Populations with special needs

CHAPTER 5

■ TRAINING MODULE

Module 5:
Identifies special populations at risk after a disaster and their specific assistance needs

■ WHY HAVE THIS MODULE?

To categorize the specific needs identified after a disaster and present effective types of post-disaster intervention

■ CONTENT

- Characteristics of different populations and their needs
- Children
- Elderly populations
- Persons with mental illness
- Persons with HIV/AIDS
- Persons with substance abuse problems
- Post-disaster caregivers and workers

LEARNING OBJECTIVES:

After participating in Module 6 the student will be able to:

- Identify and describe the characteristic reactions of special populations affected by a disaster.
- Describe the interventions needed to assist populations at risk.

  a. Children
  b. Elderly populations
  c. Persons with mental illness
  d. Persons with HIV/AIDS
  e. Persons with substance abuse problems
  f. Post-disaster caregivers and workers

SPECIAL RISK GROUPS

CONTENT SUMMARY

There are many feelings and reactions that people share in common response to the direct and indirect effects of a disaster. However, special attention should be planned for persons in certain age groups and or those handicapped by certain social circumstances or by physical or emotional disabilities. This module describes some of these groups. It begins with a review of some of the thoughts, feelings, and behaviors common to all at-risk populations that experience a disaster.

COMMON REACTIONS

1. Basic survival behavior
2. Increased stress due to loss of loved ones or loss of prized possessions
3. Separation anxiety, also expressed as fear for safety of significant others (predominant in children)
4. Regressive behaviors, e.g., reappearance of bed-wetting among children
5. Relocation anxieties and depression
6. Need to talk about experiences during the disaster
7. Wish to be part of the community and its rehabilitation efforts

SPECIAL NEEDS GROUPS

The responses and needs of "special" populations affected by a disaster vary according to the characteristics of these populations—for example, developmental stage in

children or differing degrees of capacity to cope in individuals suffering from mental illness. Trainers should develop additional presentations on these populations, augmented by teaching resources and group exercises that highlight their specific needs and the counseling modalities to assist them.

Members of special needs groups are among those most frequently encountered by workers providing counseling services in disaster areas. Some communities will have a unique or unusual composition, with the subgroups identified below.

1. Age groups
2. Socioeconomic classes
3. Cultural and racial groups
4. Persons institutionalized in acute care, general, and mental hospitals, and those in convalescent and correctional facilities
5. Survivors manifesting different intensities of emotional crisis
6. Survivors requiring emergency medical care
7. Human service and disaster relief workers

Age Groups

Each age period is accompanied by special problems which must be dealt with in everyday living. Some age groups, however, appear to be vulnerable in unique ways to the stresses of disaster. Research indicates that, in disaster situations, younger children and older adults are subject to significantly higher rates of fatalities and greater proportions of emotional and physical traumata when compared with the general population. Adolescents as a group are susceptible to unique and possible long-range effects of disaster as a result of the disruption of their peer group activities and a lack of access to full adult responsibilities in community rehabilitation efforts.

The following module subcomponents should be reproduced and distributed to workers who need specialized training to meet the needs of these population groups. To use the material on children, it is necessary to have a basic knowledge of child psychology. Again, the cultural characteristics of the community in which the disaster has occurred should be explored and used to adapt the generic material that follows. Exercises, vignettes, or videos should also reflect the culture of the community. For the subcomponent on persons with mental illness, medical help/consultation will be necessary. For the subcomponent on post-disaster caregivers and workers, it should be borne in mind that many workers are also survivors and may have experienced severe losses themselves. In addition to emergency workers, other professionals (such as teachers, policemen, hospital workers, mortuary staff) need to be considered both as workers and survivors).

CHILDREN

CONTENT SUMMARY

The effects of a disaster on a child population produce a variety of reactions that are specific for each survivor, depending on a group of variables. Hence, the interplay of the type, extent, and proximity of the impact on a child within a family living in a geographical area has to be conceptualized based on knowledge of child psychology and disaster experiences. Of all these variables, the quality of attention given to the child's subsequent needs and the parental reactions emerge as particularly significant.

Problems will vary depending upon the phase of the post-disaster period. Some problems may appear weeks or months later. Crisis workers should alert the parents to the potential for their occurrence and the phase in which they may appear. In general, children of all ages will show a combination of these symptoms: sleep disturbances, persistent fears about recurring weather events or future disasters, and loss of interest in daily activities, especially school.

Published descriptions of clinical and behavioral manifestations of children's reactions to traumatic events focus on biological, psychological, interpersonal, and social perspectives. Documented observations of post-traumatic reactions in children suffer from the lack of consensus among researchers about data-gathering, which adds to the difficulty of developing a comprehensive frame of reference.

Because the conceptualization of children's reactions is influenced by (1) the event itself, (2) the degree of disorganization within the family, (3) the impact on social structures, and (4) the attention given to the child's subsequent needs, it is difficult to design materials which identify and correlate all the factors that affect the child's behavior. The importance of parental response to children's level of distress has been identified as a powerful influence. The need to plan, develop, and offer assistance to the victims of traumatic events is prompting further study of programs to prevent pathological effects on the child's health and negative emotional consequences.

The emerging knowledge about the psychosocial processes that serve the function of adaptation at different levels of child development is filling a need for further knowledge in disaster planning. Experiences are accumulating and being shared, allowing professionals to develop tentative methods of intervention. Questions about how to intervene with children after a disaster raise a classic dilemma in crisis counseling. It is necessary to apply a consistent model to organize the information obtained, develop a child crisis theory, and select the appropriate intervention approach. A useful conceptual approach in this situation can be obtained by focusing on the stressful event in which the child finds him/herself and adopting a framework of understanding the child as an evolving interacting organism within a bio-psycho-socio-cultural environment.

There is a relationship between the approaches through which problems are defined and the intervention that is chosen and then translated into action. Post-disaster problem definition reflects inferences and assumptions about the causes of the problem. In the case of post-traumatic stress reactions in children, the

reactive-adaptive behavior that can be observed following the impact of a disaster is related to (1) the child's stage of development; (2) the child's sex and ethnicity and the economic status of the family; (3) the child's usual coping defense style; (4) the intensity of the stressor; (5) availability and appropriate "fit" between the child's needs and support systems; (6) the extent of dislocation; and (7) availability of relief and community disaster assistance resources. Collecting specific data about the survivor and organizing the data to pinpoint the problems produced by the situation in which the child finds him/herself provides guidance for the development of appropriate interventions. The way the data gets organized, all the unique characteristics that identify the survivor, the hypothetical interaction among all the factors and how they affect the child's capacity to cope are based on the assumptions chosen by the crisis counselor.

Several areas of theoretical knowledge will be highlighted because they are crucial to the understanding of behavior in post-disaster experiences and are key for intervention programs.

■ RELATIONSHIP BETWEEN CHILDREN'S DEVELOPMENTAL STAGES AND POST-DISASTER REACTIONS

As children grow and pass through the various developmental stages, changes take place in several psychobiological systems. Depending on the age of the child traumatized by the event, the intervention should be designed based on knowledge about the developmental stage of different systems: somatic, psychological, social, and behavioral. There is a relationship between the level achieved in these systems and the ability to deal with the stressful events following the disaster. Adaptive processes can be understood as strategies, approaches, or efforts that promote action whose objective is to modify the impact of the stimuli unleashed by the stressor and so tolerate, correct, modify, or diminish the effects on the organism and prevent reactive disorganization within the psychophysiological human system. These adaptive skills and their effects on the vulnerable organism of the child will be manifested in a variety of behavior patterns. The interpretation of these manifestations of the child's adaptation mechanism, the social expectations toward him within the disorganized human environment, and the social and family conflicts that generally emerge in a crisis situation will determine the level of coping and adaptation, which, in turn, will influence the methods of assistance and intervention chosen. For instance, the reactions to an earthquake of a one-year-old child, who processes stimuli and information through an evolving cognitive system, will be different from those of an older child, who will use a symbolic-linguistic mode of information processing.

■ PSYCHIC TRAUMA AND DEVELOPMENTAL EXPRESSIONS OF MOURNING AFTER A DISASTER

An important body of knowledge is beginning to reveal the processes available to children during traumatic events that involve loss. For a child, the death or

psychological unavailability of a nurturant person is not only a traumatic event, but it also constitutes a very serious developmental interference. As the child advances through the growth of multiple systems, mastering the various psychological and emotional tasks needed to achieve maturity, a stimulating interaction with his/her love objects is essential. Depending on their stage of development and cognitive/affective capacities, children will manifest differing behavior patterns expressive of disrupted organization, regressive functions, infantile emotional manifestation and patterns of cognitive functions, which incorporate the developed level of their subunits (reality thinking, abstract reasoning, causality).

In post-disaster experiences, besides the stage of development, the dynamic implications of loss and their interaction with reactive processes to the trauma set up by the disaster must be considered. All disasters are dramatic events that are accompanied by visual and auditory experiences that are incomprehensible at the moment of occurrence. Hearing the preliminary sounds of an earthquake, watching the earth open up, seeing buildings collapse all produce anxiety reactions of different levels of intensity. These are concrete, frightening events that are mentally recorded and will be internal traumatic repetitive stimuli to several infantile emotions. When these are accompanied by subsequent loss of a parent, it is difficult to sort out whether the child's reactions are indications of psychic trauma or early signs of mourning. In addition to differential needs, reactions accompanying loss should be incorporated into the evaluation and intervention guidelines.

■ RISK FACTORS IN POST-TRAUMATIC CRISIS RESOLUTION

The child's level of psychobiological function is related to the vulnerability of the child's developmental stage, biological health, and personality strength. It needs to be ascertained whether the child is showing high anxiety, depression, withdrawal, regression, disturbance of sleep and eating functions in order to measure the manifestation of disorganized psychobiological factors. To be able to measure these signals, the professional must investigate the following:

1. The psychosocial maturity or immaturity of the child;
2. The social expectations of performance behavior as judged by the child, his/her family, and others living with them;
3. Continued environmental post-disaster stress, both in social and physical accommodations, throughout the period of transition;
4. Accidental crisis events occurring in the child's life, either before or after the stressor event;
5. Social settings as post-disaster stressors.

The setting in which the child is located is an important variable that will affect the choice of psychological intervention. This statement is based on the realistic, practical experience of housing victims in crowded sheltered settings. The rapid turnover of large numbers of victims in and out of the shelter and the small number of trained staff who remain with the same family for extended periods of time influence the

type of intervention. What might be the best type of intervention within the specific setting, given the available resources?

INTERVENTION PROGRAM FOR CHILDREN—CRISIS INTERVENTION

Development and implementation of mental health services to help children suffering from the psychological consequences of a disaster have to be designed taking account the context, post-disaster timeframe, and characteristics of the identified population. Although children's responses may differ from event to event, it is possible to develop broad guidelines for the design and execution of post-disaster psychological services. The elements that enter into the design of a plan will focus only on the child population. It is assumed that a complex overall mental health program with different multilevel services is already in place; the child mental health program will be embedded and coordinated with the other services so as to delivery psychological aid effectively to all victims. The objective of the program will be the implementation of mental health intervention services for children affected by a disaster or catastrophic event. This is done with the understanding that there are many other types of services needed in such situations—for example, feeding, housing, medical services, and recreational activities.

DIRECT MENTAL HEALTH SERVICES—EARLY PHASE

The mental health intervention program can be organized along two major lines of professional activity. The first is direct face-to-face intervention with families housed in emergency shelters. Crisis counselors who start working directly with the families and the relocation centers will be available to offer psychological help to a gathered group of families in need. 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 children and their families through the phases of crisis, coping, and adaptation. As these families move through their evolving situation of emergency housing and changing human environments, they will exhibit different behaviors and express different needs in different phases of crisis resolution. The crisis counselor will develop interventive procedures to meet the objective of returning the family and the children to a functional level of adaptation. As mentioned before, the objective of crisis counseling is successful use of techniques that (1) restore the capacity of children to function by assisting them in handling the stressful situation in which they find themselves; and (2) assist the family in reorganizing its world through social support and guidance from the crisis counselor. This can be accomplished through collaboration and referral by the counselor to other support and care-giving emergency assistance groups, with all the family welfare agencies helping the children and their caregivers.

■ THERAPEUTIC CRISIS INTERVENTION FOR FAMILIES

Crisis intervention encompasses all the activities by which the worker/counselor seeks to relieve the distress of the child and assist the family through counseling. It encompasses all helping activities based on communication, which is primarily, though not necessarily, verbal interaction. Many of the families display a sense of hopelessness and demoralization. All forms of counseling use certain approaches to combat and control this painful effect. Demoralized families show behavior that reflects the feeling of being unable to cope with the multiple tasks that families have when taking care of children and that others expect them to handle well. These families' sense of self can vary widely after a disaster. The signs of demoralization in a family might include the following:

1. They express feelings of diminished self-confidence and have difficulty recognizing their ability to handle the children's and their own needs.
2. They believe that failure will be the outcome of their decisions and actions, and they appear to be struggling with feelings of guilt and shame as part of the adaptive regression.
3. The family feels alienated, depressed, and isolated, as if they had been singled out for the worst outcome.
4. The family is enmeshed in a sense of increased dependency on agency workers who may have difficulty in understanding both the confused intrafamilial reactive feelings and the family value systems based on traditional ethnic ways of behaving in a novel situation.

■ TECHNIQUES FOR HELPING FAMILIES ACROSS THE DEVELOPMENTAL PHASES OF CRISIS RESOLUTION FOR FAMILIES

Several techniques are available to the counselor who is interested in intervening during the sequential phases of crisis manifested by families and children traumatized by a disaster. These initial techniques can be grouped under the heading of "auxiliary first aid techniques." These early approaches are directed initially toward restoring family functions and helping the family adapt to the early transition experience; they can also be instrumental in reintegrating and returning the total family system to balance. Intervention procedures are related to helping the family assess, solve problems, and make decisions day by day as they move through the emergency situation, the reconstruction phase, and, finally, return to a more permanent living situation. These approaches are defined as any active interaction between the counselor and the family that tends to supplement, complement, reinforce, and promote family systems mechanisms in the new setting. By restoring the family's functions and adaptive strategies, the child is assisted in functioning more effectively.

The following is an example of this approach:

A family composed of a mother (36 years old) and father (41 years old) with two children (8 and 12 years old), were found in one of the shelters. A major avalanche

had buried their neighborhood a few hours after they had climbed to safety on a nearby hill. They had to spend six to eight hours in the cold night air before being rescued by emergency workers, who brought them to the shelter, where they were fed and offered some cots and blankets. The counselor who met with them observed that the mother was crying and appeared somewhat dazed and depressed, while the father was trying to actively organize the family activities and cheer everyone up. The children seemed to adapt to the new surroundings, and although their faces expressed tension, they did not appear to show grass behavior disturbances. Following a preliminary evaluation of the situation, it was obvious that the most expressive disturbance of feelings was manifested by the mother. A short evaluation proved that she had been unable to relax, her thinking was depressed, and she felt hopeless and helpless. The father, on the other hand, appeared to deny the reality of the situation and tried to encourage the family with false and unrealistic hopes. After a few days, the children began to lose their ability to cope, became more demanding and restless, had difficulty in eating and sleeping, and did not want to separate from the mother to go out onto the playground that had been organized for children in the shelter.

The intervention was designed to complement the mother's ability to feel more competent and reinforce the father's sense of "being in charge" through a realistic approach so that he would not have to deny and distort reality to regain his composure. The total family was helped to express some of their sadness and feeling of disorientation through the provision of knowledge, daily news, and explanations about what was going to happen in the present and in the next few days. The children were able to meet in small groups with other children, where they shared their memories about the event and were offered the possibility of expressing some of their fantasies through drawings so as to promote a sense of mastery over their feelings. The parents were asked to assist in the housekeeping duties of the shelter and to participate in organized adult activities.

The process described above provides a prototypical example of the range of procedures (behavior, actions, speech, types of meetings, face-to-face interactions) through which intervention occurs and is adapted to the situation encountered. The child and his family in the early stages of relocation will express through behavior the manifestations of the crisis and the methods of coping they are using. The resources available to the counselor will influence the procedures that can be used, the time that can be spent with the family and the activities that are available in the relocation center. The crisis counseling approach varies because different combinations of factors come into play, depending on the extent of community disruption and the availability of resources. But the objective remains clear: to restore the adaptive system of the family, which, in turn, will help the children control the regressive behaviors seen in all traumatized children.

Crisis counseling for children must be based on the ability to conceptualize and understand the crisis manifestations and the levels of infantile dysfunction during the various stages of post-disaster crisis resolution.

STEPS AND GUIDELINES FOR CRISIS INTERVENTION FOR FAMILIES

The crisis counselor establishes a relationship with the family and the child by explaining and educating the family about the psychological processes that occur in the wake of a disaster. The intervention objectives are set by (1) obtaining the information needed to plan the approach; (2) establishing credibility and gaining the family's confidence; (3) describing the intervention plan; and (4) eliciting the family's cooperation in the plan. From all this data-gathering, the crisis counselor arrives at a tentative formulation of the problem and/or the plan of action. The objectives are to alleviate the emotional distress in the family and the cognitive disorganization in the child as a first strategy.

The following key principles guide the sequential steps of intervention:

- Crisis counselors should assume that families are potentially capable of handling their own problems after being helped to recognize the areas of distress and redirect their behavior towards exploring new solutions.
- Counselors should allow the family to develop initial dependency so that the family can "borrow" confidence from the counselor and, at the same time, offer it to their children.This stage should be short-lived; long-term dependency should be discouraged.
- Counselors should generally be cautious about giving advice, although this does not preclude their informing the family about all relevant matters on which they are ignorant or misinformed. Such information will help the family solve its own problems.
- Whenever possible, depending on the age of the child, the counselor should seek to help the child understand the linkages between feelings and behavior. This may help the family understand the feelings and thoughts that signal actual progression toward crisis resolution; it will also allow the family to make sense of and put into perspective feelings that are disturbing, which will enhance their sense of mastery and control.
- Emotions that are seen in the initial post-trauma phases include sadness, fear, and anger. These are manifested in many forms and with a wide range of intensity. The counselor should accept these emotions as expressions of the pain the families have suffered and support their perspective of the event. Assistance in achieving resignation and acceptance of the reality of the situation in which they find themselves is part of the process of post-disaster grieving.

Some families temporarily become cognitively and emotionally disorganized. The intervention needs to be directed toward remedying this disorganization, as it interferes with parenting tasks. Steps should be taken to increase parents' competence and maintain their awareness that the situation generated by the disaster will demand increased individual mobilization of all their parenting skills to help their children adapt to an environment of trauma. The counselor should offer support and

encouragement to strengthen the parents' conscious awareness of appropriate social reactions in light of what is happening. This clarification is encouraging and useful for reinforcing natural parental behavior. Continued cognitive disorganization will affect the family's ability to deal with their problems and their children's problems. One of the primary aims in such cases is to help the family diminish the effects of the disorganization and reinforce their cognitive mastery by offering counseling assistance that is useful according to their specific conditions. By helping the family to diminish their sense of helplessness, their indecisive or regressive behavior, and their belief that they lack coping skills, the counselor enables the family to rebuild itself more rapidly and begin to assume responsibility for child care. By guiding families and assisting them in problem- solving and in dealing with the children directly when the children are showing signs of emotional disturbance, the counselor helps the family to pull together and continue to move forward along the crisis resolution pathway.

STRATEGIES FOR INTERVENTION FOR FAMILIES

Setting priorities for action and selecting displaced families to assist in the first few days following a disaster is a difficult triage process. As soon as families are identified, they need help to regain a sense of orientation, reinforce reality, and develop support and trust. Ascertaining families' needs for the type of resources that can be obtained and provided by other agencies is the responsibility of the crisis worker.

A wide array of resources are available to families through emergency programs, but they must be organized to meet their specific needs. Many of those needs are concrete, but others are psychological. The crisis worker can mobilize appropriate help by observing the way staff from other agencies behave or approach the family. This requires a special technique that allows the worker to elicit directly and personally from the family, in their own communication style, what they perceive as immediate needs, interpret those needs within the context of the available programs, and then collaborate with other agencies in mobilizing the resources so that the family and the children feel assisted, less helpless, less hopeless and destitute.

EARLY AND LATE AFTERMATH PHASES FOR FAMILIES

As families are relocated from emergency shelters to temporary lodgings or back to their own homes—which may be damaged but safe—a new stage of crisis emerges, manifested by expressions of increased grieving and bereavement. The crisis worker needs to develop a combination of activities that include outreach in order to follow relocated families and monitor the children's progression toward a return of function. The worker should assess the family's level of adaptation, and if the assessment does not reveal further decompensation, the worker can let the family know that he/she is available if needed. If the family notices a psychological problem or wishes to further utilize community resources, they can recontact the emergency assistance team.

It is during this sequence of post-disaster phases that children's level of development and previous experience play the greatest role in their coping mechanisms and degree of adaptation. Young children appear to rely heavily on denial as a means of accommodating the traumatic event. As children develop the ability to express their ideas, they can talk more often about frightening episodes, share experiences, reproduce distressing visual impressions in drawings, and express conflicts through repetitive play. Older children appear to respond to explicit, directive, and encouraging discussion with crisis counselors.

The same strategies that were useful in the shelters—approaching daily activities through an accurate cognitive appraisal of the situation, enhancing the family's knowledge about their surroundings so that they can understand both their own emotions and external events—appear to aid families during subsequent stages and increase their adaptive capacity, diminishing the level of depression and anxiety. If appropriate and feasible, group intervention, with parents or teachers getting together with children to discuss how they are responding to stress and what is expected as natural, healthy crisis resolution behavior, also appears to enhance adaptation.

The method of bringing parents and children together in groups is helpful because the children's problems tend to get overlooked as family members are overwhelmed not only by their own personal feelings but by the enormity of the task of reconstructing their concrete world, which takes priority. The crisis counselor's function is to provide support, offer him/herself as someone to whom the parents can come in case of difficulties, clarify the child's behavior, and suggest methods of controlling it. Often, too, the counselor will need to mobilize other social agencies, including the school, to help families who are having difficulty in adapting to their new setting and who are disrupted or have difficulty in coping with the ordinary demands of family life. At times, working with the school may be essential to provide a child with additional assistance, and contact with other adults may be helpful to the family. To enable parents to use other social and practical resources in the community is part of educating them to the fact that they may need assistance to carry out their duties for a short time, without suggesting that agencies take over their parental role. Every decision must be theirs, and it is they who must initiate every change in the sequence of life activities that will lead them to a recovery of their family dynamic balance.

TEACHING RESOURCES

CHILDREN

a. Reactive Phase
A list of reactions by age is presented to highlight the different reactions that occur in children at different developmental stages.

b. Several models of intervention for families and children are described.

The following pages are ready for use as transparencies, slides, or handouts.

IMPACT OF STRESSORS

Key variables that influence children's reactions/ consequences:

- Speed of onset
- Duration of the trauma
- Potential for recurrence
- Degree of life threat
- Degree of exposure to death, dying, and destruction
- Proportion of the family affected
- Role of the caregiver in the trauma
- Degree of displacement in home continuity
- Separation from nuclear family
- Rekindling of childhood anxieties
- Communicated anxiety between parents and children
- Cultural expectations

PSYCHIC TRAUMA PRODUCED BY A CATASTROPHIC EVENT

Key Issues

- The child's reactions will vary according to his/her stage of cognitive, affective, and sociobehavioral development.
- The reactive phenomena observed after a catastrophic event represent bio-psycho-social systems reactions and early efforts to cope with the disorganization of these systems.

  a) Need to re-establish capacity to regulate intense affect

  b) Need to formulate cognitive appraisal of initial event and subsequent evolving experiences.

  c) Need to restore bodily integrity

- Family and societal behavior toward a child is a powerful influence that can enhance or impede the trauma resolution process. The child's reliance on the family for cognitive guidance and socioemotional support is influenced by the child's stage of psychosexual development and pre-existent psychopathology.
- A mourning process accompanies all catastrophic psychic trauma due to loss of body configuration (if injured), interpersonal bonds (quantity/quality), worldview and familiarity, expectations and trust.
- Reactive depression as a clinical syndrome needs to be differentiated from the expression of psychic trauma and an effective/ineffective mourning outcome.

IMPACT OF CATASTROPHIC EVENTS

Direct impact on child

Body trauma - pain, autonomic arousal, increased tension, loss of function
Sensory changes - visual, auditory, olfactory
Emotional expressions - fear, distress, anxiety
Cognition changes - language, communication.

Indirect impact on child

Traumatic reactions of parents, siblings, friends, and extended family
Disorganization of social systems - school, church, father's/mother's employment, housing