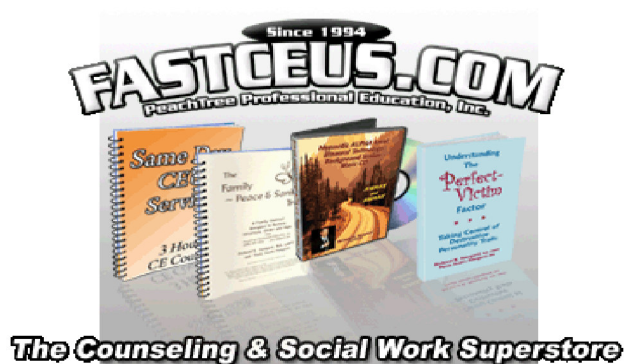

"Psychological and Counseling Interventions in Disaster"

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"Psychological and Counseling Interventions in Disaster"

3 CEU Credit Hours

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Course Description:
Understand the physical and emotional effects on survivors of natural and man-made disaster situations that may be treated by social workers and mental health counselors. Grief and Loss, Disaster Syndrome, PTSD and other Generalized Anxiety Disorders are defined and discussed, as well as special interventions for children.

Course Objectives:
At the conclusion of this course the professional will be able to:

- Identify key concepts in crisis and disaster response
- Describe The Psychological Impact of Disasters
- Understand cross cultural issues in disaster response
- Verbalize an understanding of UN guidelines for international response to disaster
- Implement social and psychological interventions with people in crisis
- Understand therapist self-care and issues impacting the mental health of service providers.

Purpose of this course:
The purpose of this CEU course is to provide discussion relevant to the mental health counselor on intervention responses to adult and children survivors of disaster events, whether natural or man-made.

Course Outline:
Part 1: Course organization, Documentation and Introduction.
Part 2: Reading of the course materials (this document)
Part 3: Administration and Completion of the Evaluation of Learning Quiz
===========

3 Clock Hours / CE Credits

If you ever have any questions concerning this course, please do not hesitate to contact **PeachTree at (800) 390-9536**.

Your instructor is **Richard K. Nongard**, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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"Psychological and Counseling Interventions in Disaster"

INTRODUCTION

All over the world, disasters occur on at least a weekly basis. Whether the adversity involves Mother Nature and her wrath (e.g. volcanic eruption, flooding, earthquake, or tsunami), or a man-made catastrophe (terrorism, oil spill, building collapse, stampede), disasters are *guaranteed* to impact survivors, witnesses and responders. Addressing threat to safety and physical well-being of those affected is, of course, a priority. But given that disasters are *abnormal life situations* that cause *extreme amounts and forms of stress*, it is important to also incorporate a mental health component to disaster intervention.

It is vital for mental health professionals to know how to best assist those affected by a disaster. Mental health interventions can provide much needed support, in order for individuals and communities to resume normal day-to-day activities in the shortest possible time. Psychological interventions can also avert or manage the development of mental health disorders associated with the disaster response. It may even be said, that neglecting the mental health aspect of disaster response can jeopardize the community's efforts towards successful rehabilitation.

This manual aims to provide mental health practitioners with a better understanding of disasters and how it affects the psychological well-being of those around it. With the goal of enhancing skills in delivering mental health services in times of disasters in mind, this manual will also discuss psychological interventions appropriate during the 3 stages of disaster management (preparation, response and rehabilitation). The care for mental health service providers and first responders will also be explored.

CONTENT OVERVIEW

This manual will cover the following four major topics:

- Disasters and Mental Health: An Overview
- The Psychological Impact of Disasters
- Psychological and Counseling Interventions in Disaster
- Burn-Out, Vicarious Trauma and Self-Care

Part 1

DISASTERS AND MENTAL HEALTH:

AN OVERVIEW

This Section Contains the Following Topics:

- An Introduction to Disasters
- Disasters and Mental Health

DISASTERS AND MENTAL HEALTH: AN OVERVIEW

Before we discuss particular psychological interventions appropriate during disaster situations, it is important we first understand what disasters are, and how they impact a survivor's psychological well-being.

AN INTRODUCTION TO DISASTERS

- **What is a Disaster?**

Almost everyone has a concept of what may be considered as disastrous. Whatever mental picture comes to mind, two things are clear: (1) a disaster is an event way outside the norm, and (2) it brings a lot of unpleasant --- *and perhaps traumatic* --- consequences. There are transportation accidents that kill entire bus loads of children in seconds, earthquakes that turn a bustling metropolis into senseless rubble, and a toxic waste spill where, while there is no evident carnage, citizens know they have already been exposed to life-threatening chemicals. There is war that you do not see, but can hear. There is the unassuming neighbor who just opened fire one day and killed a dozen bystanders. And there is flooding that can devaluate in seconds what took you twenty years to build.

What constitutes a disaster is complex, as disasters come in all shapes and magnitude. In an attempt to define the term, Quarantelli (1986) listed at least six concepts that are often associated with disaster. These include:

1. *Physical agents.* What caused the disaster? A volcanic eruption? A bomb? Disasters can be classified based on their triggers (more on this later).

2. *Physical impact.* How has the disaster affected the surroundings? Is the whole city flooded? Is there building debris everywhere? Were there injuries and fatalities? The presence of physical impact can give a clue as to whether or not a disaster took place.

3. *Assessment of physical impact.* How significant is the damage? Did the impact impair the daily living of those affected? Has transportation, communication and other basic services been paralyzed? There is a threshold when it comes to the degree of negative consequences before an event may be considered as a disaster.

4. *Social constructions of reality*. How was the event perceived by all affected? Did it bring much psychological distress? Did it result to shock, immobility and confusion? Depression, substance abuse and grief? The presence of physical damage alone does not define a disaster; it still boils down to how the event has affected the internal world of persons involved.

5. *Political definitions.* Was there an official declaration of a state of emergency? A situation can be classified as a disaster based on the affirmation of people in authority.

6. *Imbalance between demand and capability in a crisis.* Are the community's resources sufficient to address the needs created by the physical impact? Are individual coping resources enough to deal with the psychological, social and even financial impact of the incident? If the answer is no, then an event may be considered as a disaster.

Of these 6, the last one is the most relevant. In general, an event is considered a disaster based on the affected community and its members' ability to cope. If the resulting hazard is way more than the community and its members can manage, then an event may be considered as a disaster. Outside of the community's ability to cope with the event, a situation remains a critical incident.

This implies that what may be considered as disastrous depend from country to country, population to population. An earthquake that registers as a 6.0 on the Richter Scale can paralyze an industrialized city with many poorly-constructed high-rises, but its impact may be negligible to a community of sea-side dwellers with small shanties as homes --- even if the latter is worse-off economically. Similarly, an oil spill is catastrophic to a state that depends on fishing for survival, but manageable for another where living does not rely on the contaminated water --- regardless of the scale of the leak.

- **Two Kinds of Disasters --- and is the typology clinically relevant?**

Disaster managers typically classify disasters into two categories: natural and man-made.

Natural disasters, as the term implies, are those resulting from the forces of nature. Examples include atmospheric disasters like hurricanes and heat waves, water-based disasters like flash floods and tsunamis, geological disasters like earthquakes and volcanic eruptions, and biological disasters like the break-out of a deadly flu virus. Man-made disasters, on the other hand, are those that can be traced to the actions of particular individual/s. While human intention may trigger and/or aggravate natural disasters (such as illegal logging intensifying flooding), some disasters are deemed outside the accepted order of things. Man-made disasters include war, terrorism, construction accidents, and piracy.

Of interest to professional counselors is whether the distinction creates considerations when crafting mental health interventions. The answer is yes and no.

Empirical research suggests that the rate of mental health disorders, such as Post-Traumatic Stress Disorder (PTSD), tends to be higher for man-made disasters than for natural ones. For instance, a review conducted by Galea, Nandi & Vlahov (2004) found that the prevalence of PTSD in the first year after man-made disasters range between 25 - 75 percent, while PTSD prevalence after a natural disaster is within 5 – 60 percent, with most cases falling in the lower range.

The discrepancy can be a mere sampling problem; survivors of natural disasters are harder to gather. But many counselors believe that the difference exists because it is easier for survivors to accept natural disasters compared to man-made ones.

Natural disasters are *unintentional* events that affect people *indiscriminately*. On the other hand, man-made disasters, especially those that involve acts of planned aggression and/or deadly negligence, require survivors to accept a deviance in the socially acceptable order of things, the presence of targeted malicious intent and/or the fact that loss could have been prevented. Hence, counselors are advised to expect greater anger and confusion during man-made disasters than during natural ones.

Classifying disasters into natural or man-made can also help in understanding what is helpful during the bereavement process. Responses to natural disasters emphasize mourning the loss and preventing similar catastrophes. Man-made disasters, on the other hand, require not just these two, but accountability as well. Before a community can move on, there has to be a search for the guilty party and punishment for the convicted. At the very least, survivors need to make sense of the motivation behind the aggression or the circumstances behind the negligence, and affirm positive cultural values. Survivors need to know that all is still right with the world.

But these factors, aside, it may be said that disaster typology has little bearing on the general approach mental health professionals are recommended to take. The minimum required response from psychologists remains the same: affirm normal stress reactions, guide survivors through losses, and provide therapeutic interventions for surfaced abnormal reactions. Whether one is dealing with a natural or man-made disaster, these required minimum interventions apply.

- **The New Faces of Disaster**

Two developments in disaster typology should be of interest to responding mental health professionals.

Terrorism

The September 11, 2001 terrorist attack on New York City revealed a new face to critical incidents. While acts of terrorism are by no means new, it has never been as faceless and as close to home as it was when the World Trade Center was hit. Before 9/11, there was a clear line between civilians and terrorists. After 9/11, virtually anyone can be a terrorist (the New York bombers had been able to pass themselves as regular folk), any place can be terrorized (The World Trade Center and The Pentagon were two institutions that seem invulnerable), and anyone can be the target at any time (most victims were just at a regular day of work). The sheer boldness of the method used to hit New York's twin towers (crashing commercial planes into two high-rises) also brought home the fact that today's terrorists are capable in (deadly) creative ways.

This new face means a more complex way of assessing exposure to disaster. The 9/11 attack promoted a heightened sense of fear and insecurity among all citizens, that the range of victims went beyond proximity to ground zero. In fact, there were reports of stress symptoms among those merely watching the event unfold on television, more than symptoms typically found in the average news viewer. There were also stress reactions from victims of bomb threats and terrorist scare, to the extent that it is like an actual act of aggression took place. Responding mental health professionals must be sensitive to this unique new context, and intervene appropriately.

Extreme Weather Events

Second, disaster responders must be able to respond to the upward spike in the frequency of climate-related disasters, with some states and countries vulnerable to repeated attacks.

Back in 2007, the International Federation of Red Cross reported increasing intensity and frequency of severe storms and extreme weather events. This coincided with the El Niño and La Niña phenomenon (extreme heat and extreme cold respectively). Thus, climate-related disasters, like floods, are at an unprecedented high. Flooding is also associated with secondary disasters such as dengue and malaria epidemics. Disaster responders are therefore recommended to consider long-term interventions for areas identified as vulnerable to constant attacks.

- **Primary vs. Secondary Victims**

It is important to also ask: *"Who are the victims of a disaster?"* The answer represents the clientele responders need to attend to.

Bolin (1986) classifies the people affected by a disaster as either primary or secondary victims. Primary victims are those who directly experienced the critical incident and/or suffered the losses it brought. Secondary victims are those who witnessed the disaster and/or its aftermath, but did not experience the actual impact. Interestingly, while primary victims are likely to be the more affected between the two, secondary victims tend more towards seeking psychological help. This may imply a lack of information about the importance of mental health among primary victims, resistance to approach mental health workers and/or a state of debilitation that prevents help-seeking behavior.

Because of limited resources, disaster responders are urged to assist survivors in order of priority. A useful model for deciding which groups are likely to be more affected by the disaster is the Population Exposure Model Hierarchy. This model divides primary and secondary victims into 6 levels, with exposure to the disaster getting lower as you progress to higher levels.
The Population Exposure Model Hierarchy is as follows:

Level I: seriously injured victims, bereaved family members

Level II: victims with high exposure to trauma, victims evacuated from disaster zone

Level III: bereaved extended family members and friends, rescue and recovery workers with prolonged exposure, medical examiner's office staff, service providers directly involved with death notification and bereaved families

Level IV: people who lost their homes, jobs, pets, valued possessions; mental health providers; clergy, chaplains, spiritual leaders; emergency health care providers; school personnel involved with survivors, families or victims; media personnel

Level V: government officials, groups that identify with target victim group, businesses with financial impacts

Level VI: community-at-large

Knowing which populations must be prioritized when providing mental health assistance can guide responders in planning appropriate interventions. For instance, if majority of the survivors are at Levels I and II, responding professionals know that most survivors are at high risk of experiencing severe stress and rapid action is needed. If most victims are in Levels IV, V and VI, then mental health professionals know that crisis counseling may not be as big a priority in the immediate aftermath of the disaster.

- **3 Phases of Disaster Management: Preparation, Response, Rehabilitation**

When designing a mental health intervention, it is also important to note that the intervention must be appropriate to the stage of the disaster.

Disasters can be divided into three phases: *Disaster Preparation, Disaster Response* and *Disaster Rehabilitation.* Some literature breaks it down into five phases; with Disaster Response further divided into *Rescue* and *Relief*, and Rehabilitation broken down into stages of *Disillusionment* and *Reconstruction*. But for the purpose of this manual, we will use the division of disaster management into pre-disaster (preparation), immediate aftermath (response), and 6 months onwards from incident (rehabilitation). We will discuss the needs of the survivors per disaster phase in more detail later in this article.

Assumptions When Dealing with Disasters

If you are a mental health professional who will soon respond to a disaster situation, it is best to assume the following:

- possible large casualties,
- serious damage to buildings, transportation and communication facilities,
- disruption of social services,
- stoppage of business, and
- the need for rapid assessment and response.

DISASTERS AND MENTAL HEALTH

Mental health is an important concern during disasters - so much so that the United Nations and The World Health Organization mandated psychological care as the responsibility of not just psychologists and social workers, but of *all* humanitarian aid workers. The impact of disasters on survivors can generally be divided into four categories: normal stress reactions, the disaster syndrome, grief and bereavement, and psychological illnesses developed from experiencing a critical incident. We will go into detail on each one in Part 2 of this manual. Meanwhile, by means of overview, let us consider the following 3 disasters from the past 10 years and their known psychological impact:

Hurricane Katrina

One of the top 5 deadliest hurricanes in the history of America, 2005's Hurricane Katrina continues to affect survivors up to this day. Fatalities from the disaster number almost 2,000, total property damage is estimated at $81 billion, and around 100,000 people were displaced. The storm did not just cause heavy water fall, but also resulted into the malfunctioning of the levee system, flooding New Orleans City and surrounding areas. What was perceived as poor crisis management on the part of the government (not heeding warnings that a Category 4 hurricane is coming, delay in rescue and relief efforts, and intense bureaucracy in the access for aid) added to survivors' stress.

One of the studies conducted on the impact Katrina had on the mental health of survivors is that of Picou and Hudson (2010). Depression and Katrina-related stress remains considerable *32 months after the event* among residents who were separated from family members, had maximum residential damage, and suffered severe financial problems. Denied and unprocessed applications to the Mississippi State Grant Program also acted as secondary stressor for the survivors, and predict personal depression.

A follow-up study conducted by Rowe, La Greca & Alexandersson (2010) revealed that adolescent-reported Post-Traumatic Stress (PTS) symptoms were associated with greater hurricane-related initial loss/disruption, lower family cohesion, and more adolescent delinquency, whereas parent-reported adolescent PTS symptoms were associated with greater parental psychopathology, lower parental monitoring (adolescent report), and lower family cohesion (parent report).

The 9/11 Terrorist Attack

On the morning of September 11, 2001, 19 Al-Qaeda terrorists hi-jacked four commercial airplanes. Two of these planes were intentionally crashed into the World Trade Center in New York City. Fatalities include 3,000 people who were in the building and surrounding area at the time, the hijackers, and more than 800 rescue personnel.

One of the interesting findings regarding 9/11 is its impact on survivors' sense of control. People who are working for pay, had more comfortable incomes, and reported greater religiosity suffered a significant decline in their personal sense of control after the event (Wolinsky, Wyrwich, Kroenke, Babu & Tierney, 2003).

The number of people with symptoms of Post Traumatic Stress Disorder (PTSD) also increased *five to six years after* the attack. Of participants with no PTSD history, 24% reported PTSD symptoms at the initial evaluation, and 19% during the follow-up. The most affected are

the rescue-recovery workers. Loss of a spouse related to the attack is associated with symptoms of traumatic stress.

The Trapped Chilean Miners

> The ordeal of the trapped Chilean miners may be too recent to lend itself to empirical data, but it is such a unique (and in many ways, positive) account of a disaster experience, it bears looking into.

On October 12, 2010, 33 miners were trapped 700 meters deep into the dig they were working on, after part of the mountain ceiling caved in. Escape had been impossible. The miners stayed in an emergency shelter within the mine, waiting for rescue.

But rescue had been challenging; engineers predicted that digging the miners out would cause the ceiling of the shelter they were in to also cave in. Survivors were advised to wait, while rescuers figured something out. While waiting for freedom --- a wait that lasted 69 days --- survivors carefully rationed 2 days worth of supplies to last for almost 2 weeks (the miners ate a spoonful of tuna a day) before rescuers are able to deliver solid food to where they were located. The survivors were also able to dig a source of water. To keep morale up, the miners played games and exchanged stories.

Once rescuers were able to communicate with the trapped miners, the survivors were regularly sent messages of encouragement from family, well-wishers and survivors of similar catastrophes. The miners were also assigned roles to play (i.e. they took turns clearing debris from drillings that were happening above them), and light was sent down to simulate night and day. Psychologists also made sure that information they received did not provide unrealistic hope or cause for alarm; the miners were not told that rescuers were estimating three months of drilling before they could be set free, and relatives were carefully coached with what messages they could send to their loved ones.

After 69 days of being trapped, the first of the 33 miners was pulled out by rescue workers, followed quickly by the other 32. Data concerning the long term impact of the critical incident on the survivors is still forthcoming. But while doctors noticed signs of stress among the rescued miners, they have positive prognosis regarding the miners' long term psychological recovery. This is mostly because of the way the miners were able to organize themselves while underground, and maintain positive spirits throughout the whole ordeal. The Chilean miners proved to be a resourceful and resilient bunch, and the only group of miners trapped for that amount of time who survived.

- **The Role of Mental Health Service Providers During Disaster Response**

The short accounts above demonstrate the important role of mental health professionals during disaster response. The risk of developing long-term and debilitating mental illness after a disaster is real, with some symptoms of Post Traumatic Stress surfacing several years after impact. The story of the miners also underscored how the assistance of mental health professionals during a critical incident can help survivors adjust better to their situation, possibly preventing the development of mental illnesses.

What roles do mental health professionals play in disaster response?

During the pre-disaster stage, education as well as risk-avoidance and risk-management are top priority. Psychologists are called upon to take on a primarily teaching role in order to anticipate the mental health impact of a crisis event. Mental health professionals can serve as trainers and consultants. Their expertise comes handy when orienting other humanitarian workers regarding disaster psychology.

During the actual disaster, supportive and/or therapeutic approaches are required. Mental health service providers may be tasked to provide direct assistance to those affected, in terms of stress debriefing, counseling and therapy. These approaches have to be timed perfectly, so that they are sensitive to the community's readiness to process the event.

Disaster responders must also never forget that helping survivors does not end after the relief phase. Rebuilding a community carries stresses as well, and continuous support from mental health professionals is vital. Follow up of survivors for possible delayed-onset PTSD is important. Research efforts on the particular dynamics behind disaster-related mental health issues can also help in predicting future survivor reaction. In particular, the search for risk and protective factors is integral in crafting a holistic disaster response.

- **International Guidelines in Providing Mental Health Services During Disasters**

Because of the need to deliver professional mental health services to those affected by disasters, the United Nations Inter-Agency Standing Committee (UN-IASC) developed *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*[1].

According to the UN-IASC, the main goal of the guidelines is to "*enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the*

[1] The UN-IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings is available for download at www.humanitarianinfo.org/iasc/

midst of an emergency." Successful implementation of minimal responses can lay the groundwork for further ethical and effective mental health interventions.

Core principles advocated by the UN-IASC guidelines include:

1) a premium on human rights and dignity,
2) maximum participation of the local affected population,
3) doing no harm,
4) building on available resources and capacities,
5) integrated support systems, and
6) multi-layered support.

The American Psychological Association (APA), in a statement[2] released on their website June 5, 2008 affirms the UN-IASC Guidelines. According to the APA, *"any psychologist or other mental health professional who wishes to consult on or respond in emergency situations needs to be familiar with these guidelines."*

NOTE: The APA also cautions psychologists from the United States against providing direct services to disaster-affected communities in foreign countries, unless they meet the criteria set by UN-IASC when it comes to working outside one's own socio-cultural setting. Responding psychologists must recognize *"the vast cultural and world view differences between the United States and the affected regions…Mere translation of Western educational concepts and material is not adequate, and an imposition of Western diagnoses and treatment approaches may be harmful to those they are intended to help."*

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[2] The APA Statement on the role of psychologists during emergencies can be found at www.apa.org/international/resources/emergency-statement.aspx

Part 2

THE PSYCHOLOGICAL IMPACT OF DISASTERS

This Section Contains the Following Topics:

- Normal Stress Reactions
- The Disaster Syndrome
- Bereavement and Grieving
- Mental Health Disorders Associated with the Disaster Response

THE PSYCHOLOGICAL IMPACT OF DISASTERS

This section presents the common mental health issues associated with disasters.

NORMAL STRESS REACTIONS

- **Understanding Stress as a Disaster Response**

Survivors of disasters are *"normal people in abnormal circumstances."* Even when a survivor suffers no loss of property or loved one, just the shock from something that is unexpected and potentially life-threatening can trigger the body's stress response. Our body is guided by the *fight or flight instinct*; when we are faced with stressors, our muscles tense up, our heart beats faster, and our stomach clenches in preparation for action. And because stressors found in disasters tend to be more extreme than the typical stressors of everyday life, stress is a huge part of the disaster response.

As mentioned, stress reactions are normal and adaptive; they should not be labeled as pathological. Stress symptoms are expected to disappear within 4 weeks of the critical incident, unless there are post-disaster situations that cause additional stress and trauma. As post-disaster stress is typical, abnormal stress reactions are not diagnosed until after 6 months from impact.

- **Symptoms of Stress**

What are the symptoms of stress that mental health professionals should look for?

Stress reactions affect the totality of the person; it is not limited to a purely biological response. Below are common symptoms of stress to watch out for:

Physical: pounding heart, elevated blood pressure, sweaty palms, headache, ulcer, nausea, diarrhea, constipation, fatigue, sleep disturbances, chronic pain, disturbances in appetite, vomiting, trembling, twitching, nightmares etc.

Emotional: irritability, angry outbursts, depression, jealousy, anxiety, apathy, impatience, pessimism, reduced self-esteem, guilt, mood swings etc.

Mental: forgetfulness, obsessive rumination, lack of concentration, confusion, short attention span, reduced creativity, errors in judging distance, difficulty in following conversations, etc.

Behavioral: increased cigarette/ alcohol/ drug use, social withdrawal, overeating, nervous laughter, accident proneness, a tendency to sit on a daze, talking to one's self, inability to rest, etc.

Spiritual: loss of sense of meaning, anger/hatred at God/Nature/Universe, preoccupation with existential questions, changes in relationship with family, friends and co-workers, etc.

- **Particular Stressors that Affect Mental Health During Disasters**

Norris et. al. (2002) has identified 9 of the most common stressors found in disaster situations.

- bereavement (with the death of a spouse ranking as one of the most stressful events a person can encounter),
- injury to self or family member,
- threat to life,
- fear, panic during the disaster,
- horror,
- responses during the actual incident,
- separation from family,
- property damage or financial loss, and
- relocation

Important Consideration: Information as Stressor

Note that information can add or aggravate stress. For this reason, disaster managers must control the amount and quality of information disseminated to affected communities. For instance, fears of aftershock from an earthquake must be addressed with facts, so as not to trigger mass panic. Media can be a cause of strain, especially as there's a tendency to choose tragic sound bites to fit pre-established story lines. In cases of technological disasters where there is little obvious manifestation of physical damage, the quality of information received can be a sole determinant of a survivor's psychological well-being.

Stress caused by problems in living after disaster

There are occasions when the disaster itself brings little stress, however, the days and months following the disaster can cause significant disruptions in life. Because disasters have the potential to disrupt community resources, the affected population ought to expect hassles with things such as the search for bathrooms, cooking utensils, shelters and financial resources. Relocation areas tend to be small and crowded spaces, with neighbors, researchers, and

humanitarian aid workers coming and going. Locating missing relatives, communicating to responders, and procuring living arrangements only adds to the strain of the event.

At times the situation can get so bad that some agencies have called disaster relief procedures a "second disaster." Red tape, delays and disappointments, anxiety due to lack of information about food distribution can add to the stress survivors already feel. Case in point is the impact of grant application denial on the mental health of Katrina survivors.

- **Stress Management Techniques**

Our body has a natural ability to adapt to stress, hence the biological response that comes with the fight and flight instinct. But it is also worth noting that our bodies' resources for fighting stress are limited. At some point, physical, emotional, mental, behavioral and spiritual stress management skills must be applied in order to re-fuel the body's coping response.

The following are some stress management techniques mental health practitioners can share with survivors:

Physical: drinking plenty of water, eating on time, getting adequate sleep, exercising, avoiding foods that aggravate nervousness such as coffee and tea, doing breathing exercises.

Emotional: acknowledging one's feelings, venting to a friend or mental health professional, keeping a diary of one's experiences, seeking support from loved ones.

Mental: meditation, self-talk, management of irrational beliefs, active problem-solving, guided imagery.

Behavioral: joining support groups, engaging in therapeutic play, singing.

Spiritual: talking to spiritual leaders, finding the meaning behind the tragedy, communing with nature, praying.

THE DISASTER SYNDROME

- **Understanding Disaster Syndrome**

Mental health practitioners working disaster areas have come face to face with a phenomenon they dubbed as disaster syndrome or disaster shock.

Disaster syndrome is a state of stunned psychological incapacitation that results in the inability to take care of one's self or others. Those suffering from this state are unusually dependent on others, unable to think rationally, and susceptible to strong leadership from

authorities. According to Anthony Wallace who coined the term, disaster syndrome is the self's defensive reaction to the excessive amount of stress it is experiencing.

- **Diagnosing Disaster Syndrome**

Wallace believes that disaster syndrome appears in four stages.

In the first stage, the person appears to be in a daze. He or she may be walking aimlessly around the disaster-struck area, unresponsive to other people's query, and apathetic to the distress in the surroundings. At this stage, the person appears stunned into immobility. Depending on the individual, this stage can last from a few minutes to a few hours.

In the second stage, the survivor is slowly taking in what is happening in his or her environment. But while awareness seems to be returning, the ability to take proactive action remains stunted. The survivor is anxious, unable to make decisions, eager for suggestions from others, and on the constant look-out for people who may help. This stage may last for several days.

In the third stage, there is relief at being able to identify with others who experienced similar losses. This stage seems to coincide with what others have termed as the heroic stage of disaster response, the point where there is a lot of community spirit. The stage implies that the situation is slowly being accepted by the survivor, but the feelings of grief have yet to sink in. There may be an attempt to numb the pain using busyness.

In the final stage, the happy identification with survivors wears off, to be replaced by mixed feelings of both gratitude for the help and sadness/anger at the situation they have found themselves in. This stage may last for several weeks.

- **Disaster Syndrome: Myth or Fact?**

There is some controversy as to whether disaster syndrome exists or not, but it is only reasonable to assume that some degree of debilitation will occur after coming face to face with a critical incident. It is worth noting however that only a small proportion of disaster victims suffer from long-term debilitation --- in fact, many survivors end up as rescuers --- unless the disaster is sudden and violent. And even when disaster syndrome is present, the condition rarely lasts for more than a couple of hours.

BEREAVEMENT AND GRIEVING

It is reasonable to expect bereavement and grieving during disasters. There are many losses that can come in a disaster, including the loss of loved ones, property, mobility, and community infrastructure. There are intangible losses as well, such as the loss of particular dreams, ideals and opportunities. Like stress, grief and bereavement must never be pathologized. They are *normal feelings* from *normal people* in *abnormal situations*.

Bereavement during a disaster may be more than what is typical, and survivors may even experience what is called bereavement overload, a term coined by Robert Kastenbaum. Bereavement overload refers to *"the experience of having to cope with multiple losses simultaneously or in rapid succession, such that one loss cannot be accommodated before another occurs."* Bereavement overload can result in clinical issues like depression, anxiety disorder and brief psychotic break. It may also lead to social withdrawal, suicidal ideation and survivor guilt.

MENTAL DISORDERS ASSOCIATED WITH DISASTERS

Stress reactions are normal within half a year of a disaster's impact. When an individual's coping skills are not sufficient to deal with the critical incident, it is possible that survivors will develop mental health disorders after 6 months. The mental health disorders[3] associated with disasters are:

- **Post-Traumatic Stress Disorder (DSM-IV 309.81)**

PTSD is the diagnosis given for severe anxiety experienced after exposure to a traumatic event. PTSD can occur immediately after the critical incident, or after a significant time has passed.

There are three things that need to be present before one can diagnose PTSD: intrusive thoughts about the traumatic event (e.g. unwanted persistent recollection of sights and sounds, hearing the screams of victims during waking hours), avoidance of stimuli associated with the critical incident (e.g. not joining memorial services), and hyper-arousal (e.g. being overly vigilant for signs that the disaster is about to recur).

These symptoms have to be present for at least one month, and must significantly impair personal life, work life and relationships, before a mental health professional can diagnose a condition as Post-Traumatic Stress Disorder.

[3] Please refer to the Diagnostic and Statistical Manual for Mental Disorders for more information about each condition.

- **Acute Stress Disorder (DSM-IV 308.3)**

Acute Stress Disorder (ASD) has the same symptoms as PTSD, but it occurs within one month of traumatic event and lasts from just 2 days to 4 weeks (PTSD tends to last for months). Sufferers may experience unwanted recollections of the event, persistent dreams and nightmares about the disaster, depersonalization (the feeling that one is watching one's self), anxiety and low moods. Because normal stress reactions are expected within 6 months of a critical incident, there is some debate whether the diagnosis of Acute Stress Disorder is relevant in disaster intervention.

- **Major Depressive Disorder (DSM-IV 296.2 – 296.3)**

Also known as clinical depression, Major Depressive Disorder is the diagnosis given to an individual who suffers from persistent depressed mood, lack of interest in life activities, difficulty concentrating, insomnia/hypersomnia, and changes in appetite for periods lasting from 2 weeks to months. Note that in the context of disasters, a diagnosis of Major Depressive Disorder is only given if the symptoms are found longer than six months after the critical incident and the symptoms are not better accounted for by bereavement or strong stressors from the post-disaster situation.

- **Alcohol and Drug Abuse (DSM-IV Code depends on chemical abused)**

Disaster-related traumatic events and the proliferation of post-disaster stressors may result in increased post-disaster alcohol/ drug use and abuse. Substance use and abuse can be the survivor's way of coping with the difficult situation. Among the documented accounts of alcohol use was of survivors from Katrina. Exposure to each additional hurricane-related traumatic event was associated with 79.2 more drinks and 2.46 times higher odds of binge drinking, while more post-disaster stressors were associated with 16.5 more drinks and 1.23 times higher odds of binge drinking (Cerda, Tracy & Galea, 2010).

- **Brief Psychotic Disorder (DSM-IV 298.8)**

When coping resources are not enough to deal with a critical incident, a temporary breakdown in a person's relationship with reality can happen. Survivors may experience delusions and hallucinations, exhibit disorganized or catatonic behavior, and suffer from homicidal or suicidal impulses. These episodes, however, are passing; lasting about two weeks to a month. The death of loved ones, and the witness of massive deaths in one's surroundings, can trigger Brief Psychotic Disorder.

- **Generalized Anxiety Disorder (DSM-IV 300.02)**

Generalized Anxiety Disorder (GAD) is characterized by excessive and persistent worry about everyday things, to the extent that the worry is no longer reasonable. While it is normal to worry after a disaster (there is much insecurity during the relief and rehabilitation phases after all), survivors suffering from GAD worry to the extent that they have trouble with daily functioning. They obsess about the object of their worry to a point where they exhibit physical symptoms, cannot find even temporary emotional relief, and have trouble performing even the minimum tasks of every day.

RISK FACTORS FOR MENTAL HEALTH ISSUES

Some survivors are at greater risk for developing the above mental health disorders than others, and some specific factors may be considered contributive to the risk of developing these conditions.

Barton (1969) identified characteristics of disasters that influence mental health. Disasters with a large scope of impact, fast onset, and longer duration are more likely to trigger mental health conditions than disasters with minimal impact, delayed onset and shorter duration. A survivor who had been immediately trapped in a tree during a flash flood and had to stay near dangerous waters for hours watching other victims cry for help, will have greater difficulty in coping than those who had been rescued earlier. The amount of time a community has to prepare for a disaster is also inversely proportional to the risk of developing PTSD, ASD, depression and other disaster-related psychopathology.

Pre-existing social problems, for example poverty and political oppression, can also increase risk of developing mental illness. Circumstances related to the emergency can also increase risks; these circumstances include family separation, massive destruction of community structures and post-disaster crime. Those with pre-existing mental health problems are also more vulnerable than the general population to further mental health issues.

Personal characteristics of a survivor can also help him or her adjust better. The existence of a social network, an internal locus of control and possession of a repertoire of positive coping skills have all been known to increase one’s chances of successful adjustment after disaster.

Part 3

PSYCHOLOGICAL AND COUNSELING INTERVENTIONS IN DISASTER

This Section Contains the Following Topics:

- Guiding Principles in Psychological Disaster Response
- Interventions During the Disaster Preparedness Phase
- Interventions During the Disaster Response Phase
- Case Studies
- Interventions During the Disaster Rehabilitation Phase
- Special Issue: Handling Children Survivors
- Special Issue: What to Do When There's No One to Refer To

PSYCHOLOGICAL AND COUNSELING INTERVENTIONS IN DISASTER

GUIDING PRINCIPLES IN PSYCHOLOGICAL DISASTER RESPONSE

In many ways, responding to disaster situations requires mental health professionals to let go of assumptions associated with clinical work. For one, survivors are atypical clients; they rarely volunteer for psychological help. With all the disruption happening in their lives, including possibly the loss of their loved ones, home and livelihood, getting counseling would be the last thing on their minds. A mental health professional in a disaster is, therefore, not just a provider of psychological services; he or she is also an advocate of wellness during a sensitive and complicated time.

The following are 5 guiding principles that mental health professionals should remember when responding to disaster situations:

Normalize Stress and Grief Reactions.

The stress reactions experienced by survivors of disasters are *normal reactions* to an *abnormal situation*. It is important that mental health professionals refrain from labeling an individual as having a mental disorder, unless the stress reaction has been proven as extreme or prolonged. Going to a disaster-struck community bent on diagnosis is robbing survivors of the right to be significantly affected by a situation that is potentially traumatic. A disaster worker may also end up adding to survivors' stress by explicitly saying or insinuating that the latter are mentally ill.

Similarly, grief reactions must not be pathologized. Grief is a normal reaction to the many losses survivors experience. In the earlier stages of a disaster (within 6 months after impact), normal and pathological grief cannot be distinguished from one another. Assume that a survivor is coping as expected, unless he or she shows signs otherwise.

Invest in the "Social."

Among disaster responders, there is a preference for the term "psycho-social intervention" instead of just psychological intervention. This is to emphasize that disasters affect not just individuals, but communities as well. The community is an integral resource in helping survivors get on with their lives.

One of the key elements in psychological disaster response is the development of an effective support system. Encouraging survivor communities to talk to one another about their disaster experience helps in providing affirmation to what they went through. It also prevents individuals at high risk of developing mental health issues from dealing with their stress and grief in isolation. At the very least, disaster responders must encourage open dialogue and

active listening at the level of the family, as the family unit is a valuable resource in recovering from a crisis event.

Clinicians must also adapt a community building mindset, and encourage all stakeholders (survivors, government officials, private organizations, corporations, humanitarian groups, local and foreign volunteers) in a community to take part in mental health awareness. For this reason, training community leaders and volunteers in psycho-social care is important. By having a community-building orientation to disaster response, mental health professionals can assure continuous psychological care for survivors, even after disaster responders have left ground zero.

Implement a Holistic Disaster Response.

Mental health professionals are highly encouraged to conduct their intervention alongside other disaster responders, such as medical practitioners, relief workers and rehabilitation agents. Mental health professionals are also invited to view all humanitarian aid workers, not just psychologists, as having the capability, or at least the potential, to be mental health service-providers.

Why is coordination with other responders important? Psychological health does not exist in isolation, but affects other aspects of the self. For instance, stress reactions can manifest themselves in bodily ways. It is not unusual for medical doctors to find survivors who complain of symptoms that are psychosomatic. By working side by side with those conducting medical missions, a counselor can help provide holistic and effective care to survivors.

Rescue and relief agents must also be educated on the impact of their behavior and decisions on the mental health of survivor communities. How can food distribution be handled without aggravating the survivors' anxiety? Should happy music be allowed in an evacuation center to keep people entertained? What is the best way to inform a survivor that his or her relative's body has been found? How can relief workers deal with their own stress and burn-out? The input of a mental health professional is critical when answering these questions.

And lastly, coordination with other disaster responders is important because the best source of emotional relief during crisis situations is information related to securing basic needs. It is important that mental health professionals are able to direct clients to concrete action and realistic hope. Teaching clients how to go about searching for missing relatives, or who to approach for medical care may not be in a counselor's typical list of services, but during disasters, perhaps one can make an exception.

Be Resilience-Focused.

It goes beyond political correctness, but disaster responders are encouraged to refer to people affected by a disaster not as “victims” but as “survivors.” All disaster survivors start out as victims; but they are also people who have overcome a highly stressful event – if for no other reason than they are still alive. In relation to the first principle of avoiding labeling normal stress and grief reactions as pathology, mental health professionals must see people and communities affected by disasters as having the ability to recover. Survivors have resilience. Mental health professionals are challenged to empower victimized communities into taking disasters as challenges and opportunities for growth and meaning.

Erik Auf der Heide, in his paper *Common Misconceptions about Disasters: Panic, the “Disaster Syndrome,” and Looting* reinforced the idea that disaster survivors have inherent resilience. According to him, far from the typical media portrayal of survivors as helpless and too devastated to act, fellow survivors are usually the ones who start rescue and relief operations in the immediate aftermath of a disaster. But sadly, even when disaster responders deny seeing passivity and vulnerability in most of the disasters they respond to, they continue to view positive coping and community spirit as uncharacteristic behavior. Auf der Heide concluded that such mindset among disaster responders sadly results to *“inappropriate responses and an inefficient use of available resources.”*

Be Culture-Sensitive.

Lastly, it is important for disaster responders to be sensitive to the culture of the people they are going to assist. There are two main reasons for this.

First, culture sensitivity can help mental health practitioners in understanding the context behind particular thought processes. For example, indigenous communities living near volcanoes may consider eruptions as punishment from the gods. “Experts” coming in from the outside disputing these belief systems with science would just be met with suspicion and distain. Disaster workers must be open-minded and creative enough in providing assistance, without offending local beliefs.

Second, culture sensitivity can help disaster responders tap local coping resources. Each culture has ways of managing stress and grief, and it is best not to stray from what already works. In fact, disaster workers sometimes experience shock at how well some communities handle disaster situations. People living in an earthquake-prone zone may have become desensitized to the impact of a disaster, and have, over the years, developed a recovery-orientation. A psychotherapist might interpret a community’s positivity as “denial” and “repression” when the community is simply used to Mother Nature’s rants.

Remember: most disaster workers are technically outsiders to a community, and hence their help will be met with resistance. Thus is underscored the importance of lessening dissimilarities with locals and seeking the support of community leaders. In the end though, sincere concern and caring can encourage communities to open up to humanitarian efforts. Communicate your genuine desire to help; it will facilitate building rapport with the people you want to assist.

INTERVENTIONS DURING THE DISASTER PREPAREDNESS PHASE

Psychological interventions should start long before the impact of a disaster. This is especially recommended for disasters that can be anticipated, such as earthquakes, super typhoons and volcanic eruptions.

The following are two interventions mental health professionals can provide during the pre-disaster stage:

- **Psycho-Education Services**

Educating communities before impact about common stress reactions and positive coping styles can go a long way toward ensuring resilience in the event of a disaster. Psycho-education can be in the form of seminars and forums, preferably delivered alongside information on other aspects of disaster preparedness. Pamphlets and resource materials may also be distributed to community leaders and members. Likewise, the media must be kept informed, so that they can assist in disseminating information.

Because disasters can affect a great number of people in a short period of time, there is the need for training disaster responders and community leaders in basic skills in psycho-social care. At minimum, the following should be taught: crisis reactions, supportive dialogue, active listening, group facilitation and stress debriefing principles. Disasters can impact tens of thousands of lives in an instant - so imagine the logistics involved in providing psycho-social intervention! Even a group of a 100 mental health professionals will not be enough to provide personalized assistance when there are many survivors, hence the need for trainees. Traditionally, psychologists can rely on public health workers, social workers, teachers, community leaders and volunteers for assistance.

- **Systematizing Community Mental Health Services**

There is also a pronounced need to institutionalize and systematize psychological care during disaster situations, especially for third world countries where the view remains that mental health services are a luxury instead of a necessity. Mental health professionals may

need to participate in advocacy work to ensure that psychological wellness is given the same priority as provision of shelter and relief goods.

Moreover, there is a need for mental health professionals to act in coordination with one another. A problem often encountered during disasters is a high number of mental health groups in all shapes, sizes, and theoretical orientation, acting independently of one another, providing psychological processing to communities who already have gone through several psychological interventions. These groups often get stuck at providing mere psychological first aid, as many can only afford to stay for but a couple of days before going back home. The result: survivors become battered by too many concerned folks conducting assessment and initial interview, with very few staying to do actual follow-up. The constant *“so, what is the impact of this disaster on you?”* (and the response being “I have told that tale hundreds of times!”) can become a source of added trauma, making survivors resistant to other well-meaning groups of professionals coming in.

At its core, systematizing psychological response during disasters begins with having a clear chain of command, or at the very least, a clear central coordinating body. Usually this is the social services department of the local government unit, but in some cases, it is given to the private sector via professional counselor organizations or interest groups like the Red Cross. (The American Psychological Association generally defers to the Red Cross. These situations differ from country to country.) The work of the coordinator is crucial. In the beginning stages of disaster response, coordinators must obtain an accurate demographic profile of the survivors, categorized in terms of priority. For instance, survivors who are bereaved, or are seriously injured must be given priority in terms of psycho-social care. The same goes with vulnerable populations like children, the elderly and the persons with existing mental illness.

Coordinating bodies must also be in charge of making sure that all the populations who need support are served - and records of interventions and recommendations are kept *and forwarded* to all responding professionals. If you are an individual volunteering your counseling services, it is best to first ask the coordinator what has been done so far, what is the previous group or counselor’s assessment of the situation, and what is the recommended next step --- instead of going directly to survivor communities. Of course, it helps if the community decides on the disaster response framework early on. (It can be wrought with politics; for best results, refer to international guidelines.) This can prevent duplication of intervention as well as interventions that contradict one another.

Lastly, systematizing psychological care should involve a clear referral system set up. As mentioned previously, not all disaster responders can afford to stay in an area long-term. A visiting counselor must be able to know to whom he or she can make referrals if needed.

INTERVENTIONS DURING THE DISASTER RESPONSE PHASE

In the pre-disaster phase, most of the interventions are educational in nature. After impact, supportive and therapeutic help are provided.

- **Rescue Phase vs. Relief Phase: When to Step In**

The rescue phase refers to the first two weeks immediately after impact. Disaster response is targeted towards immediate needs, such as making an inventory of people and property, setting up systems for the care of survivors, tending to the injured and continuing rescue operations as needed. The phase is often referred to as the “Heroic Phase” of a disaster because while there is a lot of grieving, there is also much altruism and community spirit.

The relief phase happens around two weeks to 6 months after a disaster (earlier if the disaster has been anticipated, and relocation began even before impact). This is often referred to as the “Honeymoon Phase” of a disaster, as there is a huge outpouring of sympathy and supplies from concerned individuals and organizations. It is also a time when there is movement towards gradually stabilizing everyday rituals; survivors have a place to go home to and a system for obtaining basic goods and services. There is semblance of normality around the community or relocation areas.

When can a mental health professional step in?

A mental health professional can provide assistance as early as the rescue phase, but it is important to note that he or she must refrain from any form of structured intervention or deep psychological processing during the early stages of disaster management. There are many reasons for this. One, there are more urgent priorities at this point, such as physical safety and security, as well as the integration of separated family members. Second, survivors may still be in a state of shock and confusion (remember the disaster syndrome?), making any deep psychological processing ill-advised. Lastly, the surroundings during the rescue phase are likely not yet conducive for structured psychological assistance, as survivors may still be exposed to physical rubble and deceased people.

What mental health professionals can do during the relief stage is assist in bringing survivors into a place or state of safety. In some situations, where permanent safety is impossible, such as in a war zone, studies have shown that even a relative sense of safety can buffer the risk of survivors developing PTSD. Psychologists can help survivors by informing them how to search for missing loved ones, asking for patience while temporary shelter is being set-up, and directing survivors to providers of basic needs like food and water. Offering a

comforting hand, and assurances that you are willing to listen when they are ready to talk, can be helpful to those still in shock.

Defusing and mental health screening (to be discussed next) can also be conducted during the rescue phase.

- **Defusing**

As the term implies, defusing is an attempt to prevent a bigger blow-up by addressing "explosive triggers" early on. As proponent Mitchell describes it, defusing *"offers an opportunity for people involved in a horrible event to talk briefly about that experience before they have time to rethink the experience and possibly misinterpret its true meaning."* (Mitchell et al., 1997)

It may be said that defusing aims to give survivors an immediate sounding board, in an attempt to introduce normalization of experience - before survivors end up imagining the worst. Defusing aims to impart some degree of stability to survivors, and identify who might be in need of further psychological assistance.

Defusing is conducted within 24 hours of impact. It is often done casually, with counselors approaching survivors on-site (at ground zero or at the evacuation center), introducing themselves, and engaging survivors in conversation as the latter go about their activities. The conversation usually lasts around 15-30 minutes.

Survivors may be asked to give a brief account of what happened, although at this point, survivors tend to talk about what they experienced without much prompting. The role of the mental health professional is to provide emphatic listening and support. The counselor can also share stress reactions that survivors might expect, and demonstrate stress management techniques such as breathing exercises, meditation and pocket exercises. The most important part of the process is the validation that stress reactions are normal in light of their situation.

- **Mental Health Screening (Rapid Field Assessment)**

During the immediate aftermath of a disaster, after basic survival needs of all affected has been addressed, mental health professionals are encouraged to conduct an assessment of the community's mental health needs. Because there is a need to act quickly and because at this point the community is likely still disorganized, traditional rules in conducting empirical data gathering (e.g. using control groups) have to be disregarded. In emergencies, "hard data" are almost impossible to obtain. Psychologists, especially those who are first at the scene, are

encouraged to conduct what is called a Rapid Mental Health Needs Assessment or Rapid Field Assessment, relying mostly on their clinical experience and triangulation of sources for accuracy of information.

Information that should be included in the Rapid Mental Health Needs Assessment includes:

1. A brief description of the critical incident and how it affects the area and the population.
2. Demographics of the affected population (estimated numbers, gender and age distribution, number of vulnerable populations)
3. Survivors' current living conditions. Detail as well if survivors are expected to relocate and where the evacuation center will be.
4. How people have been dealing with the situation.
5. Particular stress symptoms survivors are experiencing
6. Coping techniques survivors are employing
7. Perceived adequacy of present coping resources to deal with the crisis reaction
8. Resources available for the affected population (including basic necessities like shelter, food and water)
9. Mental health services already being provided.
10. Recommendations for on-going psycho-social intervention
11. Contact persons within the community and how they may be reached
12. Limitations of the Report

Methodology for the Rapid Field Assessment can be observation, interviews with survivors, and coordination with local community leaders, humanitarian groups and disaster responders. To assist in quick gathering of information, mental health practitioners can use checklists to gather data about stress reactions and coping resources. (The World Health Organization or WHO has a checklist for the "Rapid Assessment of Mental Health Needs and Available Resources" for the guidance of their crisis workers.)

When making mental health assessments, it is important to note that during critical incidents, it is often the most affected that are least visible. For instance, the most traumatized may be the ones who are most likely to withdraw from visitors, and the injured are isolated for medical care. Care must be taken therefore before making any conclusions.

- **Debriefing**

Around two weeks after the time of impact, Critical Incident Stress Debriefing (CISD) may be implemented. CISD is a structured intervention aimed at addressing stress reactions by providing participants, whether survivors, witnesses or disaster workers, with opportunities to receive information on coping strategies and recovery resources. In CISD, mental health professionals can afford to go deeper into issues raised during defusing activities.

As a group intervention, CISD may also be the start of community support groups. CISD is often conducted to groups of 7-12 members, although it can be adjusted for groups as small as 3 and as large as 30. CISD typically lasts for 3 hours.

It is important to note that CISD is not therapy and should not be a substitute for therapy. What it is, is psychological first aid. It is mostly aimed at making sure facts and logic have control over emotions when analyzing crisis events, so that survivors do not end up debilitated by what they went through. It is also an opportunity for psycho-education regarding post-disaster stress. Lastly, the process is a way to identify and touch base with individuals who might need one-on-one crisis counseling.

A typical debriefing has the following parts (Mitchell et al., 1997):

Introduction Phase. In this stage, the debriefers introduce themselves and the process. An emphasis on confidentiality is made to encourage honest disclosures. Ground rules, such as speaking for one's self and respecting the person who currently has the floor, are set.

Fact Phase. At this stage, participants are asked *"what happened?"* Everyone is encouraged to share their experience of the disaster including where they were at the time of impact, what they were doing, and what they saw, heard and smelled. If there's a disaster expert present during the debriefing process (for example, a seismologist), the expert can cap the fact phase by providing a factual account of the critical incident. Facts can not only dispel rumors, but also help prevent the escalation of distress caused by misinformation.

Thought Phase. At this stage, participants are asked what their thoughts were at the moment the disaster is happening. Debriefers may also ask participants when they started to think about the critical incident. Prioritizing the disclosure of thoughts before feelings is a key element in CISD; participants' rationality must always be reinforced during crisis situations.

Reaction Phase. At this stage, the more personal and emotional aspects of the disaster experience are explored. Participants are asked to identify the most traumatic aspect of the disaster for them. Some questions that may be asked include: *"If you could erase one part of this incident, what would it be?"*, *"Which aspect of the disaster do you think you would have the most challenge in handling?"* and *"What is the worst part of this whole experience for you?"*

Symptom Phase. At this stage, participants are asked to identify what are their symptoms of post-disaster stress. Participants can be guided in acknowledging not just physical manifestations of stress, but also emotional, mental, behavioral and spiritual symptoms of stress as well. When soliciting the group's stress reactions, it is important for the debriefer to normalize the reactions by pointing to similarities in people's response. For instance, they may emphasize how X number of people report having recurring nightmares about the incident, or asking the group, *"who else experience the same reaction?"*

Teaching Phase. Debriefers, by way of a mini-lecture or group-centered discussion, can tell participants that their reactions are all normal and that it is the situation they are in that is abnormal. Debriefers should also discuss tips on how they can help, not just themselves, but their peers. Good debriefers know that providing ready-made stress management techniques is not as empowering as surfacing and reinforcing the natural strengths of the participants.

Summary and Q & A. The last stage is an integration of what has been discussed in the group. Opportunity to ask the debriefers question is also provided.

The controversy around CISD.

For the longest time, CISD has been the traditional response to the psychological needs of disaster survivors, and many empirical researches do support the argument that CISD can facilitate adjustment after a potentially traumatic event. But more recently, researchers have decried the use of CISD for critical incident survivors. For instance, in a 2007 report in *Perspectives on Psychological Science*, a journal of the Association for Psychological Science, Scott O. Lilienfeld showed that a number of psychological therapies, including CISD, especially if forced upon survivors, may actually be harmful.

So should we or shouldn't we?

The logic behind the steps of CISD is sound by theory. There is indeed a need for an avenue where survivors can talk about their disaster experience and learn basics about stress and stress management. Perhaps the happy medium is in providing CISD only for those who have volunteered for the process, or have expressed need for an intervention of this nature. Unless there is a cause for alarm, such as a suicide threat or high risk for psychopathology, the decision of some survivors to deal with the impact of the disaster quietly and/or alone should be respected. The service is available to those who want it, but it should not be mandatory. Older manuals of CISD even recommend barring the door during session. Care should also be given so that only trained and competent individuals facilitate a Critical Incident Stress Debriefing.

- **Community Support Groups**

Creating self-sustaining support groups is a good way to provide on-going psychological assistance to disaster survivors. Support groups provide affirmation that what one is going through is normal, and is in fact experienced by others in the same situation. Support groups can also be ways to get advice from people who are going through similar situations. When there is resistance to accept the help of mental health professionals, a support group of peers is a good alternative.

Support groups can be for survivors in general, or can address particular populations. An example of the latter is a support group for widowed survivors or orphan survivors. The therapeutic focus of the support group can vary depending on the needs of the participants, and the counselor's theoretical orientation

- **Crisis Counseling**

There are occasions when one-on-one crisis counseling may be required in order to provide additional support to vulnerable populations.

First off, what is a crisis? A crisis is a state when one's coping resources are not enough to deal with stressors. What constitutes as a crisis differs from person to person; what is manageable for one individual may be debilitating for another. Hence, the loss of a home may result in a crisis moment for one person, but not to another.

A crisis is also a moment when entire world views and ways of approaching life get challenged. It is not unusual for people in crisis to think, not just of the disaster they recently experienced, but of the way they have made decisions, behaved, viewed themselves, viewed others and dealt with success and failures over the past years of their life. It may be said that

crisis shakes the foundations of your personhood, so much so that you are suddenly being asked if the way you have done things all along was right or not.

Which is why dealing with crisis can be intimidating. But on the positive side, it also provides counselors and clients much opportunity. Crises are turning points; decisions can be made at a stage of crisis that can transform one's life. A person who has harbored resentment against family, for example, may suddenly realize that life is too short to bear grudges. An individual who rarely took chances may make the resolution to starting enjoying life. Very rarely in life are clients so richly motivated to change as when in crisis.

How can counselors help?

Aside from providing an avenue to vent difficult emotions, counselors can help survivors by guiding them towards greater awareness of the problem. Crisis is typically a time when we get overwhelmed by negative emotions, so much so that we do not have a complete view of what is happening. Crisis counselors must surface the person's ability to view a situation rationally, so that he or she can deal with the crisis in a non-emotional (note, not emotionless) manner.

Second, crisis counselors must be able to tap into the client's inherent coping resources. All of us have strengths --- the mere fact that the client agreed to counseling is cause for affirmation --- and counselors must help clients find and use their strengths. If the clients' range of coping resources is low, then crisis counseling is an opportunity to teach novel ways of bouncing back from adversity.

Lastly, crisis counselors must guide their clients towards concrete action. Effective crisis counseling is one that ends up with a plan. Because the client is too overwhelmed to move, a counselor must offer encouragement and support. When clients can see that some aspects of their situation are workable, they may develop the motivation and the competency to solve other aspects of their problem.

NOTE: Constant follow-up is integral in crisis counseling.

- **Grief Counseling Interventions**

There are many ways mental health professionals can help clients deal with grief. At the minimum, counselors should guide clients as they go through the feelings associated with loss. A useful guide for this process is the Kübler-Ross model.

Named after Elisabeth Kübler-Ross, the model shares how people experiencing loss tend to experience grief in 5 stages. These 5 stages are:

- Denial (We refuse to accept that something or someone is gone.),
- Anger (We get mad at the situation, at the person who's gone, at ourselves, God, persons in authority, perpetrators of man-made violence, or at family members who were unable to do anything to prevent the loss.),
- Bargaining (We offer concessions just to recover the loss. E.g. *"If my son were to be found, I promise to never yell at him again.")*
- Sadness/Depression (We began to experience the loss and the despair it brings.)
- Resignation/Acceptance. (We concede that there's nothing we can do to change things, and that the only thing we can do is move on.)

The grieving and the bereaved do not always go through all 5 of these stages, and those who do do not always go through them in the order Kübler-Ross presented. But the important point to remember is that the stages represent the normal range of emotions people go through when experiencing loss. Clients must be guided in feeling these emotions and finding socially acceptable ways of venting them. Survivors still in the anger stage, for example, may be taught anger management skills in order gain some degree of emotional relief.

Counselors are also encouraged to use various techniques known to be effective in grief and bereavement counseling. Just note that whatever counseling and therapy interventions you use, it must be both theoretically sound and culture-sensitive.

Art and music therapy, for example, as well as journaling can assist clients in managing emotions during this difficult time. Guiding families to support one another (it is perhaps not just individuals who are grieving, but families as well) as they navigate the loss is also important. Gestalt techniques such as the "empty chair method," where clients are encouraged to talk with the deceased as if he or she were physical present, are known to facilitate closure.

Encouraging clients to go after recoverable losses (such as the loss of property) can move them towards constructive action. Practical assistance, such as helping bereaved families fix funeral arrangements, may also help. Non-traditional methods, such as meditation and body prayers, may also be explored.

A common way mental health professionals support the grieving process is through the use of rituals. After a critical incident, private and community rituals can provide a symbolic

gesture of saying goodbye and attempting closure. The use of both secular and faith-based rituals can assist the bereaved in obtaining meaning from the crisis.

Private rituals include delivering a eulogy for the deceased family member/s, going through photographs (if photos survive the disaster), sharing memories about the deceased, lighting candles, and symbolic acts of letting go such as raising one's hands to the sky. Rituals are particularly helpful when there are circumstances that hinder closure --- for instance a loved one is presumed dead but the body is never found.

Lewis and Veneman (1987) and Scarisbrick-Hauser (1990) identified institutionalized rituals that can assist in community grieving. These rituals include public statements, site visits, religious and secular memorial services, public funeral services, pilgrimages, and fund-raising activities. Their role in community rehabilitation is three-fold. First, they can provide comfort to the grieving community. Second, institutionalized rituals provide a sense of solidarity among community members. Lastly, these rituals provide opportunity for the integration of cultural values into the event, and present a socially acceptable way of grieving.

- **Pastoral Approaches**

Disasters and other critical events can surface existential issues, as well as issues related to faith life and spirituality. For example, survivors may ask if the disaster is a punishment from God. In other cases, the disaster may cause a re-alignment of the person's values. Don't ignore spiritual questions, but don't impose your spirituality on people either. Accept the feelings as fact; tell them that spiritual issues are normal in their state. You can also refer the client to the appropriate pastoral worker, e.g. priest, pastor or spiritual leader.

- **Pharmacological Interventions**

Medication can be used to address stress symptoms like anxiety and lack of sleep during the aftermath of a disaster. Medication may also be critical once psychopathology has been surfaced. The use of psychoactive drugs after a critical incident, however, is controversial. If and when medication is considered as necessary, a licensed psychiatrist with background in disaster work and capability to maintain on-going contact with survivors should be on-board.

CASE STUDIES

- **Strengthening Survivor Family Systems**

It is helpful to have a systems orientation when providing psycho-social intervention. The family is the strongest support system a survivor has, and it is best to strengthen the family's ability to respond to each other's stress reactions. A small but crucial intervention can be sending information to each family on critical incident stress. If face-to-face coaching on how to communicate support and non-judgmental listening can be conducted for *all* family members, it can go a long way in preventing the development of debilitating psychopathology. Perceived emotional support is a predictor of depression among survivors of natural disasters.

Counselors are also advised to keep in mind many system elements like communication, roles, boundaries and power dynamics when building survivor families. A traumatic event can easily disrupt these dynamics, or expose vulnerabilities in the family system present even before the disaster occurred. The crisis situation is an opportunity to guide families into a new way of doing things.

In the 2006 landslide in Guinsaugon, Southern Leyte Philippines, a considerable number of the survivor families are composed of male parents and their high school-aged children. This is because the tragedy took almost everyone who had been in town that day, including students of the town's only elementary school. Most of the survivors were those working out of town (which are mostly the fathers) and those who are studying in the high school located in the nearby municipality.

A follow-up of the survivors one year after the tragedy showed that those in the new "single dad with adolescent children" system have great difficulty in adjusting to post-disaster life. Not only did they have to go through the grief of losing family members, they also had to deal with the stress of transferring to a relocation center and looking for livelihood. The dads have trouble navigating the role of solo parents, and most prefer to keep their emotions to themselves rather than communicate them to their kids. Because livelihood opportunities are scarce, many of the male survivors deal with their stress and grief through drinking alcohol. Their adolescent children, being in that interesting stage between childhood and adulthood, were also ambivalent in relating to their survivor parent, and deals with their stress through peer groups and vices.

As part of a program on building survivor families, a support group for solo male parents was created. This support group provides the participants the opportunity to share with one another what they experienced during the crisis and what they are experiencing at the moment. The support group was also used to help the parents learn more about how to

navigate the solo parent role. Skills on communication with adolescent kids, discipline strategies, and symptoms of stress in teenagers were presented. The children were also given a similar intervention, and their inherent resilience resources were surfaced and reinforced.

- **The Use of Rituals in Community Grieving**

As mentioned, community rituals can provide a symbolic expression of the community's grief and need for closure.

After the April 1999 Columbine High School massacre where two students opened fire on school grounds and killed 13 people and injured 21 others, memorial services provided the community of Colorado a means to publicly express their grief and anger. The night of the attack, students, parents, teachers and friends set up an evening service at the car park, where they brought candles and talked about their loss. The school car park also provided those who want to express their sympathy to the bereaved a place to go.

In the case of the 9/11 attack, a ceremony was held in the National Cathedral in Washington, D.C. after the disaster. Because the terrorist act had been linked to religious fundamentalism, religious leaders representing each of the major world religions were invited to the event. The move was a symbolic way of affirming the values of religious tolerance, and denouncing any act of fundamentalist extremism. It was also a way for the country's president to officially declare the need for the community (and the country) to move on.

- **The Use of Cognitive Behavioral Techniques in Disaster Response**

Cognitive Behavioral Therapy (CBT) has been found effective when handling stress reactions and PTSD, because thinking and behaving play a huge part in managing stress. And because disaster mental health interventions are time-sensitive and largely educational in nature, cognitive-behavioral techniques are a good fit with disaster interventions.

CBT can help survivors deal with the intrusive and recurrent reminders of the traumatic event through exposure therapy. For instance, following the tsunami in Southeast Asia, counselors were able to use CBT to gently but firmly guide clients through the things they fear and avoid. Survivors who developed fear of water, for example, were asked to view pictures of large water formations while listening to relaxing music. Counselors also asked clients to listen to the sounds of the sea (a stimulus that reminds them of the disaster) while doing breathing exercises.

Stress-Inoculation Training, also a technique from CBT, can help survivors gain confidence in their ability to deal with the aftermath of a disaster. In SIT, the therapist helps

the client become more aware of what triggers their fear and anxiety. For example, survivors may not be aware that their being irritable is a symptom of stress. Counselors can guide clients in not just gaining awareness of whether they have become irritable or not, but what factors trigger irritability. By being able to identify the cues of stress early, survivors can apply appropriate stress management skills and prevent burn-out.

INTERVENTIONS DURING THE REHABILITATION PHASE

- **Dealing with Disillusionment**

In the immediate aftermath of a disaster, attention and aid to survivors can be overwhelming in scope. But 6-plus months after the incident, most of the responders and workers have usually already pulled out. It is at this stage when disillusionment and cynicism among survivors sets in. Survivors feel abandoned, helpless and pessimistic. Bureaucratic delays and impediments in providing on-going aid can also lead to anger and depression.

The best way to assist survivors at this point is to empower them to take constructive action. Many organizations do reserve funds to assist during the rehabilitation phase of a disaster, and survivors can be taught how to approach these institutions for help. Clients can also be guided into a greater sense of personal responsibility.

Personal and community mobilization are keys. Individuals must be equipped with problem-solving skills so that they are empowered to search for resources on their own, without having to rely too much on humanitarian aid. Leaders must also think of creative ways of using community resources to re-construct infrastructure and restore basic social services. A good intervention is sponsoring a planning meeting, so that all stakeholders can brainstorm of ways to sustain the community even after all humanitarian aid is spent.

- **Follow Ups and Individual Consults**

Those identified as having greater difficulty in coping may be scheduled for individual counseling. A wellness clinic can be set up in the evacuation or relocation area, and/or concerned individuals may be invited to visit a nearby counseling center. Mental health professionals may also conduct home visitations to approach individuals identified by the community as high risk for mental health disorders.

- **Anniversary Reactions**

The anniversary of a disaster can trigger stress reaction among disaster survivors. Often, when the day of the year of a disaster comes close, survivors report a return of the stress reactions they had during week 1. They might feel anxiety, anger, nightmares, flashbacks, depression, and fear. When there had been repression of feelings during the immediate aftermath of a disaster, anniversaries may unearth unresolved grief. The anniversary reaction can last for several days or even weeks.

Mental health professionals can assist the community in transforming anniversary reactions into opportunities for reflection and remembrance, such as by communicating how crying and sharing memories is therapeutic, as well as conducting rituals to commemorate the loss.

They may also affirm how an anniversary of a disaster is a milestone in the recovery process. While it is a commemoration of an event that brought much sadness, an anniversary is also affirmation that survivors made it through life for *a whole year*. It is a time for noting all that one has overcome, and appreciating the people who provided help during the healing process.

Anniversary reactions are normal, and do not represent psychopathology unless the reactions are excessive and prolonged.

SPECIAL ISSUE: HANDLING CHILDREN SURVIVORS

It is a common misconception that children are not affected by disasters. Hence, they are often neglected by disaster responders when planning mental health interventions. But considering that adult caretakers can be too stressed to attend to younger survivors, it is important that responding counselors provide children survivors with much needed assistance.

- **Stress Reactions in Children**

The following are some of the stress reactions to watch for in children:

<u>Stress Reactions in Children Age 1 to 5</u>: Developmental regression, e.g. resumption of bed-wetting, thumb sucking, and separation anxiety. Children may also be prone to increased crying, loss of appetite, difficulty sleeping and irritability.

<u>Stress Reactions in Children Age 6 to 11</u>: Academic performance may suffer as school children may have difficulty concentrating on studies after a crisis event. Acting-out may also be

present, in the form of aggressive and/or attention-seeking behavior at home and/or school. Expect physical symptoms of stress as well, such as change in appetite, headaches, stomachaches, and obsessive preoccupation with disaster. At this age, fear and phobic reactions to things that remind them of the disaster may be present.

Stress Reactions in Children Age 12 to 18: Changes in a child's typical routine are to be noted, alongside the physical symptoms of stress common to adults. Children of this age may also experience sadness, social withdrawal, lost of interest in activities they used to find pleasurable, mood swings, low self-esteem and feelings of inadequacy.

- **Counseling Interventions for Children Survivors**

How can mental health service providers care for children survivors of disasters? Consider the following:

Child-Friendly Space in Evacuation Camps. It is important that children are still allowed to play even when the family is staying in a temporary shelter. This is specially so when the stay in evacuation camps take longer than one day. A child-friendly space may simply be an area where kids are allowed to run around and do whatever they want to do. In many occasions, special interest groups set up child-friendly spaces in disaster-struck areas equipped with toys and art materials for children's expression.

Provide Bed-Time Routines. Parents must be encouraged to set up routines for younger survivors, especially those from 7 years old and below. Routines are comfortable; they are predictable structures that can lessen a child's anxiety and stress. And do not worry if kids who are already used to sleeping alone may suddenly need to sleep beside parents; this is part of children's normal reaction to stress.

Encourage Expression of Feelings. Venting of feelings is not just for adults; children need to let their emotions out as well. Kids, however, may require more indirect means of expressing emotions. Music, art, play, puppets and storybooks may be used to get kids to express their emotions regarding the disaster.

Set gentle/firm limits on acting out. Relax expectations. Because the children are stressed, they may not be able to perform as well in school, or may be more irritable than usual. Acting out negative feelings is also more or less predictable. But it is important that parents communicate early what are the acceptable means of emotional expression. Kids must be given the right to act out if it gives them stress relief, but not to the extent that they may hurt themselves or other people.

Encourage reaching out to peers. Kids must also have a healthy support system. Counselors can set-up child-friendly versions of support groups. Such groups can

counter isolation and withdrawal by encouraging children to talk to peers about their experiences.

Practice Disaster Preparedness. Lastly, children may be given a sense of security by involving them in disaster preparedness drills.

SPECIAL ISSUE: WHAT TO DO WHEN THERE IS NO ONE TO REFER TO

Part of pre-disaster preparation should be setting up of referral systems for mental health needs. But sometimes a referral network is not available, and responding mental health professionals cannot maintain long-term presence within the affected community. How then can disaster responders deal with cases that need follow-up?

To begin with, the UN-IASC guidelines recommend that mental health professionals affiliate themselves with organizations that can maintain long-term presence in an affected community. This can facilitate follow-up of serious cases when needed. But on the event that such affiliation is not possible, the International Red Cross recommends three options:

One, counselors can connect with local non-governmental organizations that can conduct follow-up on the individual or family concerned. Many special interest groups do remain within disaster-struck areas for long periods of time, and they are in a position to access other mental health professionals going to the community.

Second, counselors can tap into local traditional healers. Different cultures have different ways of dealing with stress and grief, and many of them do practice sound interventions. Referring them to these local healers and/or faith-based ministers can be a way to ensure follow-up of more serious mental health cases.

Lastly, counselors must remember that while establishing a support system is not therapy, it is found to be protective from further mental health issues. If there is no one to refer a client to, a counselor must do his or her best in making sure that friends, neighbors, family members and/or community leaders continue to look out for the person concerned.

Part 4

BURN-OUT, VICARIOUS TRAUMA AND SELF-CARE

This Section Contains the Following Topics:

- Understanding Burn-out and Vicarious Trauma
- Self-Care Tips

BURN-OUT, VICARIOUS TRAUMA AND SELF-CARE

A manual on the psychological interventions during disasters is not complete without a section, even a short one, on self-care. Working within disasters can be a grueling task (it is not for everyone) and mental health professionals are encouraged to watch out for symptoms of stress, burn-out and trauma on their own person.

- **Understanding Burn-out**

Stress reactions are adaptive, yes. But at some point, the body goes into the resistance stage of stress where the body's natural ability to cope has been exhausted. When an individual still remains exposed to stress without any form of relief or replenishment after reaching the resistance stage, that individual experiences burn-out.

Three things characterize burn-out: exhaustion, depersonalization (defined as: disengagement or detachment from the world around you) and diminished feelings of effectiveness in the workplace. It may be said that burn-out is a form of energy depletion.

- **Understanding Vicarious Trauma**

Vicarious Trauma, on the other hand, refers to the "negative effects of caring about and caring for others" (Pearlman and Saakvitne, 1995). A counselor experiencing vicarious trauma may experience persistent intrusions of mental images related to the stories they hear in their clients. Counselors may also end up carrying much of their clients' emotionality long after the session has ended. Vicarious trauma may also permanently influence a counselors' sense of self and relationships.

- **Self-Care Tips**

Burn-out and vicarious trauma can affect a disaster responder's general well-being. It may also result in counter-transference that can interfere with the counseling proper. In order to prevent burn-out and vicarious traumatization, disaster workers are encouraged to practice self-care tips.

Be prepared.

Self-care when responding to a disaster starts with adequate preparation. It is important to always bear in mind the assumptions one should make when responding to crisis events. These assumptions include large casualties, loss of properties and very intense emotions from survivors.

Even before going to the scene, gather all relevant data. This way mental health professionals can brace themselves for what is to come.

Unlike rescue workers, mental health professionals do not have to go ASAP to a disaster area. They can afford to wait even as long as two weeks (there are other priorities in the immediate aftermath of a disaster), hence they can adequately prepare themselves for the work that is to come.

Be aware

Recognize in yourself the symptoms of burn-out and vicarious trauma. For instance, do you feel isolated, alienated, distant, and rejected by colleagues? Are you preoccupied with thoughts of clients outside of your work? Do you already feel numb and unable to empathize? Have you started to avoid listening to clients' stories of traumatic experience? If yes, then you know that you need to practice stress management skills and set up some boundaries.

Make use of peer support.

Peer support is an integral part of care among counselors responding during disasters. After providing stress debriefing to survivors, counselors must also debrief one another.

It is also important to solicit constant feedback. "How am I doing?" "Do you see changes in my behavior since we first came here?" Your peer can tell you to take it easy when you are already overworked and overwhelmed.

Set boundaries.

Steer clear of the Messiah complex. You do not have to provide service to everyone. Know your limitations and communicate them. For example, do not take more caseload than you can reasonably manage. Do not make 100% of your daily caseload trauma cases. Defend your personal time. If you deal with heavy issues 24/7, you will be prone burn-out and vicarious trauma.

Lastly, de-stress regularly.

Engage in self-care behaviors such as relaxation exercises, body massage, and a de-stressing diet. Inject some R & R in your work schedule. And make sure you have an outlet for your own heavy emotions. What is the use of teaching others how to manage stress when you cannot deal effectively with your own?

<END>

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~ Richard K. Nongard, LMFT, CCH, CPFT
Executive Director

"Psychological and Counseling Interventions in Disaster"

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EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

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➲ **ANSWER THE 20 EVALUATION OF LEARNING QUESTIONS – TRUE/ FALSE.**

T F 1. I have read all of the required reading material for this course.

T F 2. In general, an event is considered a disaster based on the affected community and its members' ability to cope. .

T F 3. Natural disasters, as the term implies, are those that result from the forces of nature.

T F 4. Natural disasters are intentional events that affect people very specifically and in a targeted manner.

T F 5. Classifying disasters into natural or man-made can provides no useful understanding regarding what is helpful during the bereavement process.

T F 6. Mental health is an important concern during disasters, so much so that the United Nations and The World Health Organization mandated psychological care as the responsibility of only psychologists.

T F 7. Because of the need to deliver professional mental health services to those affected by disasters, the United Nations Inter-Agency Standing Committee (UN-IASC) developed Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

T F 8. The APA cautions psychologists from the United States against providing direct services to disaster-affected communities in foreign countries, unless they meet the criteria set by UN-IASC when it comes to working outside one's own socio-cultural setting.

T F 9. Stress reactions are pathological and bizarre; they should be labeled as mental illness.

CONTINUED →

EVALUATION OF LEARNING QUIZ - PAGE 3 of 4

"Psychological and Counseling Interventions in Disaster"

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T F 10. At some point, physical, emotional, mental, behavioral and spiritual stress management skills must be applied in order to re-fuel the body's coping response.

T F 11. Disaster syndrome is a state of stunned psychological incapacitation that results in the inability to take care of one's self or others.

T F 12. Bereavement overload refers to "the experience of having to cope with multiple losses simultaneously or in rapid succession, such that one loss cannot be accommodated before another occurs."

T F 13. Responding to disaster situations requires mental health professionals to let go of assumptions associated with clinical work.

T F 14. Mental health professionals are also invited to view all humanitarian aid workers, not just psychologists, as having the capability, or at least the potential, to be mental health service-providers.

T F 15. All disaster survivors are victims and should be referred to as such.

T F 16. Cultural sensitivity can help mental health practitioners in understanding the context behind particular thought processes.

T F 17. Methodology for the Rapid Field Assessment can be observation, interviews with survivors, and coordination with local community leaders, humanitarian groups and disaster responders.

T F 18. Critical Incident Stress Debriefing is a structured intervention aimed at addressing stress reactions by providing participants, whether survivors, witnesses or disaster workers, with opportunities to receive information on coping strategies and recovery resources.

T F 19. Creating self-sustaining support does not work in situations of natural disaster.

T F 20. UN-IASC guidelines recommend that mental health professionals affiliate themselves with organizations that can maintain long-term presence in an affected community.

GRADE THIS ONLINE COURSE! – Page 4

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