Post-disaster intervention programs 4

OVERVIEW OF CHAPTER

Description: Introduces post-disaster intervention programs and applied and operational guidelines.

Purpose: To review the purpose, scope, and application of post-disaster assistance guidelines.

Content:

- Similarities and differences vis-à-vis other types of mental health intervention programs.
- Special characteristics of post-disaster assistance to survivors:
  - — Consultation and education
  - — Outreach
  - — Crisis counseling

Learning Objectives:

- To acquire knowledge of the basic organizational structures needed to set up a post-disaster mental health intervention program.
- To identify existing outreach methodologies available to disaster mental health workers.

ESTABLISHING A POST-DISASTER INTERVENTION PROGRAM

Planning for mental health service in a post-disaster environment requires knowledge, patience, and, above all, flexibility. Mental health workers will encounter situations that are unique to their profession. They will also have to respond to the networks and authorities that are already established in the area.

It is the responsibility of administrators to provide post-disaster mental health services within the web of government, community, and volunteer agencies that are helping survivors cope after the disaster. Administrators are also responsible for providing methods of information-gathering, communication channels, and a system to establish accountability for all workers.

Delivery of assistance to disaster survivors requires clarity in organizing help, dividing labor, and delegating authority. In the implementation phase of planning a disaster mental health services program, the following issues arise: funding for the project; selection, orientation, and training of staff; and design of administrative and information structures. The mental health planner or project director, with the assistance of a task force, deals with each of these issues as the project progresses. Clear boundaries and responsibilities should be assigned to post-disaster workers—i.e., what they will do themselves and what services should be referred to other agencies.

Programs can either be decentralized or centralized. Decentralized programs often have centers located in affected neighborhoods, with a team assigned the responsibility of servicing that area. In these cases, a team member serves as administrator and supervisor of team activities and also reports to the project's director. Projects with a more centralized structure may have only one facility, but may assign the responsibility for doing outreach work and crisis counseling to contracted teams within a particular geographical area.

Each type of program requires a system for keeping records and collecting information. The program must have procedures to keep accurate records of funds allocated for space, equipment, materials, supplies, and payment of staff. Confidential records are also required to note workers' observations, actions, and progress in helping individuals and families.

As the project progresses, there is a need to evaluate individual and collective performance and to report to authorities on program activities. By reviewing statistical forms, authorities will have an understanding of each worker's activities and will have an overview of the survivors and their problems. The data may be used to make reassignments or to alter program strategies. In addition, this information may be compiled on a regular basis to provide interim reports for the task force, community leaders, and funding agency. Different forms of administrative organization may be instituted in different regions of the world.

CONSULTATION AND EDUCATION

Disaster consultation and education is one of the newest, most challenging areas of activity for mental health workers. New strategies and tactics are being developed, novel approaches are emerging, and innovative methods are being tested. In post-disaster situations, the objective of disaster consultation is to increase the capacity of the emergency worker to assist survivors and work with multiple post-disaster agencies.

The primary objective of this modality is to educate the staff of disaster emergency assistance agencies so that they can incorporate knowledge and understanding of mental health issues into the task of assisting survivors. Mental health consultants must have background knowledge of both psychosocial theories and disaster assistance procedures to accomplish this objective.

Education is used by workers who are in close contact with the public media or have an opportunity to educate groups in their community. Consultation is used by experienced workers who assist the public and private emergency relief agencies helping the survivors. Crisis counseling training, which is operationally driven, necessitates practical role-playing and continuing supervision once the workers begin to interact with the survivors. Intervention approaches need to be adapted to the cultural characteristics of survivors and the time lapse post-impact.

Some of the typical problems in post-disaster consultation with emergency relief agencies are:

- Difficulty obtaining material and human resources;
- Bureaucratic responsibilities, regulations, methodology of multiple agencies;
- Lack of a recognized plan for interagency coordination;
- Different points of view and objectives;
- Power struggles and "turf wars";
- Interdisciplinary communication.

ADMINISTRATIVE ORGANIZATION

After a disaster, when large numbers of individuals have been rescued and grouped in a safe physical setting, a spontaneous, transitional, shifting community evolves. A network of disaster assistance agencies develops, composed of lay, religious, volunteer, and official government rescue personnel. The main goal of this network is to provide physical comfort, treat bodily injuries, and ultimately proceed to help reorganize the lives of affected citizens.

The following factors affect the success of a mental health consultant working within this network of assistance workers:

- The degree to which the consultant's role is sanctioned by the emergency network linking the assistance agencies;

- The knowledge, attitudes, and skills of the consultant;
- The quality and quantity of information available to the consultant.

■ CONCEPTUAL MODEL AND THEORY

With the assistance of a conceptual model to support and guide the intervention, a mental health consultant can better help in integrating psychological theories and post-disaster relief operations. The lack of such a conceptual model is one of the factors that most often leads to failure in consultation programs.

The post-disaster mental health specialist must conceptualize his/her own behavior as the mobilization of a set of forces that will, in turn, be affected by the system itself. In this case, the system is composed of all the members of the disaster assistance agencies. Acting as a collaborator, the consultant can initiate a dynamic interaction with the disaster agency staff. This dynamic interaction is an essential part of the ongoing planning process that results in the strategies for approaching disaster assistance work.

Although the mental health consultant and the disaster agency emergency staff come from different professional backgrounds, they must join their efforts and combine expertise, skills, and energy toward a common goal. Certain areas of theoretical knowledge from these professional backgrounds have proven useful in other intervention activities:

- Concepts of organization and administration for post-disaster relief programs;
- Crisis intervention and assistance;
- Principles and practices of consultation;
- Principles and practices of education.

From these broad areas of social psychology and disaster assistance operations, a philosophical framework can be developed for intervention, consultation, and education in disaster programs.

■ GUIDELINES

The following guidelines are basic to the development of this model. Awareness of these guidelines will help the mental health consultant organize intervention strategies that address the physical, biological, and/or psychosocial needs of the survivors:

- All the consultant's activities must be directed toward developing practical procedures that will be useful to the agency member who will participate as the recipient, as well as to the survivor who will be the focus of the services.
- The consultant must be aware of the traditional and cultural practices and the accepted modes of behavior in the disaster assistance setting; resulting approaches should reflect this understanding.
- All consultation and education must be directed at specific, immediate problems and/or behavior difficulties that concern the emergency relief worker. However,

potential opportunities to participate in long-range and broader planning for the agency should not be overlooked.

- The development of professional relationships should be continuously pursued at every level of organization to identify individuals who can help solve problems. However, the consultant must remain sensitive to confidentiality and the detrimental effects that a breach of trust might have on the mental health role. Sharing of data or a casual mention of something learned from the emergency relief worker has been one of the most common sources of failure for mental health activities.
- Data should be obtained, organized, and analyzed during all activities, and a continuous feedback system should be developed to share with workers and help keep the consultant focused on the objectives. A consultant can easily lose sight of the specific objectives verbally agreed upon during interagency planning meetings.
- The mental health consultant must also be aware of the resources that are available to the emergency relief workers, both individually and as a group. The consultant can then modify patterns of disaster assistance to select and support appropriate mental health approaches for crisis resolution and disaster assistance problem-solving.
- The principle of consulting and educating is based on needs identified by the emergency workers. As the scene changes, consultant and worker must reassess the worker's disaster assistance services and reconsider objectives. The emergency worker's task will change as the survivors' needs change. The mental health consultant who has current information about how the environment is changing will be best equipped to help workers evaluate their services.
- Evaluation and an organized system of data exchange will supply more than just information; it will provide the mental health consultant a broader view of the assistance effort and greater flexibility for intervention, whether through consultation techniques or educational approaches.
- The consultant must always recognize that the assistance framework exists within the context of a changing social community. There will always be gaps in even the most current reports. Interventions must focus on operations that will mobilize both the system and the individuals interacting within the disaster assistance activities. The consultant can choose either a consultation method or suggest an educational intervention.

■ INTERVENTION PLANNING

A mental health consultant in the temporary shelter or other disaster unit is not only an independent professional who responds to the needs of survivors. The consultant also assists numerous emergency relief agency staff in identifying problems and determining the best assistance procedures for traumatized individuals. To accomplish this, the consultant must articulate a plan of intervention that is harmonious with all the other efforts of the disaster assistance agencies.

Key components of an intervention plan include:

Knowledge: Conceptual knowledge of disasters, disaster behavior, and intervention approaches that is obtained prior to a catastrophe.

Information: Determination of the degree of loss suffered by the community, based on media sources, on-site surveys, and visits to places where survivors are sheltered. It is also essential to collect information that will offer a cultural appreciation of the disaster's effects.

Assessment: An assessment of how the emergency assistance agencies have organized themselves into a network and prioritized survivor needs to enable rapid identification of the cultural influences of the community and the psychological influences affecting both survivors and caregivers.

■ PROBLEMS THAT MAY ARISE DURING CONSULTATION

Problems can and do arise for mental health consultants involved in disaster program intervention. The following are examples:

Variance in Professional Training

There is often a variance in value systems, backgrounds, and training between professionals involved in post-disaster activities. The disaster agency staff's lack of familiarity with mental health methodology creates a unique problem and one which compounds the overall unfamiliarity with disaster assistance procedures. This schism between the agency staff and the mental health consultant may result in serious communication barriers.

Successful collaboration and integration of different objectives and techniques into disaster assistance will depend on how well the consultant and the relief workers can focus on the simultaneous goals of contributing to survivors' coping abilities and helping them reconstruct and reorganize their lives. This can be achieved by increasing the mental health knowledge and skills of relief workers.

Degree of Responsibility for Problem-solving

The mental health consultant must ascertain the degree of problem-solving responsibility that appears to be appropriate, based on the task at hand and the amount of professional resources and skills available. The consultant can either choose to offer expertise upon request but not become involved on an ongoing basis, or the consultant can decide to participate more actively, assuming long-range collaboration functions during all the phases of disaster assistance and interacting on many levels.

Coordination of Interventions

Procedural logistics and schedule misalignment can further complicate the coordination of interventions. In a disaster situation, where time is a critical factor,

the time that a relief worker spends with a mental health consultant competes with the intense demands from survivors for the worker's time and services. This competition produces a tension of its own, although the difficulties decrease with time as both workers find methods of saving time and energy.

■ TYPES OF CONSULTATION

Two types of consultation are most often seen in post-disaster situations:

Case Consultation (survivor-centered)

The primary task of case consultation is to develop a plan that will help a specific survivor who is having difficulties of an unusual nature. In some cases, the mental health consultant will personally investigate the survivor's psychological and social needs. The emergency agency workers will collaborate further on the case through subsequent discussions with the mental health consultant.

Survivor-centered case consultation is the type of consultation most often needed in a disaster program. The consultant advises the agency workers about the nature of the difficulties and suggests what can be done to alleviate them.

Usually, the emergency worker will present the case material to the consultant. Sometimes, the mental health professional will meet with the survivor, reach a diagnostic impression, and offer a recommendation to the emergency program worker. The program worker translates appropriate aspects of the recommendation into a plan of action that will be feasible in the disaster assistance setting.

The following is an example of a survivor-centered case consultation:

> *A Red Cross nurse working in the shelter asked for assistance to deal with a woman who was unable to make decisions. The woman had been offered several options for relocation, but kept changing her mind and could not decide whether to leave the shelter. This woman had been in a previous disaster and suffered some property losses. Reflecting on the past interfered with her decisions to choose options. The mental health consultant instructed the nurse about the effect of anxiety and past memories on the woman's emotions. Subsequently, the nurse decided that she would first need to spend some time helping the woman sort out her fears so the woman could understand that this relocation would not be a repetition of her previous experience. After she calmed the woman about this fear, the nurse was able to proceed with the development of housing plans.*

■ ADMINISTRATIVE-CENTERED CONSULTATION

A second type of consultation focuses on the design and/or modification of relocation programs and administrative procedures for the purpose of prevention, early diagnosis and treatment, and rehabilitation of disaster-related psychological disturbance.

The kinds of problems that the consultant will be called on to address for this type of consultation include:

- program planning;
- administrative organization;
- methods of multi-service delivery;
- policy-making;
- recruitment, training, and use of disaster relief staff; and
- establishment of linkages with other services.

The recipient of the administrative-centered consultation may be an emergency agency administrator, a group of program directors from the Red Cross, or a committee such as a task force of government officials. The mental health consultant's focus would be the program in question.

The following is an example of a administrative-centered case consultation:

> *After a devastating ocean storm that damaged numerous homes, survivors were housed in a large motel, where families of three or four members were assigned to one room. Fixed amounts of money were approved for meals in the motel dining room. One of the most severe problems was the lack of good communication channels between the disaster assistance agencies, the staff of the motel, and the families. The manifestation of the difficulties appeared in the behavior of the adolescents who had no means of getting around. Sporadic acts of vandalism, theft, and raucous behavior aggravated the tense relations between the motel administrators and the survivor population. Some women began to exhibit signs and symptoms of depression, insomnia, irritability, and hostility. They also made unrealistic demands of the service staff. Mental health consultants were dispatched to the motel as part of a team. After spending several days meeting with every group and obtaining the information necessary to analyze and understand the complexities of the problem, it became evident that the agency staff lacked the knowledge to understand and handle the daily problems of the group. A mental health consultant met with the agency's administrator and discussed the human dimension of the problem. To address the "burn-out" syndrome of the workers, the administration changed procedures and began to rotate staff so that there could be a "rest and relaxation" component to the staff operations schedule. The consultant contributed both knowledge and help with attitudes to remedy this identified need.*

EDUCATION AND COLLABORATION

The mental health consultant assists other agency staff in reorganizing and reconstructing the lives of disaster survivors, as well as promoting the incorporation of mental health components in communities devastated by disaster. These components should be designed to ensure the early detection and prompt treatment of survivors who suffer psychological consequences of the calamity.

Mental health professionals will be best equipped for their role as consultants and will increase their potential as a crucial link in the disaster assistance network if the support model is based on integrated application of disaster assistance principles and theories of psychosocial behavior.

The consultant has an opportunity to carry out educational activities every time there is a request for assistance in disaster relief operations. All collaborative activities in post-disaster relief operations have an educational aspect that the consultant can address to help relief workers with the problems they are encountering, and relief workers can benefit from this assistance, which enhances their personal repertoire of skills and reduces areas of misunderstanding.

It is this educational aspect of collaboration that makes it an important survivor resettlement method. The goal is to spread the consultant's mental health knowledge to the many agencies that will continue working with survivors' resettlement across the changing developmental stages of post-disaster behavior.

To be effective in helping workers deal with the problems of a survivor, the mental health consultant needs to define, set limits, and design specific boundaries with the maximum educational carryover, given the realities of the crisis climate, time constraints, shift of personnel, and rapid changes of policy in disaster assistance programs. A direct, precise, well-defined educational component will therefore be more practical and effective than the slower, methodical, and repetitive conditions needed for the process of changing the attitudes, stereotypes, and prejudices of relief workers. The targets for such educational activities are government disaster relief agencies and their staffs, as well as the community at large and civic, social, and political groups in the area of human service.

■ EDUCATION FOR THE RELIEF WORKER

To implement educational activities, mental health consultants must have skills in community organization, verbal and written communications, crisis intervention, and supervision. Perhaps the most needed skill is that of teacher—i.e., the ability to impart to others the knowledge, methods, or confidence for understanding disaster behavior and the needs of survivors.

To accomplish the training objectives, mental health consultants must design short- and long-term programs for professionals and nonprofessionals. In the immediate aftermath of a catastrophe, both mental health and emergency relief workers require quick, flexible orientation immediately following the disaster. Later on, a planned effort to provide continued training and support for the emergency program's professional and nonprofessional staff must be devised. Training content will vary depending on the experience, the specific needs, and educational background of the relief and mental health workers.

The primary training need is the acquisition of knowledge and understanding of how survivors react after a disaster. By reviewing the time phases of a disaster (pre-

impact, impact and post-impact), the types of physical and emotional problems survivors may be expected to suffer at each phase can be examined. Training in the concepts of stress, loss, and mourning; social and emotional support; and coping and adaptation are crucial in overcoming disaster-related problems.

PUBLIC EDUCATION

Public education must begin immediately after the disaster strikes and should continue until the project terminates. The emphasis of the effort will vary over time. The purpose of a public education campaign associated with a disaster assistance program is to:

- gain widespread support for the program;
- reconstruct the community;
- anticipate changes in emotions and behavior as normal reactions to the consequences of the disaster;
- publicize services for survivors; and
- report to the community on activities and progress.

Community approval and support are necessary for the effective planning and implementation of programs for disaster survivors. Also, when a program begins, the dissemination of information about the program's activities and location of services is essential. This type of publicity may take several forms. It may educate the public and the survivors about the fact that physical and emotional discomfort following a calamity is a normal reaction to stress. If there is a need for help, survivors may seek assistance from the programs by calling and asking for help.

POST-DISASTER OUTREACH AND CRISIS COUNSELING

Crisis counseling	An intervention technique that restores survivors' capacity to cope and handle stressful situations and provides assistance for reordering and reorganizing their world; education and interpretation of the overwhelming feelings produced by post-disaster stresses are available to help restore a sense of capability and hopefulness.

OUTREACH OBJECTIVES

- Providing education and information about resources available to help survivors reorganize their lives.
- Helping with identification of ambivalent feelings, acknowledging needs, asking for help, and accepting support.

- Helping with prioritizing needs, obtaining resources, and increasing individual capacity to cope with specific priorities identified.
- Providing opportunities to become engaged and affiliated.
- Providing a structured method of perceiving specific problems, self-observations, behavior, and powerful emotions through help in understanding, defining, and ordering events in the larger world.

Outreach to individuals may initiate the linkage to mental health intervention. In such situations, outreach can be followed by crisis counseling.

The goal of post-disaster psychological intervention is to alleviate a survivor's emotional distress and/or cognitive disorganization and to suggest corrective action and offer appropriate information. The crisis worker can help survivors interpret their overwhelming emotions, understand the reactive nature of feelings, and recover a sense of capability and hopefulness.

Specific elements of post-disaster crisis counseling and outreach are:

- Reorientation and adaptation to a social transition period;
- Appraisal of the support network;
- Determination of thoughts, emotions, levels of anxiety, depressive reactions, fear, anger.

During the first phase of the post-disaster experience, the primary effort is the outreach process. This "first aid" technique helps survivors get reoriented and adapted to their new transitory reality. Outreach is the crucial first step in beginning to resolve a survivor's sense of being overwhelmed by the events of the disaster.

While disaster survivors need help with reality testing to determine what has happened, what is happening, and what will happen in the future, care should be taken not to interfere with the psychological defense mechanisms used by the survivor. These defense mechanisms, which give the survivor a personal sense of remaining in control, include denial of the extent of an injury, loss, or trauma, and a sense of vagueness concerning the catastrophic event.

Further, although expressions of empathy are helpful, care must be exercised not to reinforce or reward the victim role. The healthier parts of the survivor's personality must be encouraged and mobilized to enhance the ability to "hold on" for the present.

An appraisal of the survivor's emotional reactions needs to be done to determine what assistance is appropriate in the situation and appraise levels of anxiety, depression, fear, and anger. All support system resources should be mobilized. The responsibilities of daily living can be apportioned to family members.

Crisis workers themselves should seek to strike a balance between rest and work. They should also build networks to enhance their own support systems in

order to prevent "burn out." Crisis personnel should always work to facilitate the expression and understanding of painful emotions that are part of all phases of recovery.

The setting where survivors are physically located is an important variable that will affect the choice of psychological interventions. The turnover of large numbers of survivors in the shelter and the small number of trained crisis personnel make it important for crisis workers to realize the impact of their interaction. This transitory situation must, therefore, mold the type of intervention that is used.

■ GOALS AND OBJECTIVES OF CRISIS COUNSELING

To foster mastery of coping behavior, the mental health worker should promote action directed toward the "unknown" generated by change in the survivor's environment. Appropriate action includes helping survivors follow temporary shelter procedures, await news of post-disaster events, or deal with the lack of information on the whereabouts of other family members.

In addition, the crisis worker can provide guidance concerning the survivor's immediate focus of attention. Communication of reasons for hope is crucial, as is conveying an attitude of concern and confidence about the probability of an eventual successful outcome.

Specific objectives of crisis intervention include the following:

- To identify problems generated by the disaster and the difficulties posed by the need for change.

  Example:

  Helping survivors adjust to the possibility that they may not be able to return home and may have to stay in an emergency shelter for an extended period.

- To list alternatives and strategies for action.

  Example:

  Explaining to survivors that a list of options for obtaining resources and handling living situations will be provided in the next few days.

- To build a decision-making model and develop steps for implementing it.

  Example:

  Choosing an individual to assist the survivors on a permanent basis or introducing a team of workers that is available to them.

- To operationalize alternatives.

  Example:

  Explaining and "walking through" the many operations of the shelter with the survivors.

- To take steps toward dealing with survivors' problems and get feedback on outcome and results.

  Example:

  Talking to survivors about the problems to be addressed when they move out of the shelter and asking for reactions.

■ INTERVENTION GUIDELINES

Assessing the mental health needs of survivors in a post-disaster setting can be a delicate matter. The environment is murky, time is short, and the standard methods are not available. In this confusing setting, crisis workers need to determine the mental/emotional condition of survivors and decide how that condition will affect their abilities to deal with solving immediate problems and deciding whether to refer them for professional help.

To provide support for necessary decision-making, the worker should follow guidelines to determine the appropriate type and level of activity that the survivors can perform. Furthermore, interventions must be planned in terms of immediacy versus delay and should take into account the emotional state of survivors and the staffing conditions in the emergency setting.

To measure the level of function, the crisis worker must investigate the following risk factors to ascertain the indications of emotional reactions:

- Psychosocial maturity or immaturity of the survivor's personality;
- Role of stress in social expectations of performance, as judged by survivors and others living with them, within or outside the temporary setting;
- Continued environmental stress, both in social and physical conditions, including interventions such as surgery, relocation, lack of privacy;
- Accidental crisis events occurring in the survivor's life, either before or after the disaster, that affect them or their loved ones.

■ PRINCIPLES OF CRISIS INTERVENTION

There is a need to prepare the survivor for post-disaster crisis counseling and intervention. The mental health worker plans for crisis intervention by obtaining the

information needed to plan the intervention, establishing competence and credibility, describing the psychosocial intervention plan, and eliciting the survivor's cooperation with the plan.

The counselor must discern the survivor's attitudes and expectations about the intervention and then move forward to a collaborative decision. From this awareness, the crisis worker arrives at a tentative formulation of the problem and/or plan of action.

Crisis workers should be familiar with a wide variety of approaches and should select the combination that best fits the characteristics of the problem. The objectives are to alleviate emotional distress and/or cognitive disorganization and to offer the survivor information and suggestions for corrective action.

Survivors are potentially capable of handling their own problems after being helped to recognize barriers to solutions or redirect their behavior toward exploring new solutions. Transposed dependence may initially occur so that survivors can "borrow" confidence from the crisis workers. Advice should generally be given with caution, although survivors should be informed about relevant matters on which they are uninformed or misinformed in order to enhance the problem-solving.

Communication in the initial interview may be difficult due to distorted ways of communicating stemming from high anxiety and cognitive disorganization. Often survivors are also defensive and guarded. Success in communicating freely with survivors depends on a general ability to win their trust and confidence.

Survivors need help in resolving the present crisis produced by the disaster. Discussion of the "here and now" establishes a relationship, facilitates feedback and options in solving problems, and helps survivors analyze realistic ways of moving toward the solution of problems.

Some exploration of past methods of problem-solving will aid the counselor in understanding how survivors handle the present situation. Meaning and symbolism, including psychophysiological responses to present events, are largely determined by past experiences. Therefore, a partial review of the past may help understand how survivors perceive the problems they face and what they consider acceptable options in terms of their own value systems. Interpretation that enables survivors to see the linkages between feelings or behaviors may be therapeutic, as it will allow survivors to make sense of feelings that are not clear, and it can enhance a sense of mastery and control by putting feelings in perspective.

Reinforcing positive activities and reminding survivors of their skills and strengths in handling problems is critical. It is important to focus on personal skills that are working well rather than focusing only on weaknesses or pathological aspects of the survivor's problem-solving.

The purpose of intervention is to bring about a change in the survivor's problem-solving capabilities, which have been weakened by the disaster

conditions. Specifically, survivors experience the following psychological states:

- Feelings of diminished self-confidence and inability to remember past successes in overcoming traumatic episodes. Survivors are overwhelmed by the external circumstances in the post-disaster environment and by their own confusing feelings and thoughts in reaction to a new, unfamiliar, and uncomfortable world.
- Belief that failure will be the outcome of all their traumatic and crisis experiences. This, in turn, strengthens feelings of guilt and shame as part of adaptive regression.
- Feelings of resentment because others on whom they counted for help seem unable or unwilling to provide the needed help. The reactive behavior of these other people, who include multidisciplinary crisis personnel, may be to express irritation because crisis workers often feel that survivors should show gratitude, not feelings of entitlement. The crisis worker's own fatigue and frustration adds to this, often creating a vicious circle between survivors, families, and crisis personnel.
- Increased dependency on others causes a lack of feedback that exacerbates the survivor's low self-esteem. This creates further distance between the survivor and potential support systems.
- Loss of faith in group values and in former beliefs or peers that had, in the past, given the survivors a sense of security and significance in the world. Survivors need help in reestablishing and reordering this faith.

The main objective of crisis intervention is to help survivors develop an internal sense of order and perspective, so that they will be able to organize their own environments as they are helped to process the painful and powerful emotions accompanying the post-disaster events. Another objective is to help survivors reach out, acquire, and build upon resources from recovery agencies so that they gain help in reordering their world and develop a sense of comfort, security, and self-esteem.

■ TYPES OF INTERVENTION ACCORDING TO POST-DISASTER PHASES

First Phase: Triage and Outreach Activities

The primary objective in the first phase is to lessen stress and offer support. Psychological emergencies require immediate, rapid evaluation of the survivor's behavior. A minimum of data will be available for making decisions, and both time and human energy will be limited. The skill and knowledge required to treat multiple problems may seem overwhelming.

The emergency situation not only requires that the crisis worker play a new role, but also demands types of intervention that can be classified under the concept of outreach.

Disaster triage and outreach are the procedures used by team members and other crisis workers to assess behavior, gage the degree and level of crisis, and supply guidance, resources, and information. This knowledge is provided to the assisting team so that disaster aid planning can alleviate the immediate situation and the psychosociological reactions of the survivors by assisting them in venting feelings, sharing experiences, and receiving support.

Immediately following the disaster, survivors may temporarily become emotionally disorganized. Cognitive disorganization will affect attention and focus, level of interest and involvement, ability to stop ruminating about the catastrophe, learning capacity to absorb information given by crisis personnel, and recall of skills available to solve problems. The therapeutic objective should be to help survivors minimize the effects of the disorganization and reinforce their cognitive mastery. Procedures must be implemented to increase competence and maintain awareness by allowing survivors to tell their stories and obtain validation for their suffering.

The following areas of outreach are useful in dealing with cognitive disorganization:

- Assisting the survivors by reinforcing their knowledge of their new social world, such as demonstrating time-space scheduling and recognizing practical daily living arrangements.
- Strengthening conscious awareness of the appropriateness of social reactions and informing them of normal post-trauma reactions. Many survivors believe they are "going crazy" because they notice changes in their social behavior and they therefore need reassurance.
- Helping survivors identify realistic causal relationships between events and reactions and discussing them individually or in groups.

In dealing with emotional disorganization, the crisis worker should be able to rapidly gage the type and quality of the predominant effects through social interactions with survivors. The major effects seen in the initial phase include sadness, fear, and anger, which are manifested in many forms and with a wide range of intensity. Some expressions are pronounced, while some are subdued or defensive, such as feigned composure, calm, or passive dependence.

During the triage and outreach stage, the worker should not tamper with these sets of behavior. They offer a means of psychological first-level healing that keeps the personality functioning during the acute phase. Although these behaviors cover up emotions, the worker should not encourage expression of guarded emotions until the place and time are appropriate and the worker can stay with the survivor through the process of recuperating some emotional stability.

Intervention objectives for survivors in the shelter include helping them achieve physical comfort, increased cognitive organization, and a sense of emotional control.

These approaches will help diminish survivors' sense of helplessness, indecisive or regressive behavior, and belief that they lack coping skills. In addition, these approaches help increase competency, self-esteem, flexibility to consider alternative solutions, and ability to handle the confusion and mixed communications that are characteristic of this first phase of disaster assistance.

As the days go by, crisis workers must sort out priorities for action, such as helping survivors with a sense of orientation, reinforcing reality testing, and developing support systems. De facto support systems must also be developed within the group of survivors in shelters.

In addition, the wide array of available resources must be organized to meet the specific needs of survivors, whether physical or psychological. Crisis personnel can mobilize appropriate help by observing the way survivors behave or approach them. This requires a special type of technique that allows the crisis worker to elicit directly and personally from the survivors their perceived immediate needs. The worker can then collaborate with other emergency personnel in mobilizing resources so that the survivors feel assisted, rather than helpless, hopeless, or destitute.

Second Phase and Third Phase

As survivors are relocated from emergency shelters to temporary housing and back to their reconstructed homes, a new stage of bereavement and crisis emerges. This necessitates a broader repertoire of mental health intervention activities, including crisis counseling with the objective of achieving crisis resolution and assisting with depression reactions that emerge in response to the "second disaster."

Therapeutic activities can help achieve some of the following objectives in assisting survivors:

- Providing education and information about the help available;
- Helping to identifying ambivalent feelings about acknowledging needs and asking for and accepting worker support;
- Helping survivors interact on a cognitive level, assigning priorities to needs, accepting advice on how to obtain information, and increasing the capacity to cope with the dislocation of their lives.
- Providing a structured method of perceiving problems, self-observations, behavior patterns, and powerful emotions through help in understanding, defining, and ordering events in the new environment.

Once these objectives have been met, each categorical problem can be singled out and suggestions can be made for its management. At the same time, several areas of cognitive, emotional, behavioral, and social reality are put into perspective as a first step toward understanding what is happening.

All these activities are preparatory for further work. If the survivors need and accept the offer from the crisis worker, they are led naturally into accepted methods of crisis counseling and therapy for several weeks. If necessary, they are referred to another mental health group.

■ ANNIVERSARY REACTIONS

Families report a reemergence of memories of their emotions with the return of the date of the disaster. Generally the media reinforce these memories by publishing pictures of the event. The range of distress can go from reliving the trauma to evoking unfinished mourning. For survivors who have experienced significant losses mourning is still in progress one year later. For other survivors dealing with the abnormal situation following the disaster, the anniversary can also provide an opportunity for further healing.

■ PREVENTIVE PLANNING FOR ANNIVERSARY REACTIONS

Crisis counselors should expect and be ready for a resurgence of calls asking for help to obtain further counseling. For many survivors, all that will be needed is phone counseling and reassurance that their emotions are healthy reactions. Others will need more extensive assistance and referral.

At the time of the one-year anniversary of the disaster, the workers themselves will already have returned home, or will be preparing to do so, and they may therefore have some difficulty in separating their own feelings from the survivors' reactions. Workers will need support from senior staff and trainers.

In keeping with the guidelines presented above, mental health intervention programs can be organized along two major lines of assistance activity. The first is direct, face-to-face intervention with families that were housed in emergency shelters during the acute stage of the emergency. Guided by their knowledge of the time phases and the sequential manifestation of crisis phenomenology, the workers can identify and organize a number of approaches to help families through the anniversary phases of crisis, coping, and adaptation. The second line of activity focuses on the community as families relocate to temporary or permanent housing, which may mean a complete change of neighborhood or human support networks. This is accompanied by changing phases of crisis resolution and will necessitate different crisis counseling procedures, as well as both individual and community support organizations.

The objective of mental health assistance during the anniversary period is effective use of interventions that will assist families in (1) handling the stressful situation and (2) further strengthening their coping capacity.

Crisis counselors should consult with child welfare agencies so that they can anticipate difficulties around the anniversary date, which will help prevent problems and offer broad-based opportunities to assist families and children who have been traumatized by a disaster. School personnel are also important collaborators to help children resolve any long-term problems linked to the disaster. ■

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