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PHASE TWO: THE FIRST FEW WEEKS

KNOWLEDGE

The development of a temporary infrastructure composed of human structures forming collaborative links between the mental health worker and the other agencies sets the stage for program development in the second phase of a disaster. Further objectives and activities of mental health workers are identified, and these progress as the workers join the larger systems of assistance operations that begin to grow and acquire clearer patterns and structures within days after the disaster. It is necessary to realize that emergency assistance units like the Red Cross have their own objectives, approaches, and procedures, and that their local operations are components of a much larger national system—of which they are "out-stations" in the specific disaster setting.

Procedures similar to those used in the shelters must be developed to guide mental health professionals in joint problem solving with government representatives or other disaster agency members, who represent extensions of much larger and more complex organizations. There will be variations on how administrative links with the mental health teams are formalized, and how various individuals accept the progressive introduction of mental health concepts and approaches into their own systems.

An example of the difficulty in establishing communication links in the middle of a disaster assistance intervention emerged in Massachusetts in 1978, when much of the personal data Red Cross workers got from distraught victims were not available to mental health workers because of confidentiality requirements. The Red Cross staff had not negotiated prior permission to share names and descriptions of personal episodes with mental health workers, who were interested in follow-through and subsequent visits to victims' homes to offer crisis counseling on a longer term basis than in the one-stop centers, which would close

after several weeks. Because of regional or national regulations, it was impossible to share the data.

In this situation, activities and meetings were set up with both district and regional Red Cross staff to continue developing a collaborative, professional relationship and to plan for the possibility of exchanging case information in the future. These activities further clarified the complexities of legitimization and sanction within collaborative service models. This procedure can vary, depending on whether the mental health effort is originating from a neighborhood satellite clinic, from a person who is the sole representative of mental health efforts, from workers representing mental health centers or clinics, or from official representatives of central and area departments of mental health.

For the mental health workers, an understanding of the different approaches tied to sanction, power, and the number of mental health resources (staff, time, etc.) is important in forming a workable plan. This is particularly crucial, considering that mental health systems are still in the early stages of developing roles and functions and of receiving and accepting postdisaster responsibility. Major efforts to participate, to develop procedures, and to establish relationships with disaster agencies will have to be initiated and pushed forward by the mental health governmental systems, both formally and informally, in order to achieve a status of professional usefulness in disaster assistance. Important variables for success appear to be based on the premise that official mental health personnel must be rapid in their decision making; must be efficient, with minimal wasting of other agency workers' time; and must independently accept tasks with a minimal reliance on guidance or support from the other representatives, who are themselves overwhelmed by their own tasks. Victim demands for all kinds of assistance and a general lack of familiarity with most helpers form the backdrop for those variables. Participating mental health teams must deal with those variables as they continue to offer assistance in the first few postdisaster weeks.

The following case highlights some of these issues

> Mental health professionals working with a Red Cross team in a federal center set up in a devastated town had established a method by which, when the Red Cross workers saw an individual who manifested psychological distress, they would invite the mental health professionals to participate with them in their interview The Red Cross workers called for help in the case of a 40-year-old, white, single woman who was confused, upset, and angry at the fact that she had been relocated from a high school shelter to a single house with a family. There she was renting a room but had no access to the amenities of the house, including a television. She had lost the apartment she was renting because the house was damaged and her car was flooded She was an assistant bookkeeper, but was so distressed that she had been unable to go back to

work She was asking assistance from the Red Cross in relocating to a motel and getting a loan to repair her car

Because of her psychological distress, this woman was unable to articulate her needs; thus the mental health professional was asked to assist the Red Cross worker in sorting out those needs. After getting some of the required background data, the rest of the interview was devoted mainly to the woman's ventilation of her anger and her sense of loss of a familiar setting, symbolized by her inability to use the television at her convenience and leisure in the rented room. As her rage diminished and she felt supported, she became more organized in her thinking and clearer in sorting out what she wanted It was evident that it would be almost impossible to reroute her to group housing in a motel, but that she would have to mobilize herself from the rented room to an apartment. When this task was presented, she again regressed to her infantile dependent position, saying she didn't know how to find an apartment, that she had no car and wanted someone to drive her. This again precipitated another circular pattern of asking, denying needs, begging for help, and refusing to participate in a collaborative manner to think about how one goes about getting an apartment. With further support of her anger and despair, she began to talk concretely about how, by looking through the newspaper and possibly getting a friend to drive her, she might find a suitable place The victim and the mental health worker then talked with the staff of several agencies involved in providing the appropriate resources

This case shows the complexity of mental health intervention, which must help mobilize the healthy, coping resources of traumatized victims so they can function in the large bureaucracy set up to assist hundreds of people at the same time. Disaster victims often feel frustrated by trying to deal with all the required paper work and may become annoyed with standing in long lines waiting their turn to be allocated resources that fit their specific needs The mental health professional will have to reach out actively to other agencies and support systems to develop an "action plan" that moves the victims further along in the quest of re-aligning their life settings

ROLE

The mental health worker must observe and learn how the local, state, and federal resource agents such as the Red Cross, health department, and civil defense are distributing and organizing their personnel. This understanding must be gained within new physical settings established to process help to victims. At this time the linkages established by the mental health team should continue to enhance the collaboration and systematic service coordination started during these first weeks. New group dynamics between the care-giving personnel emerge, and some agency conflict or personal difficulties become clearer. Also

needed at this time is current knowledge of any new regulations from higher authorities within the helping systems or agencies: these will have an impact on the delivery of resources at the neighborhood level. This knowledge is important for mental health workers so they can mobilize and use auxiliary resources for the benefit of victims.

In mental health disaster assistance it is not productive to use only psychological techniques or to see this procedure as one to be practiced independently of all the other events occurring in and surrounding the living space of the victim. All available assistance resources must be understood and mobilized, incorporating psychological interaction with concrete aid available from the Red Cross and other disaster relief agencies. Victims expect more than just personal interaction. They need shelter, food, money, clothes, and transportation, and all this aid must be integrated.

Major needs of life situations, as well as the victims' expectations of assistance on a concrete level, would make psychological interactions by themselves meaningless to the victim. *The knowledge of how and where to obtain concrete resources, coupled with the appropriate psychological way to help and to offer these resources to the victim as part of the total assistance effort, defines and differentiates psychological disaster assistance from traditional mental health assistance in clinics and hospitals.*

Differentiating degrees of disaster efforts within federal or local assistance networks is also necessary Whether the victim has suffered a major or minimal loss is the question raised over and over again by all workers. There seems to be a rule of thumb among experienced agency staff that people who have suffered total loss will need more of everything in the first stages of relief operations. By asking this question they begin to sort out the two categories. The following excerpts from a taped conversation between a disaster victim and a mental health worker clearly illustrates the victim's feelings of loss, confusion, and helplessness when confronted with trying to arrange for assistance within the one-stop center for help in reordering her world·

> And then one day they opened the place at the church—was it Tuesday? We went down to the place, but the way they treated us—like we didn't know how to do things Wait in line Get numbers Not even offering you a cup of coffee—that was awful. Then you were all confused You didn't know where to go first They gave you a number: you are going to go to this one, you are going to go to that one so many places to go and things to do .
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> I still did not want to come back to the house. Did you know that? You couldn't get me to come near this house for six weeks Every time I would come here, I would sit in the car but I wouldn't come in this house I just didn't want to come back here because this has been the second time we've had a storm The third time, it is going to take my life

They told me to go to the housing desk I figured they would find me temporary housing. . . . They said go to HUD—that's the housing agency I didn't know it had something to do with a big agency; as far as I knew it was just for housing. They were going to help me out and find me a house. It took me twenty years to build up my home like this and it took a half hour to destroy it I can't even cry anymore. I don't have any tears left. And they said they were going to help us with the house. Then they kept asking us, do we want to rent a house? I can't remember; I tell you the truth I can't remember.

Next thing I remember is that my little girl was very sick. I thought I could not handle anything more At this point we didn't have much strength left: it really affected us mentally I look at my poor kid and she won't even go near the house. She's scared too I'm scared. Where are we going to go? We haven't got a dime All our money is in the house

So we start coming back here What were they going to do? Everytime you looked across the floor somebody had tears on them. It was like we were all in a dream. Like my friend across sitting on her cot—her mother is 90 years old, and the poor old soul couldn t stay where she was She got very sick. . She had to go over to her son s house, and she was crying The poor woman didn't know what she was going to do Her home was all flooded

We were all in the same boat in the high school, sitting there feeling dejected, not knowing what was going to happen to us If you ask anybody else, no one knew anything. It was awful. Like you were on people's mercy. We didn't know where we were going to go and we didn't care. All you cared about was not to go back in the house with all the water. We didn't know anything. We didn't know where we were going until the last Saturday night, when we made out some forms and they first said they were going to take us to the Ramada Inn. Then they won't take us, and we have to go to another motel. Stayed there one night, went to the Howard Johnson. We didn't know that till the last minute, nobody explained anything to us. You go up and ask anything and they say, "We don't know anything about it." I guess perhaps they didn't know. You know what I mean?

The role of the mental health worker continues to be defined in terms of the various evolving expectations, activities, and behavior practiced in the changing housing arrangements and the one-stop center as the days go by. The role develops further as the workers become aware of the type of assistance they can provide in coordination with and as a supplement to other aid. The professional also interacts with the planning groups of the disaster program and supports the expectation of adding mental health components to the design and delivery of programs In the past, these plans evolved without incorporating mental health input. Now mental health objectives can emerge as part of the overall plans and assisting procedures to be organized and deployed. Other agencies begin to expect the mental health professional to be a diagnostician in problems of behavioral and emotional expressions; they are expected to treat and prescribe for individuals with problems, including diagnosis of drugs and alcohol abuse. They also view the mental health worker as

consultant, convener, and collaborator. The psychiatrist is expected to double as a physician because of his ability to diagnose and prescribe medications. Mental health professionals will increasingly be seen as members of the disaster assistance team as they are given trust and responsibility, as they participate in difficult logistic resource allocations in programs, and as they attend problem-solving meetings at all levels of agency planning.

Collaborative behavior in disaster assistance can be viewed as the mental health professional actively helping an agency worker and taking part of the responsibility for dealing with individual or group problems. This kind of behavior enables mental health professionals not only to discuss and advise, but to participate in implementing a plan for the victim. They share the responsibility of resolving problem situations, as they and the agency workers act together in ways appropriate to their respective professional training and roles Mental health professionals may visit families with the agency workers to get reports of damage and loss They may be part of a group discussion composed of two or three agency representatives and a victim. They may visit families alone and then go to the agency setting to discuss and share recommendations. In collaborative situations, both mental health and agency workers continually have direct contact with victims and families, and both contribute to the actual support program

Coordination includes those efforts that mental health professionals pursue when they endeavor to link together individuals or agencies who participate in the resource allocation and support program of a given victim. There is a need to schedule time for this to happen. Opportunities for group and decision meetings, and opportunities for discussion among individual helpers on the feasibility of sharing responsibility, have to occur if collaborative efforts are to be part of postdisaster intervention There is a danger that, due to the intensity and enormity of most recovery efforts, such efforts may become fragmented and poorly aligned to meet the multiple needs of the victim. Thus a discontinuous network of services becomes established. A mental health professional who is sensitive to systems design can prevent some of the frustrating experiences in store for victims who get lost in the bureaucratic maze of assistance efforts, a maze where all the workers are trying to do their best within logistic systems that are difficult to control

To develop and incorporate this role internally, mental health professionals must add two new important value objectives to their repertoire of interventive work skills The first value objective involves developing an ability to assist, in a collegiate-therapeutic approach, members of other agencies who are providing concrete relief resources to victims The mental health worker must first help the victims articulate their immediate needs. Because the victims are understandably distraught,

they are often unable to express their needs adequately and thus may not receive sufficient assistance from an agency worker. The following account exemplifies a double level of intervention where the Red Cross worker, along with a mental health professional, was able to observe an intervention and to follow through in a supportive manner:

> The Red Cross worker saw a woman who appeared upset and depressed and asked a mental health worker to assist her. The woman, a 35-year-old married, white citizen of a town that had been destroyed by a storm, related that her husband had been hospitalized with severe chest pains the day after the disaster. Her daughter had to go live with another neighbor because there had not been temporary housing for the whole family, and a son was living with a young friend and two older men in an apartment. The woman had finally been given an apartment to move to in a nearby town and had accepted it. When she asked her son to move in with her, he refused and became belligerent and hostile. It was evident the relationships in the family had been ambivalent even before the disaster, but because of events subsequent to the disaster family ties had broken.
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> The mental health worker supported and helped the woman ventilate and express her pain, encouraging her to cry and to share the story. The worker then called the supervisor of schools, who was in the shelter, to help the mother put together a plan of action. That plan would use the expertise of the guidance counselor of the school her son was attending to explore the problems further. The woman was able to control herself, her crying eventually diminished, her facial expression began to show more liveliness, and there were signs of hope when she accepted, in writing, the name and telephone number of the crisis counselor with whom she was going to continue working. She then turned to the Red Cross worker and was able to articulate clearly a list of things she needed for relocation.

The second value objective involves the mental health worker learning how to offer assistance rapidly, effectively, and efficiently, according to the psychological and physiological reactions experienced by the victim, and then to collaborate with the other agents to serve the victim on both a psychological and physical basis. The rapid method of intervention could be exemplified by this case:

> A 40-year-old white woman was despondent and upset while her husband was going through an episode of alcohol withdrawal symptoms. He refused to be driven to a detoxification center, and his wife was too upset to convince him or exert any influence on modifying his position. While he was being seen by the medical doctor, a mental health professional worked with her and was able to elicit a story of long suffering and difficulties in marital relations before the disaster. There had been several times when they were going to separate and then got back together, with the husband always promising that he would stop drinking. It was evident that the relationship was characterized by a masochistic bonding, the wife passively allowing the relationship to deteriorate until she couldn't stand it and then separating as the only way of exerting any influence on her husband's drinking. It was also evident that the

wife was not able to stay by herself in the shelter while the husband would be driven to the hospital, unless the mental health workers would promise to get them back together and obtain a ride for her so that she could see him the next day Finally she agreed and made a decision to follow the advice of the physician which, once put into execution, produced a dramatic change in her, diminishing her symptoms of despondency and crisis tension.

The status of the mental health professional begins to emerge as all these roles become clarified and appreciated by both the victims and the other disaster workers

SKILLS

The mental health intervention skills used during the first days after the disaster should continue to grow and proceed along set guidelines, beginning with the triage approach discussed before and adding other types of short therapeutic interventions. Objectives should be set for rapidly ascertaining personality structure, mental status, needs, and sources of trouble as a victim proceeds through life events and settles into assigned new housing Adding to the former postdisaster stresses are the many new problems that arise as groups of people are processed through group schedules and organized procedures set up to meet the logistic demands of assigning housing, resources, food vouchers, etc. What victims really need during this stage is to share actively in some of this planning and to become interrelated with the authority system in such a way that their actions become meaningful to them. Response to the loss of concrete things, accustomed life styles, and daily routines begins to emerge as victims enter the formal bureaucratic system of postdisaster assistance. This further emphasizes the difficulties the victims will face in dealing with their new lives, which continue to change almost daily Loss of familiar space produces a "schema" confusion that interferes with ritualistic, customary modes of daily behavior; this in turn disrupts planning and anticipatory actions.

Each of the mental health skills necessary for helping victims is influenced by the issue of "turf" Lack of familiarity with the setting and new patterns of relationships in work produce stress and uncertainty for the mental health worker Obviously, one's professional behavior in such unfamiliar settings must reflect and adapt to the new reality. The resulting new approaches will emphasize collaboration with other relief agencies in giving psychological assistance to victims

The following is an example After a team of mental health professionals got funding for a six-month disaster aid program, it was necessary to develop linkages to the other disaster agencies and local groups that were supporting citizens through the months of reconstructing their

homes and lives. A referral system to the project workers was formed, and meetings began regularly. This team continued to work with the ongoing disaster assistance agencies, so that all the workers involved would know what the service program would look like, what the victims were asking for, and what crisis counseling could offer. The information was shared as assistance activities were phased out in the one-stop center.

For emergency relief operations within the dispersed temporary housing, workers must continue to collaborate with Red Cross volunteers, medical personnel, and any other persons who directly participate with the victims, wherever they may be lodged within the living arrangements. When victims are in need of rapid assistance, the logistics of communication can be one of the most difficult problems, and technology is crucial.

The mental health workers' activities involve diagnosing a situation socially, emotionally, and physiologically, while determining what methods and procedures to use in helping the victims return to a functional, self-integrated level of behavior within temporary housing conditions or their own damaged abodes. Short-term procedures that should be instituted include:

- Extending and reinforcing the victims' support systems (family or agency);
- Linking the victims to recovery assistance;
- Convening resources around the victims;
- Psychotherapeutic procedures, and
- Using mild sedation or obtaining medication for posthospitalized, mentally diagnosed patients

It is important to remember that the objectives of working in temporary housing are always short term. These shelters are not the places to begin crisis or short-term therapy because changes are always imminent. It can only be a brief operation, and a crisis counseling center that is functioning in an artificial and temporary environment sets up procedures knowing that the victim has to be supported, aided to express emotions, and guided until further planning for long-term relocation begins. During this period the knowledge of where each of the victims will be living afterwards must be obtained; longer term psychological objectives can then be ascertained and provided