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PHASE ONE: THE FIRST FEW HOURS AND DAYS

This and the following two chapters present key categories of experiences and key concepts that evolve sequentially during the relief process. During each time phase, mental health practitioners face different environments and different psychological consequences and must therefore continually adapt their roles and use different skills. These chapters, then, describe mental health intervention during this relief process and give special attention to knowledge of the victim's setting or social conditions, mental health roles, and, lastly, interventive skills.

KNOWLEDGE: SOCIAL CONDITIONS

It is important for the mental health worker to have a complete understanding of the social conditions in the disaster area. In addition, the worker must view the disruption of these social conditions with the specifics of the disaster in mind. For effective organization of the proper mental health services, the worker must know:

- The type, kind, and intensity of the disaster;
- The length of the disaster and its warning period;
- The number of persons affected;
- The extent of property damage;
- The range and number of casualties; and
- The types of personal resources affected persons had at their disposal for combating disaster-related adversities.

The worker must also be aware of specific problems that will probably be encountered in assisting the postdisaster population. These problems will vary according to the type of disaster and the size of the community involved. For example, disasters such as earthquakes, tornados, and floods are usually marked by impacts that are short and sharp with little or no warning. Hurricanes and slow-rising floods are more likely to

have an impact of longer duration with at least some warning period. If the disaster strikes a large urban community, a number of services and support lines of communication, such as telephones and transportation, will be disrupted and have a major impact on the situation.

During the earthquake in Managua, Nicaragua, in 1972, all the main hospitals in the city of 400,000 were destroyed and unfit to continue providing care for their patients and for the wounded in the disaster. The need to set up complete hospitalization systems using army tents donated by foreign countries demonstrated just one of the major reconstruction needs within the heart of a city.

In the urban setting, despite severe disruptions, assistance is generally readily available through the fairly large number of trained personnel in close proximity. Conversely, when the disaster strikes a rural area there are probably fewer services to be disrupted, but there are also proportionately fewer or sometimes no assistance services available.

These variations affect the types and the intensity of human problems that emerge and come to the attention of mental health professionals The mobilization of the appropriate number and types of mental health personnel depends on the availability of data related to the needs of dispersed persons in the specific area. An important component of this appraisal is the assessment by the mental health planner of what has already been done by the people themselves and by the disaster assistance agencies involved Information is required about what concrete services have already been provided and what disaster agencies, such as a Red Cross station, are on site. This assessment allows mental health workers to mobilize themselves rapidly toward forming a link with the Red Cross and other appropriate local, state, and federal agencies for joint participation in first-aid auxiliary assistance.

It is necessary to know the type and extent of physical damage—for example, what areas or buildings have been destroyed in the disaster area—in order to determine where the mental health teams can be placed and how they must be mobilized (cars, trucks, boats, helicopter) in the different geographical settings where the damage has occurred As an example, the workers must know if the disaster victims as a group had to be relocated in temporary shelters or if there are some persons who stayed in their homes under duress The types and placement of assistance given by public service agencies will make a difference as to how the mental health teams will be physically deployed so as to proceed jointly with overall planning. For example, do members of the team have to attend disaster planning meetings and provide assistance in different parts of a city, or is everyone congregated in a central command-post setting? All this information is preparatory to planning and allocating the mental health resources, which are finite and cannot proportionately meet the needs of all the disaster victims Therefore

careful resource allocation is called for in assigning aid where it is most needed, and it is precisely in these high-need areas that the professional mental health workers most require linkages with the work of the other recovery and assistance efforts.

CHARACTERISTICS OF THE SHELTER

When members of the mental health team enter a shelter, they must quickly appraise the grouping and social system arrangement to determine where the most help is needed and where the linking points with other teams should be developed for maximum organizational effectiveness. Usually the mental health team can offer the most assistance by linking with dispensers of services at the emergency health center. These include the Red Cross centers and/or the local, state, and federal service administrators who are coping with a multiplicity of human need

It may be helpful to look at the activities of the team that participated in relief operations during the second day of the 1978 Massachusetts blizzard in one of the shelters. After members of the mental health group identified the leaders of the health system, the Red Cross, and several representatives of municipal government, a meeting was immediately called by one of the mental health professionals to discuss the organization of assistance programs and to develop a plan for collaboration. The concept of crisis counseling was introduced, and procedures for linking communication were suggested. This is the kind of action that was necessary for preliminary organization of services.

When a helpful and clear plan of action is presented amid an atmosphere of general confusion to a group of relatively inexperienced workers, it has a high possibility of being accepted and used. Information on the grouping and social system arrangement within the shelter, and on the process of collaboration and linkage with the National Guard and other forms of civil assistance, should be processed on a continuing and systematic basis, due to the rapid pace at which most events occur during the sequence of postdisaster activities This allows for better understanding the various public agencies' missions and leads to coordination of their activities with those of the mental health teams. With this information, a mental health participation plan can be developed for preserving continuity through the various agency levels and changes in recovery planning operations

This type of systematic approach is needed in trying to become organized amid the initial disorganization prevalent within the temporary shelter. The following account of a Red Cross supervisor's perceptions and personal reactions upon entering a shelter after the Massachusetts blizzard illustrates the sense of confusion

During the last parts of this, Alan had arrived and was trying to get some sense of what all the shouting was about. I had just again cornered Mr. D. to try to find out what's what with the high school and can we use a few rooms for services when Dr. C. approaches us. Lose Mr. D. again because as Shelter Manager there are always at least three people waiting to talk with him.

Introductions made and some general information on what we're each doing passed, but my head is whirling with this political stuff and I don't need to know there's a public law that says mental health will be part of the relief process. It's obvious it's needed but I can't pull my own act together right now and that's needed, too.

Many of the people in and out of the rooms I've been in are wearing ill-fitting, wrinkled clothing. O.K. for now in this shelter, but it's soon going to really get to them if they can't start taking care of themselves, including getting into some of their own and/or new clothes.

So my attention wanders to where Mr. M. is now and who else might be around to open some of these numerous rooms and give me authority to use some for a few days.

My full attention swings back when I recognize that Dr. C. wasn't just trying to let us know they were around and would be involved somehow. She wanted to work with us and wanted to coordinate so the best services could be given to the victims. In my head that translated to one more thing that should be done immediately and I couldn't see resolution even close on what I was already involved with. But Alan was picking up quick on what this link could mean and was moving right along with it. Ended up exchanging phone numbers and it wasn't until we were driving back to Boston much later that I discovered Alan had pinned down something more definite for regrouping with Dr. C. to work out some details.

That came after finally getting together with the mayor and clarifying for him and the others there that a one-stop center is a ten-day to two-week phenomenon, not a six-month to one-year set-up, as they thought. That made the political hassles lessen significantly. The mayor had thought it was to be the city's responsibility to provide payment for a building, furniture, and all supportive systems necessary for this relief process to work. So that was a big load off his mind and a few more people started to get an inkling of what's going to happen. But I still don't have anything set up to start casework services tomorrow, and it's now a full five days after the storm.

Knowing the categories of recovery activities planning that need to be carried out is helpful in allocating the available time and energy to set up levels of operation. These categories are:

- Organizational planning of services with leaders of the other relief agencies;
- Consultation with and education for other professionals on mental health aspects that need to be added to the recovery services;
- Making others aware of the specialized functions of mental health professionals that can assist in aid to victims. In past disaster operations, these functions have generally been unavailable to agencies in developing recovery operations; therefore members of these

agencies have no experience or knowledge of how to conceptualize and make operational use of mental health professionals' skills; and

- Direct intervention and help for victims through a first-aid approach.

Efforts to keep up with the operational time frames of the other professionals require that continuous communication channels be kept open and that focus be maintained on tasks. This frame of reference should be kept in clear focus as procedures evolve.

Once it has been determined where the command-post or planning center of operations will be located and also where the mental health workers will be, the objectives of mental health professionals will become clearer to other disaster workers. This information will aid in evaluating how each group working in the setting can use the other's skills. It is also essential to the development of a good working rapport with the non-mental health workers and will help ensure the efficient mobilization of mental health staff resources to the disaster victims. For example, it is necessary not only to know how Red Cross workers function in shelters, but also to know how the specific individuals in this particular community have organized themselves.

Red Cross staff members are organized in most communities as a mixture of volunteers, with some staff members flown in from other regions specifically to organize the disaster assistance. Generally there are too few staff members able to grasp rapidly how to link with mental health professionals and how to use their skills. In several instances during the 1978 Massachusetts blizzard recovery operations, the Red Cross members were "surprised" at how helpful it was to add the experience of participating mental health professionals. They felt supported as they became aware of the potential assistance and the flexibility of approach offered by the mental health professionals, who could deal with the psychological problems presented by the victims. The same feeling applied to the National Guard, the civil defense, and the medical delivery systems. There are broad guidelines of how these groups are supposed to operate, but idiosyncratic and individualistic approaches by members of various agencies have to be noticed.

An example of the kind of organizational stalemate that can take place with a member of a collaborative agency occurred with a Red Cross supervisor in Massachusetts when one of the mental health professionals started designing the procedures that would guide their collaborative participation. As soon as a Red Cross worker identified a victim with emotional disturbances or psychological problems, he would

call the mental health worker and ask for assistance. The stumbling block that appeared very soon in their negotiations was how the Red Cross worker would identify and introduce the mental health professional to the victim. The Red Cross worker acknowledged that he did not know what words to use and how to introduce the concept of psychiatric assistance for the victim's problems without feeling "guilty" about raising the suspicion that the victim needed a "shrink." A compromise was reached and the mental health professional was introduced as a crisis counselor participating in the federal program for disaster assistance.

CLUSTERING OF DISPLACED GROUPS

It is generally true that groups of varying sizes, composed of displaced family members or single individuals, cluster around the designated shelter areas provided by the authorities. It is important for mental health workers to identify these groups in terms of ethnic and socioeconomic characteristics. The immediate needs of these groups can be better satisfied if the workers have a clear understanding of the traditional customs and cultural backgrounds of those being helped. This will allow them to guide their helping approaches in a way that can be accepted and will fit the needs of the victims, for it is the special characteristics of the groups that affect behavior patterns during the initial crisis period.

The concept of cultural sensitivity can be exemplified by this case history of one victim in a shelter:

> A fifty-year-old Italian barber was sitting in a rather dejected fashion on the cot that had been assigned to him. The mental health worker approached him and asked him how things were. He started telling the story about his home that had been inundated by a storm's waves and how they had destroyed most of his basement, where he had a freezer that had just recently been fully stocked. He had spent hundreds of dollars to get the food, especially meat, for his family. He went on to say that he had been able to handle most of the trouble, even though he had the harrowing experience of having to wait for a boat to pick him up while he and his family sat and watched the water come in and recede in the basement. What had finally produced an unbearable stress and shock feeling was passing by his barber shop as he was being rescued in a boat. He saw that it had been vandalized and could not accept this. He broke down sobbing and crying as he expressed his dismay that there could be people who would do this to him. He had tried to keep a "stiff upper lip, as a man should," but lost control at the sight of the pilfered shop.

ROLE CONFIGURATION

Presented here is a detailed outline of the role of mental health workers as they should function during the first forty-eight hours after a a disaster has occurred. The specific functions of the mental health worker during this postdisaster stage are discussed both as part of the procedures of psychological assistance and as part of more concrete postdisaster services, such as obtaining resources to benefit the victims in collaboration with other agencies (e.g., the Red Cross or various local, state, and federal relief programs).

The role of the mental health professional who works with staff from other agencies and with public officials involved in directing disaster operations is still ambiguous but also an integral part of the relief effort. The evolution of these alternate roles, as practiced within new community crisis settings, has an impact on traditionally developed mental health clinical roles. Expectations of mental health professionals, both by themselves and others, present some difficulties and problems in the level of comfort experienced by workers in disaster assistance functions. For example, at one point during the Massachusetts blizzard relief aid, Red Cross staff shared their observations of how they perceived mental health workers. They felt that the mental health workers were not clear in their approaches and showed confused behavior. Although there was no question about their sincere interest in servicing the victims and in being helpful, the professionals appeared ill at ease, unsure of what to do next, and not very clear about the modality of participatory activities in the shelter.

Traditional concepts of mental health workers as being clearly aware of their own functions and duties within the clinical framework and also cognizant of expected behavior (as perceived by their colleagues) are altered in a postdisaster assistance setting. It appears that traditional behavior must be adequately adapted to fit the different sets of needs and timely demands for action operating during a disaster. These needs include the ability of the mental health worker who has access to only minimal data to work rapidly and flexibly in collaboration with other disaster aid professionals. In working with the Red Cross, volunteers, and civil defense workers, problems such as trust, communication style, and familiarity of mutual tasks emerge, and collaborative solutions may not yet be clearly identified and developed. There are issues of tradition, problems of working together related to professional differences in cultural and value systems, and conflicting ideologies on how to help disaster victims. Problems arise from different role expectations, status, and behavior; these are coupled with differing expectations within the various mental health disciplines—M.D.'s, social workers, nurses, and others—that make up the team.

The following example illustrates the problems of role definition and expectations ("What am I supposed to do, and what is everyone else doing or supposed to be doing?"). The account is a Red Cross supervisor's perception upon first entering a temporary shelter:

> The following two days we did start doing the immediate assistance at the high school. I believe it was the first of the two days that a young man showed up and identified himself as a psychiatrist. He wasn't sure what he was supposed to be doing, nor were we. Even though the caseload was relatively small that day (about forty-five, I believe), it was our first day and we were (1) feeling out what each of our co-workers was capable of doing; (2) trying to establish the most efficient physical set-up to give the greatest privacy possible for caseload processing; (3) trying to find out from the shelter manager what had happened up to that point and get a feel of who was who in the community and how they might help or hinder our relief process; (4) dealing with the general confusion and anxiety produced by the state coming in, taking people out of the shelter, and placing them in hotels (how were we to find them later if they didn't seek us out?).
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> John spent some time with the psychiatrist but was involved in solving some crisis or another, so I spent some time describing what the Red Cross does in disaster relief, relating some of the problems that people were going to have, and speculating about how our workers would link people to him. As there were no obvious problems right then, I believe I suggested he spend time in the waiting room and if he noticed anyone who was particularly anxious or depressed, he could talk with them. I think I did see him in the waiting room once after that, but when we had a person who could obviously use his help, he was gone. (I vaguely remember his coming to me and saying he had a case he had to work on at his clinic and was leaving.) This was disappointing, because it was later in the afternoon and most of us were frazzled, too.
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> I believe what happened the first several days is that early in the day when we were fresh (as were the disaster victims), we were inclined to handle situations, including victims' emotional problems, as part of our normal caseload process. We had patience and were mentally alert, so could provide emotional support along with the material relief process. If that happened, the people who were there to provide mental health services would think they weren't needed, lose interest, and tend to get back to their regular jobs, where they knew they were needed. That means they were gone by the time our energy was depleted and we could no longer handle clients' stress on top of our own.
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> As the process went on a few more days and we had a clearer picture of the delineation between our straight material assistance procedure and the crisis intervention procedure, we were more able to turn over problem situations, even when we were able to intervene ourselves.

The role of the mental health worker cannot be developed merely through interconnections with other disaster agency members who help give that role status and legitimacy. True, these interconnections help

develop and guide the objectives of mental health intervention. However, constant awareness of their roles by the mental health workers themselves will help them understand their functions; this in turn allows them to perform their duties effectively.

This new role definition needs to be immediately, energetically, and systematically developed before it can be acknowledged and accepted both by other mental health professionals and by workers from disaster assistance agencies. As groups develop and tend to link agency members, continued role clarification has to be shared. This is accomplished by making agreements, negotiations, and verbal contracts to provide answers consistently for questions raised by the situations that emerge when people are trying to solve problems. Asking "What do I do now? How can I be of assistance?" while at the same time asking "What can *you* do? How can *you* be of assistance to the victim?" is a means of providing for a consistent mode of response as a myriad of situations is presented.

This method of task division among different groups to facilitate and organize relief assistance is evident in the following approach, which shows how responsibilities were divided and assigned among a group of citizens and professionals from Managua, and another group of professionals from the United States, who were all working together after the 1972 Nicaraguan earthquake. A large percentage of citizens were deployed to temporary housing in the camp "America" (a row of wooden houses built by the Agency for International Development), where outreach workers would go from door to door looking for citizens with problems or difficulties. When they identified someone who, in their estimation, needed help, they would refer him to a special team housed in one of the small, temporary wooden homes in the camp where all the citizens had been relocated. Here psychologists from the American team, assisted by a group of students from the Managua University, obtained histories and did mental status exams. When a serious case showing the symptoms of acute crisis needed further psychological or psychiatric intervention, the person would be referred to a backup psychiatric team that operated in one of the existing outpatient sites in the city. This group of professionals, paraprofessionals, and volunteers would meet at the end of the day and rapidly exchange information or receive instructions on how to assist victims; in this way everyone's skills and interests were enhanced as much as possible.

Because of the continuous shifting due to constant relocation procedures, standard behavioral guidelines should be developed and implemented to facilitate informed and efficient problem solving among all the organized disaster relief professionals, who continue to shift roles as time goes by. Harmonious agreements and minimal conflict must be achieved so that the helping groups are ready to work and have enough energy to support and guide the painfully disorganized life and world of the victims.

SKILLS

After assessing the social situation surrounding the postdisaster behavior of victims, it is time to address methods of intervention. Decisions must be made on how mental health workers should intervene through a first-aid auxiliary approach, and what procedures should be instituted to help the victims cope by gaining a sense of control over their shifting, unfamiliar, and stressful environment. First, it is necessary for the mental health worker to practice the basic techniques for developing and establishing a relationship with a person who is showing distressed behavior. This technique is known to practitioners dealing with individuals in crisis. Second, it is necessary for mental health workers to familiarize themselves with expected individual reactions to the experience of surviving a disaster. The following dialogue between a mental health counselor and a victim shows the emotional reaction to a disaster:

Mental health counselor: I'm interested in how you are feeling. What have your experiences been like?"

Victim: "Well, it was very depressing. I was trying to figure out what I could do, and yet I couldn't seem to get any answers of what I was going to do. I more or less got to the point where we were going to have to play it by ear and let people take over. I knew it was going to take an awful lot of time to straighten out. Don't matter who help you, you couldn't replace, you couldn't put things back in place the way they were. It was gone. Whatever was there was gone—which turned out to be so true. With all the help they gave you, which you were very grateful for, it still didn't replace, it still didn't put things back the way they were. The people didn't even know what the damage was that they had suffered. They were there in their shelter, they had left everying, and they didn't know what was going to be there when they got back. Things were still up in the air so far as that goes."

This victim is expressing her sense of loss and trying to explain to herself what has happened.

The repertoire of mental health intervention skills and the objectives of intervention during the first phase of the postdisaster experience can be conceptualized procedurally in terms of a "first-aid" effort. This psychological assistance is in the form of face-to-face intervention assistance to victims. This is their first step in reorienting and adapting themselves to their new transitory reality, the first step in beginning to resolve their crisis. The disaster victims need help with reality testing in order to assess what has happened, what is happening, and what will happen. Extreme care should be taken not to interfere with defense mechanisms used by victims to remain in control. An example of handling of emotions by denial mechanisms is shown in the dialogue with a rescued victim:

Question: "How did you feel about the fact that the evacuation people were taking so long to get to you? Or did you just figure, 'what can I do?'"

Answer "Well, I was kinda angry, but I had to put myself in their shoes, too How much can they do? How many men are there? How much equipment do they have? See, you have to have that equipment ready—that's the big thing right there; You have to have the equipment You could need 300 men and they only have like 20 If you only have one boat, what good are they?"

The crisis counselor agreed with the reality. He supported the sensitivity and adaptation to this first unreal traumatic experience and did not try to stimulate the contained and defended rage For the immediate situation of the victim, being in control is the main objective of counseling

A mental health worker should couple the techniques used to aid and support a victim reacting to the stress produced directly from the disaster with techniques appropriate to the emotional reactions and sensations characteristic of one who is a member of a displaced group in a public shelter. In addition, the relationships between counselors and victims must be nurtured continuously. Workers must express empathy without acting out either a sense of omnipotence or a rescue fantasy. They must quickly appraise mental status (cognitive and defensive functions; level of anxiety, depression, fear, or anger), and relate appropriately to help victims. They should combine respectful expressions of support with the utmost efficiency of time use—an important technique for mental health workers to acquire during this stage. A balance must be struck between expressing empathy and reinforcing and rewarding "the victim role" The worker must also become aware of the healthier parts of the victim's personality and mobilize them to enhance the ability to "hold on" for the time being. One useful technique is to promise (if feasible) to see the person for another short period during that same day or the next

A middle-age widow was asking for assistance from the shelter Red Cross worker incessantly firing one question after another Were they going to be relocated? Were they going to get enough help? Could she get money to fix her home? When could she return to her house to find one of her pets? The counselor was called and proceeded to identify a high level of anxiety in an angry, compulsive personality After allowing the victim to share her troubles and fears about living in such close proximity to others, the counselor obtained data about future moves and promised the next day she would inform her of the schedule They established a ten-minute meeting every morning, and the victim became an active participant in the group shelter Her anxiety diminished, and she assisted one of the nurses with scheduling chores for other victims

While the mental health workers are developing and shifting through the roles of planner, consultant, collaborator, and counselor, they must continuously be aware of their own limitations of strength, the contagiousness of the victim's fear and anger, and their own susceptibility to it They also must guard against strong, seductive, and omnipotent fantasies of rescuing the victims The experience is intensely personal

and heart wrenching. There will be emotional upheavals in dealing with disaster victims, and rescue workers who are not sure about their own coping resources and who overtax their coping abilities will have trouble during the first few days after the disaster in keeping a balanced awareness of reality.

In summary, for the first two to three days mental health workers base aid procedures upon the diagnosis of the crisis behavior shown by the victims. They will sort out priorities for intervention, such as helping with a victim's sense of orientation, reinforcing reality testing, developing support and trust, and ascertaining a victim's need for resources available through other agencies In addition to the development of support systems around victims, there is also the development of a de facto system within the victim group in the temporary shelters. The great array of resources available must be supported and organized to meet the specific needs of the victims Many of these needs are concrete, but some are psychological. The mental health worker, ascertaining this, can then mobilize appropriate psychological help by observing the way other agencies or groups approach the victim. and by consultation in order to bring appropriate resource allocation to them. This requires a special type of technique that allows mental health workers to elicit directly and personally from the victims, in their own communication style, what they perceive as immediate needs; to interpret this content; and then to collaborate with other agencies and mobilize their resources so that the victims feel assisted, less helpless, less hopeless, and less destitute. To lessen the stress is the primary objective of this phase