HANDBOOK FOR MENTAL HEALTH CARE OF DISASTER VICTIMS

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When You Die, You Leave Your Things.
In This Case, Your Things Left You
and You Die a Little with Them.

Statement of tornado victim
Windsor Falls Locks, Connecticut
February 1980

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FOREWORD

The history of the mental health field in the twentieth century shows continual expansion of mental health knowledge and its application to diverse aspects of human problems. An important result of this expansion of knowledge has been greater understanding of the ways in which human beings—as individuals, as members of families, and as members of social communities—react to and cope with various types of stress.

Research on stress provides an important link between the scientific disciplines of anthropology, sociology, epidemiology, and biology. Scientists are interested in the physiologic mechanisms by which the organism adapts to the environment through mobilization of various adaptive systems, particularly the hypothalmic-pituitary-adrenal-cortical system, as discussed by Hans Selye, and the sympathetic nervous system, as outlined by Walter Cannon

One important extension of this research has been the linkage of internal physiologic reactions to external stimuli, whether they come from the social environment or from the natural environment. Most of modern life has been concerned with changes in the immediate psychosocial environment due to changes in interpersonal relations, economic change, or loss and separation from loved ones. However, although modern man has increasingly freed himself by means of technology from the vicissitudes of natural disaster, this is not completely true. Famine, floods, plagues, and pestilence are far less common with us than they were with our ancestors, but we are not completely free of stresses coming from changes in our natural environment Therefore, disasters due to natural conditions such as floods, earthquakes, and volcanoes still remain an important part of human experience and are logical events to study.

This study by Dr Cohen and Dr. Ahearn therefore represents an important contribution to understanding human adaptation and stress. The natural disaster in Massachusetts provided a unique opportunity to study not only the impact this event had upon individuals and their families but also the ways in which mental health knowledge could contribute to a better mobilization of social and community resources,

so as to minimize the adverse effects of this disaster upon mental health, social cohesion, and community resources.

The accumulation of knowledge in this area will have practical benefit both to other mental health workers and to the field of disaster research in general. It will also contribute to our knowledge of the ways in which the human organism interacts with its environment and the important interplay between biological and environmental factors.

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FOREWORD

Natural disasters have been profoundly distressing to affected populations since ancient times. Recorded instances of a major earthquake in Syria, in 526 A.D., took 250,000 lives, while another as recently as 1976 killed more than 655,000 people in Tangshan, China. The largest toll in loss of life was recorded in 1931, when floods and tidal waves from the Hwang-ho River in China apparently accounted for the deaths of 3.7 million persons. Although disasters in other parts of the world have resulted in a greater loss of life than those in this country, major disasters continue to wreak havoc throughout the United States annually. Galveston, Texas, has the unenviable distinction of leading the nation in disaster-related fatalities, some 6,000 persons died there on September 8, 1900, due to a hurricane and related flooding.

In calender year 1979, there were forty-two major presidentially declared disasters in twenty-five states plus Puerto Rico, the Virgin Islands, and American Samoa. More than 38,000 families were housed apart from their home dwellings, while 207,449 families sought aid at disaster assistance centers. Total federal assistance in disasters exceeded the billion dollar mark at $1.3 billion, yet only $184,528 of this amount was spent for crisis counseling to treat debilitating emotional problems. Before the establishment of the Disaster Assistance and Emergency Mental Health Section at the National Institute of Mental Health, no money at all was spent for mental health disaster assistance services. Although line-item money is still unavailable for disaster research and training, service funds can be requested in presidentially declared disasters.

The number of lives lost does not always reflect the extent to which psychological problems may exist, since those who survive often experience numerous difficulties that leave turbulence and chaos in their wake. In Idaho, the Grand Teton Dam break in 1976 flooded a sizable portion of the state for eighty miles along the Snake River; yet only eleven persons lost their lives. The damage was so extensive, however, that one-stop service centers were established in six communities to provide relief to victims during the emergency phase of the disaster

Crisis counseling services were supplied to more than a thousand persons. In 1978, as a result of severe storms and flooding in the Boston area, 84 persons died but 40,000 required food and assistance.

Curiously, despite the obvious damage to physical property, community disorganization and disruption, as well as loss of life, little attention has been given to the emotional or psychological aspects of disaster assistance, until the passage of the Disaster Relief Act of 1974, which included a section on crisis counseling. Prior to this, only a few professional articles were written on the subject For example, in 1959, Glass discussed the psychological aspects of disaster and combat, and Popović and Petrović observed adverse psychological reactions after the Skoplje earthquake in Yugoslavia in 1963.

Paradoxically, although somewhat more attention is being given to the disaster assistance field, the problem is likely to get worse before it gets better. One reason for this is the fact that the geographic regions in the United States where disasters are most likely to occur are becoming the most heavily populated Coastlines and river basin areas seem to attract people. The West Coast is particularly susceptible to earthquakes, landslides, fires, and floods. The East Coast and Gulf areas are regions frequently hit by tropical storms, hurricanes, and tornados. The Midwest and South have been particularly vulnerable to flooding and tornados. While the population explosion continues and we apparently become a more affluent society, there is an ever-increasing burden to be responsible for the welfare of our citizens, particularly in spheres where the victims are not blameworthy In fact, this was the philosophical intent behind the Disaster Relief Act

The earliest research dealing with the community problems in disaster emphasized such areas as floodplain management, mobility and rehousing problems, and issues of community organization. This work was carried out principally by non-mental health-oriented sociologists who believed it was important to discredit certain views about disaster held among the laity. Early workers felt there were a number of myths about behavioral reactions to disaster that should be dispelled. These workers did not observe panic reactions, widespread chaos and disruption, looting, or obvious mental disturbances, including anxiety, deep depressions, or psychoses Instead, they believed, on the basis of a small number of short-term reactions, that persons behaved very responsibly and worked in a cohesive manner in every disaster situation- Recently, however, it has been documented in more than a dozen major disasters that victims do indeed experience marked emotional reactions and psychological distress in these situations. Common symptoms are psychophysiological disorders, anxiety, depression, sleep disturbances, anger, resentment, paranoid reactions, marital disturbances, alcoholism, and drug abuse. Moreover, there have been numerous instances of

looting, with a breakdown in community cohesiveness and cooperation after the initial stages of the disaster.

How are communities to deal with these aspects of disaster? How can responsible administrators and mental health workers plan effectively and develop workable programs? What kinds of people are needed and how are they to be trained and prepared when disaster strikes? What kinds of intervention procedures seem most appropriate at different times during and after a disaster? How is a community to establish need for supplemental assistance in time of disaster? These questions are rudimentary, but they are invariably perplexing and create serious problems for disaster-stricken populations.

Drs. Cohen and Ahearn have performed a valuable service by writing this handbook. It will have value for administrative and organizational people, as well as for the practitioners of mental health services at various levels. The plain fact is that even most mental health professionals have not received up-to-date training in crisis intervention and emergency mental health work. This handbook appropriately introduces the reader to problems encountered in the various phases of disaster impact and sketches the problems that will be encountered. The basic concepts needed to understand disaster behavior are articulated by speaking of stress, crisis, loss, mourning, and grief, along with more unusual emotional responses

The work is invaluable in helping personnel plan for an appropriate mental health service. It emphasizes the need to obtain sanction and the support of appropriate groups and individuals and describes how this can be done in the most effective manner. Education and consultation required for disaster work are delineated with clarity and skill. In discussing psychological intervention, the various time phases, ranging from the first few hours and days to problems encountered months later, are spelled out in detail. Real meaning is given to the work by citing actual experiences, such as those encountered in the Managua, Nicaragua, earthquake of 1972 and the severe storms and floods in the Boston area in 1978

Awareness of and treatment for psychological problems in time of disaster will become more of a necessity as time goes on, for the issue has legal as well as humane ramifications. A judgment was found in favor of the plaintiffs in a class action suit against the Pittston Mining Company as the result of psychic impairment sustained when a dam broke and flooded the valley in Buffalo Creek, West Virginia, in February 1972. This judgment of $13 5 million established a legal precedent for such matters. So-called charitable immunity for nonprofit hospitals and governments is now being discarded more frequently, and it will behoove each locale to use this book to get its house in order, so to speak.

Perhaps the most commendable aspect of this work is its broad appeal.

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DISASTERS AND MENTAL HEALTH

INTRODUCTION

The purpose of this handbook is to assist mental health administrators and practitioners in the design and implementation of effective services for disaster victims. The planning and provision of mental health care after a community disaster, whether natural or man-made, requires specific knowledge in a variety of areas. Major factors that affect the design and implementation of postdisaster mental health services include knowledge of the calamity and its consequences, knowledge of the disaster victims and their probable reactions, and knowledge of particular intervention methods for giving assistance. Most mental health administrators and workers have had little or no prior experience with catastrophes or their victims. When disaster strikes, there is an immediate need for knowledge and information before help can be planned or offered. Information about types of disasters and their consequences is necessary to provide a background of knowledge for developing specific relief efforts in the mental health area. From the disaster experiences of others, administrators and professionals must gain information about victims and their behavior. Finally, in order to plan and implement effective services, information is needed on the variety of mental health roles and techniques available for helping victims. This handbook offers mental health planners and workers some knowledge, information, and approaches toward providing mental health services after a disaster.

Disasters are not uncommon, but they are generally unexpected. Most communities are unprepared for the devastation and disorganization after an earthquake flood, or tornado and thus are unable to respond quickly or effectively. Many residents of any given community cannot conceive that their town could be partially or totally destroyed by a calamity, yet this can and does happen. Mental health administrators and practitioners are similarly unprepared for such events.

Traditionally, the highest priorities in relief efforts have been the provision of food, shelter, and medical care. It is increasingly recognized, however, that psychological aid to victims in distress is also a priority. Thus it becomes obvious that preplanning and preparedness are as important in the area of mental health as they are for other relief activities. Mental health administrators need both knowledge and information in order to plan for mental health aid before a calamity occurs.

Any plan for mental health services following a disaster must include knowledge, information, assessment, and action. Knowledge of disaster-related psychological problems and information on how to resolve them can be obtained prior to a catastrophe. Once a disaster strikes, however, there is an urgent need for specific information and immediate assessment. Rapid action must be taken in the face of power loss and resulting telephone failures and difficulties in transportation. Communication problems contribute to a paucity of accurate information. During the early stages of a disaster it is hard to know what has happened, who and how many persons have been affected, where the psychological assistance is needed, and how to provide help. Ways to collect the needed information include contacts with media sources; in many cases, a personal, on-site visit to refugee shelters is required.

Once the general consequences of a disaster are known, a more complete assessment is required to detail specific groups of people who have suffered and to document the types of psychological problems being presented. Certain population groups may emerge as priority targets for services. The behavior of disaster victims varies over time and is interrelated with factors such as age, income level, previous mental health history, or degree of loss from the disaster Finally, from the knowledge, information, and assessments available, a plan of action must be developed for mental health assistance to victims that reflects the realities of those impacted by the disaster and the type of behavioral and emotional problems they are experiencing.

Principal elements in the plan of action are the identification and selection of the various mental health roles to be implemented. Often these are innovative and flexible roles that differ in many respects from those usually employed in clinics or other mental health facilities Practitioners working with disaster victims will encounter not only emotional stress, but stress related to day-to-day problems such as a need for shelter, income maintenance, medical care, locating missing relatives, or making arrangements for other services. Skills in crisis counseling and group treatment are required, as well as skills in outreach work, interagency referrals, community organization, and public education. Disaster victims seldom apply for service because the stigma of being labeled a mental patient is great among people in the "normal" population who suddenly find themselves in need of help Therefore, mental health

workers must actively search for those victims. This often means door-to-door searches in affected areas, or person-to-person referrals in emergency shelters Any plan of action must recognize these factors, set forth the target groups for assistance, detail the scope and duration of the assistance project, and outline the interventive strategies to be employed.

In the event of a disaster, four major requirements must be addressed in developing a systematic plan for postdisaster mental health assistance. The first requirement is knowledge about disasters, disaster behavior, and interventive approaches. The second requirement is information as to what has happened and who has been affected. The third requirement is an assessment of the groups most impacted by loss and their associated psychological problems. The fourth requirement is a plan of action that details the goals, targets, strategies, duration, and scope of the proposed mental health project

USES AND FORMAT OF THIS BOOK

This handbook provides information, procedures, and recommendations that have been developed to aid the mental health administrator and the professional in planning and implementing services to disaster victims. In this book mental health personnel will find essential information about:

- The types and the phases of a disaster;
- The concepts surrounding disaster-related behavior;
- Some specific physical and emotional problems suffered by disaster victims; and
- Some appropriate helping techniques to treat disaster victims

This information may be useful in a variety of ways For example, mental health administrators who live in disaster-prone areas may wish to do some predisaster planning. In order to have personnel prepared to go into action immediately after a catastrophe has occurred, service delivery strategies and staff development must be considered and disaster training programs designed for the professional staff. This book would be useful in designing such predisaster training.

After a disaster has struck an area, administrators will quickly need to identify the affected population, train their staffs, design specific service programs, and coordinate their efforts with others. At this time, mental health professionals must also be aware of the need to document what happens to disaster victims The types of psychological symptoms presented and the range of service strategies that are effective in helping victims must be considered from the beginning and incorporated into the design of an information system that will permit an accurate evalu-

ation of the program's efforts and will result in the reporting of results and findings to others.

Students of psychiatry, social work, psychology, nursing, and counseling will find this text useful in acquiring knowledge about disasters, about the behavior of disaster victims, and about methods that mental health practitioners can use to help those who have suffered as a result of a natural disaster.

The chapters of this book contain two broad sections: chapters 2 through 5 deal with mental health factors surrounding a disastrous event, and chapters 6 through 9 deal with mental health practices to assist victims of catastrophes.

Chapter 2 defines and examines the key concepts of (1) crisis and stress; (2) loss, mourning, and grieving; (3) social and emotional resources; and (4) coping and adaptation. These concepts are drawn from various studies of psychology and behavior and are seen as the basic tools of disaster knowledge. These concepts are later portrayed in two models of disaster behavior.

Chapter 3 extensively reviews the available disaster-related literature as a means to assess the types of symptoms and problems that victims present after a catastrophe. Although the assumption that subjection to natural hazards produces psychological consequences is still controversial in some circles, there is a growing body of knowledge to sustain this view. Chapter 3 also introduces models of disaster behavior that summarize the key concepts of the previous chapters and draw heavily from the literature.

Chapter 4 discusses many of the issues in planning and implementing a program of mental health services for individuals and families following a catastrophe. It suggests methods of approach to assess postdisaster needs, survey community resources, prepare a program, seek funding, and implement the program

Chapter 5, recognizing the requirements of certain mental health roles, addresses the design of training programs and also reviews the activities required of the professional who serves as consultant and educator. This chapter includes various strategies to gain program support and to educate and report to the public through use of the media It also describes techniques used by mental health practitioners to assist other relief and human service workers following a disaster

Chapters 6 through 9 present specific suggestions and techniques for mental health practice under a variety of disaster situations. These chapters are divided by time phases after the calamity; they review the knowledge requirements, settings, roles, and techniques for each phase.

This book provides the mental health administrator and practitioner with a solid knowledge base for understanding how people react after a disaster and with a guide to practice in the first hours, days, and months of the calamity.

The reader may use this book under a variety of circumstances and for a variety of purposes. It is hoped that the flexibility designed into this work will provide access to disaster information and will prove useful to those who must provide or plan for mental health services in the event of disaster

A DEFINITION OF DISASTER

Disasters are extraordinary events that cause great destruction of property and may result in death, physical injury, and human suffering. These events may be man-made or natural. Included in the first category are fires, war, civil disorder, terrorism, and chemical pollution, whereas floods, earthquakes, tidal waves, tornados, or hurricanes are natural calamities. The two categories have similarities in terms of potential mental health consequences, but the authors of this handbook, reflecting their experiences, focus primarily on disasters as acts of nature.

Catastrophes are usually unexpected but inevitable events that have a variety of characteristics. Some are slow in developing, while others occur suddenly and without any warning. Some wreak havoc over a wide area, while others are very site specific. These hazardous events also vary in their duration: Some persist for hours while others last only seconds or minutes. Finally, each disaster produces varying degrees of physical and human destruction. In unpopulated areas, an earthquake may cause little damage or harm, but in a densely populated area physical and human destruction may be great.

Disasters have been defined in many ways Each of the following definitions emphasizes somewhat different outcomes of natural mishaps.

Harshbarger (1974) defines disasters as rapid and dramatic events that result in substantial damage and great harm. He stresses the importance of community life and postulates that disasters must be considered with reference to their potential to disrupt a community's activities and cause harm to its residents.

Erikson (1976) states that two different types of trauma, individual and collective, are evidenced in the behavior of persons affected by a disaster He defines individual trauma as "a blow to the psyche that breaks through one's defenses so suddenly and with such force that one cannot respond effectively" and collective trauma as "a blow to the tissues of social life that damages the bonds linking people together and impairs the prevailing sense of community" Although one of these traumas can occur in the absence of the other, they are clearly interrelated, as they usually occur jointly and are experienced as two halves of a continuous whole in most large-scale disasters.

Schulberg (1974) discusses the link between risk events and personal reactions, using the concept of crisis This concept has been explained

in various ways, including a situation produced by one's environment, an individual's perception of an event, a clinical syndrome, the interaction of person and environment, and a critical change in role. Five features that distinguish crisis and are central to most viewpoints on crisis theory include:

- A time sequence that unfolds speedily;
- Major changes in behavior;
- Personal sense of helplessness;
- Tension within one's personal and social system; and
- Perception of personal threat.

Referring to disasters as crisis, Frederick (1977) is quick to distinguish between the terms "crisis" and "emergency." A crisis is a crucial period of time, varying from minutes to months, in which a situation affects a person's social or emotional equilibrium. As this evolves, it may develop into an emergency—a situation that presents an urgent demand and requires prompt action.

Anderson (1968) takes a different approach and defines disaster in terms of the affected population's reaction to the threat of a disaster before the disaster occurs. He describes the disaster as acute or chronic depending upon how a community responds to the threat. "Conceptually it is convenient to distinguish disaster as an *event* of acute crisis which physically disrupts otherwise 'normal' day-to-day life and causes palpable loss, from threat as a *situation* of chronic crisis which anticipates disruption in expected routine." He states that a disaster has different consequences for an individual, a family, and the various institutions of a stricken society. An acute crisis is one where the community lacks the established disaster-culture patterns that would allow it to deal with the unexpected events of a disaster. The community is caught completely by surprise. In a chronic crisis the events of the disaster are not completely unknown before the disaster occurs; the potential for threat is generally recognized before it is experienced by an individual.

Barton (1970) categorizes disasters as part of the larger group of collective stress situations that occur when many members of a social system fail to receive the expected conditions of life from the system. He adds that this collective stress can come from sources either outside or inside the system. Barton views the social system as a collectivity of human beings whose interaction maintains itself in identifiable patterns over a relatively long period of time; he states that systemic disequilibrium results from the stress of catastrophic events.

Barton says that the following factors must be considered in assessing these stress situations:

- The total scope of the situation (for instance, a small part of a system can be under stress either because it alone has suffered some major loss of input or because it is part of a larger system that is suffering such loss);

- The speed of onset:
- The duration of the stress agent (for instance, changes without warning are likely to create greater loss and leave the system with less capacity to respond than changes that give warning and allow preparation); and
- Social preparedness.

Kastenbaum (1974) describes a disaster in terms of the relative seriousness of the mishap as compared with other major events. The way a person perceives a calamity has some relationship to the way one usually defines and classifies other events The definition that something is a disaster requires a background of stability and normality with which the mishap is compared. It is thus recognized and finally identified as a disastrous event.

Traditionally, the study of disasters has emphasized the three phases of these events: preimpact, impact, and postimpact.

Preimpact Phase

This phase includes activities that precede the disaster itself, including threat and warning. A threat is the pervasive, long-term jeopardy presented by possible calamity that places certain areas and inhabitants in greater risk than others. An example might be the threat to Californians who live along the San Andreas fault or the threat to residents of central Michigan who are exposed to the possibility of an earthquake or tornados. A warning may be vague and general, such as a flood alert, or specific, such as an immediate evacuation order. Interestingly, and usually unfortunately, threat and warning are routinely ignored by the populace. Some people have a fear of acting precipitously and appearing foolish Others refuse to heed a threat or warning as a defense against something they wish would not happen. For example:

> Not everyone in the small mining town of Buffalo Creek Hollow, West Virginia, was sleeping soundly that disastrous night. Some of the coal miners had been around for many years, and they knew that the makeshift dam nearby could never hold the amount of water that lay behind it. Those who knew the danger of the mounting pressures had safely evacuated their families from the dangerous area. But others didn't know about the crumbling dam, and others just didn't believe the warnings. Those who didn't know or didn't believe were among the dead as 135 million gallons of water broke through the coal waste refuse dam with a deadly surge and roared down the valley. The force of the water, mixed with what the miners call gob—coal refuse—lifted houses off foundations, tore up railroad tracks, and sent scores of people swirling and flying to their death Explosions rocked the valley as the force of the water stormed the power houses. One hundred and twenty-five people were dead, 1,000 homes were destroyed, and the area suffered over $50 million worth of damage before the water stopped its seventeen-mile, three-hour journey that morning on February 26, 1972.

Impact Phase

This phase is the period in which a community is struck by a hazard and the time afterward when the relief effort is organized. Researchers have indicated that during this phase, fear is the dominant emotion as victims seek safety for themselves and their families. Panic is unusual and only occurs when escape is impossible. Activities shortly after the disaster have been noted as part of the "heroic phase," when victims may act heroically to save themselves and others and when altruism is usually demonstrated. The first relief efforts are frequently begun by the victims who act to help their neighbors and other victims. Some authors use the term "rescue" to describe some of these relief activities, as well as the term "inventory" to refer to the assessment of physical and human damage. Following is an example of the first stage of this phase:

> After the San Francisco earthquake in 1906, news reports around the country featured headlines such as "Little Left of Frisco, Thousands Homeless," "Parks Are Full of Sufferers," "Made A Noise Like Dynamite," "The Earth Moved Visibly," and "Crockery was Smashed, Clocks Were Stopped, Houses Tottered and Hundreds Dead." Our worst and most legendary disaster caused the death of 700 persons. Jack London, the noted writer, reported his eyewitness account in *Collier's Weekly*, May 5, 1906. "On Wednesday morning at quarter past five came the earthquake. A minute later the flames were leaping upward. In a dozen different quarters south of Market Street, in the working-class ghetto, and in the factories, fires started. There was no opposing the flames. There was no organization, no communication. All the shrewd contrivances and safeguards of man had been thrown out of gear by thirty seconds' twitching of the earthcrust" (Gelman and Jackson, 1976).

Postimpact Phase

This phase begins several weeks after the disaster has struck and usually includes the continued activities of relief, as well as the assessment of types of problems that individuals may experience. Elements of this phase have been called "remedy and recover"; they include the actions taken to ameliorate the situation and to facilitate individual and familial recovery. Some writers have referred to two additional elements of the postimpact phase— honeymoon" and "disillusionment." The honeymoon is the period of time shortly after the disaster and up to several months later, when victims demonstrate considerable energy in reconstructing their lives. During the honeymoon there is a need to ventilate feelings and to share experiences with others. Considerable organized support is offered victims at this time to help them cope with their problems. "Disillusionment" sets in when this organized support is withdrawn, or when the victims face considerable red tape in resolving their problems, or when it becomes obvious that their lives have been permanently changed.

The postimpact phase may continue for the rest of the victim's life. New problems may arise from the social disorganization caused by the disaster. Erikson (1976) has referred to this as "the second disaster." After the Buffalo Creek flood in West Virginia, many victims were relocated to trailer camps, where some began to express psychological reactions to their new living arrangements and to the lack of friendship with their new neighbors. Long-term personal problems characterized by apathy, depression, and chronic anxiety have been called "the disaster syndrome." Finally, a few writers have addressed the "reconstruction element" of the postdisaster phase, when the victims have begun to resolve their problems and the destroyed areas are rebuilt. This process may take several years.

A DEFINITION OF DISASTER VICTIMS

The term "victim" in this book refers to those individuals and families who have suffered from the disaster or its consequences. Disaster victims have experienced an unexpected and stressful event. It is widely assumed that most victims have been functioning adequately before the catastrophe, but that their ability to cope may have been impaired by the stresses of the situation. Even though victims may present symptoms of physical or psychological stress, they do not view themselves as experiencing pathology. Disaster victims may include all ages, socioeconomic classes, and racial or ethnic groups because catastrophes affect the entire cross-section of the population in an impacted area.

Some victims may suffer more than others, depending upon several interrelated factors. Those who may be particularly susceptible to physical and psychological reactions from a disaster include people who:

- Are vulnerable from previous traumatic life events;
- Are at risk due to recent ill health;
- Experience severe stress and loss;
- Lose their system of social and psychological supports; and
- Lack coping skills.

The elderly are a group that, in general, may find it difficult to cope with disasters and their consequences. It is not unusual to find older victims who are isolated from their support systems and live alone. As a result, they are often afraid to seek help. Typical postcatastrophe problems with this group are depression and a sense of hopelessness. Unfortunately, a common response among some elderly people is a lack of interest in rebuilding their lives.

Children are also a special group because they usually do not have the capacity to understand and rationalize what has happened. Consequently, they may present emotional or behavioral problems at home

or school. Perhaps the most prominent disturbances reported after disasters have been phobias, sleep disturbances, loss of interest in school, and difficult behavior.

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

Finally, another at-risk group to be considered by the mental health disaster worker includes those who, at the time of the disaster, were experiencing certain life crises. Members of this group might include, for example, people who have recently been widowed or divorced and those who have recently undergone major surgery. These victims may display a special vulnerability to the stresses generated by a natural disaster.

In summation, although the particular at-risk groups identified merit close attention from the disaster worker, victims can be found among all social, economic, and ethnic strata and among all segments of the population in the disaster area

A DEFINITION OF MENTAL HEALTH ADMINISTRATORS AND PRACTITIONERS

The titles assumed by mental health administrators differ from place to place and include such terms as medical director, program administrator, commissioner, clinic director, or superintendent. The term administrator, as used in this book, encompasses all of these titles and denotes the specific person or persons with the authority and responsibility to carry out mental health policy and program goals and to design projects. This book is written for and directed to those administrators who would be responsible for planning a program of psychological assistance for disaster victims.

In this book, the terms mental health practitioner, worker, and professional are used synonymously. These individuals include psychiatrists, social workers, psychologists, community organizers, psychiatric nurses, and counselors. If they have not had specific disaster experiences, they should receive orientation, training, and supervision. Presumably these professionals, through knowing about disasters, understanding the unique situation of each victim, and anticipating the possible behavioral adaptations to a catastrophe, will be able to assist individuals and families following a disastrous event

This book is not specifically written for nonprofessionals or paraprofessionals, although they are an integral part of the mental health team in disasters Paraprofessionals such as community workers, psy-

chiatric assistants, and volunteers often do outreach work, give support to victims, help them get to and obtain other services, and interpret services to the community. To assist paraprofessionals in these kinds of activities, professionals may wish to use this handbook to design training and orientation programs.