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Participating in Disaster Relief—What Psychiatrists to Know When Catastrophe Strikes

Profesional Objectives:

After reading this, you will:

- Be familiar with the complexities of entering, participating, assisting and collaborating with the emergency postdisaster response system;
- Know what factors may influence and modify psychiatrists' roles in disaster assistance activities;
- Be aware of a knowledge base on postdisaster mental health activities developed in the last 20 years.

Psychiatrists in ever-increasing numbers are responding to community needs after natural or other disasters. Recent examples can be found in psychiatrists' efforts in such disasters as Oklahoma City, South Florida (Hurricane Andrew, 1992) and North and South Carolina (Hurricane Hugo, 1989). In those disasters, professionals were able to utilize their knowledge of reactions to stress, trauma and loss; of grieving; and of coping techniques (Lazarus 1984, Caplan 1981).

This article is written to guide psychiatrists in their efforts when they join an emergency system that already has official sanctions and assigned responsibility.

Category 1 Posttest

CME, Inc. encourages you to take this posttest for your personal enrichment. The correct answers are listed below.

Circle the correct answer.

1. Federal assistance to fund mental health services was instituted in
   a. 1930 b. 1974 c. 1990
2. Psychiatrists need to attend to the following before they can offer their services to postdisaster victims:
   a. have knowledge of community plans for disaster.
   b. link with the emergency agency authority.
   c. be able to offer a proportion of daily time to the disaster operations.
3. Victims may show depression symptoms during the
   a. preimpact phase. b. postimpact phase—immediate phase. c. postimpact—later phase.
4. Crisis counseling, postdisaster, is defined as
   a. prescribing medication for acute symptoms. b. restoring the victim's capacity to cope.
   c. a method to resolve long-standing emotional conflicts.

Answers to Above Test:
1. b 2. a, b, c 3. c 4. b

Legislative Authority

In 1974 the enactment of Public Law 93-288, Section 413, the Disaster Relief Act, established the foundations for systematic, organized development for postdisaster mental health assistance.

The law recognized that disasters produce a variety of emotional and mental health disturbances which, if untreated, may become long-term and debilitating. Crisis counseling programs funded under Section 413 are designed to provide immediate relief as well as to prevent longer-term problems from developing.

Assistance under this program is limited to presidentially declared major disasters. Moreover, the program is designed to supplement available state and local resources and services. Consequently, grants could be obtained for crisis counseling services on a short-term basis to disaster victims, if these services cannot be provided by existing agency programs.

This legislation became a blueprint for the mental health care of disaster victims. It became a means to channel resources and to coalesce efforts of mental health professionals working with the National Institute of Mental Health, the Federal Emergency Management Agency and the Red Cross. Although the legislation primarily impacted major presidentially declared disasters, its influence permeated smaller local disasters.

The Disaster Relief Act solidified the position taken by many psychiatrists and mental health professionals interested in participating in catastrophic events.

Another event that gave further opportunity to strengthen mental health activities was the legislation that mandated states to have preparatory predisaster plans.

Psychiatry's Role

Preparation is the cornerstone of effective and efficient disaster response assistance. Mental health professionals who have been participating officially since 1974 in federally declared disasters have developed the content and guidelines to increase the knowledge in this field (Gleser and colleagues 1981, Cohen and Ahearn 1980). Since then, the role of the psychiatrist has evolved through the experiences of many individuals responding to specific disasters in their areas (Bromet 1980, Ursano and colleagues 1995, Lystad 1985, Cohen 1976). They have published and shared experiences and methods with their colleagues, thereby accumulating a knowledge base that can be used to define the roles emerging as specific to psychiatry.

The activities that will operationalize these roles are defined by the type of psychiatry practiced by the professional. Generally, psychiatrists with private practices will volunteer or work with the emergency system in specific areas or with specific objectives. Many may volunteer to use their time and skills to impart information through the mass media or serve as consultants to mental health teams. Psychiatrists that work for the government may be deployed to the "frontlines" to direct teams or work within the shelters. Psychiatrists that are employed by academic institutions are permitted to use discretionary time to participate in the community efforts. A new employment base—health maintenance organizations and managed care systems—will have to develop policy planning to use their psychiatrists in emergencies.

The conflict between attending to his or her own patients and devoting time to the community is a crucial decision to be made by each individual. It will be the responsibility of government agencies to provide a mental health service within the multiple response systems and volunteer agencies that are helping survivors cope after the disaster (Auf der Heide 1989).

Cooperation

The design, organization and implementation of postdisaster, crisis-oriented services require the establishment of integrated, interactive, flexible linkage systems between mental health organizations and emergency management agencies. While psychiatrists organize themselves to assist survivors, multiple activities are taking place within the other governmental and public systems, and decision-making about the life situation of the survivors is in other agencies' hands.

Several district psychiatric societies affiliated with the American Psychiatric Association have already established effective disaster-response programs. For example, the North Texas Chapter of the Texas Society of Psychiatric Physicians twice provided on-site counseling and support to survivors, families and relief workers following plane crashes (Black 1987).

The Northern California Psychiatric Society organized community-wide information and counseling programs after the 1989 Loma Prieta earthquake (Austin 1992) and psychiatrists in North and South Carolina played a major role in aiding victims of Hurricane Hugo. Also, after the bomb destroyed the Oklahoma federal building, the Oklahoma Psychiatric Association assisted the families of the victims and the dead (Grinfeld 1995, Karel 1995).

At a national level, a statement of understanding is in the process of being signed by the Red Cross and the American Psychiatric Association to collaborate and coordinate their efforts.

Several problems need resolution before a private psychiatrist can participate in these activities: schedule flexibility; insurance coverage—immunity from being sued (some states have a Good Samaritan law), knowledge of community disaster plans and the need to be linked to emergency planning agencies; knowledge of local psychiatry plans; and networking with disaster agencies, for example, the Red Cross.

Sequence of Reactions

Posttraumatic human reactions are described in the literature (Raphael 1986, Cohen 1986 and 1995) as being manifested by survivors across time-phases. These time-phases are categorized as follows: preimpact; impact; postimpact ; and long-term postimpact.

Each of these phases is categorized by the number of days, weeks and months from the date of impact. The literature is extensive in describing reactions of different populations traumatized by diverse disasters at different time-phases (Lonigan and others 1991, McFarlane 1987, Laube 1985, Weisaeth 1993, Cohen 1987).

Preimpact

With hurricanes or flooding, the population is alerted and prepares for the disaster. Although evacuation and action take place, a portion of the population denies the possibility of impact and doesn't face the probability of the event.

Earthquakes cannot be predicted, but awareness of probabilities is emerging in some parts of the country. California exemplifies the region of the country where preparatory plans actively educate the community.

Impact

Several hours or days after the impact of the disaster and its traumatic consequences, survivors experience a range of all the expressions of anxiety, fear, worry and disorientation. "Cognitive clouding," expressed as a sense of disorganization, slowness of thinking, confusion, difficulty in making decisions, time-confusion (past, present), characterize the function of many survivors. It can last a few hours to several days. Another universal finding has been described as "psychic numbing" or feelings of flatness, disinterest, distance from others.

Postimpact

This phase is measured in months, and is characterized by manifestations of sadness, grieving and depression. As the impact of the reality in terms of loss, needing to rebuild and changes in lifestyle consistently emerge, the affected individual will often manifest anger, frustration and rage.

Long-term Impact

The population as a whole will return to normal function. A subgroup of individuals, however, due to personality, mental health or life events, has difficulty returning to a preimpact level of function, and may manifest a variety of signs and symptoms of psychopathology.

Disaster workers who have entered and worked in the postdisaster sites at different time-phases from the impact date identify some postdisaster responses that emerge but are not clinically categorized into diagnostic nomenclature. Other clinical manifestations can be identified as acute stress disorder (*DSM-IV* 308.3). This new category has allowed for a diagnosis that does not meet criteria for PTSD (because of differences in onset, duration and symptom presentation) yet is more severe and specific than adjustment disorder.

Postdisaster Intervention

The emerging knowledge learned in disasters through the years has helped psychiatrists modify and reformulate intervention modalities to focus on the "person-situation configuration" as the unit of attention in postdisaster treatment. This type of postdisaster intervention is now systematized (Pynoos and Nader 1993, Cohen 1990). Postdisaster crisis counseling is defined as a "mental health intervention technique useful in postdisaster events that seeks to restore the capacity of individuals to cope with the stressful situation in which they find themselves." It has three aims: restoring the capacity of the individual, assisting the survivors to reorder and organize their new worlds; and assisting the survivors to deal with the bureaucratic relief emergency program.

The methodology to bring about these objectives varies according to the clinical school of thought used by the psychiatrists. The emergency circumstances mandate a short, flexible, creative and adaptable approach compared to the usual organized, systematic institutional or clinical approach. Differentiating variables such as age, sex and cultural backgrounds of survivors demonstrate that both reaction and successful interventions differ in children (Shaw and others 1995), adults and the elderly of different cultures (Bolin and Klenow 1988). In this approach the psychiatrists continue to adapt clinical skills and modify approaches as they learn from one disaster to the next. Generally, this type of crisis intervention occurs during the first weeks in shelters, tents or hospitals.

When survivors find a new housing setting, a more organized short-term therapy plus medication can be established.

Burnout Syndrome

The mental health of rescue professionals following a disaster emerged through the years as a novel and important component in emergency operations (Hartsough and Myers 1985). Characteristics of these reactions can vary from transient anxiety to long-term depression. Rescuers' jobs can expose them to gruesome sights and smells. Even though they are prepared for painful experiences in their daily work as policemen, fire fighters, ambulance drivers or other relief workers, a disaster where 10 or 100 dead bodies need disposal or many severely injured individuals need immediate assistance can greatly worsen these experiences. The impact is devastating, and nobody is prepared for or immune to its effect.

Add to this fatigue and intense dedication to the task, with reluctance to be relieved from duty even for a short break, and the burden of emergency operations is increased on rescue workers.

Organized and systematic models of intervention to assist workers are being designed (Mitchell and Bray 1990). The basic components consist of debriefing, identifying critical incidents, helping set the situation in perspective, and reinforcing the capacity and skill of the worker.

Consultation

In postdisaster activities consultation methods are used to increase the capacity of emergency workers to assist a survivor and work with the multiple postdisaster agencies.

The key goal of this modality is to increase the knowledge and skills of disaster assistance agency staff so that they can incorporate new methods and understanding of mental health issues into their work.

Psychiatrists who act as consultants must have background knowledge of both psychosocial theories of trauma effect and disaster intervention procedures to accomplish this objective.

Some of the problems in postdisaster consultation are:

- Professional variations in how to help survivors and personnel;
- Vague boundaries between agencies and their responsibilities;
- Different concepts and language used to communicate between professionals;
- Overlapping power and control in decision-making and resource allocation;
- Insufficient ratio of resources to victims.

Cross-Cultural Influences

Trauma impact is nonselective to race, skin color, gender or age. Assistance and participation in posttrauma clinical situations affecting multicultural groups demands knowledge of cultural responses by individuals of different cultures (Cohen 1992). The experiences gathered in the United States and other countries allow psychiatrists to identify commonalties and differences in dealing with traumatized patients belonging to different cultures.

As professionals, our cultural attitudes are ingrained in how we give help and how we ask for help. A disaster survivor from a specific culture will have very different ways of asking for help than one from another culture

Summary

Data gathered in the last 20 years document the experiences that give direction to assisting posttrauma victims. These data support the guidelines that will help a psychiatrist integrate the concepts derived from combat stress reactions, postdisaster reactions and sequelae to catastrophic personal incidents (rape, hostage, terrorism).

The principles found effective in clinical settings must be modified and an attitude of coprofessional collaboration must be characteristic of the psychiatrist who wants to contribute to disaster relief work. The psychiatrist who becomes conformable with the procedures needed to assist survivors will have an opportunity to know how well the knowledge and skills of the profession can assist in disaster relief.

At a national level, a statement of understanding is in the process of being signed by the Red Cross and the American Psychiatric Association to collaborate and coordinate their efforts.

Education

Opportunities for media communication and dissemination of mental health information present themselves following a disaster. The human story in disaster is intensely compelling, and media professionals quickly seek psychiatrists to interview. In the midst of community crisis, the impact of these messages exerts a strong influence.

There are two specific areas that offer objectives to be accomplished by educational methods. One area concerns knowledge of how the population has been psychologically affected by the trauma and the sequences of the stress response to the disaster. The other area is to offer knowledge of how the mental health system will respond and what professionals have to offer in postdisaster situations

The dissemination of knowledge to the public serves to explain unexpected aspects of novel behavior and reactions that can potentiate further stress if not understood When individuals are forewarned, they can anticipate their reactions and unusual emotions, and acknowledge them as appropriate under the circumstances.

Disseminating information about the types of mental health services available, including consultation and education, facilitates the actual operations of mental health interventions.

Training multidisciplinary mental health team members is another activity undertaken by psychiatrists, who can teach emergency workers how to deal with anxious, angry, frustrated and/or depressed victims. Therapeutic intervention techniques can be adapted and presented to the teams with continuing supervision and monitoring. Lectures, workshops and group supervision have become an expected contribution from psychiatry.

Characteristics of postdisaster affected families, such as ethnicity, acculturation levels, citizen status in the United States, socioeconomic strata, value systems and traditionally accepted methods of dealing with trauma will play a role in the therapeutic relationship

Dr. Cohen is director of the children's center of the Miami State Attorney's Office. She is also author of Disaster Mental Health Services: A Reference Guidebook for Training Trainers

References

1 Ahearn FL, Cohen RE, eds. Disasters and Mental

Table

Sequence of Reactions to Disaster

Preimpact	
No warning before impact (earthquakes)	Some awareness of probabilities emerging in some areas. Little preparation possible
Hours-days before impact (hurricanes, floods)	Population alerted; preparation or evacuation takes place. Some people deny possibility of disaster
Impact	
Hours-days after impact	Survivors experience anxiety, fear, worry, disorientation, disorganization, slow thinking, confusion, difficulty making decisions, time-confusion, psychic numbing Rescuers may experience anxiety, depression, burnout syndrome.
Postimpact	
Months after impact	Survivors and rescue workers experience sadness grief, depression, anger, frustration, rage.
Long-Term Impact	
Months-years after impact	Most of population returns to preimpact functioning. Some people manifest symptoms of acute stress disorder.

Health, An Annotated Bibliography. Washington: U.S. Government Printing Office; 1985.
2. Auf der Heide E. Disaster Response: Principles of Preparation and Coordination. St Louis: Mosby Co.; 1989.
3. Austin LS, ed. Responding to Disaster: A Mental Health Clinician's Guide. Washington: American Psychiatric Press; 1992.
4 Black JW Jr. The libidinal cocoon: a nurturing retreat for the families of plane crash victims. Hosp Community Psychiatry. 1987;38(12):1322-1326
5. Bolin R, Klenow DJ. Older people in disaster. a comparison of black and white victims. Int J Aging Hum Dev. 1988,26(1):29-43.
6. Bromet E. Three Mile Island: mental health finding Rockville, Md.: Report to the National Institute of Mental Health; 1980
7. Caplan G. Mastery of stress: psychological aspects. Am J Psychiatry. 1981;138(4):413-420
8 Cohen RE. The Armero [Colombia] tragedy: lessons for mental health professionals. Hosp Community Psychiatry. 1987;38(12)-1316-1321
9 Cohen RE. Developmental phases of children's reactions following natural disaster. J Emerg Disaster Med 1986;1 4
10. Cohen RE. Disaster Mental Health Services A Reference Guidebook for Training Trainers. Washington: U.S. Department of Health and Human Services; 1995. In press.
11. Cohen RE. Intervening with disaster victims. In Schulberg. HC and Killilea M eds. The Modern Practice of Community Mental Health San Francisco: Josey-Bass Inc., 1982.
12 Cohen RE. Postdisaster mobilization and crisis counseling. In: Robert AR, ed Crisis Intervention Handbook Belmont, Calif : Wadsworth Co., 1990
13 Cohen RE. Postdisaster mobilization of a crisis intervention team: the Managua experience In: Parad R, ed Emergency and Disaster Management. A Mental Health Sourcebook. Bowie, Md Robert J. Brady Co : 1976
14. Cohen RE Training mental health professionals to work with families in diverse cultural contexts In Austin L, ed Responding to Disaster—A Guide for Mental Health Professionals. Washington: American Psychiatric Press 1992
15 Cohen RE, Ahearn RL. Handbook for Mental Health Care of Disaster Victims Baltimore: Johns Hopkins Univ Press; 1980.
16 Disaster Relief Act, PL 93-288 (93rd Congress). 1974
17 Gleser EC, Green BL, et al Prolonged Psychosocial Effects of Disaster: A Study of Buffalo Creek New York. Academic Press 1981
18. Grinfeld M Oklahoma City leaves lasting legacy Psychiatric Times July 1995, pp. 1 and 5.
19 Hartsough DM, Myers DG Disaster Work and Mental Health: Prevention and Control of Stress Among Workers. Rockville, Md., NIMH; 1985
20 Karel R. Psychiatrists plunge in after Oklahoma bombing. Psychiatric News May 1995
21 Laube J, Murphy SA Perspective on Disaster Recovery Norwalk Conn Appleton & Lange: 1985
22 Lazarus R, Folkman S Stress, Coping and Appraisal. New York: Springer-Verlag: 1984
23 Lonigan CJ Shannon MP et al Children's reactions to a natural disaster symptom severity and degree of exposure Adv Beh Res Ther 1991,13:135-154
24 Lystad M, ed Innovations in Mental Health Services to Disaster Victims Rockville, Md. NIMH, 1985
25. McFarlane A, Policansky S, Irwin C A longitudinal study of the psychological morbidity in children due to a natural disaster Psychol Med 1987,17(3),727-738.
26 Mitchell JT, Bray G. Emergency Services Stress Guidelines for Preserving the Health and Careers of Emergency Services Personnel Englewood Cliffs N.J.: Prentice-Hall, 1990
27. National Institute of Mental Health. Prevention and Control of Stress Among Emergency Workers Washington U.S. Dept. of Health and Human Ser-
28. Pynoos RS, Nader K. Issues in the treatment of post-traumatic stress in children and adolescents. In: Wilson JP, Raphael B, eds. International Handbook of Traumatic Stress Syndromes New York: Plenum Press; 1993
29 Raphael B. When Disaster Strikes: How Individuals and Communities Cope with Catastrophe. New York: Basic Books; 1986.
30 Rundell JR, Ursano RS, Holloway HC, Silberman EK Psychiatric responses to trauma. Hosp Community Psychiatry 1989;40(1):68-74.
31 Shaw JA, et al. Psychological effects of Hurricane Andrew on an elementary school population. J Am Acad Child Adolesc Psychiatry. 1995;34(9):1185-1192.
32 Ursano RJ, McCaughey B, Fullerton CS, eds. Individuals and Community Responses Middletown, N.Y.: University Press: 1995
33 Weisaeth L. Disaster: psychological and psychiatric aspects. In: Goldberger L Breznitz S, eds Handbook of Stress: Theoretical and Clinical Aspects 3rd ed. New York: Free Press, 1993. ❑

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