REACTIVE PHASE RESPONSES OF CHILDREN TO A CATASTROPHIC EVENT

Preschool Child

Somatic systems

- Muscular immobilization, hyperactivity
- Temper tantrums, slow movements, not goal-directed
- Disorganization of acquired body functions
- Autonomic nervous system signs, vomiting, crying
- Sleeping/eating disturbances, pale skin, hyperventilation
- Wide pupil stare, startle reactions

Affective system

- Constricted/flat affect
- Detachment
- Rage/aggressive responses
- Fear/worry
- Anxious/suspicious

Cognitive system

- Recurrent memories, thoughts, fantasies of event
- Disturbed dream content
- Decrease of acquired performance, language
- Visual-spatial, concentration
- Distorted description of visual phenomena

Social behavior system

- Avoidance, dependence, passive/intense, energetic/impulsive
- Partial loss of toilet training
- Increased autoerotic activity
- Abrupt, destructive play

REACTIVE PHASE RESPONSES OF CHILDREN TO A CATASTROPHIC EVENT (continued)

School Age Child

Somatic systems

- Energy level affected
- Movements slow, low-intensity, or rapid, frenetic, impulsive
- Autonomic disorganization; appetite/sleep/ elimination

Affective system

- Lability of affect; anxious, sad, giggly, "nervous"
- Cautious; afraid to take chances or return to familiar places
- Increased fear of competition, of losing, of getting lost
- Increased dependency/decreased independence feelings
- Increased susceptibility of emotional reactions to sensory reminders of the traumatic event
- Initial process of mourning and reactions to loss

Cognitive system

- Constriction and hypervigilant alertness
- Intellectual functions affected; dull, obtuse
- Obsessive rumination and increased distractibility affecting memory loss
- Decreased associations leading to spontaneous reminder of event characteristics
- Increased fantasizing about how they could have changed events, controlled outcome of the incident
- Appearance of learning problems

Social behavior system

- Obsessive-compulsive expressive play, talk, curiosity about event and its consequences
- Inconsistent, capricious reactions to parents
- Argumentative and disobedient
- Poor impulse control
- Difficulty returning to routines
- Some loss of habits, customs, skills

VARIABLES THAT INFLUENCE POST-DISASTER REACTIONS IN CHILDREN

1. Serious disruption of developmental processes will produce disorganization in all psychological expressions.
2. Special significance of the event and post-disaster experiences will be related to the stage of development.
3. The quality of family relations will affect the expression of mourning manifestations.
4. The intensity of the physical and psychological trauma will influence the mourning process and lengthen the duration of the post-disaster reactions.
5. Special circumstances surrounding the child's life before the disaster (divorce, new school, surgery, immigration) should be taken into account in assessing the child.
6. The reactions to these events by important adults in the child's life should also be considered.
7. For a child who has lost his/her family, the multiple changes in the environment following the disaster are other important variables.
8. Plasticity and resiliency as protective factors should be evaluated during intervention.

VARIABLES ASSISTING IN THE RECOVERY OF FAMILIES

1. Developing structures and networks
2. Establishing reliable schedules
3. Choosing activities that enhance self-esteem, such as volunteer activities
4. Continued strengthening of social contacts
5. Becoming involved in group activities
6. Attending to material/personal needs
7. Recognizing that relationships and attachments act as regulators and modulators of emotions and cognitive systems organization, which influence patterns of relationships
8. Identifying risk factors - (action/interaction - individual - environment)
9. Learning or asking advice about children's reactions at home and in school
10. Using all available help and resources

Certain families may be especially vulnerable and can be identified in this process:

- Families with pre-existing marital or functional problems
- Deprived multiproblem families for whom this disaster may prove to be the "last straw"
- Families who are dislocated into systems that cannot or do not support them
- Families who have suffered overwhelming loss, trauma, and/or separation
- Families severely affected by survivor guilt
- Families who have split, disintegrated, or decompensated following the disaster

OBJECTIVES OF INTERVENTION

1. To help the child develop an internal sense of perspective so that he/she will be able to organize his/her own environment.

2. To assist the recuperative process of sharing painful emotions provoked by the stressor events, which will help the child (according to his/her age) put events into perspective.

3. To help the child reach out to both his/her family members and the professionals on the emergency teams in order to use the resources that are available to develop a sense of comfort, security, and affection.

INTERVENTION STRATEGIES TO ADDRESS SECONDARY STRESSES

1. Monitor secondary stresses for the child and family
2. Assist the child in identifying sources of secondary stress
3. Address emotional responses
4. Address interference with developmental opportunities
5. Enhance coping skills

TREATMENT OF REACTIVITY TO TRAUMATIC REMINDERS

1. Identification of traumatic reminders
2. Increase child's understanding of the traumatic reference
3. Assistance with cognitive discrimination
4. Increase tolerance for expectable reactivity
5. Address missed developmental opportunities due to traumatic avoidance

Current intervention practice for children includes three main points (long term):

- An opportunity for exposure to a disaster's frightening elements in a non-threatening atmosphere. Activities such as drawing pictures, sharing stories, and playing "hurricane games" let children relive the hurricane and deal with it.
- The development of skills to cope with issues that remain difficult, such as property losses and adjustment to new surroundings.
- Access to supportive social relationships when a disaster has affected the child's loved ones' ability to cope.

POST-DISASTER MENTAL HEALTH ASSISTANCE MODEL FOR CHILDREN (LONG TERM)

- An individual diagnostic and treatment service should be available for children and their families who identify themselves as in need of help and/or who are referred for psychological assistance.

- Special consultation services for social agencies that work in the post-disaster program. Direct links between the psychological teams and the agencies should be cultivated. Special problem cases should be referred for discussion and problem-solving to assist the social agencies in obtaining resources for the family and the child.

- A program of regular group discussions with the professionals who work with children should be organized. The aim is to help these professionals deal with their current problems and increase their therapeutic, supportive, and healing skills. Because assisting children who are orphaned or separated from their parents following a disaster is such a new component of social welfare systems, professionals need regular help and support in their dealings with the children and in their contacts with relatives.

- Consultation to schools should be offered for long-term follow-up of traumatized children.

COUNSELING TRAUMATIZED CHILDREN A COUNSELING MODEL (LONG TERM)

Relationship-building and information-gathering regarding the trauma

The mental health worker describes the purpose and process for assisting children who have been traumatized. He/she proceeds to gather details about the trauma from the family and child.

Assessment of the child and the child's family

The mental health worker gathers information regarding the family structure and the child's experience in the disaster, previous traumatic experiences, addictions patterns, and the presence of consequences or symptoms of post-traumatic stress reactions.

Trauma interview

The mental health worker facilitates the child's telling of the traumatic experience through drawings or role-playing, encouraging attention to specific details, including sights, sounds, smells, and accountability for the event.

Identification of post-disaster issues

The mental health worker identifies issues that need to be addressed with the child, such as difficulty coping with nightmares, physiologic reactivity, or impulse control.

Issues are also identified for the family, including management of their own and their child's post-trauma consequences and parenting and communication skills

Post-disaster intervention methods

Short-term play therapy, activity therapy, family therapy, group therapy are provided, based on the age of the child and the needs of the family post-disaster.

Consultations are held with other service providers, including the school system, social services, foster parents, etc.

Relapse Prevention

The intervention goal is for the child and family to have the skills to cope with post-trauma consequences and situations.

The return of some post-disaster problems is expected and viewed as normal. The child and family identify situations in which the consequences of trauma might get worse.

The family is encouraged to return to counseling if necessary.

GROUP WORK/EXERCISES

- After viewing the *Children and Trauma* video (CMHS-ESDRB) or a similar video, identify the intervention techniques.
- Write a post-disaster script for role-play:
  a. a family with two children aged 6 and 12
  b. a group of children in a classroom
  c. an African-American family (or a family from another ethnic minority group) with three children
- Choose one "vignette" and role-play the intervention needed.
- Develop a list of possible signs of post-trauma stress in a boy whose parents were killed in a tornado.

ELDERLY POPULATIONS

CONTENT SUMMARY

Elderly populations have a number of characteristics and concerns that make them particularly vulnerable to the effects of disasters. They may respond in an ineffective manner due to slowing of motor and cognitive activity. Some older adults may experience further trauma if they are transferred to an unfamiliar, crowded setting. As a consequence of having lived for many years, elderly persons tend to experience multiple losses, including loss of important support systems. On the other hand, they may show resilience due to having successfully managed difficulties and coped with disappointments earlier in life. Workers should be alert to signs of depression among elderly survivors, since losses sustained from the disaster may add to previous losses and lead to depression.

Elderly populations have specific reactions and needs after a disaster. As with other subpopulations, workers need to consider many individual factors that distinguish one individual from another. However, generalizing about special subgroup needs helps to develop guidelines for the post-disaster program that will meet each group's needs.

Many older adults, especially those who are poor, immigrants, or unskilled, may lack resources, have declining physical capacity, and lose important support systems in the destroyed neighborhood. They may also have more difficulty in "navigating" the channels of the emergency system, or they may fear that they will lose their "independent" status if workers become aware of their diminished capacity.

Problems that may aggravate the problems of coping after a disaster for older persons include the following:

- Relocation with family members where privacy, personal space, and daily routines are a source of stress.
- Difficulty with sleeping schedules and relying on sleep medication
- Sense of disorganization or confusion due to losses of "cues" in daily activity.

Disaster workers may be able to relate better with elderly survivors by being aware of these characteristics. These examples serve as a reminder that the bio-psycho-social characteristics of specific populations must be considered when analyzing the risk factors that influence post-disaster coping capacity.

The training materials that follow will guide discussions and help identify other specific needs of this population and the corresponding interventions.

TRAUMA REACTIONS OF OLDER ADULTS

OVERVIEW

The reactions of older individuals to a trauma will be influenced not only by the impact of the catastrophe on their lives (what they saw, heard, felt, smelled, and so on), but by memories of crises in their past. This revisitation of past events is not simply a product of regression or trigger reactions. It is essentially a normal attempt to ground one's reactions in the familiar.

The following resources can be used to select a series of slides to high light key issues for the elderly.

TRAUMA REACTIONS

- Increased memories of past and friends or eras may color disaster effects
- May move in and out of disoriented state during first days in shelter
- May show increased dependence on current friends or family, refusing assistance from authorities
- Needs to integrate post-disaster changes into context of life after the disaster
- Disorientation as routine is interrupted; a sense of isolation both in terms of place and time after relocation
- Immediate response after shock, primarily fear, followed by anger and frustration if living conditions/setting is unfamiliar
- Physiological responses: sleep disturbances, appetite disturbances
- Sense of foreshortened future and retreat into past or fantasy for safety

REACTIONS TO TRAUMATIC EVENTS AMONG ELDERLY POPULATIONS

- Fear of mortality
- Need for permanence
- Wish to reconnect with past and with friends
- Regression
  - — Generally temporary state
  - — May be long-term regression of severe, chronic condition
  - — May move in and out of regressed state during relocation
- Multiple Losses
  - — Fear of relocation to unknown neighborhood
  - — Fear of losing their dignity
  - — Loss of hope for the future
  - — Loss of cherished mementos
- Need to integrate loss into context of life
- Disorientation as routine is interrupted,
- Sense of isolation in terms of both place and time if too many relocations take place
- Use of denial as a normal defensive reaction to trauma
- Immediate fear response, followed by anger and frustration when unable to control a situation
- Physiological responses
  - — sleep disturbances
  - — appetite disturbances
  - — muscle spasms

■ TO REINFORCE COPING STRATEGIES FOR ELDERS *

- **Rebuild and reaffirm attachments and relationships**: Relationships are the connection to life. Nurturing and physical closeness is needed. Let older persons identify those to whom they want to be attached; however, do not assume family relations are friendly.
- **Consider their concerns about safety:** The elderly need to know they have options in making a choice about their safety. Evacuation is a highly controversial issue in disaster. Older adults may be less safe in evacuations than if they remain in their homes (if this is feasible).
- **Talk about the tragedy:** Remember that older persons may be venting feelings about their lives, not about the immediate event. Do not attempt to prevent this venting, since validating past concerns is an important part of establishing trust in preparing to deal with current concerns.
- **Anticipate communication lapses:** In conversations, the elderly may go back and forth from the past to the present. Workers may be confused by an individual's discussion of past events or past relationships in terms of the present disaster experience. It is important to remember that the discussion may be entirely rational and logical from the perspective of the individual.
- **Understand that stress inhibits memory:** If an older person forgets a name, place, or portion of an event, the worker should take great precautions to avoid placing pressure on the elderly person to remember. In most cases, the elder will remember, but pressure inhibits memory.
- **Prepare for sporadic conversation:** Workers should be prepared for the elderly to talk sporadically about the disaster, spending small segments of time concentrating on particular aspects of the traumatic experience as a method of defense.
- **Be aware of cultural differences:** Workers should be aware that minority elders may have different cultural and traditional backgrounds. This will influence their worldview, especially the way they regard post-disaster services and public agencies. Services delivered to the dominant groups may not necessarily be suitable for every minority group.
- **Provide factual information:** Older adults want factual information, but may be able to absorb the facts only in limited quantity. Often, they ask to have information about the disaster repeated a number of times. Eventually they will integrate it and gain better control over their emotions about the event.

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* Based on guidelines set out in documents published by various state, regional, and area agencies on aging in the United States.

- **Make short-term predictions**: The elderly should be given information on what will happen to them immediately after the disaster. Specific times and places for events should be made clear. It will help to delineate events on a calendar or clock so that the older person can more easily track the future. Workers should spend time addressing basic needs in a detailed way, such as who will help the older person, where the person will stay at night, where he/she will get clothes, and what property may be rescued.
- **Establish routines quickly:** It is best to reinitiate old routines if possible, since routines are considered an anchor in aging.
- **Reassure about normal reactions:** The worker should reassure the elderly that lapses of concentration, memory losses, physical ailments, and depression are normal reactions to tragedy and disaster.
- **Be supportive and build confidence:** The worker should strive to ensure that older persons maintain their self-confidence and dignity throughout all the post-disaster activities necessary to return them to their homes.

OLDER PERSONS AND THEIR RESPONSES*
Summary of Special Concerns

Sensory deprivation

Older persons' sense of smell, touch, vision, and hearing may be less acute than that of the general population. A hearing loss may cause an older person not to hear what is said in a noisy environment, or a diminished sense of smell may mean that he or she is more apt to eat spoiled food.

Delayed response syndrome

Older persons may not react to a situation as fast as younger persons. In disasters, this means that disaster assistance centers may need to be kept open longer if older persons have not appeared. It also means that older persons may not meet deadlines in applying for disaster assistance

Generational differences

Depending on when individuals were born, they share differing values and expectations. This becomes important in service delivery, since what is acceptable to an 80-year-old person may not be acceptable to a person 65 years of age.

Chronic illness and medication use

Higher percentages of older persons have chronic conditions such as arthritis. This may prevent an older person from standing in line. Medications may cause confusion in an older person or a greater susceptibility to problems such as dehydration. These and other similar problems may increase their difficulties in obtaining post-disaster assistance.

Memory disorders

Environmental factors or chronic diseases may affect the ability of older persons to remember information or to act appropriately.

Transfer trauma

Frail older persons who are dislocated without use of proper procedures may suffer illness and even death.

Multiple loss effect

Many older persons have lost their spouses, income, homes, and/or physical capabilities. For some persons, these losses compound one other. Disasters sometimes represent a final blow, making recovery particularly difficult for older persons. One response may be an inappropriate attachment to specific items of property.

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* Based on a guide published by the U S Administration on Aging, 1994

(continued)

OLDER PERSONS AND THEIR RESPONSES*
Summary of Special Concerns
(continued)

Hyper/hypothermia vulnerability

Older persons are often much more susceptible to the effects of heat or cold. This becomes more critical in disasters, when furnaces and air conditioners may be unavailable or unserviceable.

Crime victimization

Con artists target older persons, particularly after a disaster. Other targeting by criminals may also develop. These issues need to be addressed in shelters and in housing arrangements.

Unfamiliarity with bureaucracy

Older persons often have not had any experience working through a bureaucratic system. This may be especially true for older widowed women whose spouses dealt with such matters.

Literacy

Many older persons have lower educational levels than the general population. This may cause difficulties in completion of applications or understanding directions.

Language and cultural barriers

Older persons may have a limited command of the dominant language of the country, or they may find their ability to understand instructions diminished by the stressful situation. The resulting failure in communication could easily be exacerbated by the presence of authority figures, such as police officers, who may increase the apprehension and confusion in the mind of older persons. Many older adults speak other languages, and there is a critical need to be sensitive to language and cultural differences. Older persons in this category may need special assistance in applying for disaster assistance.

Mobility impairment or limitation

Older persons may not have the ability to use automobiles or have access to private or public transportation. This may limit their ability to reach the disaster assistance centers, obtain goods or water, or relocate when necessary. Older persons may also have physical impairments which limit mobility.

Charity stigma

Many older persons are reluctant to accept not use services that have the connotation of being "charity." Older persons often have to be convinced that disaster services are available as a government service. Older persons need to know that their receipt of assistance will not keep another person who is worse-off from receiving help.

GROUP WORK/EXERCISES

Write a post-disaster script and role-play the following:

- A retired couple—wife 62 years old and husband 67 years old-who lose their home and go to a shelter
- A widow, 68 years old, whose house gets damaged
- A single man, 70 years of age, who moved in with his son, daughter-in-law, and 3 kids after his house was flooded.

Choose one vignette and develop the appropriate interventions.

PERSONS WITH MENTAL ILLNESS

CONTENT SUMMARY

Historical changes in the care of the people with mental illness and retardation and homeless persons living in the community have resulted in at-risk populations needing special help after a disaster. Although the number of such individuals housed in shelters or in damaged dwellings may be small in comparison to the total population, each case may need skillful handling and different approaches.

Although it is difficult to identify a general set of characteristics of survivors with mental problems, some generalities apply. Most of these survivors will need additional help beyond crisis intervention, but during the first chaotic days following a disaster it is important to ask several questions in order to assist mental health workers and clarify some guidelines for action. The following questions will help workers focus on the important points.

HOW TO IDENTIFY THE MENTALLY ILL?

Individuals suffering from a diverse variety of mental illnesses will exhibit differing reactions to the many stressors following a disaster. In a post-disaster situation, these individuals will fall into three major categories:

- **Individuals living in hospitals in damaged or physically inaccessible areas**: Problems in their daily living arrangements will have been disrupted by interference with the availability of electricity, water, food, medical care, and nursing staff.
- **Individuals living in group homes**: These individuals may be affected by loss of their homes, alteration of their surroundings, or limited access to medication. The loss of a familiar setting may increase the acuteness of their emotional reactions, which may, in turn, be manifested as symptomatology.
- **Individuals living with their own or foster families**: These individuals also may have increased symptoms due to factors similar to those for individuals living in group homes.

If individuals are accompanied by a familiar adult helper (a parent, for example), it may not be difficult to ascertain the diagnosis and the medication needed. This is not the case if the individual is discovered alone; in such cases, the signs of disturbance in cognition, disorientation, and communication problems (severe difficulty in explaining who he/she is and what has happened) will make it clear that this is an individual who needs special attention. Individuals who cannot follow simple, life-

preserving instructions will need individual monitoring. However, during a disaster, it is always necessary to rule out any undiagnosed head injuries that might cause similar symptoms.

HOW TO DIFFERENTIATE BETWEEN THOSE SUFFERING FROM ACUTE STRESS AND THOSE WHO ARE MENTALLY ILL?

Individuals who manifest behavior that appears inappropriate for the situation should be given a rapid assessment to differentiate between individuals suffering from acute stress and those with mental illness according to whether they exhibit the following conditions:

- intense stress-reaction
- acute psychotic reaction
- effect of head injuries
- disorganization of functions in a mentally retarded individual

These four conditions are accompanied by several signs that differentiate them.

Stress reactions are manifested by (1) changes in cognition-orientation, memory, thinking, and difficulty in decision-making and (2) changes in emotions, lability, blunting, flatness. There is no break with reality awareness or loss of self-identify. The person behaves within social conventions and relates in a passive way during the acute stage.

Acute psychotic reactions have three severe manifestations which can be classified as expressions of anxiety, affective, and thinking behaviors. In general, it has been reported that diagnosed psychiatric patients behave in a subdued, calmer way than usual when they are faced with emergency situations. Some individuals may have a psychotic break if they suffer severe and prolonged trauma. Their behavior might range from apathetic, depressed, bizarre thinking, and difficulty in understanding the routine of the shelter/hospital to hyperactive, manic, unrealistic, and difficult to control.

The signs and symptoms of the **effect of head injuries** can mimic the characteristics of many psychiatric disorders, but a careful neurological exam may reveal localized signs of trauma. This diagnosis should be ruled out whenever a severe, acute clinical picture that indicating mental disorganization emerges.

Mentally retarded individuals may manifest disorganized and disoriented behavior due to the sudden changes in their routines. Their expressions of this new experience may include anxiety and infantile clinging behavior, which can be alleviated by simple instructions, support, and guidance. These individuals will manifest more infantile behaviors and have simple and concrete speech, as well as slowness in understanding instructions or suggestions.

■ HOW TO ASSIST THE MENTALLY ILL?

A number of individuals with mental illness are dependent on psychotherapeutic medications, and obtaining information about their regimen should be a priority. This should be followed by an attempt to structure their schedules and remove the patients from intense stimuli situations whenever possible. Using other survivors to assist in basic daily living activities may also be beneficial.

■ WHAT ARE SOME COMMON MEDICATION REGIMENS OF PERSONS WITH MENTAL ILLNESS?

Psychotropic medication is prescribed for different types of mental disorders. The three most common medications are antipsychotic drugs (for schizophrenic syndromes, for example) antidepressives (for minor and major depressive disorders), and lithium (for manic episodes of bipolar illness). Most patients are knowledgeable about their medication and would respond to inquiry in this regard.

■ WHAT ARE THE GUIDELINES FOR THE USE OF PSYCHOTROPIC MEDICATION WITH DISASTER SURVIVORS?

It is expected that the survivor will be assisted by a medical professional, but mental health workers should be aware of the following:

a) Basic medical precautions should be followed when prescribing medication to survivors. In general, the approach should be conservative in dealing with anxiety and psychophysiological reactions (headache, stomach ache, and sleeplessness), which are the primary manifestations during the first few days. Though survivors may wish to short circuit these very uncomfortable emotions, workers should consider first trying reassurance and counseling, with attention to the individual's living conditions, to determine whether the anxiety ameliorates without medication. If this does not happen, and psychological efforts are ineffective or the anxiety is overwhelming, then the worker should refer these survivors to a clinic.

b) Former mental patients (now living in the community)—for example, those individuals who have been diagnosed with schizophrenia or patients with dysthymic disorders (mania or depression)—will need continued monitoring of medication usage, as their judgment may become dysfunctional in the wake of a disaster.

WHAT TO DO ABOUT ANTISOCIAL BEHAVIOR PATTERNS IN EMERGENCY SITUATIONS?

Antisocial behavior is defined as the intrusive manner in which individuals clash with the norms of the community in which they live. Disaster survivors are suddenly and painfully thrown together in a desperate and unfamiliar setting. The behaviors that emerge as they try to cope and adapt might be defined by those in positions of authority as being "antisocial" because these individuals (1) break rules, (2) never seem to accept schedules, (3) refuse to take their turn dealing with helpers, and (4) in general are identified as "trouble-makers," who may also steal and lie. Diagnosing these behaviors and sorting out which are motivated by anxiety and which by personality disorders can challenge the skills of disaster workers.

Because diagnosis must be rapid during the emergency phase, it may be difficult to ascertain the motivating emotions driving antisocial behavior. The best approach is to increasingly set limits on disruptive actions.

Survivors who act out due to anxiety will experience relief if structure and support are provided. They will express mortification or guilt, and will verbalize some of their fears. In the case of aggressive, self-centered, and nonempathetic individuals, crisis workers need to use stronger measures, including segregation from the group, until more individual measures are available.

HOW TO DISTINGUISH ANTISOCIAL BEHAVIOR FROM A STRESS DISORDER?

Mr. B., a 34-year-old white male, was having difficulty sleeping. He complained about the discomfort and noise of the shelter and expressed irritation at all the rules that regimented his living activities. He was verbose, sarcastic, and angry. After an evaluation, it was decided that no medication would be prescribed but that he would be assigned a new sleeping area in the shelter. This change necessitated a rearrangement of bedding and Mr. B. did not like the new setting, either. He began to disobey the rules of group living and had problems in his unit, which prompted further investigation. He exhibited general annoyance, verbalized his dissatisfaction with rules, and boasted that he had "ways" of dealing with authority. In contrast to "stress-induced" behavior, his behavior was demanding, manipulative, and showed constant intrusion and lack of sensitivity to the rights of others, plus boasting of his "ability" to disobey authority.

An example of "increased limit-setting on disruptive actions" is provided by episodes in emergency wards where individuals begin to fight first verbally and then escalate to physical interchanges or actions against individuals that add misery to their living conditions. The first level of "limit-setting" is a personal discussion with the " survivor," which is followed by increasing control as the fighting escalates.

WHAT ARE THE SPECIAL NEEDS OF THE MENTALLY RETARDED?

Except for severely mentally retarded individuals, most retarded persons will not need special measures. Some may need assistance with instructions on how to manage in the shelter or obtain resources offered by agencies. Some careful explanation of what has happened and what plans have been made for the next few months may be of great relief to them. In cases where mental retardation is severe and accompanied by physical handicaps, it may be necessary to ask another survivor to assist in daily hygiene, feeding, and sleeping activities.

ARE THERE OTHER ILLNESS OR INJURIES THAT MASQUERADE AS RETARDATION?

There are many syndromes that are accompanied by symptoms of mental retardation. For example, an individual suffering from epilepsy may be taking an anticonvulsant, although such individuals may also have some degree of mental retardation.

HOW TO DEAL WITH EXTREME STRESS CAUSED BY THE EMERGENCY?

The information presented in previous chapters describes the interventions for addressing the emotional and cognitive reactions of survivors. Reactions to extreme stress are characterized by strong signs of fear, anxiety, disorganized speech, and inability to be consoled or quieted down. Most acute, severe reactions are short-lived when the survivor is surrounded by other individuals who are all in a similar situation and offer a role model for good coping. If the survivor has experienced physical injury, then his/her reactions will have to be evaluated in terms of pain, dependence, fear of abandonment, and central nervous system functional status as a reaction to trauma and/or medication.

WHAT RELOCATION FACTORS ARE LIKELY TO INCREASE/REDUCE STRESS?

One of the most painful conditions that survivors experience is a sensation of disorientation and lack of control over their lives. This experience is aggravated by further by the relocation that most survivors have to undergo. The process of preparing, supporting, and assisting survivors in all the location changes can intensify or ameliorate their discomfort. In their interactions with survivors, counselors should take into consideration the survivors' fear, anxiety and lack of knowledge about "the authorities" who are doing all the talking and making decisions and plans on their behalf. Any support or information that can be given to enhance survivors'

sense of control over their choices, which in turn will moderate anxiety and elevate self-esteem, will be helpful. Keeping them closer to support systems, friends, clergy, and family will be beneficial to their recovery of psychological health. Communicating imminent changes to survivors will also be helpful.

HOW TO MOBILIZE SOCIAL SUPPORT SYSTEMS AFTER AN EMERGENCY?

During a disaster and its aftermath there is often an outpouring of interest and resources by individuals in the community. Hence, the problem with support systems is not quantity, but quality—i.e., finding the appropriate "fit" between the needs of the survivors (age, sex, culture, socioeconomic status, health, etc.) and the human interest and support available. The matching of assistance to survivors has to be organized in some effective manner, which may be flexible and simple, but with genuine and serious attention to motivation, consistency, and appropriateness.

There are many organized groups in different countries whose objectives are to assist individuals in crisis. Religious groups are also available to aid survivors who ask for assistance from persons with a specific religious affiliation.

A list of available groups could be identified by geographic region. Informational support groups (non-family), while generous and enthusiastic, may need some guidance and organization to assist survivors.

HOW TO LESSEN THE STRESS OF THE HOSPITAL SETTING AND RELOCATION?

Starting from the premise that the population housed in a hospital setting has been relocated and may face further relocation, it follows that some effects of the stressors will be manifested through psychophysiological reactions. How to lessen the stressor impact on these at-risk populations is the objective of disaster planners and workers. From the curriculum content presented in earlier chapters, two major types of emotional reaction emerge: (1) reactions to the event itself, including the rescue; and (2) reactions to hospital conditions. Not much can be done about the first source of stress, except to assist survivors in sharing their stories and venting some of their pent-up tensions. As for the second source of stress— living conditions in the hospital—some flexibility might be introduced with regard to the provision of information about their physical status and prognosis and guidance and support with schedules for medical intervention and present plans of care. Daily bulletins with clear information, coupled with methods to deal with rumors about what has happened to their neighborhood, are helpful.

A "problem-solving" hospital team can expedite simple requests or can educate survivors, explaining why some of their problems cannot be solved or attended to immediately. This type of communication can diminish expectations that could, if

unchecked, culminate in further painful disappointments. Most survivors would prefer to be busy, active, and helpful, so any functions that can realistically be assigned to them will prove "moral- boosting."

Personnel trained to "absorb" painful, emotional, and angry expressions of distress, without reacting personally and becoming defensive or promising immediate solutions, may be one of the most valuable resources available to lower stress levels and mitigate survivors' reactions.

HOW TO COORDINATE HEALTH WITH MENTAL HEALTH?

Generally, mental health workers do not participate in the acute, emergency stage of disaster response, due to numerous organizational and budgetary constraints. This does not mean that government authorities in the affected region could not decide to allow public mental health professionals or appointed private systems to respond. Given the conditions in the acute phase, there is a need for pre-planning and a direct line of communication to mental health workers who are potentially available to participate in emergency operations. Once the decision to participate and the plan of action is in effect, mental health workers can assist in triage and debriefing operations, in consultation and case work-up, and in crisis intervention. To coordinate all these efforts smoothly, the administrative design should include mental health professionals in decision-making, logistics, scheduling, and setting functional priorities.

HOW CAN USE OF MENTAL HEALTH PROFESSIONALS IN THE INITIAL POST-DISASTER PERIOD ASSIST IN THE MEDICAL EMERGENCY INTERVENTION PROGRAM?

The mental health professional can bring expertise in crisis intervention techniques and medical knowledge of psychopharmacology to assist other members of the post-disaster health team. The scope of assistance will depend on the background and area of expertise, array of skills, and knowledge of the mental health team, whose members can range from psychiatrists specializing in crisis/emergency intervention, who would have the broadest base of experience for participating in the emergency response, to non-medical professionals who work in shelters and have little experience in crisis work. The assistance of mental health professionals has begun to enhance disaster emergency efforts because it brings a component of knowledge that is needed to deal with behavior patterns of not only the survivors but the helpers as well. The knowledge base of the mental health professionals working side by side with medical teams is continually increasing as more begin to practice "in the field." Mental health professionals should be considered members of every disaster triage health team. Their work, aimed at addressing psychophysiologic symptoms and reactions (affect, thinking, behavior) can be a valuable therapeutic addition to the medical emergency activities of a multidisciplinary post-disaster emergency effort.

PERSONS WITH HIV/AIDS

Individuals with HIV/AIDS present special challenges to the post-disaster worker. Due to the widespread myths and lack of knowledge about the transmission of HIV, survivors develop fear and anxiety when they find out that an individual who is HIV-positive is living, sleeping, or using the toilet facilities near them in a shelter. Mental health workers can help educate survivors and other crisis workers to reduce the fear of infection. Everyone involved in setting up post-disaster shelters needs to be able to plan to take care of patients with HIV infection, know the measures to prevent viral transmission, and be able to educate all workers to reduce unfounded fear of infection.

A grid like the one below, which shows four groups of people who may be present in a shelter, may be a helpful organizational tool for planning services for HIV-infected individuals.

Issue	HIV-infected Workers	HIV-infected Persons	HIV-negative Workers	HIV-infected Disaster Survivors
Medical	???	XXX	—	????
Social/sexual activity	—	???	—	???
Psychological problems/stress	XX	XXXXX	XX	XXX
Legal rights	X	XX	X	XX

The question marks signal that individuals who may not be identified as infected may pose a problem for shelter management in the "issue" area listed in the left column. The symbol "X" signifies that the issue must be considered when dealing with the care of an HIV-infected person in a shelter. As an example of how the grid might be used, if there is a strong suspicion that there may be an HIV-infected person in the shelter, the issue of how to deal with his/her social/sexual activity will have strong implications for prevention of HIV transmission, the individual's level of experienced stress, and his/her legal rights.

Some of the problems that need attention are:

- Reliance on volunteers in times of disaster necessarily results in a mix of values, attitudes, and cultural characteristics, as well as various levels of emergency preparedness among workers.

- Few volunteer shelter personnel are familiar with public health regulations and procedures for dealing with HIV-infected individuals in disaster *situations.*
- Training for shelter managers generally does not include content and skills relating to the mental health care of persons with HIV infection or of those living in close proximity to them.
- Experienced disaster workers are more comfortable with HIV-related information than new, inexperienced workers.
- In a disaster, there is a phenomenon of focusing on some problem, perhaps even a small one, which may provide some sense of control for disaster survivors.

TWELVE-POINT KNOWLEDGE BASE NEEDED BY WORKERS IN POST-DISASTER PROGRAMS

1. Recognition that individuals with HIV/AIDS are a new at-risk population in disaster assistance planning.
2. Identification of the unique needs of HIV-infected survivors, including medical, psychosocial, and legal needs.
3. Development within emergency agencies of clear lines of responsibility for the needs of individuals with HIV/AIDS in shelters, specialized housing, and hospitals.
4. Planning in a coordinated structure to link medical and government agencies to address the needs of survivors diagnosed with HIV/AIDS.
5. Incorporation in all training and emergency manuals of emergency care guidelines for the care of disaster survivors with HIV/AIDS.
6. Development of an inventory of existing and potential resources to respond to HIV/AIDS-related problems, including availability of health and mental health personnel; capabilities of the public health system, prison system, and mental health institutions; and preparedness of existing community-based organizations and networks, transportation and geographic location of shelters, etc.
7. Development of training materials about disaster management for incorporation in all community HIV/AIDS training programs.
8. Development of a "shelter-model" process to deal with the day-to-day problems of disaster survivors living with individuals who are HIV-infected or have AIDS.
9. Development of community emergency models for coordinating community-based HIV/AIDS services with government emergency response systems. Such models should focus on preplanning and prevention approaches to the care of HIV-infected disaster survivors
10. Awareness of the legal rights of individuals with HIV/AIDS in times of disaster in keeping with federal, state/provincial, and local laws concerning handicapped, HIV-infected, and at-risk individuals.

11. Awareness of mental health concerns in general, and HIV-related mental health concerns in particular, for medical and nonmedical mental health personnel and specially trained health personnel for disaster work.
12. Specialized training in mental health management during times of disaster to encourage therapeutic attitudes for survivors with HIV/AIDS.

POPULATIONS WITH SUBSTANCE ABUSE PROBLEMS

CONTENT SUMMARY

Individuals who are dependent on daily intake of drugs or alcohol raise difficult management issues for administrators of post-disaster programs. Counselors are asked to assist directly or through consultation to resolve the multiple problems that this population poses while they are housed in shelters or temporary housing (tents, mobile homes), whether short- or long-term for the duration of the assistance.

HOW TO IDENTIFY THE DRUG ADDICT? - POST-IMPACT PHASE

Individuals who are addicted to drugs manifest physiological signs of withdrawal when the drug is unobtainable. In most post-disaster areas, reserves of drugs are small and will diminish rapidly. Behavior and speech will identify drug users who understand the reality of not being able to obtain the needed substance. A list of the psychophysiological manifestations of drug withdrawal should be available for all disaster personnel.

WHAT ARE THESE PSYCHOPHYSIOLOGICAL SIGNS OF DRUG WITHDRAWAL?

The following signs can be expected from drug-addicted survivors following a disaster when they have no access to drugs:

- **Apprehension:** vague uneasiness or fear of impending catastrophe
- **Muscle weakness:** evident even on mildest exertion
- **Tremors:** coarse, rhythmic, nonpatterned, evident during voluntary movement and subsiding at rest
- **Psychoses and/or delirium:** usually resembling delirium tremens (DTs); acute panic attacks may occur

Other conditions which might mimic withdrawal are hysterical disorders or poisoning by contaminated drugs or food.

WHAT TO DO TO ASSIST THE DRUG ADDICT?

Counselors should refer individuals who are showing symptoms of drug withdrawal to medical/nursing staff. Symptoms of central nervous system and cardiovascular problems should be monitored. If these symptoms indicate a prognosis that is cause for concern, the appropriate acute medical measures should be taken.

The counselor needs to enlist medical personnel to assist in the treatment of these survivors. After the acute phase is controlled, a psychosocial crisis intervention is the recommended method of assistance.

■ WHAT TO DO ABOUT ALCOHOL ABUSE AFTER THE EMERGENCY?

Individuals who are addicted to alcohol will show signs of withdrawal if they have no access to alcoholic beverages. Unless the abuse has been chronic and severe, these individuals will exhibit various signs of central nervous system irritability and general discomfort, but will "weather" the acute stage of the post-disaster period. If the behavior and central nervous system signs are dysfunctional, the individual will pose a problem for the personnel in charge of managing the shelter and should be referred to medical personnel.

To assist the individual who shows disorganized and dysfunctional behavior, a structured schedule of psychological assistance can be instituted. Generally, these individuals are difficult in a passive-aggressive manner, but they do not actively and aggressively disrupt living areas.

What are the signs of alcohol withdrawal?

The signs and symptoms of alcohol withdrawal are:

- Mild or early symptoms ("impending DTs") may appear in the first week after the last drink. All the body's systems are affected: gastrointestinal, muscular, central nervous system; vegetative (sleep) and characteristic psychological and behavior patterns may emerge.
- Advanced or severe manifestations may be seen among some survivors with early symptoms. The emergence of increased irritability, severe tremulousness, and auditory hallucinations may be indications of imminent delirium tremens.

■ ASSISTING DRUG-ABUSE SURVIVORS POST-DISASTER

Situations such as those described below * may be found after a disaster. It is helpful for a counselor to be aware of these problems so as to assist and refer, but it is not within the scope of the crisis counseling program to provide treatment or conduct specialized groups. **

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* Based on the observations of mental health workers who assisted survivors of Hurricane Andrew (Florida, 1992).

** Program Guidance: Substance Abuse within the context of the Crisis Counseling Program. Washington, D.C.: U.S. Department of Health and Human Services, Center for Mental Health Services; 1995.