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PHASE THREE: THE FIRST FEW MONTHS

KNOWLEDGE: THE SOCIAL SETTING OF THE VICTIM

The high levels of anger and frustration experienced by victims during the first few months after a disaster are heightened by various psychodynamic reactions to the necessary shifts in living locations. Other factors contributing to the frustration include an increasing awareness of what has been lost, difficulty in understanding how to get fiscal and economic relief, physical fatigue, emotional stress, and continuous change in the degree of personal comfort. Generally, the shelters for large groups are closed within a short period of time. Victims are then relocated and housed in temporary settings such as trailers, wooden houses (as in Managua), hotels, and motels. Some move in with relatives or friends, while others return to damaged housing and begin to patch it up.

The shifting world of the victims in the postdisaster months presents new sets of stresses in addition to those generated by the initial crisis. The physical settings offered to the victims by agencies, relatives, or friends present different logistics and resource-development problems for mental health professionals, who must now go out and locate the dispersed victims. One advantage is that they find the victims developing new environments that provide a greater degree of personal comfort and privacy and some freedom to organize their lives according to their own desires and styles. Smaller, more private physical surroundings in which to meet and talk present different opportunities for interaction between the mental health worker and the victim. Because the situation is more centrally focused on individual family members, the techniques and skills necessary to intervene begin to approximate the traditional and known techniques of mental health professionals.

While these temporary arrangements are progressing, a parallel major mental health activity is ending with the closing of the one-stop centers.

Just as the mental health workers are developing an understanding of how this setting functions, of the objectives and activities of other agency representatives within that setting, and of the type of personnel assigned by the government, the center is closed. The specific agency documentation necessary to obtain further assistance or resources, the official regulations, the conditions and constraints for mental health workers—all continue to change. The mental health worker who may have just begun to develop an organization of services must also change and move on. A dispersed resources allocation model must be created, although the group of agencies that must remain in close contact may vary from community to community.

It is essential for the leader of the mental health team to ascertain all these new changes in time to make plans relevant to the other disaster agencies' patterns of change. He or she must understand how the new arrangements work, and develop relationships with the new, multilevel leaders of local, state, and federal agencies, as well as special private agencies within the community.

The longer reconstructive efforts and mental health planning activities should determine where continued collaboration will occur. This in turn will set the stage for linking agencies to participate in further collaborations and for determining how resources around victims will be systematically organized for mental health interventions in the following months.

The developmental and evolutionary process started during the first few hours of the disaster among the groups assisting victims enters a new stage with new problems, including those of communication. A complex of work boundaries, agency power structure conflicts, agency objectives modification, and differing levels of skills and sophistication of professionals and lay workers all emerge and add to the many difficulties in exchanging accurate information. There is a need to review verbal contracts made among workers and to remind the appropriate personnel of these agreements during these sequential shifts of location. This becomes especially necessary because of busy phone signals and distorted messages conveyed by victims, and because of all the new helpers now appearing on the scene, such as real estate appraisers, plumbers, carpenters, and so forth.

The impact and characteristics of the disaster continue to change as the intensity, disorganization, and level of confusion begin to diminish in general among the care givers and the victims. The developmental stages of adaptation to reality, crisis resolution, and the psychological environment of the victim shift in a parallel fashion. Victims begin to present individual, specific characteristics associated with different levels of adaptation that fluctuate over time. Those victims who will eventually be more vulnerable to mild or moderate psychological or physiological

decompensation will begin to show signs of psychophysiologic stress as a reconstitution of the crisis. They will begin to seek and accept aid in larger numbers in the counseling centers. As an example, the following case illustrates how one victim was helped by the concerted efforts of both the mental health worker and the more traditional dispensers of concrete aid:

A widow, 56 years old, had always lived in the beach area of a town hit by a hurricane. The woman asked for counseling assistance through some friends. She complained of weakness, had lost fifteen pounds, and found herself very nervous. She looked agitated and cried very easily. She had lost her husband five years previously and lived alone. The victim also talked constantly and spontaneously and was preoccupied by the delay in obtaining the funds promised by the federal assistance agency and by not being able to get reimbursement for the workers she wanted to hire to fix her home. She wanted her own workers instead of having them sent by the agency. The agency insisted that they would send workers, but she did not trust them, did not wait, and hired her own people. Now she owed them money and had received a bill for the work done independent of "government guidelines." She still needed a substantial amount of repair work and felt that what the workers did as a part of minimal repairs was not enough. Her stress symptoms seemed related to her dissatisfaction with the fact that official agents did not seem to respond to her letters and phone calls. She also received the wrong set of forms when she asked for a grant and a loan and had been denied fiscal assistance for the furniture she lost because the loss was not well documented.

The woman complained that she had great difficulties in daily functioning and in dealing with the agencies "because I don't have a man." It was clear that, although there were several real disaster-based problems, her dependency needs flooded and overwhelmed her. She was still mourning and dealing with only partially resolved bereavement feelings. Her defense mechanisms, weakened by the disaster stress and aftermath events, were not able to contain her conflicts within a rigid and obsessive personality structure that did not allow her to deal with rage and anger.

The victim felt that she did not know how to deal with a "masculine" world. The mental health worker was able to guide her through all the intricacies of dealing with the agencies and receiving more appropriate support. She also helped the woman get in touch with a good support system that she had not utilized: a large family nearby and many good friends. In addition, the counselor helped her remember the times when she and her husband were able to handle some difficulties, and this rekindled her awareness of personal skills.

After six or seven visits, the victim appeared much better. But shortly after that she called again, and when visited she appeared agitated and exhausted, showing signs of speech pressures and insomnia. Her problem was that "I have not paid my bills and people are expecting their money which I don't have." It appears that the check to pay some of the bills got lost and some of the payments were delayed. The worker contacted the appropriate agent,

began to straighten it out, and told the woman to call back in two days if she had not heard anything. She called a day or two later saying "I couldn't wait any longer, so I walked to the agency and was able to straighten out the communication mishap." After that she was able to get a handle on her emotions and sustain the anxiety of waiting.

One more episode occurred when there was a mix-up about an unpaid bill and the woman walked to town with her sister to talk rather angrily with an individual at the agency. Afterwards she called the worker and felt extremely guilty about "blasting him" and was afraid that she had antagonized him and would not receive her money. When she did receive the money a week later she felt better, appeared to regain control over her behavior, related comfortably with the worker, and reported that all her symptoms had disappeared. This women needed to see her "concrete" world return to a semblance of her previous one. This happened when she paid all her bills.

ROLE OF THE MENTAL HEALTH WORKER

The role of the mental health worker undergoes another major shift when the activities become divided along two levels between individuals, temporary, family-focused shelters and the centralized offices of agencies for resource distribution and mental health assistance. Role expectations, developed in the temporary shelters, about what the mental health assistance will encompass reappear at this time. The role of the mental health worker may suffer a dislocation and become vague or confusing to members of other agencies who, for the most part, have returned to their central offices. The victims suffer a similar confusion and may wonder just what the mental health workers can do for them at this stage of the reconstruction of their homes and lives.

For example, if a victim is having difficulty in obtaining money or other resources to repair a damaged house, s/he may see little or no use in "merely talking with the mental health worker" even though s/he may be suffering from insomnia, intense discomfort with aggressive feelings, or crying spells. It is again necessary for the mental health worker to develop an internal concept of a psychological intervention and to participate in efforts involving the acquisition of concrete resources. Mental health therapeutic assistance can be provided after people have been educated and have developed appropriate expectations of what mental health efforts can contribute to others, such as care givers and victims. By their efforts and the repertoire of behaviors displayed, mental health workers can reinforce the importance of the newly emerging mental health role in disaster assistance during the third stage.

The roles started in the temporary shelters can be used as a foundation to build a co-professional collaborative role. For example, the relationship with Red Cross team leaders, who are the same in the temporary housing and the one-stop centers as they were in the temporary shelters, may continue on a collaborative and sharing basis, but the relationship changes in strategy and responsibility. As the agencies come to know each other better, arrangements can be made and modified on how the mental health worker is to function and which mental health techniques are useful to other professionals. Improvements can be made accordingly, and changes in interactive procedures can be adopted on a trial basis. This area of collaboration is so new that few guidelines are available.

The same type of negotiations will have to be developed with the leader, generally a federal administrator, of the central FEMA office. Generally, this administrator will have had little experience in crisis counseling or dealing with mental health work focused on a certain population. It is helpful to have links with this administrator to reinforce the position that all mental health activies are a part of the federal assistance offered to a population after a disaster.

A staff intervention approach to assist the victim follows the case manager model for dealing with a stressed individual's life situation. The objective is to bring together resources that will support and assist the victim's ability to cope and find solutions to problems. Within this managing role, the mental health worker must incorporate the roles of planner, linker, and convener of resources while participating with the health and postdisaster intervention operations which, by this time, have changed location, objectives, amounts of resources available, and personnel.

State and federal resources mobilized to help reconstruct homes and neighborhoods continue to be crucial in attending to the mental health problems presented by victims. Important linkages must be established between mental health leaders and planners, managers, and members at the higher administrative levels of public and private agencies. Many problem-solving approaches depend on the amounts of concrete resources and assistance available to the victims.

Major communication problems, misrepresentations, and delays between resources offered and services delivered to homeless victims are an additional and important part of recurring grief in the postdisaster crisis. Active and systematic collaboration between all levels of official representatives and the mental health workers promotes an effective and efficient use of support systems for the victims. The continuous need for documentation and communication between different agency members reinforces the role of the mental health people as intervenors

and assisting members of the overall disaster aid team. Difficulties often arise in collaboration, coordination, and interpretation of documentation language; these problems are symbolic stressors to the victims and further interfere with crisis resolution. The difficulties must be analyzed and new procedures developed to find solutions. This can be facilitated by researching issues of confidentiality and regulations mandating exchange of information. Discussions and acceptance of certain areas of collaborative exchange will help the mental health worker develop community support systems to aid victims. These exchanges are frequently limited by social and/or legal constraints that impede cooperative endeavors.

SKILLS TO PRACTICE

The necessary repertoire of mental health intervention techniques increases as different aims, objectives, and psychological levels of intervention are identified. Because the tempo of disaster service activity changes eventually, usually after several weeks, new planning can take place. Reflecting on and choosing options for action while having more time for interventions promotes the use of known therapy modalities. Changes in the physical and social environment, the emotional state of the victims, and the organization of disaster assistance agency structures from the first hours in the shelters will influence the choice of different approaches in mental health intervention. The stability of the victims' living arrangements within various housing settings continues to shift, and the pace of their requests for assistance slows down and becomes irregular. Each family appears to have different specific needs and different presenting problems. These particular fluctuating changes manifest themselves as variations of crisis phenomenology behavior. The mental health workers at this stage work with individual families, tailoring their services according to the type and amount of other assistance already given and according to the level of psychological resources available to the mental health team.

The following example highlights these issues. This case involves a family of four in which the husband contacted a crisis counselor:

> The husband was a 59-year-old unemployed auto mechanic. He lived with his 55-year-old wife and two daughters in their late teens. During the storm, their home was flooded and they were evacuated. Initially they were placed in a school designated as a disaster shelter. This was followed by a move to a motel for six weeks, after which they were able to move in with relatives until their house could be repaired.
>
> Initial contact was established with the crisis counselor by visiting the outreach office. The husband was the key member of the family who initiated

and followed through on contacts and who manifested symptoms of tension, suspiciousness, anger, and occasional loss of impulse control. The other members of the family complained of fatigue, depression, sleep problems, and trouble in daily task activities. These behavior patterns seemed to be related to their sense of frustration and impatience about the repair of their home.

While assisting the family members in checking on all their forms, the worker began to inquire about some of the experiences the family had undergone since the storm and asked questions concerning the evacuation and their living situation. As the four individuals tried to remember and relate what had happened, they became more visibly agitated and tense. The father had to leave the room for a short time to calm himself. The wife told the worker that her husband had a history of hypertension and seemed to lose control easily and react with anger, becoming immobilized by his emotional and physical state. She believed that the problems brought about by the damaged house, their evacuation, and the way they had to live were aggravating his health. He lost his "cool" when he accompanied an inspector to check the damaged house prior to beginning the work necessary to make the house safe once more.

The worker was able to assess that the husband needed crisis counseling immediately. He also offered support to the other family members but concentrated in his meetings on the issues presented by the husband. He proceeded to offer help with some of the bureaucratic steps in obtaining the right resources and also embarked on a short-term crisis resolution therapy with the father. After five weeks this involvement began to taper off as the psychological symptoms of crisis diminished. The client acknowledged feeling much better, and meetings were scheduled for once a month.

One day the client appeared at the office with a problem concerning his application for a repair loan. As technical assistance was again offered, it was evident that this event had rekindled the angry reaction of the victim. By the intensity of the emotional reaction the client was having toward the situation confronting him, the worker picked up the cues learned from the previous counseling and rapidly set up a therapeutic alliance to solve this problem. However, the therapeutic attachment sometimes conflicted with the client's need to make decisions and act independently. This need was met by offering options with specific objectives and expected outcomes within a certain time frame. This approach was seen as useful by the victim, who recovered through this process a sense of orientation and capability.

Once again, as the perceived crisis proportion of the new event abated, the worker became less active with the family. Periodic checks by the worker demonstrated that things were going fairly well, and the client was taking some initiative for keeping the family affairs in relative balance. They finally moved into their house and on the last check appeared to be back to their usual functioning.

In this last phase, with increased mobilization, the potential for educating larger numbers of volunteers and mental health professionals to continue helping emerges as a possibility. The small mental health

team that generally starts in a shelter gets more members by the active involvement of other mental health professionals who become interested and offer time in the assistance operations. The possibility of practicing short-term therapy, helping couples and families, and starting group therapy becomes more feasible. At the same time, crisis intervention, counseling, and referrals to backup services within mental health clinics or hospitals continue. The skills practiced to form the linkages and collaborations with other agencies begin to recede as a primary activity. Although the need to manage resources and to collaborate with other agencies still exists, the psychodynamic characteristics of the cases that remain in the community appear to be more complex and more extensive. At this time, psychopathology symptoms will be displayed, rather than the short-term dysfunction and overwhelming "postdisaster syndrome" found during the first days.

The fact that families are relocated farther out into various distant communities, while agency members return to their own central, separate offices in different parts of a city, creates both physical and psychological distance, as well as a time barrier. Unless good linkages have been established from the beginning, this adds to the psychological and concrete problems associated with assisting victims. Busy phone lines continue to be a problem, and mental health workers find themselves not only assisting the victims in psychologically processing postdisaster symptoms, but also helping them cope with the added frustration caused by delays or mix-ups in getting concrete help.

Mental health workers must also intervene if victims continue to be unable, because of emotional problems, to communicate their recurring housing or job needs to other agencies. Bureaucratic problems of communication and decision making, problems with disaster agency workers who are often unavailable to help, or problems with misplaced or delayed authorization documents all serve to reinforce and aggravate postdisaster emotional instability and add stress, which has just begun to be resolved by the therapeutic intervention of the crisis counselor. The phenomenon of victims backing over and over again into despair, frustration, and depression, after experiencing a hopeful sense of resolution, creates a continuous area of psychological work to which the mental health workers must become sensitive. A worker must develop skills to differentiate among the phenomenological levels of naturally occurring mourning, crisis, adaptation, and reality behavior caused by impatience and frustration.

Although each stage of assistance has its difficulties, this last stage is particularly hard as victims who have been housed in temporary shelters return to their own disrupted or fragmented world and family. The victims are now faced with the uphill battle of organizing their lives, jobs, or disrupted pasts. They are trying to make these adjustments

while still operating under extreme emotional tension and fatigue, and while still caught up in phases of mourning. Individuals who are unable to function at levels of accustomed behavior continue to be identified by care givers. Conversely, some persons are able to be task oriented in their daily lives. They have developed adequate coping skills and have resigned themselves to dealing with the painful experience of the disaster and the traumatic experience of many moves. However, the task of readapting is further complicated if there has been the loss of loved ones or of important personal real estate property such as shops, clinics, or offices.

Emotional reactions are presented at different levels of severity when dealing with the last phases of mourning processes and their sequels. Recognizing the appropriate phenomenology, in order to identify and ascertain the phase of mourning, and knowing how much assistance to give through an "ego-auxiliary" approach are two of the skills necessary to understand the level of resolution victims have reached at this time.

Table 2 charts the areas of concern through the phases of disaster, in constructing a plan to meet the mental health needs of disaster victims. It depicts the interphasing of key issues facing mental health workers as they try to gather professional resources, deploy them, and actively apply their skills. It points out how specific activities are phase focused within a developmental unfolding of psychological needs, rescue and relief operations, and crisis resolution with its adaptation outcome. The figure presents the beginning and end points of active assistance. It shows that all activities must be interrelated, and it sets up the proposition that a certain percentage of crisis outcomes will last a longer time than previously expected

CONCLUSION

This handbook presents the basic and applied knowledge of the effects of a disaster on human behavior. It is an attempt by the authors to assemble, organize, and present the type of knowledge known to the field and to document fruitful intervention techniques for mental health professionals who will be called upon to assist disaster victims

This is still a pioneering area of mental health intervention, but already it offers glimpses of how basic research in the fields of biology, brain chemistry, psychosomatic medicine, behavior models, and crisis intervention could enhance and offer future methodology in intervention.

The handbook analyzes the role of mental health workers and also identifies a series of new roles, which still need further clarification and definition Mental health professionals will have to participate at the planning level with key government leaders in both federal and state

Table 2. Postdisaster Planning and Intervention for Mental Health Workers

	Phase I	*Phase II*	*Phase III*
Planning Operations	Activate decision to assist Enter field of action Get data on disaster assistance Develop linking procedures	Identify leadership role Develop direction and management of operations Reinforce further links with new disaster assistance groups Select and acquire physical area for mental health operations	Continue to meet systematically and participate continually with ongoing and long-term planning
Consultation and Education	Develop collaborative and participatory relations with disaster assistance groups Develop joint procedures with Red Cross staff Offer technical assistance to medical professionals Participate with the educational media through TV, newspapers, radio, and community activities	Develop and negotiate consultation relations with disaster assistance agencies Participate and collaborate with agency procedures (HUD, FEMA, etc.) Link disparate and fragmented human services	
Psychological Intervention Objectives: *Process* *Techniques* *Function* *Roles* *Level of responsibility taken*	Develop procedures (intake, documentation, confidentiality, referral system, closure of cases, access to documentation, storing of documentation, etc.) "Triage" First-aid assistance Counseling and support Guidance and advice	Outreach: Crisis counseling Comprehensive assistance Advocacy: Referral to clinic or hospital Short-term therapy Clarification and education Assistance to obtain resources	Close cases Monitor acceptance of referral Check closed cases that had special problems Offer linking to further services if individual wants or needs them Follow-through

agencies. They can educate and consult in the early emergency development of resources, when rapid decision making can offer the best possibility of intervention based on knowledge of group psychology and psychophysiologic reactions. This will necessitate increased knowledge in planning and needs assessment techniques. It is a new field for mental health professionals, who will collaborate with civil defense, Red Cross, emergency preparedness, and similar agencies. Other skills and approaches are also new in the area of consultation, education, and working with the public media. New use of technology in rapid communication and transportation, which is being incorporated into disaster assistance planning, will have to be incorporated into mental health intervention techniques as well.

Finally, this new methodology for psychological assistance to victims of disasters needs to be researched to evaluate the most effective and cost-efficient way of applying it. Not enough resources will be available in the immediate future to assist the large numbers of traumatized individuals suffering from the effects of both man-made and natural disasters. Thus we need to learn methods of intervention that both control and prevent devastating psychological after-effects from the loss and trauma that accidentally shatter the lives of unlucky individuals.

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