviewer. Simple language should be used in speaking with the children so that they are not excluded from the helping process.

The use of play

Few children are able to sit and talk directly about their difficulties or to explore the roots that underlie these difficulties. Most of them are not able to talk about their problems even at a superficial level. Involving the children in play is effective in helping them work through their troubled feelings. Play is one of the natural modes of communication. The fantasies that are verbalized while playing often provide much information about the psychological processes that are at the bottom of children's problems. Children's play following disasters will reflect their experiences. Paints, clay, dolls and water-play allow children outlets for their feelings. They will build dams out of blocks, for example, and have them collapse, or they will build towers and pretend the earth is shaking - activities that obviously mirror an earthquake. Children's drawings will depict on a more or less realistic level the feared cyclone winds or tornadoes. Fortunately, children's play discharges feelings that have been bottled up.

Children seem to use play therapeutically. It is best when they are allowed to make their own interpretations. Adult interpretations often dampen this expressive avenue. Any adults who care for children - teachers, counselors, parents - can encourage children to express their feelings in play. The play experience should be a pleasurable one for both adults and children. Adult helpers should get down to the children's level - literally play on the floor with them when necessary. Secondly, the community counselors must have the capacity to project themselves into the children's situation and to see the world through the children's eyes. The community counselors must also have the ability to remember their own childhood experiences sufficiently to be able to appreciate the children's situation.

Parents sometimes feel guilty about the fact that their children are having problems and may feel threatened that outsiders are needed to help. Play therapy involves the parents who can be taught to understand how the children express their feelings and fears through play. Under optimal circumstances, parents play with their children. Following a disaster or other family crisis, parental energies are drawn away from the children. Attracting the families back to their ordinary roles with the children is therapeutic to all concerned.

Individual counseling

Individual counseling may simply be a time for children to "have someone to talk to". As stated earlier, most children find "just talking about feelings" difficult. However, there are times when friendly, supportive adults are just what children need when their own parents are not able to listen to them because they are busy with their own problems. Because disasters arouse natural fears and anxieties in children, community counselors' reassurances and emotional support are important. Individual therapy by trained, experienced therapists can be used in severe cases to help the families and children understand the underlying roots of the problem.

Role of the family

A basic principle in working with a child with an emotional problem is that it is a family problem, not just the child's problem that is presented. The family should be considered the unit to be counseled. Every member should be involved with the process. In addition, one should take advantage of the assistance provided by the concern, interest, and availability of various members of the family. Sometimes adult members of the family may be experiencing emotional distress but hesitate to seek help. The family is frequently more able to seek help on the children's behalf than on that of its adult members. The family may, in fact, use the children's problems as a way of also asking for help for others in the family. This request should be respected not confronted. By having the family involved, others in the family can also be helped. Denial that problems exist may still occur, however, in some cultural and disadvantaged areas.

Before the family can help, however, the children's needs must be understood. This requires an understanding of the family's needs. Families have their own shared beliefs, values, fears and anxieties. Frequently, the children's malfunctioning is a mirror of something wrong in the family. Dissuading them of their fears will not prove effective if their families have the same fears and continue to reinforce them. A family interview should be conducted in which the interviewer can observe the relationship of the children and their families, conceptualize the dynamics of the child-family interactions, and involve the family in a self-help system.

The parents' or adults' reactions to the children make a great difference in their recovery. The intensity and duration of the children's symptoms decrease more rapidly when the families are able to indicate that they understand their feelings. When the children feel that their parents do not understand their fears, they feel ashamed, rejected and unloved. Tolerance of temporary regressive behavior allows the children to re-develop anew, those coping patterns, which had been functioning before. Praise offered for positive behavior produces positive change. Routine rules need to be relaxed to allow time for regressive behaviors to run their

course and the re-integration process to take place.

When the children show excessive clinging and unwillingness to let their parents out of their sight, they are actually expressing and handling their fears and anxieties of separation or loss most appropriately. They have detected the harmful effects of being separated from their parents and, in their clinging, are trying to prevent a possible recurrence. Generally, the children's fears dissolve when the threat of danger has dissipated and they feel secure once more under the parents' protection.

Children are most fearful when they do not understand what is happening around them. Every effort should be made to keep them accurately informed, thereby alleviating their anxieties. Adults, frequently failing to realize the capacity of children to absorb factual information, do not share what they know, and children receive only partial or erroneous information. Children are developing storehouses of all kinds of information and respond to scientific facts and figures, new language, technical terms and predictions. The children learn these new words from the media and incorporate them readily, using them in play and in talking with each other.

The family should make an effort to remain together as much as possible, for a disaster is a time when the children need their significant adults around them. In addition, the model the adults present at this time can be growth enhancing. For example, when the parents act with strength and calmness, maintaining control at the same time, they share feelings of being afraid, they serve the purpose of letting the children see that it is possible to act courageously even in times of stress and fear.

When the family's equilibrium is upset by stress, it may be pushed off-balance temporarily, and the family shows signs of not being able to fulfill its usual functions. Time and informed interventions help in re-establishing the family and its developmental role.

Group sessions

a. Children's Groups

The group experience for children of latency age and older is a natural one because of their daily experiences in classroom settings. Children find it easier to relate to each other than to adults. They gain a lot from a group in which they can talk openly and honestly about their feelings after a disaster. Finding peers who are interested encourages even withdrawn children to talk about their feelings. A leader can provide emotional support and needed information to the group. Children frequently distort the information they receive and are afraid of "feeling foolish" about asking questions. A peer group encourages them to ask their questions, foolish or not.

Group intervention with children is especially useful for therapeutic expression, as they are able to express their fears before their peers once they are reassured that having fears and anxieties is acceptable and that other children (even the bravest ones) also have these feelings. Children retell their experiences with great enthusiasm in group discussions with other children of similar age levels.

Groups function well when the leaders are democratic and care about children. If adults run the group in an authoritarian manner, the group will not "work", and the children will not feel free to talk about their feelings. When groups of children talk about disaster or draw pictures about them, they are helped to dispel their fears about such happenings.

The following is one example of a group technique:

Form a group with a maximum of 12 children. Introduce the purpose as a chance for everyone to learn about the experiences of others in the disaster.

- (1) Ask all the children what happened to them and their families in the disaster.

- (2) As the stories appear, ask the children to tell about their own fears (perhaps even act them out in dramatic play).
- (3) In the course of the discussion, provide factual information on the disaster (what happened, why).
- (4) Ask members of the group to take turns being helpers. The children are paired and then take turns, first asking for help with a problem and then acting as helpers with the others' problems.
- (5) Assign two children as co-leaders to help control restlessness and distractibility among the children.
- (6) Provide the children with paper, plastic materials, clay or paints and ask them to depict the disaster. The less verbal children will find this helpful.

b. Parents' groups

Working with parents in a group is an excellent means of helping them understand their children's behavior and providing them with specific advice on how they can deal with problems. In the group, parents have the opportunity to share their concerns with other parents who may be having similar concerns. Advice from other parents is frequently more acceptable than advice from "experts".

A parent group is useful when it is also educational. Parents often want to be informed on techniques for handling specific problems, such as fears and anxieties, sleep problems, school difficulties and behavior problems.

Often the parents in groups express their own fears. Helping the parents understand their own fears makes them more effective with their children. The groups and group leaders are most supportive to the parents when they reinforce strengths present in the families and help them see how they have been able to deal efficiently with problems in the past. If additional help is needed from other resources in the community, the group leaders should have the information available.

Dealing with sleep disturbances

In dealing with sleep disturbances it is helpful to explore the family's sleep arrangements. The family may need to develop a familiar bedtime routine, such as reinstating a specific time for going to bed. They may find it helpful to plan calming, pre-bedtime activities to reduce chaos in the evening. Teenagers may need to have special consideration for bedtime privacy. Developing a quiet recreation in which the total family participates is also helpful.

Other bedtime problems of the children, such as refusing to go to their rooms or to sleep by themselves, frequent awakening at night or nightmares can be met by greater understanding and flexibility on the part of the parents. The child may be allowed to sleep with the parents. A time limit on how long the change will continue should be agreed upon by both parents and child, and it should be adhered to firmly. Some children are satisfied if the parents spend a little extra time at night with them before they sleep. If they come out of bed at night, they should be returned to it gently, with the reassurance of a nearby adult presence. Having a night light or leaving the door ajar are both helpful. Getting angry, punishing or shouting at the child rarely helps and more frequently makes the situation worse. Sometimes, it becomes clear that it is actually the parent who is fearful of leaving the child alone. Closeness between parents and children at bedtime reduces the children's and adults' fears.

Providing families with information on how to handle bedtime fears can best be done in the family setting or with groups of families meeting together. The families feel reassured upon learning that what they are experiencing is a normal, natural response, and that time and comfort are great healers. Learning that the sleep disturbance behavior is a problem shared with other families is reassuring.

Dealing with school avoidance and school phobia

Puppetry and psychodrama conducted by a counselor or teacher in the classroom or in special groups are helpful in re-enacting the

disaster. They may be followed by discussions and reports by the children of their own experiences in the event. Field trips to disaster sites may be arranged, and group meetings with students and parents may be held. Coloring books, word puzzles, connect-the-dot pictures and arithmetic problems about the disaster build self-confidence. Class projects may be developed in which all the information about the disaster or a previous similar one is collected and made into a book with color drawings. Craft models or replications (such as dams, earthquake geology, volcanoes, rivers etc.) may be built. Puppets may be made and used to re-enact the disaster.

Children can be encouraged to construct their own games as a way of mastering the feelings associated with the disaster. For example, children play tsunami games in which they set up the rules by themselves. In one game, each child is designated as an object, such as a tree, house, car etc., and one child is the tsunami making a noise like the sea and running. The other children begin to run and knock each other over. The "tsunami" leaves, and all the children get up and return to their normal activities. Another example has children building a dam in a gutter or ditch and filling it with water. One child then breaks the dam and allows the water to escape harmlessly down the street or into the ditch.

Dealing with loss

Counselors need to know that mourning has a purpose and that crying by both a child and an adult is helpful. A child needs to be aware that thoughts about the dead person are likely to come to mind over and over. Forgetting takes time and overt mourning helps to integrate the loss more quickly. The family that expresses concern and annoyance at a child who asks the same questions about death over and over again needs to understand that this is the child's way of adapting to the loss.

It is not unusual for a disaster, particularly a major disaster, in which there has been loss of life, to trigger children's questions about death and dying. The fear of the loss of mother or father underlies many of the questions and symptoms a child may

develop, such as sleeplessness, night terrors, clinging behavior and others. Often, when loss has occurred, the children's problems are overlooked. No one assists them in handling their reactions to the loss. When a mother or father dies, most children are fearful of what will happen to them if the remaining parent dies as well. Being told that adults will look after them is very reassuring. The children should be encouraged to voice their questions. The adults should be as honest as they can be with their answers. For example, questions about what happens to a person after death can be answered with the statement that the wisest men and women through the ages have tried to answer this question. However, there is no sure answer. Explanations dealing with heaven and hell or afterlife, or the flat statement that after death there is nothing, are confusing to a child.

Dealing with antisocial behavior

One way to counteract this is to involve adolescents and their peers, under adult direction, in clean-up activities which may be therapeutic to the teenagers and beneficial to the community. The adolescents also serve as an excellent resource for helping elderly people and babysitting for families.

It should be remembered, however, that young people of this age have difficulty expressing their fears and anxieties, lest they seem less competent to their peers and themselves. The use of peer groups, in which teens can talk about their disaster experiences and ventilate feelings, is helpful in relieving buried anxieties. A "natural" setting for these groups, such as school, work or task sites, or wherever teenagers congregate, is desirable. Training teenagers to lead their own peer groups should be considered. School pupil leaders, NCC and NSS cadets are natural leaders/trainers and they can be used to implement this.

Dealing with special children

Parents of special children may need the short-term support of the community counselor. For example, parents would be helped by learning that their children have greater need for reassurance so that they can anticipate and be tolerant of the increased demands.

The parents would also benefit from a self-help group with other parents of special children. Special education teachers can be a source of assistance for the children. Persons familiar as much as possible to the families and children, can be very effective in assisting both.

Planning in advance for the needs of children in residential settings, such as treatment centers for mentally ill, mentally retarded or physically handicapped children, and for day programs for children, such as childcare centers and schools, should have high priority. These agencies should all have their own plans that include staff deployment, evacuation to alternate settings, and ways to contact and inform families of the well-being and location of their children.

Dealing with injured or ill children

Like any children who undergo medical procedures, children who have been physically injured in a disaster or who have become ill and have been brought to the hospital or the hospital or medical camp will be less traumatized by the injury if the medical procedures that are about to occur are explained to them. In most up-to-date hospitals this is part of the hospital routine. Consultants can inquire about the local hospital and professional associations and involve them in crisis planning. Every effort should be made to have a member of the immediate family remain with the child during hospital stays and to be present when the child receives medical care. This is reassuring to the family and to the child.

Parents should encourage children to return to school. They should talk with their teachers about any problems that are evident either at home or in school. Parent-teacher meetings and programs can assist in integrating school and family efforts at reassurance and can encourage the child to understand his/her feelings and to cope with loss and the need to get on with life.

It is important to be aware that each child may react differently, even within the same family. Each child may need a different type

of help to cope with his/her feelings about and reactions to the disaster.

Dealing with adolescents

At this age the motor skills of young people are often equal to those of adults. However, it is important for adolescents not to exceed their abilities and to realize that other aspects of their personalities are not as advanced as their physical development. The mental maturity of adolescents has no direct relation to their physical growth. Adults should not allow themselves to be influenced by appearances and expect an adolescent to have an adult mentality.

Adolescents have a great need to appear competent to those around them. They struggle to gain independence from their families and are divided between a desire for increased responsibilities and a wish to return to the dependent role of childhood. Beyond the family and the school, peer groups have a favored place in their concerns and provide them with various means for validating themselves.

Dealing with the traumatic encounter with death

This will involve encouraging the person to talk through the particular aspects of the experience, to tell their story, to deal with the feelings that were and are aroused, including fear and helplessness. There is often a great deal of release when the person is able to do this. However, sometimes the experience is still too frightening and painful, so this must be taken gradually and in amounts that are manageable for the individual. If the person is intensively preoccupied with reexperiencing the trauma, then they may need to be helped to lessen emotional distress, whereas if their response is essentially numbing, then they need help to get in touch with and express their feelings. The person may also need education about normal reactions and how to gradually come to terms with the feared experience, the importance of gradual exposure and cognitions about the event in line with the appropriate interventions as indicated in the sections below. They may also be helped by writing down their experience. There may be a need for several sessions. If high levels of arousal continue however, the person is likely to need specialist referral.

If stress symptoms are persisting and have not started to ease after a couple of weeks post-disaster, specialist referral should be made.

Counseling for loss

The bereaved person initially needs comfort and support to accept the news and reality of death. Wherever possible the bereaved should be supported to see the body of the dead person and say their goodbye. If there is gross mutilation of the body or the body cannot be found, then special support to talk through fears about the nature of the death and the possible suffering of the deceased

may be critical. Thus the person needs to be gently encouraged to talk of the lost person, if this is a personal bereavement. Grief counseling involves reviewing the relationship with the person, talking over and sharing memories about it, both positive and negative, and expressing the complex feelings that are evoked, including anger, guilt, sadness etc. The bereaved person needs support to talk of the circumstances of the death for these may have been personally traumatic and this trauma component may have to be worked through as well. Memorial ceremonies may be especially helpful allowing public acknowledgment and support for those bereaved.

Dealing with older adults

In the normal course of life, older adults typically have coped with losses prior to the disaster. They may have successfully adjusted to losses of employment, family, home, loved ones or physical capabilities. For some, coping with these prior losses has strengthened resilience. For others, the prior losses may have worn down the individual's reserves and the disaster is an overwhelming blow. As a result of the disaster, irreplaceable possessions such as photographs or mementos passed on through generations may be destroyed. Pets or gardens developed over years may be lost. Psychosocial community counselors must recognize the special meaning of these losses, if they are to assist with grieving.

Older adults living on limited incomes tend to reside in dwellings that are susceptible to disaster hazards due to the location, construction and age of the buildings. Because of financial limitations and age, they may not be able to afford the repairs to their homes. Leaving familiar surroundings is especially difficult for those who experience deficits in hearing, vision or memory, because they rely on known environmental cues to continue living independently.

Self Help Groups

Self-help and other support groups provide valuable roles in practical assistance, information, lobbying and often considerable counseling in interpersonal interaction which assists survivors to work through their grief.

Self Help Groups (SHG):

Bring together: similar groups (idea of "community").

Create: a favorable climate, which allows the message to be heard.

The Message:

Whatever the people are experiencing is normal. They can recover from it and they will be able to return to their activities (idea of "expectancy").

A. Counsel those in the greatest need first

Set your priorities so that those closely involved with the disaster get counseled first. In this way, you ensure your energies go to those in greatest need. You have only so much energy and so many resources. Use them wisely.

B. Counsel homogenous groups

For SHGs to work, individuals need to feel safe. Counsel those who were present at an incident or those who witnessed one separately from those who did not. Those who were present at an incident often feel uncomfortable when people who were not directly involved in the incident participate. As well, details mentioned during a session could unnecessarily traumatize those who were not there. One way to ensure this is to counsel at a peer level.

Composition of the group

In order to encourage discussion, the composition of the group should be homogenous.

Who should be grouped together in a SHG session?

Anyone associated with a traumatic incident can participate in a SHG session. The issue is: who should be grouped with whom?

The significant person for the group

This person is recognized or identified as being helpful and significant for the group.

The number of participants

A group should be restricted to a maximum of twelve participants or less if the emotional load is extremely heavy.

The climate

The meeting must take place in a favorable atmosphere of support and understanding. Each person's reactions are offered to the group and accepted.

Rules for SHG meetings

Freedom of speech

Anyone is free to remain silent if that is his/her choice, but everyone is encouraged to participate.

Respect others

Do not relate details, which could embarrass other participants.

Equality

During the session, all participants are equal.

Respect cultural aspects

The cultural aspect of a group must be taken into consideration.

Certain traditions, beliefs and customs can influence the expression of emotions.

Expressing oneself during the session

The participants are strongly encouraged to express themselves during the session.

Pay attention to the silent participants

Attention must be paid to the people who do not speak but who seem to be disturbed. They can be approached privately later on, in the event that they are simply individuals who are reticent to express themselves in front of a group.

No Criticism:

A BASIC RULE: No one is allowed to criticize someone else.

Types of sessions

Information sessions

Information sessions presented jointly with the organizations involved are intended for the whole community. They consist of providing general information and dealing briefly with the current difficulties, the reactions that may be shown by the survivors, services available, and the problems typically associated with returning to normal life. The activities suggested for information sessions are all optional. None are mandatory, neither for the disaster survivors nor for the members of their families or witnesses of the event.

During these information sessions, the following messages are among those given with regard to physical and emotional reactions:

- the physical and emotional symptoms are part of a stress reaction and are considered normal;
- these symptoms occur in most people in a situation of stress, threat or loss. They are primitive reactions of the mind and body, and their purpose is to help the individual survive;
- stress syndromes, although normal, can, however, present health risks if they persist, since they rob people of energy and make them vulnerable to illness. In some cases, they can even have repercussions on a person's whole life;
- there are many ways of dealing with stress reactions, such as surrounding oneself with people one feels good with and with whom it is easy to talk about what one is experiencing, doing vigorous physical exercise or using relaxation techniques.
- the most effective way of relieving stress is verbalization sessions on the event.

Verbalization sessions

Verbalization sessions on the event are a simple but effective

method of assisting the population and responders to cope with and carry on with normal life. A verbalization session on the event usually permits the alleviation of acute stress reactions in order to reduce or prevent delayed stress reactions.

This method is a rational way of dealing with stress reactions. Focus is on **THREE** specific objectives:

- to help people express their feelings;
- to assist them in understanding their emotional reactions and their behavior;
- to promote a return to a state of equilibrium in each individual.

Dealing with disaster responder stress

As with disaster survivors, assessment hinges on the question of "How much 'normal stress reaction' is too much?" Many reactions listed earlier are commonly experienced by disaster responders. However, when a number are experienced simultaneously and intensely, functioning is likely to be impaired. Under these circumstances, the responder should take a break from the disaster assignment for a few hours at first, and then longer if necessary. If normal functioning does not return, then the person needs to discontinue the assignment.

Support is essential when a disaster responder's personal coping strategies are wearing thin. Counseling support involves exploring the meaning for the responder of the disaster stimuli, prior related experiences and vulnerabilities and personal coping strategies. Suggestions can be made for stress reduction activities. Usually, stress symptoms will gradually subside when the community counselor is no longer in the disaster relief environment. However, if this does not occur, then professional mental health assistance is indicated.

Stress reduction strategies

- Reducing physical tension by taking deep breaths, calming self through meditation, walking mindfully
- Using time off for exercise, reading, listening to music, taking a bath, talking to family, getting a special meal to recharge batteries
- Talking about emotions and reactions with community counselors during appropriate times

- Cognitive strategies (e.g., constructive self-talk, restructuring distortions)
- Relaxation techniques (e.g., yoga, meditation, guided imagery)
- Pacing self between low and high stress activities, and between providing services alone and with support
- Talking with community counselors, friends, family, pastor etc. about emotions and reactions

Self-awareness

- Early warning signs for stress reactions recognized and heeded (see following section)
- Acceptance that one may not be able to self-assess problematic stress reactions
- Over identification with survivors' grief and trauma may result in avoiding discussing painful material
- Vicarious traumatization or compassion fatigue may result from repeated engagement
- Exploration of motivations for helping (e.g., personal gratification, knowing when "helping" is not being helpful)
- Understanding differences between professional helping relationships and friendships
- Examination of personal prejudices and cultural stereotypes
- Recognition of discomfort with despair, hopelessness and excessive anxiety that interfere with capacity to "be" with survivors
- Recognition of over identification with survivors' frustration, anger, and hopelessness resulting in loss of perspective and role
- Recognition of when own disaster experience or losses interfere with effectiveness
- Involvement in opportunities for self exploration and addressing emotions evoked by disaster work

Dealing with the media

Communication with the public by print media and by television and radio is crucial in a disaster. There is a policy for handling media requests for interviews with psychosocial professionals, whose messages must be consistent with ongoing events. All media management should be coordinated with clear and consistent messages. Bearing these issues in mind, if interviews are given it would not be helpful, for example, to tell the public that the danger is minimal if, at the same time, they are watching television footage of armed security forces in full chemical or biological protective clothing. Trust and credibility are key components of communication regarding environmental risk.

Psychosocial professionals interviewed by the media have a powerful opportunity to facilitate the public's understanding of psychosocial issues and the roles of psychosocial community counselors. The media can be used to disseminate important information, such as expected psychological responses to the disaster and agencies that are providing services. Messages should encompass the normalcy of reactions and emphasize that recovery will occur for the majority of those affected. Carefully constructed descriptions of expectable reactions, such as sleep difficulty, irritability and difficulty in concentrating, provide a framework for survivors to understand and anticipate likely reactions, which may help to decrease fear about emotional responses and also may help survivors identify friends or family members who may be in need of professional help.

An important issue to consider in any disaster is the assignment of a person or persons to talk to the media, as the media will have an inevitable presence following any large-scale incident. Unfortunately, some psychosocial professionals in this situation may lose judgment or accuracy, because media interviews can be

anxiety-provoking as well as intoxicating, hence, media interviews can produce statements that would not ordinarily be made. Such effects may also relate to the novice or inexperienced psychosocial responder who unexpectedly finds themselves under the glare of television lights and who exaggerates situations or in other ways loses a professional stance, such as giving unauthorized statements regarding survivors.

The broader issue of interviewing those who have survived or the families of survivors may be a double-edged sword. Depending on the context, media presence can be an unwanted intrusion on a survivor or an opportunity to ventilate and receive social acknowledgment and support through a voluntary interview.

Media management is a specialized role and must be coordinated with the appropriate body.

Appendix 1

Age specific symptoms of psychological trauma due to disasters and appropriate responses by community counselors

Pre-school (1 - 5)

Symptoms	Response
Resumption of bed-wetting, thumb sucking	Give verbal assurance and physical comfort
Clinging to parents	Provide comforting bedtime routines
Fears of the dark	Avoid unnecessary separations
Avoidance of sleeping alone	Permit child to sleep in parents' room temporarily
Increased crying	Encourage expression regarding losses (i.e., deaths, pets, toys)
Loss of appetite	Monitor media exposure to disaster trauma
Stomach aches	Encourage expression through play activities
Nausea	
Sleep problems, nightmares	
Speech difficulties	
Tics	
Anxiety	
Fear	
Irritability	
Angry outbursts	
Sadness	
Withdrawal	

Childhood (6 - 11)

Symptoms	Response
Aggressive behavior at home and/or at school	Give additional attention, consideration
Hyperactive or silly behavior	Relax expectations of performance at home and at school temporarily
Whining, clinging, acting like a younger child	Set gentle but firm limits for acting out behavior
Increased competition with younger siblings for parents' attention	Provide structured but undemanding home chores and rehabilitation activities
Change in appetite	Encourage verbal and play expression of thoughts and feelings
Headaches	Listen to the child's repeated retelling of disaster event
Stomach aches	Involve the child in preparation of family emergency kit, home drills
Sleep disturbances, nightmares	Rehearse safety measures for future disasters
School avoidance	Develop school disaster program for peer support, expressive activities, education on disasters, preparedness planning, identifying at-risk children
Withdrawal from friends, familiar activities	
Angry outbursts	
Obsessive preoccupation with disaster, safety	
Decline in school performance	

Pre-adolescence and adolescence (12 - 18)

Symptoms	Response
Rebellion at home or school	Give additional attention and consideration
Decline in previous responsible behavior	Relax expectations of performance at home and school temporarily
Agitation or decrease in energy	Encourage discussion of disaster level, apathy experiences with peers, significant adults behavior
Delinquent behavior	Avoid insistence on discussion of feelings with parents
Social withdrawal	Encourage physical activities
Appetite changes	Rehearse family safety measures for future disasters
Headaches	Encourage resumption of social activities, athletics, clubs etc.
Gastrointestinal problems	Encourage participation in community rehabilitation and reclamation work
Skin eruptions	Develop school programs for peer support and SHG, preparedness planning, volunteer community recovery, identifying at-risk teens
Complaints of vague aches and pains	
Sleep disorders	
Loss of interest in peer social activities, hobbies, recreation	
Sadness or depression	
Resistance to authority	
Feelings of inadequacy and helplessness	
Decline in academic performance	

Adults

Symptoms	Responses
Sleep problems	Provide supportive listening and opportunity to talk in detail about disaster experiences
Avoidance of reminders	Assist with prioritizing and problem-solving
Excessive activity level	Offer assistance for family members to facilitate communication and effective functioning
Crying easily	Assess and refer when indicated
Increased conflicts with family	Provide information on disaster stress and coping, children's reactions and families
Hypervigilance	Provide information on referral resources
Isolation, withdrawal	
Fatigue, exhaustion	
Gastrointestinal distress	
Appetite change	
Somatic complaints	
Worsening of chronic conditions	

Depression, sadness
Irritability, anger
Anxiety, fear
Despair, hopelessness
Guilt, self doubt
Mood swings

Older adults

Symptoms	Responses
Withdrawal and isolation	Provide strong and persistent verbal reassurance
Reluctance to leave home	Provide orienting information
Mobility limitations	Use multiple assessment methods as problems may be underreported (e.g., repeat observations, geriatric screening questions, discussion with family)
Relocation adjustment	Provide assistance with recovery of problems possessions
Worsening of chronic illnesses	Assist in obtaining medical and financial assistance
Sleep disorders	Assist in reestablishing familial and social contacts
Memory problems	Give special attention to suitable residential relocation
Somatic symptoms	Encourage discussion of disaster losses and expression of emotions
More susceptible to hypo and hyperthermia	Provide and facilitate referrals for disaster assistance

Physical and sensory	Engage providers of transportation, limitations (sight, hearing) chore services, meals interfere with recovery programs, home health, and home visits as needed
Depression	
Despair about losses	
Apathy	
Confusion, disorientation	
Suspicion	
Agitation, anger	
Fears of institutionalization	
Anxiety with unfamiliar surroundings	
Embarrassment about receiving "hand outs"	

Appendix 2

Specific interventions following a disaster

Treatment options

- Arrange for medical care for physical symptoms
- Persuade survivors to talk with family physician, clergyman, friends or to accept professional help
- Help find medical and financial assistance
- Keep channels of communication open with members of the family
- Help family to recognize physical signs of depression and need for professional counseling
- Provide strong and persistent verbal reassurance
- Assist with recovery of physical possessions; make frequent home visits, arrange for companions
- Give special attention to suitable residential relocation, e.g., familiar surroundings and acquaintances
- Help in re-establishing familial and social contacts
- Assist in obtaining medical and financial assistance
- Help re-establish medication regime
- Provide escort and transportation services
- Channel all assistance through local religious and community sources
- Place emphasis on informational and educational assistance

- Outreach all services with the exception of those requiring special facilities such as hospitals and clinics
- Assist in relocation to safe housing
- Provide reassurance and information regarding disaster status
- Assist in making contact with loved ones and friends
- Encourage involvement in housekeeping and rehabilitation duties
- Provide opportunities for group discussions of fears and anxiety
- Give verbal and physical reassurance
- Assist in coping with some specific and tangible problem
- Help in relocating loved ones
- Help in getting care for loved ones who are injured
- Help in locating and making arrangements for loved ones who did not survive
- Give assistance and encouragement in assessing extent of damage to personal property and beginning to repair or rebuild damaged home or business
- Assist in getting medical attention if needed

Appendix 3

Some examples of disaster related emotional problems

CAUTION:

Trainers and community counselors should realize that they are not and should not consider themselves to be experts in the diagnosis and treatment of mental disorders. The community counselor's role is first to identify those in need of help and then to offer verbal support, information, and advice when requested. Sometimes physical assistance, such as moving a victim's belongings or helping to repair damage to homes and property, is most helpful in overcoming emotional distress.

Frequently among community counselors, questions are raised about the types of emotional distress to be expected with disaster victims. There is also interest expressed about learning ways in which these problems can best be handled by community counselors in the field.

Following are some case illustrations of the more typical types of disaster-related emotional distress along with a brief discussion of ways the situation might be handled.

Depression

A middle-aged man is found pacing up and down in front of the remains of his tsunami destroyed home. He does not respond to community members who are trying to help him but continues walking about aimlessly in what remains of the house, wringing his hands.

This illustration of depression differs somewhat from the usual picture of the individual suffering from apathy and withdrawal, with no interest in what is going on around him. The example demonstrates that depression is frequently masked by or expressed in, agitated activity, which is aimless or nonproductive. Unless the depression in this phase is recognized and helped, it may readily progress to more serious mental and physical problems.

Help for the depressed person in this instance might take the form of verbal help, such as reassurance, encouragement, giving information about where and how to get help, and offers of physical assistance in salvaging belongings, making sure he has had something to eat recently, and providing hot coffee or tea while conversing.

Grief

A man appeared in our medical relief camp 3 weeks after the tsunami and asked for help in acquiring a set of fishing materials. While giving the required information to the registration clerk, he mentioned in passing that his son was killed in the tsunami.

This man appears to be in complete control of his emotions. He seems to be going about the business of re-establishing his life in a well-organized fashion. However, such behavior would be considered healthy and desirable only after a suitable period of mourning or "working through" the grief reactions to the death of his son.

In this instance, there had been no time for mourning. The father was busying himself with constructive tasks that actually served to screen the emotional pain in order to avoid dealing directly with his loss. He would probably at some point experience the flooding of emotions he was now damming up and that he would be overwhelmed by them.

What could be done in such a case? This man should not be confronted directly with his loss. This would challenge his psychological defense of suppressing his emotions under these circumstances. Perhaps a brief, gentle comment on his loss is all that can be done at this time. Such a comment might permit the

beginning of the experience of grief. The bereaved father has thus felt the touch of gentle understanding and in a sense has received permission to deal directly with his loss. The community counselor would want to alert relatives or close friends to the probability that the father might need help in the future in dealing with his grief.

Depending on the situation, there are many approaches, which might be appropriate for assisting those suffering grief. It often might be desirable to convey empathy through those close to the victim rather than directly.

Anger

Some villagers who were not allotted houses following the Andhra cyclone were seen throwing stones at construction responders. Some victims of the tsunami, in remote villages, exhibited anger toward relief responders for not doing enough to help them obtain relief materials.

Anger is one of the natural and expected reactions to adversity. The degree of anger felt and ways in which it is expressed are related to many things, some of which are external, as in the case of negligence which caused or contributed to the catastrophe; and some of which are a reflection of the individual's experience of helplessness and frustration in the disaster itself.

In dealing with anger in disaster victims, it is important for the community counselor to be aware of the value of "ventilation" as a means of reducing the excess emotion, which interferes with constructive handling of the causes. That is, it is important that the angry victim be permitted to express his/her anger verbally. It is generally not desirable to take direct action while in the grips of such strong feelings. On the other hand, an understanding listener should not try to exhibit anxiety while listening to the angry outbursts and recitals and not try to "talk him out of" being angry, nor express disapproval or other guilt-inducing reactions. Many people find it uncomfortable and difficult to listen to angry reactions of others. If one is aware of its therapeutic value and is sufficiently motivated, however, this important service becomes easier with practice.

Guilt

A woman appeared at our medical relief camp with various physical symptoms such as stomach cramps, loss of appetite, and severe headaches. Medical examination provides no apparent basis for the complaints. During a conversation with her, one of the nurses finds out that her child miraculously escaped in the tsunami, while the child of a close friend and neighbor was killed.

Further interviews with a counselor revealed that the woman was suffering an overwhelming sense of guilt because she was spared the tragic loss suffered by her friend. Counseling helped her to accept the unpredictable nature of the disaster, which ruined one person and spared the next. The woman was able to overcome her guilt and to offer welcome assistance to her neighbor in coping with her loss.

Guilt is a frequent occurrence among survivors of a disaster. We all experience to some degree the uneasiness, which accompanies sudden and unexplainable good fortune. Our own sense of worthwhileness is called into question. Why have we been spared misfortune when others have suffered? We are glad to have been so favored, of course, but at the same time feelings of guilt arise because secretly we are relieved that the losses occurred to someone else instead of us. The opportunity to talk about and confront directly these natural human reactions with someone who is understanding and shares the same weaknesses is of great value. The knowledge that such feelings occur with most people provides a sense of acceptance and belonging which permits one to go on and to do what can be done to help others who have been less fortunate.

Apathy

An elderly man owned and operated a small private fishing boat rental. The tsunami destroyed his boat and equipment and killed his wife. The old man was discovered by neighbors several weeks later. He had taken to his bed, neglecting to eat or care for himself. At the time he was found, his weight and physical condition had

deteriorated to the point where he was almost dead. At first he refused assistance. However, as a result of patient and persistent efforts by the neighbors, he was persuaded to allow himself to be taken to the hospital. Although he initially regained his health, he did not survive long after being placed in a residence for the elderly.

In this case, the old man felt he could never regain what he had lost in the flood. There simply was not enough time or opportunity. He had little left to live for.

In disasters, apathy is frequently found in the elderly who have suffered significant losses of possessions, their homes, friends, and neighbors. There is a feeling, often all too real, that they will not again be able to recover or replace these losses. Assistance must take very concrete and immediate forms if it is to be of any value. Relatives or friends must be located if possible. Physical relocation should be as near as possible to what is familiar for the older person. Readjustment to new surroundings and strangers is often an overwhelming and sometimes impossible effort, as in the case illustrated above. As many people as possible should be involved, especially other elderly people who have gone through the same experience. When apathy is encountered in the middle-aged person or in the adolescent, emphasis should be on immediate and active attempts to recover and replace the losses, to become involved in community rehabilitation, and to participate in social activities. The last mentioned is of particular importance for the adolescent.

Fears

An otherwise normal 6-year-old girl living by the sea, who has survived the tsunami, becomes terrified and cries whenever she hears the sound of the waves crashing on the shore at high tide. A 4-year old tsunami survivor develops the habit of going out and staring at the sea, looking for another tsunami. A 7-year-old is found crying and crouched in a corner whenever his mother leaves the house.

These persisting fears are often found among young children and sometimes among adolescents and adults following a disaster. They are referred to technically as "traumatic neuroses". With most otherwise healthy persons such persistent fears tend to subside as time passes. If they continue to appear some months after the disaster it is apparent that the intervention of a mental health specialist is needed. Much can be done, however, in the immediate post-disaster period to relieve these symptoms and prevent their continued self-reinforcement.

With children, it is essential that the child be given additional warm affection and understanding when experiencing the recurrence. Above all, the child should not be scolded or punished for exhibiting these fears. Talking with the child in a gentle and reassuring manner is helpful. Permitting or encouraging the child to talk about what is frightening him is also important. For adolescents and adults who display recurrent fear symptoms, permitting the victim to relive the experience verbally, to become actively involved in recovery efforts, and to learn more about the causes and means of possible protection from future disasters are particularly useful.

The "burn-out" syndrome

A relief volunteer is making his field visits to affected villages in remote areas. His job is to identify those who have suffered psychological trauma and counsel them. He is out in the field for almost 16 to 18 hours. He comes home utterly tired. His face shows fatigue. His efficiency is at a low ebb. He feels the accumulating frustrations and anger of the people he is trying to assist and is unable to sleep or attend to his family.

The man is exhibiting excessive fatigue, irritability, anxiety, impatience and all symptoms of the beginning of the "burn-out" syndrome. Front-line community counselors typically overextend themselves in disasters. This most often occurs when there are not enough relief community counselors, and the ones available want to help as much as possible. Sometimes, however, even when replacements are available, community counselors refuse relief

and push themselves beyond their effective limits. Such action might seem altruistic and commendable. In reality, the tired and inefficient relief community counselor can be more of a liability than an asset in rescue and recovery activities. The community counselors, during and immediately following the disaster, need all the strength and energy they can gather. They must have clear heads to make critical and sometimes life-saving decisions. They must be able to cope not only with the physical consequences of the disaster itself but with the fears, anger and physical and emotional suffering of the victims.

It is essential, therefore, that the community counselor is not overtired or weak from lack of food or rest. Often the community counselor fails to recognize these signs in him/herself although they are obvious to others. Those responsible for supervision of front-line relief community counselors must do everything possible to forestall the occurrence of the "burn-out" syndrome.

Bizarre behavior

A young man living 5 Km from the coast rushed to the ravaged area after the tsunami and helped clear 30 corpses in the first two days. He then worked for the next two days in the community kitchen helping to prepare and serve food, hardly sleeping in the process. From the fifth day he began to behave peculiarly. He would sit and stare into space for long periods of time, or wander about searching for something. When asked what he was doing he would say "Nothing. I am fine". He would not sleep at night sitting up and saying that whenever he closed his eyes he would see corpses.

Sometimes the effects of the disaster can prove to be an overwhelming experience for victims and relief responders alike. The excessive stress causes a breakdown of usually effective coping mechanisms. The individual exhibits irrational and bizarre behavior. He may temporarily "go crazy". He needs to be treated by mental health experts.

Appendix 4

Contrary to popular misconception, this is an unusual rather than a usual occurrence during disasters. Most frequently, individuals who suffer emotional breakdowns are those who have had previous histories of breakdown and likely have had to be hospitalized for mental health treatment in the past. There are generally a few people in any community with histories of emotional breakdown. It is valuable for local mental health professionals to be aware of those who are more likely than most to suffer serious mental disturbance as a consequence of the disaster. Immediate assistance is required in the form of admittance to a hospital or emergency professional attention when the victim shows behavior, which could be harmful to himself or others.

Suicide

A man who lost his family in the tsunami confined himself to the temporary shelter allotted to him for four days. On the fifth day he hung himself from a nearby tree.

As with mental breakdowns, suicide is not a common occurrence among disaster victims. The seriousness of this tragic aftermath is such that mental health and other relief community counselors need to be alert to those individuals who might be likely to react to excessive stress in this way. It has been found that those who do commit suicide usually have some previous history of attempts or communications to others about their intent to do away with themselves. Awareness of who in the community is susceptible to this sort of self-destruction is one of the vital roles the local mental health community counselors can play in alleviating the emotional suffering which accompanies all disasters.

Setting up disaster psychosocial response

Services and training

The skills and competencies required of disaster psychosocial response workers are sufficiently different from typical mental health practice to demand specialized selection and training. When a disaster strikes a community, it is ideal to have a cadre of psychosocial response professionals with special training who can be quickly mobilized, oriented and deployed. If the impacted area does not have this capacity, then mutual aid agreements with communities having trained and experienced disaster psychosocial response workers will be helpful in the chaotic times immediately following impact.

Staff selection

Disaster psychosocial response work is not for everyone. This challenging and rewarding work requires that psychosocial response professionals be flexible and socially extroverted. Despite altruism and a sincere desire to help, not all individuals are well-suited for disaster work. Whether designating and training disaster staff before or during a disaster, the psychosocial response manager must consider several selection issues.

Ideally, selection of professional or paraprofessional staff should consider demographics of the disaster-affected population, including ethnicity and language; the personality characteristics and social skills of the staff member; the phase of disaster; and the roles the worker may play in disaster response and recovery efforts. Workers selected for disaster response and recovery work should not be so severely personally impacted by the disaster that their

responsibilities at home or their emotional reactions will interfere with participation in the program or vice - versa.

Demographics of the population

Managers should choose staff with special skills to match needs of the population. For example, staff with special expertise in working with children and the local schools should be included. If there are many elderly persons in the community, the team should include persons skilled in working with older adults.

Ethnicity and language

Survivors will react to and recover from disaster within the context of their ethnic background, cultural viewpoint, life experiences and values. Psychosocial relief workers with limited local dialect speaking skills may have difficulty communicating and understanding needs and feelings. All aspects of disaster operations must be sensitive to cultural issues, and services must be provided in ways that are culturally appropriate. For these reasons, it is essential that psychosocial response staff be both familiar and comfortable with the culture of the groups affected by the disaster. It is highly desirable that they be fluent in the local dialect. Ideally, community counselors should include individuals indigenous to specific cultural groups affected by the disaster.

Qualities of psychosocial response program staff

A necessary quality for individuals participating directly in planning and implementing psychosocial intervention is the ability to remain focused and able to respond appropriately. Disaster psychosocial response staff must be able to function well in confused, often chaotic environments. Workers must be able to "think on their feet," and have a common-sense, practical, flexible and often improvisational approach to problem-solving. They must be comfortable with changing situations, and able to function with role ambiguity, unclear lines of authority, and a minimum of structure. Many of the most successful disaster psychosocial response workers perceive these factors as challenges

rather than burdens. Initiative and stamina are required, as well as self-awareness and an ability to monitor and manage their own stress.

Workers must be able to work cooperatively in a liaison capacity. They should be aware of and comfortable with value systems and life experiences other than their own. An eagerness to reach out and explore the community to find people needing help, instead of a "wait and treat" attitude, is essential. Workers must enjoy people and not appear lacking in confidence. If the worker is shy or afraid, it will interfere with establishing a connection. Staff must be comfortable initiating a conversation in any community setting. Additionally, workers must be willing and able to "be with" survivors who may be suffering tragedy and enormous loss without being compelled to try to "fix" the situation.

Long-term psychosocial response programs, covering the period from about one month to one year post-disaster, are different in nature and pace from the immediate response phase. Psychosocial response workers need to be adept and creative with outreach in the community.

Action oriented staff thrive in the immediate post-disaster period. However, the results of outreach and education efforts are often hard to measure, as survivors traditionally do not seek out psychosocial response services and there are few "clients" to treat and count. Clinically oriented staff accustomed to an office-based practice often question their usefulness and effectiveness. "Action-oriented" staff who thrived in the immediate response phase may not enjoy or function well in the longer-term recovery phase where patience, perseverance, and an ability to function without seeing immediate results are assets.

Ideally, the disaster psychosocial response team should be multi-disciplinary and multi-skilled. They should have knowledge of response of survivors to disaster, post-traumatic psychological reactions and grief reactions and age related disaster psychology. Survivors are often reluctant to come to psychosocial response centers for services, so staff must be able to provide their services in nontraditional community-based settings.

Staff should be well-acquainted with the functions and dynamics of the community's human service organizations and agencies. They should have experience in consultation and community education. Excellent communication, problem-solving, conflict resolution and group process skills are needed, in addition to an ability to establish rapport quickly with people from diverse backgrounds.

Psychosocial response staff need to understand and be able to function effectively in a complex and fluid political and bureaucratic network.

Do mental health professionals require training?

Mental health professionals frequently assume that their clinical training and experience are more than sufficient to enable them to respond adequately in disaster. Unfortunately, traditional mental health training does not address many issues found in disaster-affected populations. While clinical expertise, especially in the field of crisis intervention, is valuable, it is not enough. Mental health professionals working in disaster psychosocial response programs need to adopt new procedures and methods for delivering a highly specialized service in disaster. Training must be designed to prepare staff for the uniqueness of disaster psychosocial response approaches.

Most of the problems and post disaster symptoms are normal reactions of normal people to abnormal events. Few require traditional psychiatric treatment. Very few people seek out psychosocial response assistance following disaster, and mental health staff who simply open the doors of their clinics to clients or patients will have little to do.

Because of this, outreach to the community is essential. Outreach is more than simply setting up decentralized clinical services in impacted areas or advertising psychosocial response services. Outreach means mingling with survivors in shelters and the community. The key to effective outreach is the community counselors' ability to establish rapport and to have interaction with individuals in an informal, social context.

Disaster psychosocial response training will help mental health professional staff to understand the impact of disaster on individuals and the community. It will provide information about the complex systems and resources in the post disaster environment. It will also help staff to fine-tune clinical skills that are relevant and useful in disaster, and will aid them in learning effective community-based approaches.

Logistics of training in the middle of a disaster

Immediately post-impact, psychosocial response administrators may feel pressured to deploy their staff without delay. The urgency of disaster underscores the value of having a core team of staff trained in disaster response before a disaster occurs. If such a team is not in place, training must be conducted during the disaster response and recovery activities. This can require some juggling of schedules and personnel, but it has been done and remains essential to the success of the psychosocial response. Administrators and staff will need to shift from the pace of a regular work week to "disaster time" which often involves working 12 to 16 hour days and weekends.

In the urgency of immediate response, the timeframe required for a comprehensive disaster psychosocial response training (2-5 days) is probably unrealistic. In addition, skilled trainers may not be instantly available. Such a comprehensive training may need to be postponed for a few days or weeks. In the short-run, the following suggestions will be helpful.

If possible, select disaster response staff with good crisis intervention and community relations skills, as these are the skills most transferable to the disaster situation. A trainer should ideally have disaster experience, but if one is not immediately available, an experienced disaster relief worker or mental health professional can use materials from this handbook or other training materials to provide staff with basic training.

Time allotted to this "basic" training may vary according to local circumstances, but if possible, at least one and a half days should be devoted to training and orientation.

On the job training can be provided by linking inexperienced disaster psychosocial response workers with those who have had prior disaster experience. Experienced workers may be part of a core team that was trained pre-disaster, or they may be mutual aid staff who have come from another jurisdiction to assist. An experienced worker assigned to a team of new workers can provide on-scene consultation, direction, and role modeling.

Orientation of disaster psychosocial response staff to field assignments

Besides training, managers should be sure that an orientation to the disaster is provided to psychosocial response staff before deployment.

The following topics should be covered:

- 1. Status of the disaster:** nature of damages and losses, statistics, predicted weather or condition reports, boundaries of impacted area, hazards, response agencies involved.
- 2. Orientation to the impacted community:** demographics, ethnicity, socio-economic makeup, pertinent politics etc.
- 3. Community and disaster-related resources:** handouts with brief descriptions and phone numbers of human service and disaster-related resources. For volunteers or mutual aid personnel, provide a brief description of the sponsoring psychosocial response agency.
- 4. Logistics:** arrangements for workers' food, housing, obtaining messages, medical care etc.
- 5. Communications:** how, when, and what to report through psychosocial response chain of command; orientation to use of cellular phones and other communications equipment being used.
- 6. Transportation:** clarify mode of transportation to field assignment; if workers are using personal vehicles, provide maps, delineate open and closed routes, indicate hazard areas.

7. Health and safety in a disaster area: outline potential hazards and safety strategies (e.g., protective action in earthquake aftershocks, flooded areas, etc.). Discuss possible sources of injury and injury prevention. Discuss pertinent health issues such as safety of food and drinking water, personal hygiene, communicable disease control, disposal of waste, and exposure to the elements. Inform them of first aid/medical resources in the field.

8. Field assignments: outline sites where workers will be deployed (shelters, meal sites etc.). Provide brief description of the setup and organization of the site and name of the person to report to. Provide brief review of appropriate interventions at the site.

9. Policies and procedures: briefly outline policies regarding length of shifts, breaks, staff meetings, required reporting of statistics, logs of contacts etc. Give staff necessary forms.

10. Self-care and stress management: encourage the use of a "buddy system" to monitor each other's stress and needs. Remind them of the importance of regular breaks, good nutrition, adequate sleep, exercise, deep breathing, positive self-talk, appropriate use of humor, "defusing" or talking about the experience after the shift is over. Inform workers regarding debriefing to be provided at the end of the tour of duty.

Objectives of comprehensive disaster psychosocial response training

Comprehensive training on disaster psychosocial response should be provided for all staff, volunteers and trainers, who will be involved in disaster response and recovery, including management and administrative personnel who will be closely involved. Training should be mandatory.

Effective disaster psychosocial response training will provide participants with certain knowledge, skills and attitudes that will enhance their effectiveness in the disaster setting. Because involvement with disaster psychosocial response work requires a perceptual shift from traditional psychosocial response service delivery, the acquisition of new skills and information is essential.

The objectives of a comprehensive disaster psychosocial response training are to provide participants with the knowledge, skills and attitudes that will enable them to:

1. understand human behavior in disaster, including factors affecting individuals' response to disaster, phases of disaster, "at risk" groups, concepts of loss and grief, post-disaster stress responses and the disaster recovery process.
2. intervene effectively with special populations in disaster, including children, older adults, people with disabilities, ethnic and cultural groups indigenous to the area and the disenfranchised or people living in poverty with few resources.
3. understand the key concepts and principles of disaster psychosocial response, including how disaster psychosocial response services differ from traditional psychotherapy; the spectrum and design of mental health programs needed in disaster; and appropriate sites for delivery of psychosocial response services.
4. provide appropriate psychosocial response assistance to survivors and workers in community settings, with emphasis on crisis intervention, brief treatment, post-traumatic stress strategies, age-appropriate child interventions, debriefing, group counseling, support groups and stress management techniques.
5. provide outreach psychosocial response services at the community level through community counselors.
6. understand the stress inherent in disaster work and recognize and manage that stress for themselves and with other workers.

Selection of trainer

In the immediate response to the disaster, the importance of rapidly training and deploying disaster psychosocial response staff may require the program to involve a local psychosocial response professional with no disaster experience as the trainer. While having prior disaster experience is preferable, it may not be practical. Alternate relevant background experience might include: crisis intervention in a psychosocial response center,

critical incident stress management with emergency service workers, experience in community-based settings, breadth in professional and clinical work and effectiveness as an educator. The person or persons chosen to provide disaster psychosocial response training should have knowledge, skills and experience that will enable them to meet the above training objectives. In addition, the individual should have a good understanding of principles of adult learning, and must have excellent training skills to promote learning of knowledge, skills, and attitudes.

Teaching disaster psychosocial response involves working in the domain of emotions. Students often find that the material about disaster triggers deep feelings in themselves, and the trainer must be comfortable and skilled in group process and appropriate classroom discussion of emotions.

If a large group of people is being trained (over about 60), it is advisable to have more than one trainer to facilitate group discussion and skills practice. It is also possible to use trainers with different areas of expertise to teach various aspects of the material.

Training about ethnic groups affected by the disaster should ideally be done by individuals indigenous to the specific groups and familiar with conducting ethnic diversity training for majority culture groups.

Setting up the training

The training should be held in a comfortable setting with audio-visual equipment suitable for the room and size of the group. Although less than thirty participants is an ideal size for training, logistics may dictate that the group be larger. Under those circumstances, having additional small group facilitators and trainers to review and give feedback on role-plays enhances the depth of the training.

Qualifications of community counselors

1. Possess at least some high school education (to master information and concepts to be taught).

2. Are indigenous to the area, if possible.
3. Represent a cross section of the community/neighborhood members with regard to age, sex, ethnicity, occupation, length of residence in the community etc.
4. Are motivated to help other people, like people, and have sensitivity and empathy for others.
5. Are functioning in a stable, mature and logical manner.
6. Possess sufficient emotional and physical resources and receive sufficient personal rewards to be truly capable of helping.
7. Can work cooperatively with others.
8. Are able to work with people of other value systems without inflicting their own value system on others.
9. Are able to accept instructions and do not have ready-made, simplistic answers.
10. Have an optimistic, yet realistic, view of life, i.e., a "health engendering personality."
11. Have a high level of energy to remain active and resourceful in the face of stress.
12. Are committed to respect the confidentiality of survivors and are not inclined to gossip.
13. Have special skills related to unique populations (e.g., children or older adults, particular ethnic groups) or useful to disaster recovery (e.g., understanding of insurance, building requirements etc.).
14. Are able to set personal limits and not become too involved with survivor recovery (e.g., understand the difference between facilitating and empowering survivors as opposed to "taking over" for the survivor).

Appendix 5

Suggested structure of community counselor training

Duration: 1^{1/2} days

Day 1

Program introduction - 15 mins

Experience sharing by participants - 60 mins

Tea Break - 15 mins

Psychological effects of disaster (Trainer) - 30 mins

Group work - identifying psychological effects - 60 mins

Reports by group leaders - 30 mins

Lunch

Handling psychological effects of disaster (Trainer) - 30 mins

Group work - handling psychological effects identified earlier - 60 mins

Report by Group Leaders - 30 mins

Tea Break - 15 mins

Implementation (Trainer) - 15 mins

Group Work - development of individual action plans - 60 mins

Summary of day's proceedings and day close (Trainer) - 15 mins

Day 2

Opening (Trainer) - 5 mins

Recap of previous day proceedings by group leaders - 30 mins

Presentation of individual action plans by participants - 60 mins

Tea break - 15 mins

Comments, discussion and questions - 60 mins

Valediction - 15 to 30 mins

Lunch