



Office of
Mental Health

Fundamentals of Disaster Mental Health Practice



PARTICIPANT MANUAL

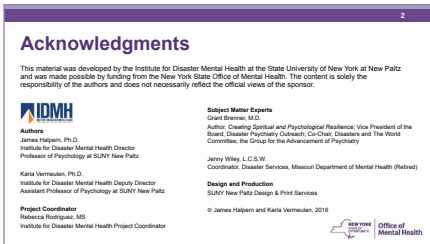


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Acknowledgments



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Program Overview

“To every person there comes in their lifetime that special moment when you are figuratively tapped on the shoulder and offered the chance to do a very special thing, unique to you and your talents. What a tragedy if that moment finds you unprepared or unqualified for work which could have been your finest hour.”

-Sir Winston Churchill

This training will prepare you for that “tap on the shoulder”—for the moment when disaster strikes and you have the opportunity to help people at a time in their lives when they most need it. By understanding how disaster characteristics impact individuals, recognizing disaster stress and reactions, understanding risk and resilience, and learning early intervention best practices, this training will make you better equipped to provide the supportive recovery environment that is so crucial to the healing of those whose lives have been touched by disaster.


A note about references in this training regarding where DMH may be used: The primary goal of this training is to prepare mental health professionals with the skills and knowledge necessary to function as a responder to a disaster response/recovery site. Most frequently those sites will be mass care shelters or Disaster Recovery and Assistance Centers, but they may also include public health PODS and hospitals. Regardless of the setting (and the particular reference used in this training material) the skills and practices necessary to assist individuals and families at a critical time remain the same.

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Training Program Goals/Objectives

After participating in this day-long training, you will be able to:


- Describe **how disaster mental health differs** from more traditional mental health practices
- Understand the **range of typical reactions** that are expectable in survivors following a disaster, including physical, emotional, cognitive, behavioral, and spiritual responses, as well as the collective effects on families, groups, and communities



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Training Program Goals/Objectives


- Understand and be able to recognize the **extreme reactions** experienced by some disaster survivors and identify evidence-based best practices for longer-term treatment of PTSD and other reactions
- Identify **risk factors** that make certain groups or individuals more vulnerable during and after disasters
- Become familiar with the procedures of DMH deployment to a disaster recovery site



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Training Program Goals/Objectives

- Review the principles of **Psychological First Aid** and practice its elements
- Understand **early interventions** and the role of screening and referral to identify and assist those demonstrating a need for mental health interventions
- Understand the importance of **self-care** for disaster responders, and consider healthy coping mechanisms in preparation for participation



Training Program Goals/Objectives (Participant Competencies)

After participating in this day-long training, you will be able to:

- Describe how disaster mental health differs from more traditional mental health practices
- Understand the range of typical reactions that are expectable in survivors following a disaster, including physical, emotional, cognitive, behavioral, and spiritual responses, as well as the collective effects on families, groups, and communities
- Become familiar with the procedures of DMH deployment to a disaster recovery site. While the primary focus will be on NYS deployment, local mental health, healthcare, and public health deployments will be covered as well.
- Understand and be able to recognize the extreme reactions experienced by some disaster survivors and identify evidence-based best practices for longer-term treatment of PTSD and other reactions
- Identify risk factors that make certain groups or individuals more vulnerable during and after disasters
- Understand the role of screening and referral to identify and assist those demonstrating a need for mental health interventions
- Review the principles of Psychological First Aid and practice its elements
- Understand the importance of self-care for disaster responders, and consider healthy coping mechanisms in preparation for participation

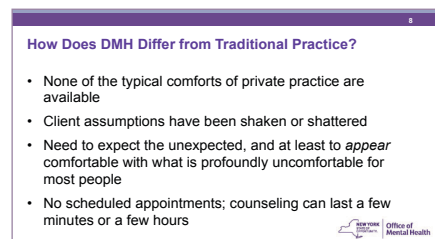
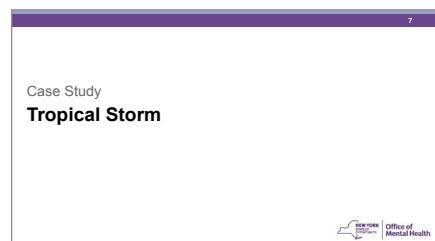
Module 1.

What Is Disaster Mental Health?

Consider the following case study and think about how it differs from your typical work situation.

A tropical storm dropped 12 inches of rain in an upstate New York county. There was a fear of mudslides and talk of copperhead snakes and bears roaming the neighborhood as their habitats were disturbed. Local residents were less afraid of wildlife and more distressed about their flooded homes. At the Disaster Recovery Center, clients waited to meet with caseworkers who would be able to arrange for damage assessment and provide them with immediate emergency funds for food, clothes, and lodging. The line was long, extending far outside. Some had to wait for hours in the blazing heat; some held children; some were in tears. Some were wet and all were hot and miserable. Most mental health workers were inside the building. However, others were assigned to “work the line.” This meant letting survivors in the queue know how long we thought the wait would be, and getting them water and snacks or small toys for the children. Most of what we did involved making contact and conversations, letting them know they were not alone, that we cared about them and what they were going through. We introduced ourselves, told them where we were from, gave them a bottle of water and asked how they were doing. We did a lot of listening. Clients told us about belongings that were lost. They struggled to do a mental inventory of what would need to be replaced—and they talked about items destroyed that were not replaceable, such as wedding albums or photos of deceased relatives. Many were thankful that there were no injuries but most were upset and frustrated with family members, nature, luck, and God. Many were upset with themselves for not having enough home insurance, or not protecting their property, or keeping valuables in the basement, or living in an area that has a propensity towards flooding.


When you respond to a disaster, you leave the familiar and ordinary world and many of the props and structures of routine work and clinical practice. The settings where you might work can be most unusual. There’s no couch and no comfortable chair for the therapist, no office and no waiting room. You enter a world where assumptions have been shaken or shattered. We



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How Does DMH Differ from Traditional Practice?

- No insurance forms!
- Everything is unpredictable, with unusual sights, sounds, and smells
- May be underwhelmed one day, overwhelmed the next
- Must be able to triage needs
- **Helper flexibility and open mindedness are essential**



live our lives thinking that the earth doesn't shake so violently it brings down buildings, that rainstorms end without creating chaos, and that planes don't crash. Yet when you enter the disaster scene you need to expect the unexpected, and at least *appear* comfortable with what is profoundly uncomfortable for most people. You might be doing counseling on a bench out in the cold. There are no scheduled appointments. There are no insurance forms. Counseling can last for a few minutes or a few hours. The practice of disaster mental health is unpredictable. There can be unusual sights, sounds, and smells. You might be underwhelmed one day, overwhelmed the next. It's not unusual for you to go to a Disaster Response Center (DRC) and find that there are far too many mental health workers on the scene. It's also quite possible that when working in a shelter or DRC that was recently set up, you'll need to be an expert at triage, deciding whom you should help first—an angry parent, a crying child, an upset volunteer, or an overworked kitchen staffer.


It should be clear from the case study that disaster mental health is quite different from traditional practice, and it requires helpers to remain flexible and open minded. Disaster mental health is not for everyone, and even if you are right for it, there may be times when you should not be doing this work. If you're under unusual stress, are grieving yourself, or if you think you're not quite fit for duty, it may be best to postpone working at a disaster. If there's one thing you can count on, it's that there will be another disaster at some point in the future. The emotional hazards of this work and the importance of self-care will be discussed in Module 6. Although it's reasonable to be careful and circumspect when you're deployed to a disaster, with training and experience you have the opportunity to be very helpful to people who are very much in need.

The Role of the Helper

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The Role of the Helper

- DMH is *NOT* traditional therapy
- We assume the survivor isn't suffering from a disorder, but is struggling to process extreme but understandable stress
- Our help must adapt to each client's situation, actively addressing acute needs



Let's begin by noting what Disaster Mental Health is not. You won't provide any type of analytic therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy or Eye Movement Desensitization and Reprocessing therapy. No traditional therapy is appropriate because you're not approaching clients as patients suffering from a *psychopathological disorder*. You approach disaster survivors with the attitude that they are under extreme but understandable stress resulting from their recent experience; they're not disordered but in fact are having appropriate reactions in most cases.

You can utilize your clinical skills and assist survivors in this most difficult time because as a mental health professional, you're experienced working with people in pain. You have the

ability to be calm in trying circumstances. Your clinical training has taught you that each case is different and that one size does not fit all.

Remember that when you assist disaster survivors, flexibility is most important. In one situation and with one client you might need to be very active. After an earthquake there could be aftershocks, but survivors will want to check their homes and remove some valuables. You might need to tell them forcefully that they're in an unsafe place and need to get to safety. Similarly, you might say to an older client who is furiously shoveling mud out of his house that he needs to be more careful not to over-exert himself. However, your next client, in the house next door, might not need such direct guidance, but only your warmth, support, and empathy. In this home you might need to listen for a long time as survivors tell you that they lost their photograph albums that were stored in the basement.


In traditional counseling, most therapists are “eclectic,” working with some combination of exploration, insight, problem-solving, and action. In disaster work, your orientation and emphasis must be very adaptable. At one DRC, a couple was very distraught because they weren't sure where they and their children would sleep that night. A counselor sat sympathetically and comforted them, explaining that everything would work out and that the situation was only temporary. However, a more effective response would have included exploring possible practical solutions by checking with the clients to see if there were friends or family who might help out, or to call agencies and advocate for the client. In fact, many relevant agencies will have representatives present at a DRC, so the responder might identify the appropriate desk for assistance and take the individual there directly.

At the same DRC a client was very distressed that a family member was hospitalized. This time, effective help meant providing calm, reassurance, and helping the client to obtain support from those who cared about her. These vignettes remind us that our allegiance is to our clients, not to any particular counseling approach, and that we have to be very adaptable when doing disaster work—sometimes providing direct guidance and sometimes providing active listening. These cases also remind us that one size does not fit all. This is one reason why Critical Incident Stress Debriefing (CISD), an early approach to providing mental health assistance post-disaster, is no longer recommended for the general public. The practice of DMH requires too much flexibility to think that any one protocol or structure of clinical intervention is the best way to help all disaster survivors.

“I Don’t Need Mental Health”

“I Don’t Need Mental Health”

- We may face resistance from:
 - Emergency management officials who don’t recognize need for DMH (for themselves as well as survivors)
 - Survivors who are reluctant to seek or accept professional assistance, but may welcome human contact and assistance
- Don’t emphasize titles and credentials – connect first and build trust to provide DMH help



In the aftermath of the most horrific event it’s possible that a disaster mental health supervisor may experience difficulties communicating with a government official or emergency management official regarding the need for mental health services. Why? The officials might not understand or see the importance of mental health services because they’re focused on catching the bad guy who perpetrated the disaster or are busy thinking about how to get the roads open or the injured to hospitals. Bear in mind that it’s not uncommon for government officials, first responders, and emergency managers to be traumatized themselves but to be too busy to identify or acknowledge their distress. Additionally, there continues to be a stigma associated with the need for mental health services. The responsibility of DMH leadership is to assess and provide DMH help to the impacted community and for DMH workers to acknowledge that we may not always be welcomed with open arms by officials or community members.

If you’re assigned to help at a shelter or DRC and sit at a desk in front of the room with a sign that says “mental health,” it’s unlikely that you’ll get much business. If you’re supporting a Family Assistance Center in a hospital and ask if anyone needs “mental health,” they’re likely to say no. Survivors who are upset, anxious, and stressed are usually not looking for a “shrink,” psychologist, or social worker. They’re often reluctant to ask for or accept professional services. What they are looking for is human contact and support. You don’t need to hide the fact that you’re a mental health professional, but you don’t need to announce it. In most cases it is not helpful to introduce yourself as Dr. Smith or Social Worker Jones. Instead, you can explain that you’re working with the state or county (or Red Cross, or other affiliation) and are experienced in helping people with stress or loss or grief, or in helping families deal with disaster. Most likely you will introduce yourself without titles, make a connection, and build on that connection to establish trust and provide DMH help.

Settings

Disaster mental health can take place at more locations than we can list. It could be delivered on a boat or bus, taking survivors to or from memorials. It could occur on a park bench not far from where a neighborhood was destroyed by flood or fire, at a morgue, in a church, in front of a home that was destroyed by a tornado or hurricane. The following is a list of some of the sites where you might be deployed within your own community, in another state, or even in another country.

- Disaster site
- Disaster Recovery/Assistance Center
- Family Service Center or Family Assistance Center
- Medical Points of Distribution (PODs)
- Outreach teams
- Headquarters/ Emergency Operations Center (administration, support)
- Shelters
- Hospital Family Assistance Center
- Schools
- Memorial services
- On the phone

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DMH Settings

- Disaster site
- Disaster Recovery/ Assistance Center
- Family Service Center or Family Assistance Center
- Medical Points of Distribution (PODs)
- Outreach teams
- Headquarters/Emergency Operations Center
- Hospital Family Assistance Center
- Shelters
- Schools
- Memorial services
- On the phone

These unusual settings raise issues for practitioners that are not found in an office setting. If you're outside or in a shelter, for example, and speaking with a survivor, there are privacy issues. It might be best if possible to walk away from the crowd and try to find a more quiet or discreet setting. At a memorial you might be speaking with a survivor when another mental health practitioner recognizes you, does not realize you're engaged in counseling, and calls out and intrudes on your conversation. You might have to tell your colleague that you're having a private conversation and will catch up with them later. If you're part of an outreach team, checking on survivors whose homes have been badly damaged, you might have to consider whether or not the home you're about to enter is safe. If survivors are moving back into an impacted neighborhood, you might encounter reporters badgering a survivor. Your most helpful intervention might be to provide some psychoeducation to the reporters by asking them to be gentler with survivors, to appreciate the enormous stress survivors are under, and to please give them the space they need now. The diverse and unique settings where disaster mental health is practiced always make for significant challenges for the practitioner. Assignments to shelters, FACs, and especially DRCs are more common than most for OMH personnel so we'll describe these settings in more detail.

Disaster Recovery Centers

Disaster Recovery Centers (DRCs) are established to provide information and referral services to individuals and families affected by a disaster. They run as a joint operation between FEMA and New York State agencies. Many state and federal agencies as well as volunteer organizations will be present, offering both information and immediate assistance across a wide range of areas from submitting insurance claims, to FEMA registration, to housing. In some instances, Mobile DRCs may be utilized to expand the reach to survivors. Providing DMH assistance at a Mobile DRC will be dependent on the logistics in each situation.

DMH responders support the DRC operation by ensuring that visitors and/or staff at the center are provided immediate emotional support if needed.

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Settings: Disaster Recovery Centers

- Joint operation between FEMA and NYS agencies
- Provide information and referral services to individuals and families affected by disaster
- DMH responders support the DRC operation by ensuring that visitors/clients and staff at the center obtain immediate emotional support if needed

A sample guidance providing specific information on being deployed by OMH to a DRC is included in the Appendices.


The DRC Site Manager coordinates all activities at the Recovery Center. If this is your first day on the site, locate and check in with the Site Manager and let them know who you are.

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Settings: Disaster Recovery Centers

Your role at a DRC:


- Check in with the DRC Site Manager who coordinates all activities and introduce yourself to workers at each table
- Let DRC staff know who you are, what your primary role at the center is, and that they can look to you for assistance should someone appear to be in need of emotional support
- Stay mobile when not working directly with an individual or group, circulating throughout the center to identify situations that might benefit from your assistance



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Settings: Disaster Recovery Centers


- If someone appears to be in distress, assess the situation and provide necessary assistance
- Be prepared to make a referral to local outpatient services or a hospital if necessary
- Provide a calming presence for DRC staff and educate them about the need for self-care



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Settings: Shelters

- Typically staffed by American Red Cross or local government housing services personnel and volunteers
- Often located in schools, churches, or other facilities via prearrangement
- Atmosphere is often hectic; conditions often crowded with little privacy




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Settings: Shelters



- Residents likely to be stressed and anxious
- Rules to ensure safety can be perceived as restrictive or upsetting



One of your first objectives at the DRC should be to introduce yourself to the other workers at each table at the center. Let DRC staff know who you are, what your primary role at the center is, and that they can look to you for assistance should someone they're working with appear to be in need of emotional support. You should plan to stay mobile when not working directly with an individual or group, circulating throughout the center to identify situations that might benefit from your assistance. If someone appears to be in distress, assess the situation and provide necessary assistance. A discreet and private counseling area should be available should you need such space to work with an individual(s).

In keeping with DMH principles, you should not address acute psychological situations but be prepared to refer such situations to local outpatient services or a hospital if necessary. Referrals or the need to contact emergency services should be coordinated with the Site Manager. The environment at DRCs may be chaotic, especially in the first days after the disaster. You can assist the staff of the DRC by providing a calming presence while checking in with them about their own situations and responses to the event and educating them about self-care.

Shelters

When there is an impending disaster and an evacuation is necessary, or if power is out during a cold or heat wave, or if victims are unable to return to their homes because they were destroyed or damaged, shelters provide a safe haven for those who cannot stay with family or friends or stay in a hotel. These shelters, typically staffed by American Red Cross or local government personnel and volunteers, could be in churches or schools where arrangements have previously been made. The atmosphere in a shelter is often hectic and stressful as residents worry about possible damage in the case of impending disaster, or think about their known losses in the aftermath of one. The conditions in a shelter are often crowded. There is little privacy, often with rows of cots placed in a large space to accommodate as many displaced people as possible. Issues may arise regarding the Americans with Disabilities Act, accessibility, and room for people with disabilities and their service animals. There can be many more people sharing a bathroom or TV than most are accustomed to. When shelter residents have to wait for long periods of time to use the bathroom, or children are misbehaving, or adults are agitated or complaining, or someone is snoring loudly, tension grows. Also, there are rules and proce-

dures intended to ensure safety and maximize the comfort of all, but which can be upsetting for some residents: no tobacco, alcohol, or illegal drugs; no pets; lights out at a specific time. All of the psychological first aid and other interventions we will be discussing are likely to be used if you assist in a shelter.

Family Assistance Centers

A Family Assistance Center (FAC) may be established after a mass casualty incident has occurred. The term FAC is applied to both assistance centers established following a major transportation accident and those established in hospital settings. In each case, the location of the FAC is a major consideration with the goal being creating a private, secure meeting place for survivors, family members, and friends. In transportation events this is usually in a hotel, conference center, or similar setting, while a hospital might identify an area away from patient care. It is in the FAC that information is shared regarding the survivor status, the victim identification process, incident investigation, management of personal effects, and the provision of disaster crisis counseling services. Following a commercial or commuter aviation accident, the FAC is established by the air carrier and managed by National Transportation Safety Board's Transportation Disaster Assistance Division, with crisis counseling and mental health support services provided by the American Red Cross. Regular briefings are held to provide families with updates about the event, the investigation, memorial services, and other relevant information.

The FAC differs from a disaster services center in that its functions address the unique needs of family members of those who are killed and injured. It should not be confused with a pre-existing victim support program office or center or one specifically established to provide ongoing case management, mental health counseling, and other traditional disaster or crime victim services and referrals.


DMH in Public Health and Healthcare Emergencies

Public health emergencies are incidents that threaten or compromise the physical health and welfare of a population. This can be the spread of disease, the intentional release of a chemical or biological agent, or a small community's only hospital being inundated by flood waters. Specific characteristics of potential public health emergencies or disasters include those incidents that cause an unexpected number of deaths, injuries, or illnesses and/or exceed the therapeutic capacities of local and regional healthcare services.

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Settings: Family Assistance Centers


- Same term used for two situations:
 - Centers set up after major transportation disasters, often in a hotel or conference center, involving many agencies (NTSB, Airline, FBI, law enforcement)
 - Centers set up in hospitals after mass casualty incidents
- Goal in both cases is to create a private, secure meeting place for survivors, family members, and friends



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Settings: Family Assistance Centers


- Regular briefings provide survivors, families, and friends updates about the event, the investigation, memorial services, and other relevant information
- Differs from DRC by focusing on unique needs of family members of those killed or injured in disaster



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DMH in Public Health Emergencies


- Incidents that threaten or compromise the physical health and welfare of a population:
 - spread of disease
 - intentional release of a chemical or biological agent
 - disaster that impact hospital functioning
- Cause unexpected number of deaths, injuries, or illnesses
- Exceed therapeutic capacity of healthcare system



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DMH in Public Health Emergencies


- Response is often long-term as an outbreak spreads and is eventually contained, so no single beginning or ending date, with different timing for those impacted
- Cause is often invisible; may be a delay between exposure and development of symptoms so fear and anxiety are common among people who believe they've been exposed and are going to become ill



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DMH in Public Health Emergencies


- Healthcare and mental health workforces may be depleted by the disease, and professionals may face their own/families' fears of exposure
- DMH may be provided via phone or social media, providing limited cues about client reactions



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DMH in Public Health Emergencies

- DMH may need to address specific stressors related to public health emergencies:
 - Real or perceived threat of pandemic outbreak
 - Anxiety around mass dispensation of medications at Points of Dispensing (PODs)
 - Emotional distress of quarantine or isolation
 - Addressing overwhelming demand for services in a hospital surge



While mental health helpers can play an important role in public health emergencies such as a pandemic, many of the stressors these events elicit are different from a more traditional disaster. They often require a long-term response as an outbreak spreads and is eventually contained, so there's no single beginning or ending date, with different timing of recovery and different anniversaries for families impacted. The cause is often invisible and there may be a delay between exposure and the development of symptoms so there's often a great deal of fear and anxiety among people who believe they've been exposed and are going to become ill – sometimes so much fear that they develop genuine physical symptoms in response to their emotions. The healthcare and mental health workforces may be depleted by the disease, and professionals may face their own fears of exposure as well as confronting resistance among family members to their reporting for duty. Mental health services may be provided by phone or, increasingly, through social media or by text. While this protects helpers from personal exposure, many find it difficult to adapt to the limited cues about client reactions these technologies allow. Overall, public health emergencies can be expected to create unusually high stress for both survivors and helpers.

Public health and healthcare emergencies do create some specific settings in which mental health support can play a critical role in improving the overall outcome for individuals including:

- **Infectious disease**
 - o Pandemics — a global outbreak that occurs when a new disease virus causes serious human illness and spreads easily from person to person. The real or perceived threat of a pandemic outbreak presents significant challenges for communities and specially their healthcare facilities and healthcare professionals.
 - o Mass Dispensing or Vaccination — some disasters present significant public health risks to the larger community. These risks can result from exposure to biological agents such as anthrax, plague, smallpox, and other deadly pathogens or more common diseases such as influenza or the not so common Severe Acute Respiratory Syndrome (SARS). In the event of such a public health emergency, there may be a need to administer specific antidotes or medications that can prevent or mitigate the physical health complications associated with these agents or diseases. These sites, known as Points of Dispensing locations (PODs) can present both logistical and mental health challenges.
 - o Quarantine and isolation — Exposure to particular biological or chemical agents or diseases may require isolation or quarantine to reduce the risk of spreading the disease to others. Isolation means to separate individuals known

or potentially “infected” from those who are healthy. Quarantine is the mandatory restriction of potentially exposed individuals to a designated area. The highly restricted environment of isolation and quarantine can lead to considerable distress and those placed under such constraints may struggle with feelings of anger, depression, anxiety, loneliness, fear, and/or grief. In those instances, DMH counselors may be called upon to provide assistance to individuals or small groups.

- **Hospital surge**

in a healthcare setting this refers to an influx of patients that can overwhelm or exceed that facility’s capabilities to respond to the healthcare needs of those patients. These patients may be suffering from real or perceived physical health issues resulting from potentially life threatening public health incident, such as influenza or a mass casualty incident.

The DMH Role Over Time


In all of these response settings, staff sometimes refer clients to DMH workers if the client is highly distressed or agitated. Sometimes a staff member signals he or she needs help from a DMH worker during the interview. Sometimes it’s clear without such a signal that a staff member or client could benefit from a mental health intervention. If the service center is crowded there can be lines of clients waiting for services both inside and outside the center. Disaster mental health practitioners “work the crowd,” making supportive contact with clients, engaging in conversations with clients who are waiting, providing brochures to adults, and giving toys, coloring books, and crayons to the children. The role of DMH workers in these circumstances is to act as a kind of emotional shock absorber, maintaining calm by lowering the arousal level through these simple actions, and through outreach that offers modest but cumulatively helpful stress relief.

In service centers and DRCs, DMH workers also provide assistance to stressed workers. One way to accomplish this is to spend time with workers socializing in the kitchen or break room, having lunch with them, and lending a hand with all of the tasks and chores that need to be done to keep a center operating. DMH workers may make sure that there’s toilet paper in the bathrooms and replace light bulbs. This is helpful for the obvious reasons of keeping the bathrooms usable and the lights on, but it also builds a sense of trust and camaraderie with the workers who DMH is there to support, should they need assistance. Counselors monitor the staff for stress, encourage them to take breaks and time off, and advocate for an environment that’s

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DMH Role Over Time


- Specific stressors DMH helpers address vary by timing, setting, and client role:
 - Working the crowd of distressed or frustrated clients waiting for services in a DRC
 - Stepping into an interaction when a client is clearly upset
 - Supporting other workers by providing practical assistance, psychoeducation, and a chance to vent



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DMH Role Over Time

- In all situations, DMH serve as “emotional shock absorbers”
- Must be aware of practical considerations (like how to dress) as well as own emotional strain



conducive to mental health. Many assistance centers also have meetings either before opening in the morning or after closing. These meetings are an excellent time for DMH staff to address the group about self-care.

Settings typically change over time. In the immediate aftermath of a disaster, you might be asked to take calls at a helpline, or assist in a shelter. It can take some time to set up a DRC, where you might be assigned days or weeks after the disaster. If survivors had to evacuate, you might go door to door helping them with the adjustment of moving back home. There are very different challenges depending on how long after the disaster you are deployed. In the earliest stages, when there is little information, survivors are more likely to be in shock, there's more likely to be press and hubbub, and it may be harder for you to be grounded. Later in the response you might see more despair or depression among survivors, including sadness and difficulty understanding why the press and the public are no longer paying attention to these survivors. Staff members' needs evolve as well as the strain of an extended deployment or the cumulative stress of being the target of survivors' frustration takes a toll.

As you can see from the unusual settings and circumstances where you might be working, DMH workers need to be aware of practical considerations. Preparedness is important not just for potential survivors but for helpers as well. You may need to be ready to respond with little advance notice. This means keeping IDs handy along with a "go bag" with clothes and supplies for several days. Helpers also have to be very mindful of how to dress, and to give consideration to the weather. We'll return to these logistical issues in Module 6.


Who Responds to Disasters in New York State?

Given the potential for extreme distress and lasting psychological reactions following a disaster, it's essential that the mental health response be provided by people with appropriate professional training. Different organizations involved in the formal response have specific standards to ensure proficiency—but you should be aware that mental health helpers often show up after a disaster as "spontaneous volunteers" who are not affiliated with a particular organization, meaning their credentials have not been vetted. To protect the safety of both survivors and spontaneous volunteers (who may be survivors themselves) these well-meaning people should be turned away by the mental health lead and encouraged to seek disaster mental health-specific training to ensure they understand the particular demands of this kind of response.

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Who Responds to Disasters in New York State?

- Regardless of role, specific training is essential! Spontaneous volunteers should be turned away, encouraged to seek training



State or County Mental Health Responders

Members of the county DMH Teams and the cadre of OMH Disaster Mental Health Responders usually possess advanced degrees in a mental health discipline and/or a CASAC degree, and/or have significant experience as a psychiatric nurse. All members must complete this training or the previous *Disaster Mental Health: A Critical Response* training. In response to large-scale events, OMH may be called upon to assist in the assessment of need and coordination of DMH services with federal resources tasked with assisting New York State. OMH is also responsible for the overall program implementation and oversight of the Crisis Counseling Program (CCP) a program of disaster mental health services funded through the Federal Emergency Management Administration.

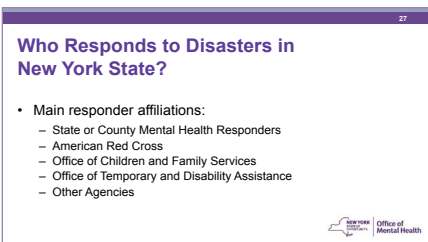
American Red Cross

The Red Cross Disaster Mental Health workforce is made up of a combination of currently and formerly licensed mental health professionals as well as non-licensed professionals working in a mental health setting. All Red Cross DMH workers are required to take specific Red Cross trainings and adhere to the processes and procedures defined by the Disaster Mental Health program.

Other Agencies

The Office of Children and Family Services and the Office of Temporary and Disability Assistance play a vital role helping New Yorkers recover from a disaster. As members of the State's Disaster Preparedness Commission (DPC), both agencies co-lead the Disaster Assistance Center Task Force whose mission is to provide a place where people can go for help in the aftermath of a disaster (i.e., DRCs and Disaster Assistance Centers).

At multiple disaster settings (e.g., shelters, DRCs, memorials) you can expect to see representatives from many government and non-governmental agencies: FEMA, NYS and NYC Emergency Management, County Emergency Management, Departments of Health & Mental Health, Small Business Administration (disaster loans), Internal Revenue Service (tax counseling and assistance), The Department of Labor (information and assistance for individuals applying for Unemployment Insurance Benefits and Disaster Unemployment Insurance), National Transportation Safety Board, FBI Victims Services, Domestic and Foreign Airlines, Disaster Chaplaincy Services and other spiritual providers, American Psychological Association, Disaster Psychiatry Outreach, National Association of Social Workers, Port Authority of NY & NJ, Local and State Victims of Crimes, National Guard. You can also expect to see representatives from Voluntary Organizations Active in Disaster (VOAD) a coalition of non-profit organizations that respond to disasters as part of their overall mission. They provide anything from clean up kits to food to donated goods and labor. The coalition's membership



includes Catholic Charities, United Way, Salvation Army, American Red Cross and numerous other faith-based and voluntary organizations.

Most of these agencies are described by acronyms and their staff often uses acronyms to describe services, policies, and procedures. Don't be hesitant to ask them the meaning of these abbreviations.

Spiritual Care in Disaster Response

According to a guide by National Voluntary Organizations Active in Disaster, "spirituality is an essential part of humanity. Disaster disrupts people's spiritual lives significantly. Nurturing people's spiritual needs contributes to holistic healing. Everyone can benefit from Spiritual Care in times of disaster."

Spiritual Care includes anything that assists an individual, family, or community in drawing upon their spiritual perspective as a source of strength, hope, and healing. In disaster, anything that nurtures the human spirit in coping with the crisis could be considered spiritual care. Disaster Spiritual Care providers may not share a religious or faith tradition with the individuals, families, and communities they try to help, and the recipients of the care may not belong to any religious community at all. The underlying goal is to provide sensitive, appropriate care for all people and to celebrate and respect every spiritual perspective.

In the short term, the primary purpose for pastoral and crisis intervention with both individuals and families is to offer security and safety. Over the long term, the primary purpose is to assist and facilitate the restoration of faith and hope, and to help find meaning in life following a disaster, particularly when there has been a loss of life.

It's not unusual for hospitals to include spiritual care as a part of their response to an event that includes multiple casualties or a high emotional impact, such as a mass shooting incident. These interventions have a high value to those impacted and provide a sometimes-critical support to those in need. While Disaster Spiritual Care and Disaster Mental Health both provide invaluable assistance they do so on parallel tracks and one is not intended to be employed as a substitute for the other. See the Resource Guide Appendix for links to further guidance on the role of spiritual care in DMH.

Spiritual Care in Disaster Response

- Includes anything that assists an individual, family, or community in drawing on their spiritual perspective as a source of strength, hope, and healing
- Disaster Spiritual Care providers may not share a faith with those they try to help, and recipients may not belong to a religious community
- Underlying goal is to provide sensitive, appropriate care for all people and to celebrate and respect every spiritual perspective



Spiritual Care in Disaster Response

- Short-term purpose is to offer security and safety
- Longer-term purpose is to facilitate the restoration of faith and hope, and to help find meaning in life following a disaster, particularly when there has been a loss of life
- Disaster Spiritual Care and Disaster Mental Health both provide invaluable assistance, but they do so on parallel tracks – one is not intended to be employed as a substitute for the other



Who Are Your Clients?

Everyone impacted by the disaster is someone who could potentially benefit from your assistance, but consider that not everyone is looking for therapy or counseling. You need to balance being more proactive than is typical in your primary work setting and yet not too intrusive or overbearing. As a supportive presence you make connections and set the stage for help you or others might provide later on. However, although you can be helpful to all who are involved with the disaster, do not assume that everyone needs and is looking for your counseling. Some survivors really benefit most from the help and support they receive from family, friends, and clergy.

In traditional practice, when a client calls asking for help, their status as patient is often unambiguous. In Disaster Mental Health, we typically do not “treat patients,” as we’re not often making diagnoses. Rather, we’re assisting those impacted by the extreme stress caused by disaster. If you’re assigned to a shelter you need to have a very wide lens as you assess whom to help. It might be clear that a parent needs help with a frightened child, or that a couple is arguing over what they forgot to bring to the shelter, or a shelter worker may approach you to say that there’s a resident showing strong signs of distress who needs help. However, if there are no obvious indicators, you can still provide considerable assistance.

- You might check with the shelter managers to determine if there are residents or staff members who could use support.
- You might walk around the shelter or DRC and introduce yourself to residents/visitors and let them know you’re available if they need anything, or wander into the kitchen or break room so you can get to know staff members and build a sense of connection and trust in case they need help later in the response.
- You might also check to see if people are generally comfortable—decent lighting, food, and clean bathrooms.
- You can let people know that food is on the way, that toys are available for children, that the storm has passed, that the local sports team won the game.
- You might just listen to their complaints about shelter life or frustrations with response resources.
- You can check in with response leaders, reporters outside the operation, or first responders coming in for a break to see how they’re doing and if they could use some DMH support.

Who Are Your Clients?

- Potentially everyone impacted by disaster – but remember that not everyone is receptive to accepting help
- In DMH role, may need to be more proactive than usual yet not intrusive or overbearing
- Some survivors benefit most from help and support from family, friends, and clergy



Who Are Your Clients?

- May be obvious who needs help with distress, anxiety, anger
- Other actions are more subtle – you could:
 - Check with the shelter managers about residents or staff members who could use support
 - Walk around a shelter or DRC, introduce yourself to residents/visitors and let them know you’re available if they need anything



Who Are Your Clients?


- Check to see if people are generally comfortable – decent lighting, food, and clean bathrooms
- Let people know food is on the way, toys are available for children, the storm has passed, the local sports team won the game
- Listen to complaints about shelter life or frustrations with response resources
- Check in with response leaders, reporters outside the operation, or first responders coming in for a break




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Remember...

- People don't always want to talk about the disaster – sometimes they need a break
- Appropriate humor can provide needed relief, but be cautious – allow the survivor to take the lead




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Remember...

- Survivors may find it difficult to tell their stories multiple times to different DMH workers – be sensitive to this when you meet a client and, if possible, introduce the client to the worker taking over your role to provide a soft handoff

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While taking all of these actions, remember that people don't always want to talk about the disaster. Sometimes they need a break. Appropriate humor can also provide needed relief, but be cautious about being perceived as insensitive by those who are suffering. Allow the survivor to take the lead in incorporating humor into any exchange. It's also worth noting that individuals experiencing reactions may find it difficult to tell their stories multiple times to different DMH workers cycling in and out of volunteer disaster roles. Be sensitive to this when you first meet a client and, if possible, when you're preparing to rotate out of a deployment, try to introduce the client to the incoming DMH worker who is taking over your role. This can provide a soft handoff and eliminate additional stress if the survivor needs more than a brief intervention.

Now let's turn our attention to the wide range of reactions you're likely to encounter when you're called to assist during or after a complex emergency.

Module 2.

Disaster's Impact

Range of Reactions

As was discussed in the article you read about Disaster Characteristics, reactions to disasters tend to correspond in particular patterns to the event cause, size, expectedness, and timing. However, those group-level patterns are also impacted by the survivor's individual characteristics (such as pre-existing strengths or vulnerabilities), and by characteristics of the response (for example, were survivors' needs met in the short- and long-term?).

This module will examine the wide range of responses you may encounter while helping disaster survivors. Experiencing and recovering from a disaster is new for most people so a key role of the DMH helper is to demystify their emotions—which requires familiarity with the full range of typical reactions. Helpers and survivors alike may be surprised by how varied individual responses can be. Not only will each person experience a specific combination of reactions across a number of realms so you'll see **inter-individual differences** between survivors, but those reactions also change as people adjust to what has happened to them and begin to absorb the extent of their losses, leading to **intra-individual differences** as particular people's reactions shift over time as well.

Both of these types of difference can complicate the recovery process for survivors, and complicate your ability to help. Since you probably won't know how survivors functioned before the disaster it may be difficult in a brief interaction to assess whether a person's reactions seem in line with expectable distress or are indications they need more intensive support. And at any point in time, survivors may compare and judge themselves or others for their disparate reactions, including within families (for example, "my partner just wants to put this behind us and move on—how can s/he be so unfeeling?" vs. "my partner just keeps dwelling on what happened—why can't s/he try to put this behind us and move on?"). That can increase stress, perhaps making one partner feel weak or misunderstood and the other partner frustrated and impatient.

Then as an individual moves through the painful process of adjusting to their losses, new emotions can emerge. While ultimately the arc of this evolution typically bends towards recovery, the shifts along the way can be destabilizing for a survivor who has perhaps learned to manage a certain level of anxiety about their situation, only to have that emotion evolve into a new (likely temporary) sense of hopelessness about the future.

Range of Reactions: Key points

- Group-level patterns vs. individual reactions
- Inter-individual differences AND intra-individual differences over time
- No knowledge of client's pre-disaster functioning
- **Post-disaster traumatic stress may resemble Posttraumatic Stress Disorder, but doesn't equal it!**




Further complicating the picture, be aware that early responses to extreme stress can look somewhat like Posttraumatic Stress Disorder or Acute Stress Disorder. People may develop a heightened startle response or be generally anxious and have problems sleeping. They may re-experience the event, especially when triggered by cues in the environment (for example, storm clouds after a hurricane, or loud noises after a bombing). While these responses can be very disturbing for those experiencing them, our expectation is that over time these reactions will fade away for most people, becoming less frequent and less intense. The disaster becomes a “normal” if unpleasant memory, one which is accessed from time to time but that doesn’t possess the immediacy of the original experience so it doesn’t activate a self-sustaining cycle of the physiological arousal of the “fight or flight” response.


While that gradual reduction of symptoms is the usual outcome, this natural recovery process does not occur for some individuals who will go on to develop PTSD or other serious conditions, which we’ll discuss briefly toward the end of this module. The bottom line is that post-disaster traumatic stress does not equal Posttraumatic Stress Disorder, and one goal of mental health interventions after disaster is to assist survivors with the former in order to prevent the latter.

Reactions by Type

See the manual for complete lists of reactions in each realm:

- Emotional
- Behavioral
- Physical
- Cognitive
- Spiritual



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Reactions by Type

Common or typical reactions are those that “make sense” after disaster exposure and therefore don’t suggest that the individual is at risk for developing lasting emotional or psychological problems. These reactions are typically grouped into different areas of functioning: emotional, behavioral, physical, cognitive, and spiritual.

Common Reactions of Disaster Survivors

Emotional:

- Depression, sadness, tearfulness
- Anxiety, fear
- Guilt, shame, self-doubt
- Apathy, emotional numbing
- Feeling overwhelmed, hopeless, out of control
- Panic
- Irritability, impatience
- Anger, hostility, rage, resentment
- Emotional lability (mood swings)

Behavioral:

- Avoidance of reminders of the disaster
- Blaming (of self or others)
- Change in sleep habits (sleeping too much or too little)
- Change in diet (eating too much or too little, seeking comfort in unhealthy foods)
- Numbing through alcohol or drugs
- Hypervigilance, inability to relax
- Social withdrawal, isolating oneself
- Increased conflict with family, co-workers, outbursts of aggression
- Immersing oneself in activity to avoid thinking about event
- Crying easily
- Trying to over-control relationships, bullying others
- Change in sex drive

Physical:

- Jumpiness, edginess, agitation, increased startle response
- Appetite change (general increase or decrease, craving for sweets)
- Increased desire for caffeine, nicotine, alcohol
- Cardiovascular symptoms (palpitations, breathlessness, rapid and shallow breathing, lightheadedness)
- Gastrointestinal distress (indigestion, nausea, constipation, diarrhea)
- Sleep disruption (fatigue, exhaustion, insomnia)
- General somatic symptoms (muscle tension or pain, headache)
- Worsening of chronic health conditions

Cognitive:

- Disbelief, sense of unreality
- Worry, rumination, preoccupation with situation
- Difficulties with memory or concentration
- Reduced ability to focus, solve problems, or make decisions
- Confusion, slower processing speed
- Cognitive misappraisals (inappropriately blaming self or other, all-or-nothing thinking)


Spiritual:

- Change in relationship with God or higher power (increase in faith, questioning of faith)
- Change in religious practices (increase or decrease in prayer, attending services)
- Questioning of belief in a just world
- Struggle with questions about reality, meaning, justice, fairness

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Reactions by Type

- This vast range makes assessment difficult, but underscores importance of providing support to all survivors
- These reactions make sense, but still feel overwhelming to the survivor – don't minimize them by describing them as "normal"
- Knowing reactions are likely to improve over time shouldn't be used as an excuse not to provide assistance



This broad range of expectable reactions underscores the challenge of assessment in post-disaster settings. As noted earlier, unfamiliarity with survivors' pre-disaster functioning can make it difficult to differentiate an individual's reaction to the event from his or her typical manner of expression or interacting with others. Additionally, survivors' changing reactions over time make it difficult to determine how vulnerable specific survivors may be to more lasting psychological consequences. While these facts can make the practice of disaster mental health seem daunting, they also underscore the importance of providing a positive, safe, and supportive recovery environment so all survivors have the best possible chance to bounce back from their disaster experience. Psychological First Aid and psychoeducation, described later, can both be considered "universal interventions" that can and should be offered to everyone post-disaster in hopes of activating people's natural recovery and heading off any lasting effects.

That said, there are two key points we would like to make regarding these typical reactions.

First, although they are common and reasonable in response to a particularly traumatic event, they're often shocking and overwhelming to those experiencing them. Survivors will often say that they think they're going crazy, they fear they'll always feel this way, they feel weak for not being able cope better, and so on. A common phrase in the field used to be "you're experiencing a normal reaction to an abnormal situation." We encourage you NOT to use this wording as it feels anything but normal to the person in the throes of these intense emotions, so describing it that way risks sounding dismissive or insensitive to the survivor, undermining their trust in your ability to assist them.

Instead, it may be more helpful to describe these feelings as reactions that are painful but understandable under the circumstances; to explain that many people experience similar strong feelings and that most start to feel better once some time has passed; and to provide information about finding someone to talk to if they're not starting to feel better soon or would like to speak to a helper now. That approach acknowledges and validates the person's current suffering while creating an expectation of recovery—and while providing resources to help in the event that additional assistance is indeed needed now or later. We'll return to this point when we practice Psychological First Aid.

Second, our professional recognition that these reactions are common and will most likely improve over time should not be used by response organizers as an excuse for ignoring or dismissing how much distress they may be causing survivors at that moment. A great deal of recent research in the field has focused on some people's innate resiliency (i.e., the work of Bonanno and various collaborators) and ability to achieve Post-Traumatic Growth after a loss (building on the work of Tedeschi

and Calhoun). While DMH helpers certainly want our clients to reach these positive outcomes in the long run, we should remain vigilant that an overemphasis on these results for some survivors isn't used as a reason to limit resources for support in the short-term. Although migraine headaches pass with time, health care professionals still provide assistance for the pain. Similarly, although most people recover from disaster stress eventually, we should still do all we can to mitigate this suffering.

Reactions Throughout the Disaster Life Cycle


Disasters unfold over time, and most can be divided into phases, though there are some exceptions: Slowly unfolding threats like climate change or chronic situations like ongoing civil unrest may make it hard for people to identify a clear "before" and "after." However, more traditional events do have an identifiable impact phase, and you may discover that survivors divide their lives into the pre- and post-disaster.

We referred earlier to intra-individual changes as a survivor's reactions evolve over time. Understanding the "disaster life cycle" may provide insight into some typical patterns of reaction, though as always the characteristics of the event, the individual, and the response will impact any given person's state at a particular time. That means that the following patterns are useful as a general guideline, but don't expect every person you help to follow them in a linear fashion. Individuals may have very different responses at a given point, or they may cycle back and forth between phases as, for example, reminders of the event cause a recurrence of symptoms or new access to resources increases optimism and reduces negative emotions.

Disaster mental health workers are generally not present for the **pre-impact** and **impact** stages and usually work with survivors during the **post-impact** stage. However, in some cases of expected events, DMH workers are asked to provide pre-impact assistance in shelters in anticipation of an extreme weather event, or to provide immediate, on-scene mental health support, especially when there are fatalities or injuries, or when other disaster responders are understood to need psychological support (for example, in a disaster involving child victims). There also may be secondary events like the aftershocks of an earthquake that mean DMH helpers are on-site during the subsequent impact period.

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Reactions Throughout the Disaster Life Cycle



- Most (but not all) events have an identifiable impact phase
- Survivors may divide their lives into pre- and post-disaster

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Reactions Throughout the Disaster Life Cycle

- The "disaster life cycle" provides insight into **typical** patterns of reaction, though characteristics of the event, the individual, and the response impact any given person's state at a particular time
- Don't expect every person you help to follow this pattern in a linear fashion

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Reactions Throughout the Disaster Life Cycle: Pre-Impact

- Receiving a warning creates a decision-making situation where most factors in the decision will point to NOT taking the recommended action
- If warning was received and ignored: guilt, self-blame


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Reactions Throughout the Disaster Life Cycle:

Pre-Impact

- If no warning was received: Survivor may feel stunned; be unable to process experience immediately; look for someone to blame for lack of warning; feel vulnerable about future events
- DMH probably not present, except in shelter opened in advance




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Reactions Throughout the Disaster Life Cycle:

Impact

- Characterized by magnified arousal levels as the fight, flight, or freeze response is activated – survival is the goal
- Panic is rare; purposeful and productive actions are more the norm




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Reactions Throughout the Disaster Life Cycle:

Impact

- How competent or helpless a person acts and feels at this time can play a key role in how they'll process the disaster experience later
- Again, DMH probably not present, except in shelter opened in advance




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Reactions Throughout the Disaster Life Cycle:

Post-Impact

- Heroic / Rescue
- Disillusionment
- Honeymoon
- Reconstruction

Timeframe for each stage varies depending on the scope, intensity, and duration of the catastrophe as well as the resources available for recovery





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Reactions Throughout the Disaster Life Cycle:

Post-Impact

Heroic / Rescue

- Adrenaline-fueled rush to save lives and protect property
- Physiological and psychological arousal may limit thinking and coping capacities
- Focus is on action – emotional effects are just beginning to be absorbed, so little role for DMH


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Reactions Throughout the Disaster Life Cycle:

Post-Impact

Honeymoon

- Strong sense of community as those impacted feel unified by their collective experience
- Influx of attention, media, money, and personnel at the scene



Before and During Impact

As noted in the reading on characteristics, disasters with warnings allow people to prepare cognitively and emotionally, helping to jumpstart coping mechanisms. If there's little or no warning, there may be more initial shock, disbelief, and fear. However, if there was a warning which people disregarded, you can expect to see a great deal of shame, guilt, and self-blame later on.

The impact stage is characterized by magnified arousal levels as the fight, flight, or freeze response is activated. Survival is the goal. Contrary to stereotype, panic is rarely seen (the exception being when access to escape is perceived as insufficient, as in a rapidly spreading fire in an enclosed space). Instead, purposeful and productive actions are more the norm. How competent or helpless a person acts and feels at this time can play a key role in how they'll process the disaster experience later, though in hindsight people often have unrealistic beliefs about what they could or should have done better at the time of impact that may need to be addressed. Still, this underscores why preparedness is so important—when disaster strikes, the prepared individual has the best options available without having to figure it out in the heat of the moment.

Beyond Impact

The post-impact period can be broken out into the heroic, honeymoon, disillusionment, and reconstruction phases, indicating a progression of emotional reactions. The timeframe in each of these stages varies depending on the scope, intensity, and duration of the catastrophe as well as the resources available for recovery.

The immediate aftermath of disaster often brings out the very best in people during the **heroic** phase, as those impacted attempt to assist each other, often before external help arrives. People struggle to help their neighbors, dig survivors out of rubble, provide first aid, and so on. Sometimes the lingering physiological arousal impairs judgment and the rush to help exposes survivors to additional harm. As in the impact phase, the focus here is generally on action while the emotional effects are just beginning to be absorbed.

Once the dust begins to settle, there's often an influx of attention, media, money, and personnel at the scene to help those directly affected. This leads to a **honeymoon** period where those impacted feel unified by their collective experience. Community feels strongest at this time, and people are most able to put aside individual differences. Survivors often downplay the significance of material losses in their elation at having survived, so you may hear statements at this time like "Our house can be replaced, the only thing that matters is that we're all alive!" Community members are shored up by the assistance and attention they're receiving and optimistic that they'll quickly be able to get

back to normal. Social barriers and other differences are minimized and a collective community spirit rules as neighbors vow to get through it all together.

Like any honeymoon, that phase does not last. With the inevitable reduction in attention and response resources as time passes and external interest wanes, the **disillusionment** phase descends as survivors begin to absorb their losses and that immediate sense of community bonding fades. (Note that in many events, survivors bypass a honeymoon and go directly to this phase, especially if there has been the death of a loved one, community members feel neglected by outside helpers, or other factors block the temporary optimism of the honeymoon period.) This phase can be thought of as a kind of reality check: Realization of the full extent of losses and the barriers to recovery begin to sink in, and community members may feel abandoned by the media, the public, and the aid agencies that had previously been so helpful. The communal spirit begins to erode as disparities in damage and resources become apparent. This phase may be the lowest emotional point for survivors as they come to terms with the permanent impact of the disaster, recognizing and accepting what they've lost and what they must do to try to create a "new normal." This is clearly a time when mental health helpers should be available to assist survivors.

Eventually, the **reconstruction** phase typically begins as the community and its individual members accept that they must adjust to changed circumstances on their own. Depending on the scope of the event this can last a few months or extend to decades. The tasks here may be quite profound depending on the extent of change and loss. While outside mental health helpers (for example, those deployed to an impacted region by the American Red Cross) may not be present for much of the reconstruction phase, local helpers can and should remain attentive to survivors' longer-term mental health needs, providing ongoing psychoeducation and support for those who are recovering as expected as well as identifying and assisting those in need of clinical help. Additionally, anniversaries and other ceremonies are often supported by a DMH presence, providing a chance for mental health professionals to monitor long-term reactions and do outreach to community members who may still be struggling with their reactions.

This stage model affects DMH planning and practice by suggesting what survivors may need at the different points in the process of recovery, and how those needs are likely to evolve in the future. For example, asking hurricane survivors who have just lost their homes and narrowly escaped death to process their sense of loss and grief in the earliest stages may do more harm than good. Awareness of the phases also allows us to anticipate and prepare for upcoming mental health needs. Without this understanding, a helper might conduct a needs assessment


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Reactions Throughout the Disaster Life Cycle:

Post-Impact

- Survivors often downplay significance of material losses in their elation at having survived
- DMH should ideally establish a presence now, in order to have foundation for helping in later, more difficult stages

NOTE: Honeymoon phase may not occur in events with fatalities, very extensive damage, or a lack of response resources




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Reactions Throughout the Disaster Life Cycle:

Post-Impact

Disillusionment


- "Reality check" – full extent of losses and challenges of recover are absorbed
- Outside assistance and attention begins to pull out




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Reactions Throughout the Disaster Life Cycle:

Post-Impact



- Community bonding fades as disparities in damage and resources emerge
- Lowest point, where DMH help is most needed




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Reactions Throughout the Disaster Life Cycle:

Post-Impact

Reconstruction

- Community and individuals accept they must adjust to changed circumstances on their own
- Goal is to establish a "new normal," including accepting things won't be the same as before – but could be better in some ways




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Reactions Throughout the Disaster Life Cycle:

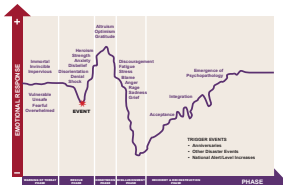

Post-Impact

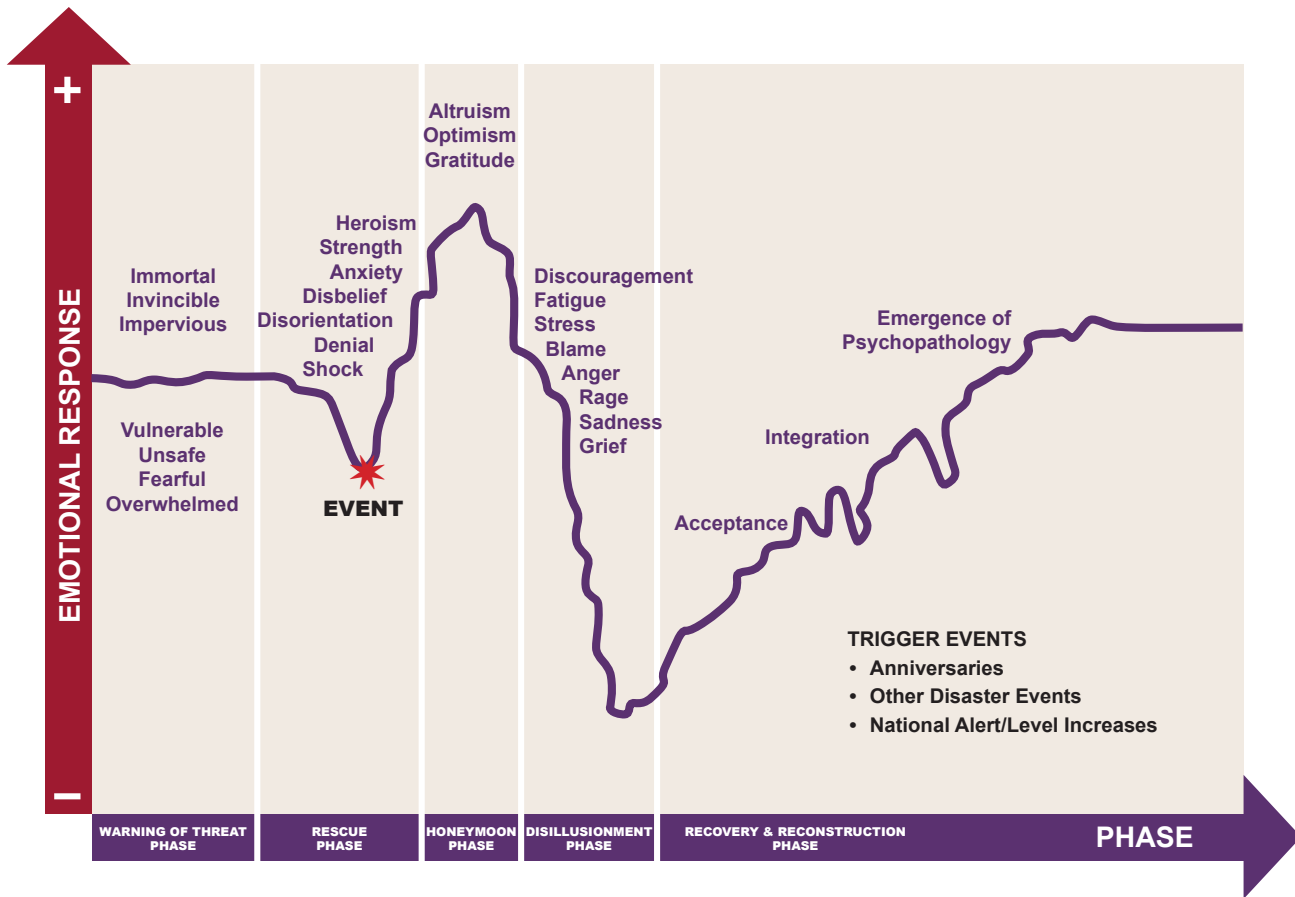
- Provision of mental health services shift from deployed DMH to local helpers



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Reactions Throughout the Disaster Life Cycle:



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Reactions Throughout the Disaster Life Cycle

- Response stages are not always a clear and linear process
 - People will progress at different rates
 - May skip some stages, esp. Honeymoon
 - May revisit earlier stages, especially when reminded by anniversaries or repeated events
- But, knowing patterns of reactions allows for planning and anticipation of future needs

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during the honeymoon stage, conclude that the community is coping well, and depart before the negative reactions of the disillusionment phase emerge and services are most needed. But we can't emphasize strongly enough that **these phases are not universal**, so as always, you need to understand where the individual you're assisting is in their personal adjustment process at that particular point in time.

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Proximity and the Dose-Response Relationship

- Those closest to the point of impact typically :
 - demonstrate stronger emotional reactions and the most need for support
 - have the most resources directed towards them

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Proximity and the Dose-Response Relationship

Disasters exist in space as well as time: Each can be thought of as a bull's-eye. Consistent with the dose-response relationship described in the reading, those closest to this epicenter—the point of impact—typically demonstrate stronger emotional reactions and the most need for support.

Naturally, most of the convergence of aid after a disaster occurs in the impact zone, so mental health services do tend to be directed to those indicated by the dose-response guideline. However, it's important to keep in mind that experiencing a disaster even from some distance can produce strong emotional

reactions. In fact, research after the World Trade Center attacks on September 11, 2001, suggested that even watching an event on television could induce PTSD-like symptoms, though these tended to be short-term in nature and were not associated with diagnosable PTSD a year later among viewers without a family psychiatric history and/or pre-attack trauma history (Neria et al., 2006). Similarly, the current official diagnostic criteria for PTSD do not recognize media exposure as a triggering experience except in the case of certain professional roles (DSM-5, 2013), but that doesn't mean that this exposure can't cause short-term distress among those not directly impacted, particularly if they identify with the victims in some way. Encouraging people (including ourselves) to limit media exposure can help prevent this type of vicarious trauma.


Another group whose mental health needs are often overlooked in the focus on direct survivors are the helpers—particularly those who are not official first responders, since those professional groups do tend to receive protective training and post-event support. A recent example of this is the loggers and heavy equipment operators who participated in rescue and recovery efforts in Oso, WA after the 2014 mudslide that killed 43 people. While these volunteers contributed essential technical skills to the rescue and recovery efforts that lasted for four months until the final body was recovered, they did not have the training and preparation for dealing with the gruesome sights they encountered, nor did they have the needed support structure afterward (Lurie, 2015).

Returning to the attacks of 9/11, an analysis of workers enrolled in the World Trade Center Health Registry who were involved in on-site rescue and recovery efforts found significantly higher rates of probable PTSD two to three years later among those in occupations who were not likely to have had prior disaster training or experience (Perrin et al., 2007). While there was widespread recognition at the time of the impact on police and firefighters given the high rates of colleague casualties, this study found probable PTSD rates were equally high for emergency medical workers (14.1%) as for firefighters (14.3%). Examining two generally overlooked groups, they found rates of 13.0% among sanitation workers, and a remarkable 20.8% among construction or engineering workers, particularly those involved in search and rescue activity in the collapsed buildings. They also found that unaffiliated volunteers had probable PTSD at triple the rate of those working through volunteer organizations, 24.7% versus 8.4%. The authors specifically point to the lack of access to mental health services among unaffiliated volunteers, construction/engineering workers, and sanitation workers as a likely cause of their higher rates of distress, compounded by a lack of recognition of their efforts relative to professional first responders.

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Proximity and the Dose-Response Relationship

- This focus may lead to overlooking other groups in distress:
 - Those who identify closely with victims
 - Responders, esp. unofficial/volunteer
- Keep an open mind about who may need DMH support



There's no shortage of other examples of groups whose needs have been overlooked in disaster mental health planning because they were not directly proximate to the event at the time of impact. Our main point here is that recognizing the dose-response relationship is important, but it's also essential to be on guard for those whose needs may not be recognized and not to "profile" those impacted by disasters. One of the most helpful attributes of a disaster mental health worker is having an open mind and making it safe for clients to allow their personal experience to unfold and to be treated as individuals, regardless of whether their distress would be predicted by the research on group-level reactions.

Risk Factors

As we've seen, proximity to the event and the dose of exposure received are among the strongest predictors of post-disaster distress. There is also evidence that certain groups of survivors merit additional attention because they may have more intense needs before, during, and after disaster. For example, members of certain vulnerable populations may need more assistance evacuating due to mobility issues or special equipment requirements. They may have difficulty residing in a general shelter because of physical or psychological challenges. They may have lost necessary assistive devices (glasses or hearing aids, crutches, oxygen tank) during the disaster, or lost the caregiver they relied on for support. Because members of these groups typically require more resources before, during, and after disasters, they can slip between the cracks of response agencies that are already stretched thin.


As this graphic illustrates, this means it's likely that members of these groups will have had a more difficult experience of the event itself—a higher dose—which is itself a risk factor, *and* they may have fewer recovery resources than the general population, another risk factor. Therefore, it's important to recognize that these populations are viewed as vulnerable not because of any intrinsic weakness, but because of certain characteristics that tend to exacerbate their experience before and during the event. This, in combination with the potentially compromised strength of their support systems, can aggravate their reactions afterwards.

There's not enough time in this training to address all risk factors in detail, but as a starting point we encourage you to consider how you'll address the special needs of the following vulnerable populations throughout the disaster cycle. These are groups that are likely to be present in any community, but you should also consider your own region and how you'll prepare for other groups with specific needs. For example, do you have a large population

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Risk Factors

- What puts people at risk for more extreme reactions to disasters?
 - Dose (intensity/length/proximity of exposure to event)
 - Lack of resources/social support
 - Membership in a vulnerable population




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Vulnerable Populations

"Groups whose disaster-related needs may be more complex or intense than most survivors' needs, exceeding what can be fully addressed by traditional service providers."

(Halpern & Tramontin, 2007, p. 138)




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Vulnerable Populations

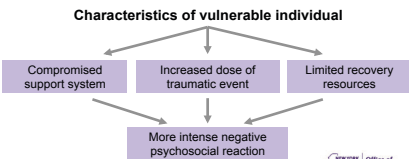
Examples of additional needs:

- Assistance evacuating
- Special sheltering conditions
- Restoration of medications or assistive devices
- Provision of assistance with activities of daily living




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Mediating Factors



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    graph TD
      A[Characteristics of vulnerable individual] --> B[Compromised support system]
      A --> C[Increased dose of traumatic event]
      A --> D[Limited recovery resources]
      B --> E[More intense negative psychosocial reaction]
      C --> E
      D --> E
    
```



of immigrants or members of a particular faith who you'll need to adapt post-disaster services for?

For all of these groups, remember that they're likely to be the best advocates for their own needs, so your efforts to address those needs should take a collaborative approach (just as it should with everyone you work with). They're the experts on their own situations, so be sure to focus on what you can do *with* them to support their recovery, not what you should do *for* them.

Children

Some in the field like to claim that kids are universally resilient and bounce back easily from negative experiences, and they are indeed generally able to recover provided their socioemotional needs are met. However, children are also vulnerable in a number of specific ways that differ from adults. They may be unable to physically escape a situation, so they're more susceptible to physical injury and traumatic exposure. They depend on caregivers for physical and social-emotional safety, so if caregivers are physically or psychologically unable to care for them, children are at great risk of suffering. And the impact is not limited to short-term distress: Untreated stress reactions can disrupt normal development, which can lead to prolonged social-emotional difficulties.

Children's reactions and needs must be viewed in context of the family system: Did parents/other family members also experience the event? How are they coping with their own experience? Do they feel capable of handling the child's reactions? What were pre-existing strengths and weaknesses in the family, such as socioeconomic status, parental conflict or unity, or other stressors? As this contextual emphasis implies, children's treatment is also best framed within the family system. In particular, short-term DMH efforts are largely focused on helping caregivers help their children, both by providing psychoeducation about how children indicate distress at different developmental stages and by giving caregivers tools to support their children and themselves.


Frail older adults

While healthy older adults may have no different needs than younger adults, those who are already coping with limitations in one or more functional realms that impact their activities of daily living may be more susceptible to a cascade of negative effects from disasters. They may have mobility problems that impair their ability to take protective action or to cope with conditions in a shelter. Pre-existing medical conditions may be exacerbated, especially if access to medications or assistive devices is disrupted. Even mild cognitive limitations are likely to worsen under stressful or chaotic post-disaster conditions. As a result, older

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Vulnerable Populations: Children


- May be unable to physically escape a situation, so more susceptible to physical injury and traumatic exposure
- Depend on caregivers for physical and social-emotional safety – at risk if caregivers are physically or psychologically unable
- May suffer disruption to their normal development, leading to prolonged social-emotional difficulties if not resolved



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Vulnerable Populations: Children

- Reactions and needs must be viewed in context of family system:
 - Did parents/other family members also experience the event? If so, how are they coping?
 - What were pre-existing strengths and weaknesses in the family? (i.e., SES, parental conflict/unity, communication patterns, other stressors)
 - Do they feel capable of handling the child's reactions?



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Vulnerable Populations: Children


- DMH focuses on helping caregivers help their children via psychoeducation and by giving caregivers tools to support their children and themselves




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Vulnerable Populations: Frail Older Adults


- Pre-existing limitations that impact activities of daily living may limit ability to take protective action or cope with shelter conditions
- Medical conditions may be exacerbated, especially if access to medications or assistive devices is disrupted



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Vulnerable Populations: Frail Older Adults


- Cognitive limitations likely to worsen under stressful or chaotic post-disaster conditions
- Extreme resistance to evacuating – leaving home, mementoes, pets
- May have a foreshortened sense of future – believe they won't live long enough to create the "new normal" younger adults hope for



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Vulnerable Populations: Frail Older Adults

- Often have a limited social circle to turn to for support
- May resist seeking or accepting help because they don't want to feel like a burden to others
- BUT: many older adults exemplify strength, resilience, and inspiration, and can be a source of knowledge, experience, skills, and wisdom provided physical needs are addressed



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adults are often particularly resistant to evacuating, especially if that means separation from a beloved pet.

When they do experience losses, older adults may have a foreshortened sense of future, a belief that they won't live long enough to create the "new normal" younger adults hold out hope for. They also often have a limited social circle to turn to for support, and may resist seeking help because they don't want to feel like a burden to others. As a result, older adults may be reluctant to discuss their "state of being" with DMH. These individuals may frequently tell you to go help someone in more need so a number of visits and the establishment of trust will be needed. That said, many older adults exemplify strength, resilience, and inspiration. They can be a vital source of knowledge, experience, skills, and wisdom in all phases of emergency and disaster response, provided their physical needs are addressed.

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Vulnerable Populations: People with Physical Disabilities

- Far from a homogenous group, but often treated like one in planning so many needs are overlooked
- People with serious disabilities may be on lower SES spectrum with few resources for preparation or recovery



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People with physical disabilities

In considering this group's needs, remember that the impact of a specific disability results from the interaction between an individual's impairment and their environment, including physical barriers and availability of services and assistive technologies. The same condition may be completely manageable in one setting or with access to certain aids, and highly debilitating in another. How many of us would instantly become disabled if we merely lost our eyeglasses in a disaster? As this suggests, the primary goal in assisting people with physical disabilities is to restore needed services or equipment, or remove barriers that worsen mobility or sensory impairments.

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Vulnerable Populations: People with Physical Disabilities

- May feel guilt or shame about needing additional assistance, or anger about needs being overlooked
- Post-disaster needs primarily logistical, not emotional



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Note that people with physical disabilities are a far from homogenous group—yet they're often treated that way in disaster planning and response, leading to inappropriate communications or services that fail to help large segments of those in need (National Council on Disability, 2009). Their vulnerability is compounded by the fact that people with serious disabilities often have limited employment options and may be living at the lower end of the economic spectrum of their community. This means they may lack the discretionary funds to pay for transportation or to stockpile food, water, and other supplies, and they may live in less sturdy housing that can't withstand extreme weather conditions. Some may experience guilt or shame post-disaster, feeling like a burden on others rather than like active members of the response, or they may feel anger about having their needs overlooked. Still, the disaster-related needs that differentiate people with physical disabilities from the general population are primarily logistical rather than emotional, so addressing those needs as quickly as possible is the best way to foster recovery.

People with serious mental illness

Like physical disabilities, psychiatric disabilities are widely prevalent. About one in five American adults have experienced some type of mental illness, primarily anxiety disorders and major depression (National Alliance on Mental Illness, 2015). Here again, remember the emphasis on context: If a pre-existing condition does not impair a person's ability to function in their environment, it shouldn't be viewed as a disability in that context. However, a condition that was well controlled before a disaster may become a disability afterward if treatment is unavailable or the distress of the event causes symptoms to worsen.

Another particularly challenging issue in assisting this population is addressing the stigma they may face from other disaster survivors. If a mentally ill person's behaviors are alarming or off-putting, community members may fear or shun them. This is especially problematic if a person with any visible sign of mental illness is housed with the general population in a shelter, where anxiety and tensions are likely to be high already. This has the potential to exacerbate both the person with mental illness' symptoms and the other residents' concerns about safety. Even though very few mentally ill people ever commit acts of violence, when those events do occur they tend to receive extensive media coverage, so members of the public often have a vastly inflated perception of the risk of contact with this group. Any pre-existing fears may be heightened amid the stress and unfamiliarity of the shelter setting. As a result, people with mental disorders may be the target of hostility, or have needed services such as sheltering denied. As with people with physical disabilities, your top priority should be helping the survivor reconnect with support systems and restoring access to needed medications.

Responders


Also keep in mind that first responders, body handlers, journalists, and others who become involved in a disaster response in a professional capacity may require specialized attention. People who choose to join these professions tend to be quite resilient, but virtually everyone can reach a breaking point if exposed to enough grotesque or traumatic sights, sounds, and smells in the line of duty.

Hopefully this brief overview of vulnerable groups will serve as a starting point for you to plan for needs you may face in your community.

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Vulnerable Populations:
People with Serious Mental Illness


- Widely prevalent: ~1 in 5 American adults have had some mental illness, esp. anxiety or depression (NAMI, 2015)
- People with a history of SMI are at higher risk of recurrence post-disaster but **not** destined to it



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Vulnerable Populations:
People with Serious Mental Illness

- Stigma from other survivors may cause anxiety or hostility, esp. in shelter settings
- DMH focus is on helping the survivor reconnect with support systems and restoring access to needed medications




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Vulnerable Populations: Responders



- Professional responders (including journalists) are generally highly resilient, but everyone has a breaking point
- Take care not to overlook specialized DMH needs among these groups



Cultural Competency

Cultural Competency

- Cultural factors like religion, language, beliefs, and traditions influence how people understand and respond to their experiences
- Especially powerful in times of great stress



Cultural Competency

- Competency involves understanding appropriate behaviors (i.e., eye contact, touching) but also broader reactions to disaster:
 - Individual's **appraisal** of a traumatic event
 - How they **express** their distress
 - How they **cope** with it



Cultural Competency

- Expressions of mourning and grief are strongly tied to cultural beliefs and customs
- Expected levels of expressiveness vary widely, can make assessment challenging
- Inability to follow sacred traditions may compound the loss, adding a sense of guilt or failure to honor the dead to the grief about the death itself



Cultural Competency

- Cultural beliefs shape survivors' perceptions of responsibility for an event:



- God's will
- Karma/fate
- Random act of nature



Cultural Competency

- Also expectations about consequences, esp. for human-caused events:
 - Desire for vengeance
 - Desire for justice via legal system
 - Punishment is God's role, not man's



This is another complex topic that we'll touch on briefly but encourage you to pursue additional training in. Many of us tend to think of cross-cultural sensitivity in terms of behaviors: Is it appropriate to make eye contact with someone, or for an unrelated male and female to be alone together? These are certainly important issues to be aware of when working with a client from another background so you don't inadvertently cause offense or give someone reason to reject your assistance.

But the broader lesson is that culture shapes survivors' reactions to disaster, including their **appraisal** of a traumatic event, how they **express** their distress, and how they **cope** with it. Aspects such as religion, language, beliefs, and traditions influence how people understand and respond to their experiences, and these influences tend to become especially powerful in times of great stress. In particular, expressions of mourning and grief are strongly tied to cultural beliefs and customs. For example, the intense expressiveness of some cultures in response to sudden death might lead a mental health provider to overestimate the extremity of the client's reaction, while a culture that teaches quiet grief might lead a provider to underestimate its intensity. An inability to follow sacred traditions in the disrupted post-disaster environment may compound the loss, adding a sense of guilt or failure to honor the dead to the grief about the death itself.

Cultural beliefs also may shape survivors' perceptions of responsibility for an event, and expectations about punishment (Lord, Hook, & English, 2003). For example, do they view a natural disaster as God's will, as fate or karma brought about by the victims' actions, or as a random act of nature? Clearly those different attributions will influence how one makes meaning of the event, which is an important step in accepting its impact. For a human-caused disaster, do those impacted want vengeance against the perpetrator, believe the legal system should hand down justice—or believe that punishment is solely God's responsibility?

Another important cultural factor to be sensitive to is survivors' trust in and comfort with authority figures. Immigrants may have come from countries with corrupt or abusive rulers or regimes, creating suspicion about government representatives. Members of some racial groups may have a deeply entrenched mistrust of police and other authority figures due to a history of mistreatment. Undocumented immigrants are likely to avoid any contact with the system out of fear of deportation. All of these issues may make some survivors hesitant to seek or accept needed assistance post-disaster, especially if they perceive you as a

representative of the system they fear or mistrust. Building connections through a trusted representative of the group, such as a clergy member or respected elder, can help to overcome suspicion. That can be difficult to manage in the post-disaster environment so consider establishing those connections in advance with appropriate members of cultural groups in your area.

In general, we advise you to become familiar with values and customs for the various religious and ethnic groups you may encounter in disaster response in your community, and whenever possible to enlist appropriate community leaders or spiritual care providers in your response plans to ensure they're sensitive and appropriate.

Disaster Loss and Grief

Disasters are distressing because they cause loss—at worst, in the form of the death of loved ones, but also in other tangible as well as symbolic or more abstract forms.

Tangible losses include pets and property (home, treasured mementoes, important documents). Disasters can rob people of their health or occupation. Less obvious but equally real losses can include a sense of personal invulnerability, self-esteem or identity, and trust in God or protective powers. All of these losses must be mourned as part of the adjustment process; failing to do so may lead to greater psychological or emotional problems over time, especially when future losses occur.

It's now understood that mourning is an ongoing process, not the pursuit of an endpoint after passing through a fixed series of stages. It is more useful to think of the outcome as adjustment to the loss rather recovery from it—a rebuilding around the missing piece that can never be replaced. A core task of this adjustment process requires bereaved people to come to terms with their changed place in the world, including alterations in their identity and social interactions. For example, a widow may need to find a new social circle that isn't based on getting together as a member of a couple; a father who focused his identity on providing for his family may need to find a new source of motivation if his family is killed. This process is deeply painful and often takes far longer than people expect it to, especially in a culture that continues to promote the myth of "closure."

While any significant loss causes grief, disasters often complicate the situation for the bereaved person:

- The survivor may have experienced the disaster personally and be dealing with traumatic memories as well as coping with the loss. In particularly dire cases, bereavement must be put on hold while the focus is on survival.

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Cultural Competency



- Some survivors may mistrust authorities and resist seeking help:
 - Undocumented immigrants fearing deportation
 - Immigrants from countries with corrupt or abusive rulers or regimes
 - Members of racial groups with history of mistreatment by police and authority figures



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Cultural Competency


- Build connections (in advance if possible) through clergy, community leaders, other trusted group members to overcome suspicion

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Disaster Loss and Grief


- Disasters cause a wide variety of tangible losses:
 - Death of loved ones
 - Death of pets
 - Valued property (home, treasured mementoes, important documents)
 - Health
 - Occupation
- Also more existential losses: Faith, sense of personal invulnerability, self-esteem, identity



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Disaster Loss and Grief

- All of these losses must be mourned
- Ongoing process, not a fixed series of stages
- Outcome is not "closure" but adjustment – rebuilding one's life around the missing pieces that can't be replaced
- Requires acceptance of permanence of the loss, and resulting change to one's identity and roles in life



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Disaster Loss and Grief: Complicating Factors


- Survivor may have experienced the disaster personally and be dealing with traumatic memories
- Almost always sudden and unexpected so no chance to say goodbye or resolve issues with the deceased, or to prepare emotionally or practically for the loss



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Disaster Loss and Grief: Complicating Factors


- If human-caused, likely to be anger, blame, and a desire for justice or vengeance
- Survivors may get involved in lengthy legal or criminal proceedings
- If the survivor received and ignored a warning, self-blame, guilt, and shame are common



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Disaster Loss and Grief: Complicating Factors


- Survivor may be dealing with multiple deaths at once, and/or with other losses → "bereavement overload"
- Or may downplay their own distress, recognizing other survivors had more extensive losses



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Disaster Loss and Grief: Complicating Factors


- Media attention means survivors may be forced to do their mourning in public, or face constant reminders of the loss
- Disrupted post-disaster conditions, or situations like the inability to recover remains, often mean survivors are unable to complete customary rites



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Disaster Loss and Grief: DMH Role

- Awareness of complexities of disaster-related loss will help you validate experiences of victims who may be unable to understand or legitimize their sadness or grief
- May be able to help with difficult decisions related to viewing remains and ritualizing death when remains aren't available



- Disaster-related deaths are almost always sudden and unexpected so there is no chance to say goodbye or resolve issues with the deceased, or to prepare emotionally or practically for the loss.
- If the event was human-caused, there is likely to be anger, blame, and a desire for justice or vengeance that can interfere with the adjustment process. Survivors may get involved in legal or criminal proceedings that can keep reawakening the grief for an extended period of time, sometimes years (though the pursuit of justice can be a source of comfort).
- If the survivor received and ignored a warning that could have prevented the loss, self-blame, guilt, and shame are common.
- The survivor may be dealing with multiple deaths at once, and/or with other losses like home or pets that would normally have provided stability and comfort, leading to "bereavement overload" that overwhelms the normal coping capacity.
- On the other hand, recognizing that other survivors had more extensive losses in the same event may lead people to downplay their own distress rather than accepting their need to mourn.
- Media attention to disasters means survivors may be forced to do their mourning in public, or face constant reminders of the loss.
- Disrupted post-disaster conditions, or situations like the inability to recover remains, often mean that survivors are unable to complete customary rites. Friends and neighbors who would usually provide practical and emotional support following a death may be preoccupied with their own disaster-related needs, depriving the bereaved of the comfort of traditional mourning rituals.

As a disaster mental health helper, your awareness of these different aspects of loss will enable you to validate the experience of disaster victims who themselves may be unable to understand or legitimize their sadness or grief.

Issues Around Remains

You can also help survivors with difficult decisions, particularly around whether to view a loved one's remains if the body is disfigured, creating a painful dilemma for family members who must weigh a desire to view remains against the added distress that might be caused by witnessing the harm done to a loved one's body. There's little empirical research to serve as guidance in such cases, but anecdotally, many DMH professionals have found that family members prefer to view and have access to remains, regardless of the condition of the body. Not having access (or at least the choice) may be more problematic, leav-

ing people to imagine the devastated condition of the body—or to hold out some shred of hope that the victim is still alive somewhere. Both the absence of remains and their delayed or incremental return can be disruptive to the grief process, making a death harder to cope with. For example, family members may struggle with decisions about how to ritualize the loss. For some it will be important to wait until even a fragment of their loved one is recovered, while others will choose to proceed with some type of memorial service in the absence of any remains.


Public Memorials

DMH helpers are often asked to provide support at public memorial events, both shortly after the disaster and later at anniversary ceremonies. In this role, you may feel overwhelmed at the scope of emotion encountered, between the number of participants and the intensity of their anguish. However, there may be little for you to actually *do* beyond providing a calm and supportive presence, and being open to listening to those who want to talk about their loss. Most people at these events will be accompanied by friends or family members whose support is more welcome than an unknown mental health helper's. Still, however little you might actually do at such an event, mourners may thank you for providing support and for simply being there. Your participation in the memorial reaffirms trust and reminds mourners that people are not indifferent to their suffering.

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Disaster Loss and Grief: DMH Role

- DMH often provide support at public memorials – may be little to do beyond provide visible, calm presence which reaffirms trust and reminds mourners that people are not indifferent to their suffering



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A final point on disaster-related loss

After a traumatic death, the interaction between posttraumatic stress and grief raises specific treatment implications. The current consensus is that when you note significant posttraumatic symptoms, addressing stress reactions takes precedence over treating bereavement.

Survivor Guilt, Self-Blame, and Shame

Many who survive disasters where others have died or suffered terribly experience some form of self-judgment about their role in the event. Survivors often feel they didn't do enough to help or save others at the time of a disaster, or that they're somehow unworthy of having been spared. These beliefs may be fueled by cognitive distortions or misappraisals, involving either overestimating what the person could possibly have accomplished or underestimating how much the individual actually did or how heroically they acted. Indeed, being labeled a hero for one's actions may increase these negative perceptions and increase a sense of inadequacy.

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Survivor Guilt, Self-Blame, and Shame

- Many survivors experience some form of self-judgment about their role in the event

Survivor guilt:

- Trying to understand why one lived when others died, or why one's losses were less severe than others'
- Involves comparing one's good fortune with misfortune of others, so characterized by uncomfortable interplay between relief and empathy for others who weren't so lucky

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Guilt is common and takes different forms. Survivor guilt comes from trying to understand why one lived when others died, or why one's losses were less severe than others'. Since this involves comparing one's good fortune with the misfortune of others, it's characterized by an uncomfortable interplay between relief at one's own relatively positive outcome and empathy for others who weren't so lucky. Survivor guilt may be increased by a person's perceived similarity to victims, and can lead to spiritual or existential questioning: "Why did God/chance let me live when others died?" Of course there's no answer you can provide to that kind of question, but simply allowing the survivor to express the emotion can be a first step towards resolving it.


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Survivor Guilt, Self-Blame, and Shame

Performance guilt:

- Belief one could and should have done better – been better prepared, acted more bravely, rescued more people (or been present at all)

• Self-judgments often involve misappraisals or distortions, overestimating what one could have accomplished or underestimating how much one actually did




Performance guilt is the belief that one could and should have done better—been better prepared, acted more bravely, rescued more people, and so on. A variant can be found among those who were not present but feel they should have been, and that if they were there they could have protected others from the harm they experienced. Of course in hindsight we can always think of *something* we could have done differently, so there's often some basis of reality underpinning this type of guilt. However, survivors will often distort or exaggerate perceptions of their performance via a kind of magical thinking ("I had a bad feeling that morning and never should have let her get on that plane") or fantastic belief ("If I had just acted more quickly I could have disarmed the gunman before he shot anyone"). Some gentle reality testing can help the survivor understand the limits of what they could have done differently, alleviating at least the inaccurate elements of this type of guilt.

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Survivor Guilt, Self-Blame, and Shame

• Sometimes self-judgments are realistic and can't be corrected or dismissed, leading to **shame**:

- Judging the core self as weak, worthless, or powerless in the eyes of others, unable to take action or protect oneself or loved ones
- Reflects fundamental devaluing of the self in relation to others
- Restoring connectedness with the DMH helper can begin to help the shamed survivor reconnect with others whose acceptance of their worth they rely on




However, sometimes this type of emotion is realistic and can't be corrected or dismissed. In particular, we've noted that if someone received a warning and didn't heed it, resulting in harm to themselves or their family, guilt, self-blame, and shame are likely. Shame is a remarkably powerful emotion. Where guilt generally reflects self-judgment about an action one did or didn't take, feeling shame involves judging the core self as weak, worthless, or powerless in the eyes of others, unable to take action or protect oneself or loved ones (Raphael et al., 2008). Herman (2007) describes shame as "a relatively wordless state, in which speech and thought are inhibited. It is also an acutely self-conscious state; the person feels small, ridiculous and exposed.... Shame engenders a desire to hide, escape, or to lash out at the person in whose eyes one feels ashamed. By contrast, guilt engenders a desire to undo the offense, to make amends." As this suggests, relieving a survivor's sense of shame is particularly difficult as it reflects a fundamental devaluing of the self in relation to others—but since shame is the result of a fractured social bond, restoring connectedness with the DMH helper can begin to help the shamed survivor reconnect with others whose acceptance of their worth they rely on.

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Addressing Guilt and Shame

- Self-judging emotions are painful but may serve a defensive or protective function against even more confusing feelings of powerlessness
- Underlying cognition is something like "The damage was my fault, so by changing my behavior I can make sure that never happens again"



Although they can be quite painful, guilt and shame may serve a defensive or protective function against even more confusing feelings of powerlessness and the arbitrary randomness of events occurring beyond anyone's control: The underlying cognition is something like "The damage was my fault, so by changing my behavior I can make sure that never happens again." As a disaster mental health responder, you may be able to recognize cognitions that suggest the presence of shame or guilt, gently correct potential misappraisals, and help the survivor work towards acceptance of what they did or didn't do—and what they can or can't control in the future.

Resilience

As we discussed earlier, recovery is the norm for the majority of people who experience disasters or other traumatic events. Over time, and with appropriate support—which could be provided by mental health professionals, spiritual care providers, or simply by the person's normal circle of family and friends—most survivors return to their pre-disaster level of functioning. While some in the field refer to that as "resilience," others consider resilience to be distinct from recovery. Specifically, resilience is seen as the ability to resist developing serious negative reactions in response to traumatic experience rather than the ability to bounce back from negative reactions.


What makes some people resilient and others vulnerable appears to be a complex interaction among genetic, developmental, neurobiological, and psychosocial risk factors, offset by protective factors including physical health, positive emotion, social connectedness, self-efficacy, and cognitive flexibility (Southwick & Charney, 2012). Bonanno (2004) identified the personality trait of hardiness as being associated with resilience in the face of extremely adverse events. He describes hardiness as including three dimensions: a belief that one can influence one's surroundings and the outcome of events; the belief that one can learn and grow from both positive and negative life experiences; and being committed to finding meaningful purpose in life. Another major report (Norris et al., 2002) that combined results from numerous studies of more than 60,000 disaster survivors found that resilience was associated with the following characteristics:

- Membership in the majority culture
- Previous experience of a less serious disaster
- Professional training
- Stable, calm personality
- Perception of social support
- Belief in own coping capacity

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Addressing Guilt and Shame

- As DMH responder, try to:
 - Recognize cognitions that suggest the presence of shame or guilt
 - Gently correct potential misappraisals
 - Help survivor work towards acceptance of what they did or didn't do – and what they can or can't control in the future




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Resilience




- Resilience is the ability to *resist* developing serious negative reactions in response to traumatic experience
- Different than recovery, which refers to bouncing back from negative reactions



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Resilience Factors


- Bonanno's (2004) "pathways to resilience":
 - **Hardiness:** personality trait involving three dimensions:
 - Commitment to finding meaningful purpose in life
 - Belief one can influence one's environment and the outcome of external events
 - Belief one can grow and learn from both positive and negative life experiences



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Resilience Factors


- **Self-Enhancement:** tendency to over-inflate own skills or importance
- **Repressive Coping:** emotional-level suppression of distress
- **Positive Emotion & Laughter:** used to undo negative emotion



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Resilience Factors

- From Norris et al. (2002):
 - Membership in majority culture
 - Previous experience of less serious disaster
 - Professional training
 - Stable, calm personality
 - **Perception of social support**
 - **Belief in own coping capacity**




While the first four characteristics are not really subject to post-disaster intervention, the last two are. As a DMH helper you can try to help survivors recognize and draw on their existing sources of support, and you can try to increase their sense of self-efficacy by encouraging them to participate actively in recovery activities.

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Community Resilience

FEMA's Whole Community approach:



- All members of a community are considered part of emergency management team
 - members of social and community service groups and institutions
 - faith-based and disability groups
 - academia
 - professional associations
 - private and nonprofit sectors
 - other government agencies



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Community Resilience

- Each group can contribute essential insights to strengthen disaster planning and response



Resilience can also be supported at the community level. This is the major aim of FEMA's Whole Community approach to emergency management, which involves engaging diverse representatives in planning and response, including members of social and community service groups and institutions, faith-based and disability groups, academia, professional associations, and the private and nonprofit sectors, as well as government agencies who may not traditionally have been directly involved in emergency management (FEMA, 2015). In essence, this approach considers all members of the community to be part of the emergency management team—including local mental health professionals who can contribute essential insight in planning for and responding to the range of disasters that could impact their area.

To reiterate a point made earlier in this module, resilience has become something of a buzzword in the field, and in popular media coverage of disasters. While this emphasis on a positive outcome is understandable and we want to do everything possible to support recovery, as mental health helpers we need to be on guard that exaggerated expectations about natural resilience aren't used as an excuse not to provide services to all who need them in the immediate and longer-term aftermath of catastrophic events.


Post-Traumatic Growth

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Post-Traumatic Growth

- Distinct from resilience and recovery
- Not just maintenance of pre-event functioning, but an actual *increase* in functioning in one or more realms:
 - Relating to others
 - New possibilities
 - Personal strength
 - Spiritual change
 - Appreciation of life

(Posttraumatic Growth Inventory, Tedeschi & Calhoun)



Moving even further into the potential positive effects of very negative experiences, there's growing recognition that some people don't just maintain or return to their pre-trauma levels of functioning, but they eventually experience an actual *increase* in functioning in one or more realms, resulting in what researchers and clinicians Tedeschi and Calhoun dubbed Posttraumatic Growth (PTG). After assessing survivors of diverse kinds of distressing events, they identified five realms of possible growth:

1. Relating to others
2. New possibilities
3. Personal strength
4. Spiritual change
5. Appreciation of life

Over time, they found that many (though by no means all) people experience improvement in one or more of these realms. However, that growth is earned at a great cost, as achieving PTG appears to require a period of negative response before growth occurs. In one study of 9/11 survivors (Butler, 2009) growth was more likely to occur among people who experienced higher levels of initial global distress and higher levels (both positive and negative) of event-related changes in existential outlook. Interestingly, those who demonstrated more resilience initially were less likely to report subsequent growth; it appears that achieving PTG first requires an immersion in the suffering caused by the traumatic event which leads to a reassessment of core values.

While the concept of PTG is sometimes questioned or dismissed as a form of denial of the significance of an experience, Tedeschi and Calhoun (2013) point out that the phenomenon can be identified in literature across time, and in the teachings of numerous religions. Recent research has also empirically demonstrated it among members of diverse cultures in response to a range of events including illness and traumatic bereavement as well as disasters. Since you're most likely to be assisting clients early in the response, it's clearly not advisable to tell clients they will eventually grow as a result of the trauma. However, you might see signs of PTG that should not be dismissed—and these findings allow helpers to be more realistically hopeful about survivors' long-term outcomes.


Extreme Reactions

While the range of typical reactions to disaster described earlier is painful for survivors, these symptoms tend to be transient, resolving over time given an appropriately supportive recovery environment. However, some mental health consequences of disaster exposure are more severe, though less common. These extreme reactions impede a survivor's natural, spontaneous recovery and may require long-term treatment. Note that delivering this treatment is not considered part of the disaster mental health response, though certainly the same professionals may provide clinical interventions once they shift back from the temporary DMH role to their more usual therapeutic setting. (However, please remember that it is *not* appropriate for clinicians who encounter survivors via their DMH role to self-refer clients to their private practice for longer-term treatment.) Given that, we'll briefly describe the extreme reactions you may see in disaster survivors.

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Post-Traumatic Growth


- Achieving PTG appears to require a period of negative response before growth occurs:
 - In one study of 9/11 survivors (Butler, 2010) growth was more likely to occur among people who experienced higher levels of initial global distress and higher levels of event-related changes in existential outlook
 - Those who demonstrated more resilience initially were less likely to report subsequent growth as measured by the Posttraumatic Growth Inventory



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A Caution About Resilience & PTG


- Current buzzwords in DMH field and popular media
- Nice to emphasize positive outcomes – but:
 - Not very comforting to discuss with survivors in the early stages of post-disaster distress
 - We need to be sure expectations of resilience aren't used by authorities to excuse not providing services!



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Extreme Reactions


- Most post-traumatic reactions are transient and resolve over time
- Less common but more severe reactions:
 - Impede the survivor's natural recovery process
 - May require formal long-term treatment



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Extreme Reactions


- That treatment is NOT part of DMH response, though it may be delivered by same mental health professional in different role
- Self-referral of a DMH client for long-term treatment is neither appropriate nor ethical**



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Extreme Reactions:
Posttraumatic Stress Disorder


- Essentially an inability to integrate memory of traumatic experience
- Event is perceived as ongoing threat, activating physiological arousal and distress each time it's remembered



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Extreme Reactions:
Posttraumatic Stress Disorder


- Sufferer learns to avoid triggers – often generalized to chronic emotional numbing
- Negative alterations in cognition and mood accompany the avoidance and vigilance
- Much higher rates of PTSD follow intentional interpersonal violence than natural events



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Extreme Reactions:
Posttraumatic Stress Disorder


- Can only be diagnosed after symptoms present for 30 days
- Symptoms tend to become self-reinforcing – essential to identify and treat early or disorder becomes more difficult to reverse
- But, PTSD can be entirely cured with appropriate treatment



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Extreme Reactions: **Complicated Grief**

- Grief is not a mental disorder but a painful and expectable process of adjustment to loss
- Often takes much longer than expected, but not viewed as disordered provided some improvement occurs
- Some people get "stuck" and avoid people, activities, or places that evoke reminders of the death – they may benefit from professional assistance



Posttraumatic Stress Disorder

PTSD is one of the more serious clinical diagnoses after exposure to a disaster, but the label is often misapplied in popular use. At its most basic, PTSD is an inability to integrate memories of traumatic experiences into one's day-to-day experiences. Rather than learning that the event is over and no longer presents a threat, some people with PTSD continue to experience physiological arousal and fresh distress each time the memory is revisited. To prevent that from occurring, the sufferer learns to avoid triggers of the memory, a strategy that tends to become generalized until the person narrows their life drastically to avoid anything that might reawaken the experience, to the point of chronic emotional numbing and dissociation. Not surprisingly, the combination of intrusive memories, persistent avoidance, and constant vigilance are accompanied by negative alterations in cognition and mood.

The DSM-5 estimates projected lifetime risk for PTSD at 8.7% in the United States, but rates related to disaster exposure vary widely: The National Center for PTSD cites prevalence rates of 28% after a mass shooting and 34% after a bombing, compared with 4 to 5% after natural disasters. This pattern is consistent with rates from individual traumatic experiences, which are significantly higher following intentional interpersonal violence than in response to accidents or other experiences lacking that element of personal malevolence.

PTSD can only be diagnosed after symptoms have been present for 30 days. Given the nature of the core symptoms, the condition tends to become self-reinforcing, as individuals progressively narrow their lives to avoid exposure to triggers of the traumatic memory. As a result, identifying and treating the condition as early as possible is essential before symptoms become entrenched and more difficult to reverse.

Complicated Grief

Grief is not a mental disorder. It's a painful and expectable process in response to the death of a loved one, which is usually followed by a gradual return of the capacity for reinvestment in new interests and relationships. There's no timetable for this adjustment process and it often takes far longer than survivors expect, but as long as there is some level of continuous improvement the bereavement is not generally viewed as disordered. However, some people's grief simply doesn't progress; they're sometimes described as being "stuck." They experience strong emotions of longing, loneliness, and emptiness. Efforts are made to avoid people, activities, or places that evoke painful memories or reminders of the death, and loss of interest in activities and disrupted sleep are often present. In this case, professional assistance may be indicated.


Substance Abuse

The good news is that an analysis by North et al. (2011) of almost 700 survivors of 10 disasters found that only 0.3% of the sample developed an acute new onset of alcohol use disorder. This is consistent with previous research that found it's rare for survivors to turn to drugs or alcohol at a problematic level for the first time post-disaster, though use of substances for occasional stress release was not uncommon. The bad news is that 83% of participants in North et al.'s analysis who had been in recovery at the time of the disaster acknowledged consuming alcohol after the event. The authors conclude that continuing or recurring substance use disorders made up the vast majority of problematic cases, so post-disaster support should target survivors with a history of drug or alcohol use rather than focusing on assessing for new onset of substance use disorders. This underscores the importance of getting a sense of substance use patterns among those you're helping post-disaster and providing information on positive coping that steers those at risk away from relapse, such as posting information about local 12-step meetings in shelters, or encouraging those in recovery to be sure to continue whatever sobriety practices helped them in the past.

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Extreme Reactions: Substance Abuse

- Few new onsets of alcohol or drug use disorder seen after disasters
- But, those in recovery are at high risk of relapse post-disaster, and those with current use disorders likely to continue
- DMH efforts should target those with SA histories, encouraging positive coping and attendance at 12-step meetings or other sobriety practices



Summary of Disaster's Impact

In your role as a disaster mental health practitioner, you most likely will not provide treatment to survivors with the more extreme reactions and conditions. However, you clearly can and will treat psychological trauma in its earliest stages, at a time when you may have the ability to support survivors and prevent them from developing extreme reactions. How survivors eventually fare is not predestined, and you may be able to guide reactions towards a healthier outcome with an appropriate, sensitive, and well-timed intervention—described in the next module.

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Summary: Disaster's Impact



DMH responder role is not treating the minority of survivors with extreme reactions, but trying to **prevent** those reactions by providing **timely universal support** to all impacted.



Module 3

Psychological First Aid and Other Early Interventions

The Importance of Early Intervention

It has been said that when a disaster occurs there are really three traumatic events that take place. The first, of course, is the disaster itself, but the damage doesn't stop there.

The second traumatic event is the negative messages that survivors can receive from community members and bystanders. Some survivors of Hurricane Katrina were asked why they lived in New Orleans, an unsafe place, or why they didn't follow the warnings to evacuate. Some 9/11 survivors were asked why they worked in the World Trade Center, an obvious target for terrorists. These questions are actually disguised accusations, creating protective distance between questioners and survivors. Such questions and negative bystander reactions can be harmful to survivors. Being the target of such negative remarks, when added to the injuries caused by the disaster, is one predictor of long-term emotional consequences of disaster (Brewin et al., 2000).

The third trauma is the self-talk that can result from the first two traumas. For weeks, months, and even years after the original disaster, survivors can be critical of themselves. They can view themselves in unhelpful and distorted ways, seeing the self as inadequate or helpless or inferior. This negative self-talk is another long-lasting form of trauma.

Traditional mental health practitioners assist patients with this third level, helping survivors to view themselves with less self-blame and in more positive ways. Some have stated explicitly that they cannot help at the first and second stages of the traumatic events, but disaster mental health practitioners believe otherwise. Cumulative experience has shown that it's helpful to offer assistance before disaster strikes, building resilience through preparedness. We also believe that we can provide assistance soon after the impact of disaster to ensure a **positive recovery environment**, by providing support to the survivors and making sure that they're not exposed to negative, blaming reactions of others. By doing this, disaster mental

The Importance of Early Intervention

- Disasters involve three traumatic events:
 - The disaster itself
 - Negative messages survivors receive from others
 - Negative self-talk by the survivor: Judgments about one's behavior and actions; seeing the self as inadequate, inferior, helpless



The Importance of Early Intervention

- Traditional therapy addresses the third level – but **DMH targets the first two to ensure a positive recovery environment**
- Supporting natural recovery processes reduces need for long-term counseling



health helpers help survivors to develop a more positive attitude towards themselves, leading to less need for help with negative self-talk and less need for long-term traditional therapy.

Evidence-based Principles of Early Intervention

The attitudes and actions we'll cover in this section stem from principles that have accrued broad empirical support from research on stress, coping, and adapting after potentially traumatic experiences. A highly regarded article written by a group of 20 international mass trauma experts (Hobfoll et al., 2007) states that in order to improve the lives of survivors of disaster or mass trauma, there are a few basic principles that should be followed. Each of these recommendations is supported by research, although the authors note, not necessarily research using randomly controlled trials.

The five essential elements for early interventions Hobfoll and colleagues recommend are:

Safety

First steps after a disaster require the removal of actual or perceived threats to reduce the physiological responses to fear and anxiety.

Calming

Anxiety and distress are common responses to disasters, but once the immediate danger has passed, heightened anxiety or arousal can become dysfunctional.

Efficacy

Promoting self-efficacy can begin with restoring one's ability to regulate negative emotions and solve practical problems. It can also include facilitating community activities like mourning rituals, getting children back in school, or rebuilding economic infrastructure.

Connectedness

Connecting children with parents and neighbors with neighbors provides social support and increases the chances for longer-term recovery.

Hope


Hope is a belief that one's actions can bring about a positive outcome. For some, hope involves a belief that luck or the government will address needs. For many, hope arises through a belief in God.

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Evidence-Based Principles of Early Intervention

Intervention and prevention efforts should include:

- Promoting sense of safety
- Promoting calm
- Promoting sense of efficacy in self and community
- Promoting connectedness
- Instilling hope

(Hobfoll et al., 2007) 

How can these elements be applied to assist disaster survivors? In essence, they provide the theoretical basis of the currently recommended early intervention, Psychological First Aid (PFA).

Psychological First Aid

The National Institute of Mental Health defines Psychological First Aid as:

Evidence-informed and pragmatically oriented early interventions that address acute stress reactions and immediate needs for survivors and emergency responders in the period immediately following a disaster. The goals of Psychological First Aid include the establishment of safety (objective and subjective), stress-related symptom reduction, restoration of rest and sleep, linkage to critical resources, and connection to social support. (NIMH, 2002)

As you can see, this definition is consistent with the principles described above. PFA interventions are meant to address the interrelated practical, physical, and psychological needs of survivors. These interventions are universal, meaning they're appropriate for children, adolescents, adults, and entire families—anyone who has been exposed to disaster or terrorism, including first responders and other disaster relief workers.

At its core, the practice of PFA is meant to remove any barriers to survivors' natural recovery processes and to provide basic, immediate supportive care—to provide the emotional equivalent of treating a small wound before it has a chance to develop into a more serious problem.

Elements of Psychological First Aid

It should be noted that there is no standardized list of PFA components, but that the various versions found in the literature and in practice are generally consistent in spirit. These include models proposed by a range of experts including the American Red Cross (2002), the National Institute of Mental Health (2002), the *Disaster Mental Health: A Critical Response* training curriculum (Herrmann, 2005) and *Disaster Mental Health: Essential Principles and Practices* (Halpern, Tramontin, & Vermeulen, 2010).


Remember that the elements of Psychological First Aid are a blend of attitudes and actions on the part of the helper—less a process than a toolkit of components that can be drawn on as needed for each specific survivor. As a result, these elements are not presented in any particular order, nor are they meant to describe a sequence of how they should be utilized, since

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Defining Psychological First Aid

- Evidence-informed and pragmatically oriented early interventions that address acute stress reactions and immediate needs for survivors and emergency responders in the period immediately following a disaster

(NIMH, 2002)




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Defining Psychological First Aid

- The goals of psychological first aid include the establishment of *safety* (objective and subjective), *stress-related symptom reduction*, *restoration of rest and sleep*, *linkage to critical resources* and *connection to social support*


(NIMH, 2002)



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PFA Characteristics



- Short-term; here and now
- Focus on interrelated practical, physical, and emotional needs
- Goal is to remove any barriers to survivors' natural recovery processes and to provide basic, immediate supportive care
- Universal – can and should be provided to all survivors**



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Elements of Psychological First Aid

- PFA is not a process, but a toolkit of components to be used as needed, in any order appropriate
- Different models exist, but all share core principles



that will be determined by the post-disaster situation and by the client's specific needs. You can see that the components of PFA described in the online training you completed (listed in bold) are the basis for the expanded model described here.

- **Providing comfort care**
 - Being calm
 - Providing warmth
 - Showing genuineness
- **Recognizing basic needs and helping to solve problems and complete practical tasks**
 - Attending to safety needs
 - Attending to physiological needs
 - Assisting with problem-solving
- **Validating survivors' feelings and thoughts**
 - Providing acknowledgment and recognition
 - Expressing empathy
- **Connecting people with their support systems**
 - Helping clients access social support
 - Helping clients avoid negative social support
- **Providing accurate and timely information**
- **Providing education about anticipated stress reactions**
- **Reinforcing strengths and positive coping strategies**

Providing Comfort Care

Survivors who have recently been through a traumatic experience often need a reminder that the entire world isn't disrupted, and that others care about what they've suffered. Helpers can address this need in a number of ways.

Being Calm

Disasters can increase both physical and emotional arousal levels. One core aim of PFA is to reduce this globally heightened arousal level (NIMH, 2002), which may be best accomplished via the helper being calm. Harry Stack Sullivan (1940) noted long ago that emotions, and anxiety in particular, can be very contagious. By remaining calm the helper is modeling calm for the survivor. A calm and steady helper allows survivors to better master or regulate their feelings.


Providing Warmth

"Unconditional positive regard" or warmth as described by humanistic psychologist Carl Rogers in the 1950s means relating to clients with comfort and acceptance of what they feel and say. This is not always easy—especially if the client is irritable, unreasonable, or angry. Yet providing warmth and kindness, expressed as attentiveness, open posture, and a soothing tone of voice no matter what the client says, is important to the helping process.

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Providing Comfort Care: Being Calm


- Disasters increase physical and emotional arousal levels, and anxiety is contagious
- A core aim of PFA is to reduce this globally heightened arousal level
- Your remaining steady and calm helps survivors master or regulate their feelings



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Providing Comfort Care: Warmth and Genuineness

- "Unconditional positive regard" is valuing the client and offering him or her a warm, prizing acceptance
- Compassion and kindness is expressed in attentiveness, open posture, soothing tone of voice, and acceptance of anything the client says



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Providing Comfort Care:
Warmth and Genuineness



- Only *genuine* empathy and warmth are helpful for clients
- Remaining genuine during a major response requires self-care



Showing Genuineness

Warmth and empathy are only useful to the extent that they are real or genuine. Clients can feel manipulated if we show them a fake smile or repeat platitudes about courage or resilience. Because disaster work can expose us to terrible sights and sounds and stories, we need to know our limits so we can stay genuinely empathically engaged. If you're working at a mass casualty disaster or in a very protracted response where you hear so much grief and anger that you begin to feel numb and lose that ability to genuinely connect, it's wise to take a break or get some support so you can be present for the client.


Recognizing Basic Needs and Helping to Solve Problems and Complete Practical Tasks

Along with the emotional distress they cause, disasters often generate a variety of physical threats and logistical demands that can feel overwhelming to survivors, especially in the early hours and days while they're still trying to absorb what they've just experienced. DMH workers can step in to help people whose judgment and decision-making ability is temporarily impaired in the following ways.

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Recognizing Basic Needs:
Attending to Safety and Physiological Needs

- Survivors need to feel that they, and their loved ones, are safe in order to begin their recovery
- Protect survivors from any threat or danger from the ongoing disaster, especially those who may be so disoriented that they are not able to care for themselves



Attending to Safety Needs

It cannot be overemphasized that in order to begin their recovery after a disaster, people need to feel that they and their loved ones are safe. Helpers should protect survivors from any threat or danger from the ongoing disaster, especially those who may be so disoriented that they are not able to care for themselves. Attending to safety needs may mean strongly encouraging a survivor to not enter a damaged home or venture into a neighborhood with downed power lines. Sometimes survivors are reluctant to stay with family or friends or go to a shelter. Helpers should encourage survivors to reside in a safe place.


If it seems clear that the danger has passed, helpers should remind survivors that this is the case—but remember that those who have been through a traumatic experience may be relatively safe but not *feel* safe. Superficial reassurances of safety may therefore end up being experienced as unempathetic dismissiveness of survivor's concerns.

Helpers can further support client safety and stability by encouraging families to resume and maintain their routines. This may not be feasible immediately, but children should be encouraged to go to school as soon as possible after the disaster, meals should be eaten at regular times, and so on.

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Recognizing Basic Needs:
Attending to Safety and Physiological Needs

- Clients can be taken to receive medical attention
- Clients may be offered water, hot drinks, or blankets
- Support client stability by encouraging families to maintain their routines



Attending to Physiological Needs

Mental health professionals are sometimes reluctant to address medical needs. However, if we observe that a client is injured

or ill we must be sure that they are taken to receive medical attention. If there is any threat to the physical health of a client, we should attempt to address it immediately by obtaining proper medical care, connecting survivors with resources for restoring access to prescription medications, and so on. This can help to reduce anxiety as well as directly addressing physical needs: After one disaster when authorities acknowledged the presence of tetanus bacteria in floodwaters, a mental health worker was observed attempting to calm a frantic survivor who was looking for tetanus shots for herself and her family. Although the calming was well intentioned, it would have been more effective if the helper simply assisted the survivor in locating where to get the tetanus shots. On the other hand, especially in public health emergencies, people may have unfounded or unrealistic concerns, especially if rumors are being passed around the community. DMH helpers may need to assist survivors in locating appropriate medical assessment while countering rumors that are known to be false.

On a less urgent level, helpers should also offer food, water, hot drinks, or blankets. People in distress often ignore their physical state and forget to eat or drink, so providing these services addresses a genuine need as well as demonstrating that the helper is present and cares about their well-being.

Assisting with Problem-Solving

Survivors often face pressing decisions that they could normally handle with ease, but which seem insurmountable in their unfocused, distracted state shortly after a disaster. We might provide assistance in problem solving as we aid clients in finding shelter, or as we help them to decide which friend or relative to stay with. This may involve being far more directive than we would be in more traditional forms of counseling, but we should still strive to involve the client in any decision in order to begin to reactivate their usual capacity for autonomy.

Validating Survivors' Feelings and Thoughts

The experience of surviving a disaster is so new and unfamiliar for most people that they'll often find they can't access their feelings initially, or they may minimize them out of recognition that others have experienced worse losses than they did. DMH helpers should try to encourage survivors to recognize and accept their emotions through these actions.


Providing Acknowledgement and Recognition

While it's true that we don't want to intensify survivors' feelings by acting panicky or suggesting that their normal stress reactions are unusual, we also don't want to downplay the seriousness of the situation. Survivors require acknowledgement and validation that they have experienced a trauma. If the signifi-

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**Recognizing Basic Needs:
Assisting with Problem Solving**



- Survivors are often distracted and confused, and may struggle with decisions they could usually handle
- You can assist clients in finding shelter, or deciding which friend or relative to stay with



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**Recognizing Basic Needs:
Assisting with Problem Solving**


- You may need to be more directive than in your usual professional role, but still try to involve the client in decision-making to reactivate their autonomy

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**Validating Survivors' Feelings and Thoughts:
Providing Acknowledgement and Recognition**


- Survivors require acknowledgement and validation they've experienced a trauma and their stress reactions are understandable
- The fact that others suffered worse losses doesn't minimize the impact of that individual's own losses



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**Validating Survivors' Feelings and Thoughts:
Providing Acknowledgement and Recognition**


- If the significance of the trauma is downplayed by helpers or others, survivors may not take the necessary time to rest and recover
- Media attention can provide validation and/or feel insensitive or voyeuristic



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**Validating Survivors' Feelings and Thoughts:
Expressing Empathy**


- **IF** survivors want to describe what happened to them, be prepared to listen, but do NOT push them to talk
- Attend to all aspects of the survivor's communication at both the emotional and cognitive levels



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**Validating Survivors' Feelings and Thoughts:
Expressing Empathy**

- You must be willing to enter the survivor's world of pain, loss, anguish, hopelessness, rage, shock, and despair
- Survivors should not be left alone with unmanageable or uncontrollable feelings



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**Connecting People with Their Support Systems:
Helping Clients Access Social Support**

- Social support can be expressed as **instrumental, emotional, or informational support** - all can help an individual cope with stress
- Perceived social support can be a significant buffer to stress, even if the support comes exclusively from one reliable person



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**Connecting People with Their Support Systems:
Helping Clients Access Social Support**



- Survivors should be physically reunited with loved ones who can provide emotional support and security



cance of the trauma is downplayed, survivors may not take the necessary time to rest and recover. The presence of helpers shows survivors that the community is not indifferent to the disaster they experienced. Media presence also validates survivors' experience that something unusual has happened and deserves attention, though this presence can also be perceived as insensitive or voyeuristic. DMH helpers can offer support including helping survivors decide whether they want to speak to the media or keep their experience private.

Expressing Empathy

Helpers should be prepared to listen to survivors describe what happened to them; they should concentrate and attend to all aspects of the client's communication at both the emotional and cognitive levels. The helper must be willing to enter the client's world of pain, loss, anguish, hopelessness, rage, shock, and despair. We not only need to listen but to convey to the survivor that we've heard what they said. If clients decide to tell their stories or to discuss extremely painful feelings, be certain to not leave them alone with unmanageable or uncontrollable feelings. Be sure they've calmed down or that trusted family and friends arrive before leaving the scene.

Connecting People with Their Support Systems

It's widely recognized in the field that most survivors receive far more comfort from their existing support networks than from any kind of professional intervention, so helping to restore access to loved ones is an important element of PFA—with some caveats.

Helping Clients Access Social Support

Social support can be expressed in different ways, but all can help an individual cope with stress. **Instrumental** support is practical in nature, taking the form of money or help with tasks and chores. **Emotional** support provides an individual with warmth, caring, and a trusting relationship. **Informational** social support can include advice or guidance that's intended to help someone cope with difficult circumstances. There is substantial evidence that perceived social support is found to contribute to resilience, even if the support comes exclusively from one reliable person (Norris et al., 2008). If possible, survivors should be physically reunited with loved ones who can provide emotional support and security. Helpers should ask directly "Who might you contact who could help you at this time?" "Do you need help in getting the phone number or do you need to borrow my cell phone?" Sometimes survivors resist contacting loved ones in a time of need because they don't want to be a burden; if this is the case you might ask how they would react if the situation were reversed and a friend in need was hesitating to reach out to them for help.

Helping Clients Avoid Negative Support

Sometimes helpers make an unintended mistake by suggesting that survivors contact family and friends. We need to recommend that clients contact family and friends *whom they can trust to be supportive*. Remember that not all relationships are supportive—in fact, most of us are aware that some family and friends can be sources of stress and misery. When you encourage clients to contact their natural support system, first try to be sure that these contacts will not strain the client with additional stress. Ask: “Who will you call? Will that person be helpful and supportive?” A recovery environment that’s impoverished, punitive, blaming, demanding, anxiety-filled, and invalidating is one that creates a risk for PTSD (Brewin, 2003).

Providing Accurate and Timely Information

Accurate information is one important antidote for the uncertainty and anxiety that survivors experience following a disaster. Accurate information may not always be easy for helpers to access, but we must try—and we must be sure never to give out inaccurate news, or information we’re not authorized to release to the public. It’s far better to acknowledge that you don’t know the answer to a client question than inadvertently mislead them.

Survivors need different kinds of information. Some questions concern immediate needs. Survivors may want to know exactly what happened, who was responsible, is it truly over, how extensive the disaster damage was, and when they’ll be able to return home. They’ll want information about physical health risks such as mold, tetanus, recurrent flooding, etc.


They’re likely to have numerous questions about recovery resources such as shelter locations. Information about financial resources is also important, as survivors need to know what assistance they are eligible for. This is a new experience for most people so they may need to be educated about, for example, the implications of the president declaring a national disaster for individual assistance, or what forms they need to complete to receive aid from the Red Cross, FEMA, or Small Business Administration, or how to file a claim with their insurance company. Helpers should be aware of any up-to-date lists of available resources for victims, as addressing those practical needs can help minimize immediate anxiety.

There’s another category of information that has more urgency than any other: when survivors are missing loved ones. Red Cross and other relief agencies often have special services that can assist survivors when loved ones are missing. Even when there’s little hope that a loved one will be found alive, relatives still may want to know details about the recovery process (e.g., will there be a continued search for bodies after a plane crash?

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**Connecting People with Their Support Systems:
Helping Clients Avoid Negative Support**


- Not all relationships are supportive; relationships can be sources of stress and misery
- When you encourage clients to contact their natural support system, first try to be sure that these contacts will not strain the client with additional stress

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**Connecting People with Their Support Systems:
Helping Clients Avoid Negative Support**


- A recovery environment that’s impoverished, punitive, blaming, demanding, anxiety-filled, and invalidating is one that creates a risk for PTSD

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Providing Accurate and Timely Information


- Accurate information is an important antidote for the uncertainty and anxiety survivors experience following a disaster
- Survivors will need a number of different kinds of information:
 - What happened? Who was responsible?
 - Is it truly over?
 - How extensive was the disaster damage?
 - When will we be able to return home?
 - What recovery resources are available?

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Providing Accurate and Timely Information

- Be aware of any up-to-date lists of available resources
- Frame important communications in simple language and provide in writing if possible
- Be sure never to provide unconfirmed news, or divulge information you’re not authorized to

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Will all remains be identified? Will they be released after identification or held for possible criminal proceedings?).

Whether the information you're providing is about a missing loved one or a more mundane matter, it's important that all communication be framed in simple language. Remember that cognitive ability can be impaired after a disaster due to stress or trauma, so we need to be certain that the information we provide is received. You may need to summarize or review what is being said, or provide it in writing as well as verbally.

Providing Education About Anticipated Stress Reactions

We'll discuss psychoeducation as an element of PFA, but bear in mind that it can be provided at any point in the disaster cycle, though the nature of the information is likely to change depending on timing and intention.

People who have not previously experienced a traumatic event and the resulting typical reactions may be further distressed by their own emotions, so psychoeducation after a disaster often involves normalizing the experience of survivors and informing them about effective means to reduce and manage their stress. According to the National Institute of Mental Health, most survivors don't actively seek out psychoeducation or other mental health services after a disaster, so as a key component of early intervention efforts it's important that mental health workers perform outreach, defined as an "array of disaster mental health services extended to survivors wherever they congregate, designed to increase understanding of common reactions, coping, and when and where to receive more in-depth help" (NIMH, 2002).


However, helpers should not force information on survivors who aren't receptive, as some individuals may have a repressive coping style that functions best by avoiding stressful thoughts. For this group, information about potential unpleasant symptoms may produce more anxiety than it allays. The take-home point here is that it's usually not advisable to pressure survivors to talk or engage with us if that doesn't feel right for them at that time. A gentle, supportive, encouraging approach is the default.

As noted earlier, one of the most common disaster mental health interventions is to remind clients who may feel that their distress is extreme or unending that they're experiencing an expectable or typical reaction to an abnormal or atypical event. Survivors can be reassured that the fact that they're having trouble concentrating or are easily startled reflect common reactions to disaster and that they're not going crazy. Survivors can also be reassured that for most people this stress will eventually pass,

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Providing Education About Anticipated Stress Reactions


- Psychoeducation is an important element of PFA but can be provided at any time
- Goal is to demystify the experience, explain why reactions make sense given the circumstances



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Providing Education About Anticipated Stress Reactions

- Educate about stress management and stress reduction:
 - Teach effective coping mechanisms
 - Promote awareness of ineffective coping mechanisms
- Don't force information on those who aren't receptive



but that if they don't start to feel better or they feel in need of speaking to a mental health professional now, help is available. Parents can also receive information on typical stress reactions of children so they can see that their children are acting in reaction to the disaster. Explaining that children often react to stress by regressing developmentally and becoming more needy or clingy than usual can increase the parent's patience and understanding that the child's demands are probably temporary.

Reinforcing Strengths and Positive Coping Strategies

While we do want to acknowledge the impact of disaster on the survivor, it's equally important for us to acknowledge and support a survivor's strength, competence, courage, and power. This can allow the survivor to access his or her resilience and help to begin to restore a sense of control. Helpers should allow survivors to determine the kind of assistance they receive, the pace of any kind of self-disclosure, and as many other aspects of the response process as possible. We can ask: "How have you gotten through tough times before?" or "What skills do you have that will allow you to get through this?" These questions remind the survivor that it's likely that they've bounced back from very stressful events before and that they can recover from the present one. One very useful approach is to ask the survivor to participate in the relief operation, provided it's safe and appropriate for them to do so. This can be especially helpful to parents, whose children can see them as in control or powerful. It can also be helpful to children who can gain a sense of usefulness at a time when they are likely to be feeling helpless.


Acute stress can often increase the use of ineffective coping mechanisms. Survivors can be cautioned about the use of ineffective and self-defeating coping mechanisms that might provide momentary relief but will ultimately cause additional problems, and they can be encouraged to utilize more effective approaches.

COPING MECHANISMS	
EFFECTIVE	INEFFECTIVE
<ul style="list-style-type: none"> • Getting enough sleep • Taking breaks • Eating a balanced diet • Connecting with others • Limiting TV exposure • Exercising • Allowing yourself to receive as well as give • Using spiritual resources • Balancing work, play, and rest 	<ul style="list-style-type: none"> • Not getting enough rest or sleep • Overworking • Binge eating • Isolating oneself from other • Excessive television watching • Drinking and smoking • Attempting to regain a sense of control by becoming overly controlling of others—bullying those around you

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Reinforcing Strengths and Positive Coping Strategies

- Survivors can be cautioned about ineffective coping mechanisms that provide momentary relief but ultimately cause additional problems, and encouraged to use more effective approaches




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Reinforcing Strengths and Positive Coping Strategies

Effective Coping Mechanisms

- Getting enough sleep
- Taking breaks
- Eating a balanced diet
- Connecting with others
- Limiting TV exposure
- Exercising
- Allowing yourself to receive as well as give
- Using spiritual resources
- Balancing work, play, and rest




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Reinforcing Strengths and Positive Coping Strategies

Ineffective Coping Mechanisms

- Not getting enough rest or sleep
- Overworking
- Binge eating
- Isolating oneself from other
- Excessive television watching
- Drinking and smoking
- Attempting to regain a sense of control by becoming overly controlling of others - bullying those around you



Some Cautions When Using PFA

- Goal is to help survivors return to pre-disaster functioning, not fix all of their problems
- Survivors of a disaster should not be treated identically; individual needs and cultural differences must be respected
- Some survivors may prefer the comfort and support of peers or clergy, while others prefer to work their problems out alone or only want support from family members



Some Cautions When Using PFA

Even when you're using an evidence-informed practice, there are still cautions you should be aware of. Remember that when we provide disaster mental health, we're attempting to help survivors return to pre-disaster functioning. We might find a survivor struggling with many problems not related to the disaster. We should not be overly ambitious and try to solve issues that are unrelated to the disaster. Similarly, we should note that sometimes a disaster survivor could be suffering from more than one trauma, so the distress we observe could be a result of an altogether different event. In conversation with survivors we can ascertain what other life stressors they're facing. In this way we can be more certain that we're actually assisting with the impact of the disaster trauma.

Also remember that survivors of a disaster should not be treated identically. Individual needs and cultural differences must be respected when providing PFA or any other mental health service. Some survivors may prefer the comfort and support of peers or clergy, while others prefer to work their problems out alone or only want support from family members. Although we may offer assistance, we need to be careful to not intrude if the client isn't receptive. There's a fine line between helping and meddling.

Early Interventions Beyond PFA

Early Interventions Beyond PFA

- Correcting distorted self-cognitions
- Rumor control
- Mitigating conflict
- Assessment and screening
- Referrals for long-term care



While PFA elements are likely to make up the majority of your DMH activities, you may need to draw on other clinical skills as you try to assist disaster survivors and other responders. Early interventions beyond PFA include:

- Correcting distorted self-cognitions
- Rumor control
- Mitigating conflict
- Assessment and screening
- Referrals for long-term care

Correcting Distorted Self-Cognitions

- Trauma survivors often think in ways that are distorted and not helpful:
 - It was my fault
 - I am shameful or
 - I am stupid
 - I am weak
 - I cannot protect myself or my family
 - I am inferior to other people
 - I will never get over this
 - It will happen again
 - I am in danger
 - I cannot trust anybody
 - I want to get revenge
 - I want it to be undone



Correcting Distorted Self-Cognitions

As they try to process their experience, trauma survivors often think in ways that are distorted and not helpful. Any of the following thoughts or beliefs may be detected when speaking with a survivor:

- It was my fault
- I am shameful or inferior

- I am stupid
- I am weak
- I cannot protect myself or my family
- I am inferior to other people
- I will never get over this
- It will happen again
- I am in danger
- I cannot trust anybody
- I want to get revenge
- I want it to be undone

Although you're unlikely to have multiple meetings with survivors, and will not have the time to do long-term cognitive therapy in your DMH role, you can still help clients think differently and attempt to find a more helpful perspective **that is consistent with reality** (Beck, 2011). If a home burned down because a client fell asleep while smoking, it's not useful to say "It wasn't your fault." Instead you could help this client see that mistakes like that can happen and that he will eventually have to find a way to forgive himself. With other survivors self-blame is a clear distortion. As we discussed earlier, self-blame and shame are often significant issues for disaster survivors and can be a focus for counseling in the acute aftermath of disaster. A survivor who experiences self-blame and self-recrimination may be able to come to understand that, in truth, "I did the best I could." In different situations after a disaster has passed, a survivor may think "I'm still in danger." A counselor might help a survivor to restructure the cognition to "Even though it feels like I'm still in danger [emotional reasoning], I know the danger has passed [rational restructured cognition]."

Rumor Control


Rumors are common in disasters, wars, public health emergencies, and other times of uncertainty as anxiety, stress, and a lack of reliable sources increase the chance of rumor and misinformation. A rumor's potential impact is related to its importance and its ambiguity—the more important and ambiguous the material, the more likely it will be spread. There are many reasons for the spread of rumors following disaster. Don't forget that in our discussion of common reactions post-disaster, people who have been through a traumatic experience often demonstrate a diminished ability to think clearly and critically, which may cause them to pass along destructive rumors and misinformation.

Rumors can give people a hook to hang their fears and anxieties on: If survivors are still feeling fearful while being told they're safe, they may seize on a rumor about continuing threat that justifies or explains the emotion they're already feeling. Rumors

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Rumor Control


- Rumors are common in disasters, wars, public health emergencies, and other times of uncertainty as anxiety, stress, and lack of reliable sources increase acceptance of questionable information
- Caution people about the likelihood of rumors and misinformation which can increase distress and cause hostility against scapegoats



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Rumor Control

- Take a proactive position on rumor control, including a commitment to providing accurate information – no matter how dire
- There should be consistency in the information provided, which requires cooperation and coordination among authorities, the media, other sources



may also feed the desire to find someone to blame for a disaster, leading to ill-will and potentially even violence against members of certain religions, ethnic groups, or others selected as scapegoats. This issue is even more potentially harmful today than in past decades as rumors can be broadcast instantly via the Internet, texting, Twitter, and other forms of social media.

Therefore, as mental health professionals we must educate the population about the likelihood of rumors and misinformation, and urge officials to take a similar stance on rumor control. If there's dire but confirmed information, we should provide it, since failing to do so will undermine trust and open the door for rumors to fill in the information vacuum. Helpers and authorities should also be consistent in the information provided—messages should not contradict each other. This requires cooperation and coordination among authorities, media, and other information sources. Remember that we discussed the importance of providing accurate information and orientation to services. In DRCs, shelters, or Family Assistance Centers, mental health providers can provide accurate lists of resources and other information and also display another list clearly labeled “Current Rumors.”

Mitigating Conflict


The frustration and scarcity caused by disaster increase conflict. Sometimes survivors feel they need to compete for shelter space, cleanup supplies, recovery funds, and most importantly emotional support. Family members are needy, expecting more from one another than they have the capacity to deliver. Survivors often feel that assistance does not come at the right time, or not quickly enough, or it comes in the wrong form—and sometimes they're right. Disaster workers also face their own conflict-escalating issues, most notably the burnout that can occur when they become emotionally, psychologically, and physically exhausted from coping with cleanup, recovery, long hours, fear and worry, and a lack of resources. The resulting stress may lead to friction among workers, or between workers and clients.

The best way to handle conflict is to keep it from occurring in the first place by monitoring stress levels, encouraging workers to take breaks or take time off, and encouraging survivors to use healthy coping mechanisms. When you see conflict, you can step in as a neutral third party in order to help break through the self-perpetuating cycle that characterizes many conflicts by reminding workers or survivors that everyone is under stress. You can support reciprocal empathy and assist in helping parties to work towards compromise and collaboration.

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Mitigating Conflict


- The frustration and scarcity caused by disaster increase conflict:
 - Survivors may feel they need to compete for shelter space, cleanup supplies, recovery funds, etc.
 - Competition for emotional support and disparate coping styles cause conflict within families
 - Overstretched disaster workers can experience tension with each other and with clients



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Mitigating Conflict

- Prevent conflict by monitoring stress levels, encouraging workers to take breaks or take time off, and encouraging survivors to use healthy coping mechanisms
- Intervene if necessary by stepping in and helping de-escalate arguments



Assessment and Screening

In the practice of disaster mental health, we're always and continually involved in observation and assessment (not diagnosis). We need to appraise the current status of individuals, groups, and the overall affected community. There should be ongoing evaluation of the characteristics of the recovery environment, including whether survivors' needs are being adequately addressed and what additional interventions and resources are required. Mental health workers should be asking themselves if the environment is suitable for psychological recovery. Is it physically safe? Is it unnecessarily noisy or chaotic? Is information being provided regularly? Even such practical issues as making sure the food being served in a shelter is appropriate to residents' cultural and dietary preferences can provide comfort and a sense of being seen and valued as human beings at a time when survivors may feel they have little control over their circumstances. Helpers should continually assess whether more workers are needed and ask for such resources if necessary.

As the relief operation proceeds, there should be ongoing monitoring of the stress level of the affected population as well as those working on recovery needs. Helpers need to decide if a follow-up visit to the home of a survivor is needed or if a client needs a referral to a community mental health center for additional help. Other types of assessment might include:

- Whether spiritual support might be helpful
- If additional information should be made more accessible to more members of the community
- If the community is by and large angry or disappointed
- If disaster workers need to take breaks or be rotated out and replaced
- Whether medical or psychiatric referral is warranted (see below)

In addition to this more general needs assessment, individual mental health assessments should be considered. As we've discussed, after a disaster most people recover on their own or with support from friends and family, so early interventions should make sure there is a positive recovery environment. This is the intent of Psychological First Aid. However, some people will need more than basic help. How do we best identify these survivors and ensure that they get the additional treatment they need? Efforts can take a number of different approaches, focusing on observable behaviors, experiential factors, or endorsement of symptoms.


Behavior-Based

The need for referral for individual assistance is often demonstrated through survivors' actions. We won't cover mandated reporting here, but if you notice the possibility of child abuse or

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Assessment and Screening

- DMH helpers should conduct ongoing needs assessment throughout the response:
 - What additional interventions and resources are required?
 - Is the environment suitable for psychological recovery?
 - Is it physically safe? Is it unnecessarily noisy or chaotic?
 - Is information being provided regularly?
 - Are practical issues like dietary needs being addressed?
 - Is there a need for more staff? Should some staff members be rotated out? Should spiritual care providers be included?
 - Is the community angry or disappointed for reasons that could be addressed?



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Mental Health Assessment: Behavior-Based

Watch for those who are:

- threatening harm to self or others
- expressing irrational thoughts or beliefs
- experiencing significant cognitive impairment
- enacting ritualistic behaviors
- hysterical or panicking
- dissociating



maltreatment, you must comply with the law, which requires reporting. Similarly, you must report any imminent attempt to injure oneself or others.

Beyond reporting any threat of harm, you should be on the lookout for behaviors that indicate problematic psychological responses. We've noted that much of the distress that we observe in disaster survivors is an expectable or typical reaction to abnormal or atypical events. However, if a survivor tells you he or she is getting messages about the disaster from outer space, or simply is thinking that life is no longer worth living, these should *not* be considered normal reactions but indicate that additional attention is needed.


If you notice psychotic symptoms or significant cognitive impairment such as major memory disturbance, an inability to make simple decisions, or obsessions, a referral for further assessment is indicated. If you notice serious withdrawal or repetition of ritualistic behaviors, or aggressive behavior (screaming, slander, threats), a referral would be in order. Although very intense reactions such as hysteria or panic attacks are not uncommon following traumatic experiences, they may indicate the presence of Acute Stress Disorder, which needs treatment. Also be on watch for signs of dissociation, another indicator of possible Acute Stress Disorder that can be easy to overlook. Sometimes it's not the person who is sobbing or yelling who really needs the most help, but the one sitting quietly on their cot, completely disengaged from their surroundings.

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Mental Health Assessment: Experience-Based

Intended to identify those:

- who have acute stress disorder or other clinically significant symptoms stemming from the trauma
- who are bereaved
- who have a preexisting psychiatric disorder
- who require medical or surgical attention
- whose exposure to the incident is particularly intense and of long duration

(NIMH, 2002) 

Experience-Based

Another approach to screening focuses on characteristics of the individual or his or her experience that are recognized from past research as risk factors. This approach is consistent with *triage*, the sorting of disaster survivors giving priority to those most likely to need help. The National Institute of Mental Health takes this approach, which suggests the following groups are considered to be at high risk and deserving of special attention, including those:

- Who have Acute Stress Disorder or other clinically significant symptoms stemming from the trauma
- Who are bereaved
- Who have a preexisting psychiatric disorder
- Who require medical or surgical attention
- Whose exposure to the incident is particularly intense and of long duration
- Who have seen grotesque injury or death
- Who were panicked that they would not live

Clients with several of the risk factors listed above should receive additional attention and care. Assessing most of these risk factors is usually not too difficult. If a client is injured or bereaved or is showing extreme distress, it is often apparent,

but it may take some conversation to discover that the survivor had a long or intense exposure to the disaster. It also may be more difficult to ascertain if the client has a preexisting psychiatric disorder. One possible way to determine this is to ask if the client took medications that got lost in the disaster that need to be replaced.

Symptom-Based

Another approach to screening was developed by Brewin and his colleagues (2008), who take the direct route of asking survivors about their symptoms. They developed a simple test that can be administered to quickly identify those survivors for whom a more in-depth evaluation for PTSD is merited. This 10-item instrument (presented below) is intended to tap into the hyperarousal and reexperiencing symptoms associated with PTSD. When it was first used to screen the survivors of a train crash, the researchers found that of those who answered yes to six or more questions, 86% were found to have PTSD based on extensive clinical interviews. In contrast, among those who endorsed five or fewer items, only 7% were found to have a clinically diagnosable reaction. Brewin and his colleagues used this “Screen and Treat” approach on a larger scale in the aftermath of the London subway bombing in 2005. It again proved to be a sensitive and specific way of identifying survivors for whom a more intense diagnostic interview was indicated, allowing clinical resources to be targeted effectively.


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Mental Health Assessment: Symptom-Based

Trauma Screening Questionnaire (Brewin, 2008)

Survivors are asked if they have experienced the following at least twice in the past week:

1. Upsetting thoughts or memories about the event that have come into your mind against your will
2. Upsetting dreams about the event
3. Acting or feeling as though the event were happening again
4. Feeling upset by reminders of the event




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Mental Health Assessment: Symptom-Based

5. Bodily reactions when reminded of the event
6. Difficulty falling or staying asleep
7. Irritability or outbursts of anger
8. Difficulty concentrating
9. Heightened awareness of potential dangers to yourself and others
10. Being jumpy or being startled at something unexpected

Answering yes to more than six items indicates the need for additional assessment.



Screen and Treat Trauma Screening Questionnaire

Survivors are asked if they have experienced the following at least twice in the past week:

1. Upsetting thoughts or memories about the event that have come into your mind against your will
2. Upsetting dreams about the event
3. Acting or feeling as though the event were happening again
4. Feeling upset by reminders of the event
5. Bodily reactions when reminded of the event
6. Difficulty falling or staying asleep
7. Irritability or outbursts of anger
8. Difficulty concentrating
9. Heightened awareness of potential dangers to yourself and others
10. Being jumpy or being startled at something unexpected


Answering yes to more than six items indicates the need for additional assessment.

The screen and treat approach emphasizes the importance of outreach and targeting limited resources to those who most need them. While this assessment tool is very promising, keep in mind that using it requires an ability to refer those who are identified as being at risk to an appropriate provider or facility that can treat the client with evidence-based practices. Therefore, it should only be implemented if there's an overall plan that would allow for outreach and long-term treatment following the screening, since it would be unhelpful and unethical to communicate to survivors that they are at risk for PTSD if we have nowhere to send them for treatment. Consult with your supervisor about whether using this questionnaire is appropriate.

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Referrals for Long-term Care

- People may self-identify as wanting mental health assistance beyond PFA, or you may identify them through any assessment method
- DMH responders should know before disaster strikes where and how to make a referral for follow-up care:
 - What local agencies are available to provide continuity of care?
 - Will there be fees for services?
 - Is there a waiting list?



Referrals for Long-term Care

However those in need are identified (and they may well self-identify as wanting more intensive assistance), there will be times when it's necessary to make a referral for long-term treatment. *As part of preparedness and planning, a disaster mental health worker should know before a disaster strikes where and how to make a referral for follow-up care.* There should be collaboration with local and neighborhood agencies and organizations and/or hospital behavioral health services to ensure continuity of care. As part of this planning, ideally helpers should be able to let survivors know if there will be a fee and, if so, how much it is; or if there's a wait list for receiving services and, if so, how long. Of course you may not always have access to that information, but you can at least suggest survivors ask about those points when they pursue the referral so they know what to expect.

As part of coordination and collaboration before a disaster strikes, disaster mental health workers should establish relationships with local mental health associations and county or government mental health organizations so that follow-up treatment can be seamless.

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Referrals for Long-term Care

- Some clients may feel embarrassed or ashamed about needing help, or reluctant to face the traumatic memory; reassure and support them for seeking treatment



In general, therapists should be sensitive to the fact that those seeking long-term treatment following exposure to disaster could be feeling reluctant, ashamed, and embarrassed about needing help, as well as fearful of the painful feelings and memories connected with the traumatic event. Patients should be reassured and supported for acknowledging their problem and seeking treatment. There is no trick or technique that will provide such reassurance. A traumatized patient will only be reassured and develop trust over time, as the counselor demonstrates some combination of competence, caring, and effectiveness.


The chances for effective treatment will increase if the client is referred to a clinician using evidence-based practices. Delivery of these treatments is beyond the scope of this training, but it's important for DMH helpers to know what forms of treatment survivors should be referred for. The International Society for Traumatic Stress Studies first published guidelines for the treatment of PTSD in 2000. The revised guidelines (2008) identify the practices listed below as the most effective current treatments.

Recommended Evidence-Based Long-Term Care Approaches for PTSD

- Prolonged Exposure Therapy
- Cognitive Processing Therapy
- Stress Inoculation Training
- Other forms of cognitive therapy
- Eye Movement Desensitization and Reprocessing
- Medication

Recommended Evidence-Based Long-Term Care Approaches for PTSD

- Prolonged Exposure Therapy
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- Other forms of cognitive therapy
- Eye Movement Desensitization and Reprocessing
- Medication

(International Society for Traumatic Stress Studies, 2008) 

As this list suggests, various forms of cognitive behavioral psychotherapy are considered the treatments of choice, though there are no disaster-specific PTSD treatments, as these therapies were generally developed to address PTSD in survivors of sexual assault or other individual traumatic experiences. The efficacious, cognitive-behavioral, evidenced-based treatments that exist for this disorder are short-term and highly structured. Present day state of the art treatments for PTSD include Prolonged Exposure therapy, Cognitive Processing Therapy, and for children, Trauma-Focused Cognitive Behavioral Therapy, among others. These treatments embrace the perspective that PTSD is treatable, and their overall philosophy is to remove “blocks” to recovery. Each has a different emphasis, with Prolonged Exposure emphasizing exposure and emotional processing. In Cognitive Processing Therapy, there is less exposure but increased cognitive processing—hence it is a more “frontal lobe” approach that may be appealing to those who are resistant to the idea of intense exposure to memories of the traumatic experience. These are treatments of hope, with therapists serving as coaches who expect the active engagement of their clients, but they are challenging for clients to complete as they require confronting the traumatic memory they have learned to avoid.

Other clients may need referrals for assessment of ongoing anxiety, depression, panic attacks or mental health treatment for other longer term stress reactions that they or their children are experiencing.

Module 4.

Practicing Psychological First Aid

In groups of three, participants will take turns as Client, Counselor, and Observer. Each participant will take one scenario to roleplay as Client. The Counselor should not see the scenario or Client script other than to know the setting, which the Client should read to the group before beginning the exercise. The Observer will act as timekeeper, allowing 10 minutes for the roleplay and 5 minutes for discussion.

After each roleplay the Observer will lead the discussion by first getting feedback from the Client, then the Counselor, and then offering his or her observations. The Observer should reference the checklist of interventions and provide feedback as to how interventions could have been used or used more effectively. Observer and Client are both encouraged to provide constructive criticism.

Clients should not overact nor overwhelm Counselors but rather give the Counselor the opportunity to practice skills. Clients can go off script depending on the response of the Counselor, but try to return to it when possible.

After the three scenarios have been practiced, the entire class will reconvene to discuss reactions to the roleplay exercise for 15 minutes.

Module 5.

Disaster Recovery Center Exercise

This group exercise is intended to provide you an opportunity to practice delivering disaster mental health interventions in the context of an actual setting, a Disaster Recovery Center. Your instructors will assign you a specific role and provide the kind of background information you would likely have available in that role. They will provide timing cues for when your specific role begins and ends.

Throughout the exercise, try to pay attention to your own emotions and reactions as you try to fulfill your role. If you're acting as a survivor, what did you find most helpful in your interactions with the DRC workers? What could they have done differently to support your needs? If you're a worker, what did you find most difficult in trying to help your client, and what did you find most rewarding? At the end of the exercise the group will discuss their experiences and reactions.

Module 6.

Helping in Chaos: Practical Considerations and Self-Care

Now that the DRC roleplay has given you a brief taste of the kinds of pressures and demands you might experience during a disaster response, we'll conclude this training by discussing how you can prepare for both the logistical and emotional demands of disaster mental health work.

Note that throughout this module we refer to “deployment” which typically means travelling to a distant location to participate in the response when local resources can't meet post-disaster demands, but most of the same points will apply when you get involved in a response in the hospital in which you work, or in your own community. In those cases you may have fewer concerns about issues like who is looking after your family in your absence and less stress from trying to help in an unfamiliar environment, but that's likely to be offset by the fact that you may have experienced your own disaster-related losses, and you may essentially be working a double shift, juggling your professional responsibilities with your own recovery needs.

Logistics of Deployment

One of the defining characteristics of DMH work is that every event is so different, making it difficult to predict exactly what conditions you'll be heading into. That means that even very experienced responders need to remain flexible and adaptable. Still, there are some general preparation lessons you can learn from veterans in the DMH field.

Is it the Right Time for You?


Assuming that you have some choice in whether to get involved in a disaster mental health response, the most basic preparation begins with evaluating your personal readiness to participate, and acting now to address any barriers to deployment that are within your control. Otherwise it's far too easy to overlook a need or responsibility that will later impede your ability to work safely and productively. It's difficult to be fully engaged in helping survivors if you're distracted by concerns about home.

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Logistics of Deployment

Note: This module refers to “deployment” – typically travelling to a distant location to participate in the response when local resources can't meet post-disaster demands – but most points apply when you get involved in a response in your own community, likely resulting in:

- Fewer concerns about issues like who is looking after your family in your absence
- Less stress from trying to help in an unfamiliar environment




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Logistics of Deployment


- More stress because you may have experienced your own disaster-related losses
- Need to essentially work a double shift, juggling professional responsibilities with your own recovery needs

In all responses, flexibility and adaptability are essential!



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Is it the Right Time for You?



- *If* you have a choice about whether to respond, start by assessing your personal readiness and addressing barriers to deployment (if possible)



To this end, Rosser (2008) identified three primary considerations to address prior to disaster deployment:

- Ethical considerations to family: Could my family manage well in my absence from home?
- Professional obligations: Is there anything so important in my work that I could not respond immediately?
- Ethical consideration to self: Could I be useful and am I volunteering for the right reasons?

To be certain that your circumstances will permit you to be an effective helper, you should not only engage in self-reflection, but also have a conversation with friends, family, and work associates well before you go on an assignment. Can you leave work or your family if there's a community emergency? How much time can you commit to being available or on-call in the event of a disaster without overextending yourself? These conversations should be attended to **in advance of accepting an assignment**, since desperate calls from work or an overburdened spouse can interfere with or undermine your effectiveness while on the job. You'll be a more effective disaster mental health worker if you feel supported by colleagues, family, and friends while on assignment.

Sometimes disaster work isn't a good fit for someone at a particular point in his or her life. Perhaps you have young children or an elderly parent who needs care, or a particularly demanding work schedule. Perhaps you've recently experienced a personal loss. Perhaps you don't feel seasoned enough as a clinician. It's entirely permissible—and advisable—to postpone doing this work to a time best suited to your capacity to respond. If there's one thing we can guarantee it's that there will always be ample opportunities to get involved at a later time. Also, you may feel prepared to respond to some types of events such as floods or fires that caused property damage but not to a mass casualty incident like a plane crash, or a school bus accident that caused deaths or injuries to children. As a beginning DMH helper you should not feel required to respond to such "hardship" assignments.


What Information You'll Be Provided

As mentioned previously, the most frequent DMH deployments are to Disaster Recovery Centers, though it's possible you could be sent to another setting.

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Is it the Right Time for You?


- Primary considerations (Rosser, 2008):
 - Ethical considerations to family: Could my family manage well in my absence from home?
 - Professional obligations: Is there anything so important in my work that I could not respond immediately?
 - Ethical consideration to self: Could I be useful and am I volunteering for the right reasons?
- Be sure to discuss these points with family and colleagues before accepting an assignment



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Is it the Right Time for You?


- You may decide it's NOT an appropriate time due to:
 - Family obligations
 - Work obligations
 - A recent personal loss or stressor
 - The nature of the disaster
 - The population impacted
 - Lack of confidence



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What Information You'll Be Provided


- Where are you being assigned?
- How do you get there?
- Will you require any specific identification to gain access to the site?
- Will you need any specialized protective clothing?
- Are there health hazards associated with this service site?
- How long are you expected to work?
- Who is your supervisor and how can you contact him or her?
- Is there anything specific you need to bring?
- What are the reimbursement procedures for expenses?



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What to Bring

- Try to balance packing efficiently with making sure you have what you'll need to function in potential deployment settings:
 - Comfortable, washable clothing
 - Sturdy but comfortable footwear
 - Seasonal needs (gloves, hat, sunscreen)
 - Phone/tablet with useful apps – and all needed chargers
 - ID and evidence of credentials
 - Medications and hygiene supplies
 - Comfort/stress relieving items



As the **DMH: Preparing for Deployment tipsheet** in the appendix states, pre-deployment *must have* information should include:

- Where are you being assigned?
- How do you get there?
- Will you require any specific identification to gain access to the site?
- Will you need any specialized protective clothing?
- Are there health hazards associated with this service site that you should be aware of?
- How long are you expected to work?
- Who is your supervisor and how can you contact him or her?
- Is there anything specific you need to bring (i.e., brochures, forms, etc.)?
- What are the reimbursement procedures for expenses?

What to Bring

If you're deployed to a distant location, you'll want to balance packing as efficiently as possible with making sure you have everything you need to keep functioning, including any items you'll want for self-care and stress relief. You may not know the settings you'll be working in (for example, inside a shelter or walking around a neighborhood doing outreach) so be prepared for whatever the season and climate may present. See the tipsheet in the appendix for more packing suggestions, but basic recommendations include:

Attire:

- Comfortable clothing, preferably items that can be washed in a sink and hung dry if necessary
- Footwear that's sturdy, comfortable for hours of standing or walking, and ideally waterproof (Now is not the time to break in new boots!)
- Seasonal accessories—warm hat, scarf, and gloves for winter events; sunglasses, hat, sunscreen, and insect repellent for warm weather events

Other:

- Evidence of relevant credentials (badge, proof of licensure)
- Driver's license and healthcare insurance information
- Personal hygiene items
- Medications (prescriptions, aspirin, vitamins)
- Breath mints or chewing gum
- Hand sanitizer
- Granola bars/other healthy transportable snacks
- Small flashlight (preferably hand- or solar-chargeable)
- Small notebook and writing implements

Comfort/stress relieving items—to be tailored to your personal preferences:

- Books or other reading materials
- Smartphone/other device with games, music, other pastimes (don't forget the charger)
- Photos of loved ones or other reminders of home
- Bible/Koran/other spiritual care materials

Also consider useful apps to load on your phone or iPad such as:

- GPS/mapping
- Language translation tools
- Flashlight
- PFA reminders
- First aid guide
- Weather tracker
- Skype or Facetime to stay connected with home

See the list of DMH and Emergency Management Smartphone and eTablet apps in the appendix for more specific suggestions.

If you need to pack in a hurry it can be easy to forget essential items, so even if you don't go as far as having a pre-packed "go bag" on hand (which is ideal but not always practical) it can be very useful to write up a checklist of everything you'd like to bring. That way, when an event occurs you're simply following the list rather than needing to make a lot of decisions.

Reporting Expectations

For OMH deployments, a summary of DMH support provided is required at the end of each day. The **DRC Daily Report** provides information critical for the maintenance of Situational Awareness. An electronic version of the form will be provided to you in advance of your deployment; a sample is included in the appendix. If necessary, print a sufficient number of copies for use during your assignment.

The information requested includes the number of families received at the Center (this can be obtained from the registration desk), as well as:


- The number of individuals seen by mental health staff
- General description of the mental health services provided
- The nature of challenges being encountered
- The methods you employed to address those concerns
- Any other noteworthy events/issues occurring that day

You will email your summary each day to DMHOMH@omh.ny.gov. Receiving this information from each deployed DMH helper will allow the PMH coordinator to adjust where personnel are deployed as demand in each site shifts over time.

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What to Bring


- See the **DMH: Preparing for Deployment tipsheet** in the appendix for detailed packing guidelines
- If possible, pack a "go bag" in advance so you don't forget anything if you need to deploy quickly, or at least prepare a packing checklist to follow

 Office of Mental Health

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Reporting Expectations

- On OMH deployments, the **DRC Daily Report** includes:
 - Number of families received at the DRC
 - Number of individuals seen by mental health staff
 - General description of the mental health services provided
 - The nature of challenges being encountered
 - The methods you employed to address those concerns
 - Any other noteworthy events/issues occurring that day

 Office of Mental Health

Self-Care

Self-Care

- DMH helpers report satisfaction from their involvement with disasters:
 - Immediate gratification from helping others
 - Feelings of empowerment during crisis times
 - Relief from routine mental health work and demands
 - Emotional closeness with other responders
 - A sense of unique privilege



Self-Care

- However... without the proper preparation, responders can also suffer adverse impacts to effectiveness and competence
- **Practicing good self-care is not a luxury, but an ethical responsibility**



Serving others during times of extreme crisis shapes helpers, most often in positive and satisfying ways. Mental health workers who have responded to catastrophic events have reported many rewards including immediate and gratifying personal satisfaction from helping others, feelings of empowerment during times of potentially debilitating crisis, relief from routine mental health work, emotional bonding with responder teams and community, and a sense of privilege resulting from providing mental health services in unique circumstances when they're sorely needed.

Yet without the proper overall preparation and mindset, DMH helpers can also suffer negative consequences from their work. Vicarious forms of trauma and burnout are well documented among responders, but self-care can play a significant role in coping with and preventing problems resulting from disaster experiences. If self-care is ignored, unmanaged distress may not only adversely affect your personal wellbeing, but potentially that of your clients and the response effort as a whole. This can raise professional concerns in the area of your effectiveness and competence. As a result, practicing good self-care to maintain your personal welfare is not a luxury, but an ethical responsibility. In this final section, we'll outline the unique stressors inherent in disaster service, discuss how to prevent them, and provide guidance on transitioning back to normal life once your part in the response operation concludes.

Occupational Hazards of DMH Work

- **Burnout:** gradual exhaustion and depletion of emotional energy that comes from being overworked, without sufficient rest, reward, or recovery
- **Compassion fatigue:** emotional duress caused by overextending one's capacity for selflessness, resulting in general disengagement from the desire to help others



Occupational Hazards of DMH Work

Just as disaster survivors may have a variety of emotional reactions to their experiences, mental health helpers can be impacted by their work in a number of recognized ways. Vicarious traumatization, compassion fatigue, and burnout are all terms we use in trying to capture the effect of others' suffering on our own mental health. These terms have sometimes been used interchangeably, but there are important differences between them.

Burnout is the gradual exhaustion and depletion of emotional energy that comes from being overworked, without sufficient rest, reward, or recovery. This concept was first used in the occupational stress literature to describe emotional consequences resulting from an impossible work situation specific to "people work" for human service workers and mental health professionals who work intensely with other people's problems.

Another hazard that's closely related to burnout, **compassion fatigue** is defined as the emotional duress experienced

by those in close contact with trauma survivors. Compassion fatigue is caused by overextending one's capacity for selflessness, resulting in a variety of symptoms including feelings of numbness or helplessness, apathy, decreased self-esteem, impatience, sleep changes, withdrawal from relationships, loss of purpose, and decreased morale and motivation (Figley, 1995). The cumulative result of these symptoms is a general disengagement from the desire to help others, which can be deeply distressing for mental health professionals whose identity is largely based on perceptions of ourselves as helpers. Fortunately compassion fatigue is a "treatable" reaction that can usually be addressed through self-care.

Vicarious trauma occurs when a helper experiences a trauma reaction due to exposure to a client's traumatic experiences. Vicarious trauma is rooted in mental health professionals' empathy for their clients: By listening to the intimate or explicit details of a client's story, helpers can come to feel as though they witnessed these events personally. Vicarious trauma is specific to those assisting trauma victims (e.g., trauma therapists, rescue workers, hospital and emergency medical staff), and it can lead to "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne, 1995) that may require professional treatment to overcome.

In addition to these psychological hazards, you should also be conscious of potential **physical health concerns** of deployment. Mental health workers are never knowingly sent into an area with environmental hazards. However, you should always be aware that there are risks that may be unknown at the time of deployment and that things can change rapidly at disaster sites. Issues such as air quality and safe water are two examples. Take necessary precautions to protect yourself and be sure to review the CDC guidance at www.cdc.gov/travel about specific immunizations or cautions about hazards in the affected area.

Preparing Mentally for Deployment

Earlier we discussed logistical preparations for deployment, like making sure work and family needs are covered. It's equally important that you prepare mentally for your role in a disaster response, particularly if you're new to the field and have limited experience to draw on, or you're being assigned to a very intense event where you may be exposed to a great deal of survivor distress.

The principles of stress inoculation can be very useful in this regard. Stress inoculation begins with the assumption that an upcoming experience will expose you to some unavoidable level of strain. Rather than trying to eliminate that stress, which would

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Occupational Hazards of DMH Work


- **Vicarious trauma:** helper experiences a trauma reaction due to exposure to a client's traumatic experiences
- **Physical health concerns:** potential for injury or illness while deployed, poor air quality, disease exposure, other unrecognized hazards



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Preparing Mentally for Deployment

- "Stress inoculation" is a kind of mental dress rehearsal for what you might experience and how you'll successfully cope with it
- SI assumes that an upcoming experience *will* expose you to some unavoidable level of strain – rather than trying to eliminate that stress, goal is to manage it by taking mental steps in advance:



be impossible, the goal is to manage it (Meichenbaum, 2007). This involves several steps that ideally should be undertaken before the exposure actually occurs—it's a kind of mental dress rehearsal for what you might experience and how you'll successfully cope with it.

First, **identify potential stressors**, including environmental stimuli (troubling sights, sounds, and smells you may be exposed to at the site), likely organizational hassles (inter-agency chaos, inadequate resources, frustrated or hostile clients), and personal concerns (such as worries about family while you're deployed).

Second, **appraise those stressors**. How likely is each to occur? Most importantly, do you perceive it as a threat or a challenge? Perceiving a particular issue as a threat is likely to overwhelm your coping mechanisms and lead to negative self-talk that further undermines your ability to address the issue. In contrast, reframing it as a challenge can help to activate your resources and coping skills. It's the difference between entering a situation thinking "I can't handle this" and "this will be difficult but I know I'll do my best."

Third, **identify potential coping strategies**. These should be both personal and professional. How will you break down overwhelming seeming problems into manageable pieces? Who can you turn to for professional back-up and supervision? How will you remain in touch with family to make sure they're safe? How will you release your stress at the end of each day?

You certainly won't be able to foresee every possible issue that you'll encounter, but making the effort to have at least a basic mental game plan in place before you deploy can go far towards keeping your stress manageable while you're engaged in the response.

Managing Stress During a Response


No doubt we've all seen those lists of good self-care practices: Eat well, get enough sleep, exercise, and so on—all of the things we know we should do but that are often difficult to maintain in daily life, let alone during periods of intense demands. Acknowledging that some healthy habits just won't be possible at certain times underscores the importance of having multiple self-care strategies in your personal tool kit so when one isn't available, you have other options to fall back on.

Best-practice self-care strategies used by mental health professionals to minimize disaster distress include:

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Preparing Mentally for Deployment



- **Identify potential stressors** – what do you expect to find most troubling?
- **Appraise those stressors** – how likely is each one, and do you perceive it as a threat or a challenge?
- **Identify potential coping strategies** – what specific actions can you take to handle each stressor?



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Managing Stress During a Response

- Good self-care practices (eating well, sleeping enough) are often difficult to maintain in daily life let alone during periods of intense demands, so having multiple strategies to call on is essential



- Social support and countering isolation professionally and personally, including staying in touch with family and friends, sharing with disaster “buddies,” and seeking supervision as needed
- Physical self-care through taking breaks, exercising, and eating as healthy a diet as possible
- Mindful awareness and self-reflection, including journaling and meditation
- Spiritual activities including praying, speaking with a chaplain, cultivating meaning in the experience, appreciating nature, and empathetic engagement with clients
- Relaxation exercises such as stretching, guided imagery, or deep breathing

Of course, not all of these activities will appeal to or provide comfort for every helper, so just as you should encourage clients to use coping mechanisms that have worked for them in the past, you should think about what helps you deal with stress and plan for how you can practice that during and after a disaster response. You’re far more likely to implement activities you’ve mapped out in advance than to develop positive habits on the fly in the midst of the response, so we encourage you to take some time to develop your own self-care plan now. The bottom line: Identify what works for you, and be sure to do it.

Disengaging and Transitioning Back to Normal Life


New DMH helpers are often surprised that one of the most challenging parts of the experience isn’t the intense period of deployment, but the return to ordinary life afterward. Whether you were away on a disaster assignment for weeks or spent one day immersed in an extreme crisis, you’ll have been functioning at a heightened tempo in stimulating, meaningful, and extraordinary circumstances, and this new rhythm doesn’t just come to a halt when you leave the operation.

When you return home your excitement and adrenaline level may be at odds with those of your family, friends, and co-workers. You may wish to share your stories, but those closest to you may not be able to relate or process these with you. They may even be resentful about the additional work they had to do to cover for your absence. Or you may feel your experiences are a private matter but find that others are curious and ask lots of invasive-feeling questions. Be prepared for this kind of discrepancy between your post-deployment functioning and that of those around you who didn’t share your powerful experience.

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Managing Stress During a Response


- Best-practice self-care strategies used by veteran DMH professionals include:
 - Social support and countering isolation professionally and personally, including staying in touch with family and friends, sharing with disaster “buddies,” and seeking supervision as needed
 - Physical self-care through taking breaks, exercising, and eating as healthy a diet as possible



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Managing Stress During a Response


- Mindful awareness and self-reflection, including journaling and meditation
- Spiritual activities including praying, speaking with a chaplain, cultivating meaning in the experience, appreciating nature, and empathetic engagement with clients
- Relaxation exercises such as stretching, guided imagery, or deep breathing



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Managing Stress During a Response


- Not all practices appeal to every person, so think about what helps you deal with stress and plan for how you can practice that during and after a disaster response
- Plan ahead: Develop your own self-care plan now
- **The bottom line:** Identify what works for you, and be sure to do it!



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Staying Resilient when Disaster Hits Home


Mirta San Martin
 South Beach Psychiatric Center Psychologist;
 Administrator, South Beach Critical Incident Response Team;
 and Consulting Clinician for Police Organization Providing Peer Assistance



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Disengaging and Transitioning Back to Normal Life

- Often one of the most challenging parts isn’t the intense period of deployment, but the return to ordinary life afterward:
 - Difficult to slow down from the intense tempo during deployment
 - You may be full of stories that family and co-workers don’t want to hear, or you may feel they don’t understand what you’ve been through




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Disengaging and Transitioning Back to Normal Life

- They may resent covering for you during your time away
- Routine work matters may seem dull relative to DMH demands

- If possible, take some time off to decompress before returning to work
- Seek out support, possibly from another DMH worker who understands first-hand




You may need to give yourself time to get used to a very different intensity and pace, including returning to work issues that can seem banal or tedious relative to the rush of disaster mental health work. A best practice in post-assignment self-care is taking time to decompress physically and emotionally. For example, don't come home from a disaster and go to work the next day if you can avoid it. Find your off switch and cultivate your other sources of joy and satisfaction. Full engagement in activities worlds away from disaster response can help to restore order and balance to your life. Identify who you can speak with for support, if that's your wish or need. Just as military veterans sometimes find each other to be the most understanding of their experience, you may find you're most comfortable talking to another DMH helper.

Summary

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- We hope this training has provided understanding of the mental health issues created by disasters, and how to respond to them to support survivors' recovery
- If possible, seek out additional training, and prepare yourself mentally to respond
- As a mental health professional you can play a vital role throughout the disaster cycle in preventing, mitigating, and treating the psychological effects of disaster



Now that you have completed this training, you should have a solid understanding of the essential principles of disaster mental health, including disaster characteristics and typical reactions, and you should be familiar with the most current evidence-supported best practices for early and longer-term interventions. The exercises have given you a taste of both the challenges and rewards of helping disaster survivors in a time of intense need, and demonstrated why self-care is so important if you're to maintain your own well-being throughout a response.

Of course, this one-day training couldn't possibly cover all of the intricacies of disaster response, so we strongly encourage you to seek out additional training and readings on how to deal with specific cultural groups, how to help members of vulnerable populations, how to assist bereaved survivors, and how best to be prepared to respond to specific types of events such as mass casualty incidents or public health emergencies. As a mental health professional you can play a vital role throughout the disaster cycle in preventing, mitigating, and treating the psychological effects of disaster. We hope you'll apply your skills to help prevent harm in your community, and to treat survivors in the aftermath of disasters.

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Appendices

1. Resource Guide for DMH Responders

2. On the Go: The App Resource Guide

3. Sample OMH Deployment Communications:

- Disaster Mental Health Guidance: Disaster Recovery Centers
- Preparing for Deployment
- Disaster Recovery Center Daily Report

Resource Guide for DMH Responders

Note to Reader

The websites and tip-sheets listed in this guide can be used as a resource for yourself to further your disaster mental health/trauma knowledge, and they can be used as “quick guides”—fast access to important information such as self-care in the field. They can also be shared with survivors or other colleagues and responders.

Membership Organizations

International Society for Traumatic Stress Studies (ISTSS)

Offers on-line resources, on-line trainings and peer-reviewed journal.

www.istss.org/

World Association for Disaster and Emergency Medicine (WADEM)

Offers on-line resources, peer-reviewed journal and annual international conference.

www.wadem.org/

American Psychological Association (APA)

Offer resources, general and topic-focused peer-reviewed journals.

www.apa.org/

Organizations with Comprehensive Resource Pages

NYS Office of Mental Health Disaster Mental Health Planning and Response Resources

https://www.omh.ny.gov/omhweb/disaster_resources/

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov/

SAMHSA Disaster Behavioral Health Interventions Inventory

www.samhsa.gov/sites/default/files/dtac/supplemental-research-bulletin-may-2015-disaster-behavioral-health-interventions.pdf

Institute for Disaster Mental Health

www.newpaltz.edu/idmh

National Center for PTSD

www.ptsd.va.gov/

National Child Traumatic Stress Network

www.nctsnet.org/

Preparing to Respond/Coming Home

Adjusting to Life at Home: Tips for Families of Returning Disaster Responders. SAMHSA.

<http://store.samhsa.gov/product/Adjusting-to-Life-at-Home/SMA14-4872>

Self-Care

Help for the Helpers. Institute for Disaster Mental Health

www.newpaltz.edu/idmh/4_help_for-the_helpers_english.pdf

Tips for Disaster Responders: Preventing and Managing Stress. SAMSHA.

<http://store.samhsa.gov/shin/content//SMA14-4873/SMA14-4873.pdf>

Population-Specific Resources

Survivors

Tips for Survivors of a Traumatic Event: Managing Your Stress. Substance Abuse and Mental Health Services Administration.

<http://store.samhsa.gov/shin/content//NMH05-0209R/NMH05-0209R.pdf>

Tips for Survivors of a Traumatic Event: What to Expect in Your Personal, Family, Work, and Financial Life.

<http://store.samhsa.gov/shin/content//NMH02-0139/NMH02-0139.pdf>

Disaster Distress Helpline and Related Resources. Substance Abuse and Mental Health Services Administration.

www.samhsa.gov/find-help/disaster-distress-helpline

Children/Parents

Psychosocial Issues for Children and Adolescents in Disasters. Substance Abuse and Mental Health Services Administration.

<http://store.samhsa.gov/shin/content//ADM86-1070R/ADM86-1070R.pdf>

After a Crisis: Helping Young Children Heal. National Child Traumatic Stress Network

www.nctsnet.org/products/after-crisis-helping-young-children-heal

Talking to Children about the Bombings. National Child Traumatic Stress Network

www.nctsnet.org/products/talking-children-about-bombings

Guiding Adults in Talking to Children about Death and Attending Services. National Child Traumatic Stress Network.

www.mainedisasterbehavioralhealth.com/wp-content/uploads/2013/02/talking_points_about_services.pdf

My Helping Book: A Guided Activity Coloring Book for Children. Institute for Disaster Mental Health.

www.newpaltz.edu/idmh/3_children_activity_book_english.pdf

Cultural & Spiritual

Developing Cultural Competence in Disaster Mental Health Programs. Substance Abuse and Mental Health Services Administration.

<http://store.samhsa.gov/product/Developing-Cultural-Competence-in-Disaster-Mental-Health-Programs/SMA03-3828>

Light Our Way: A Guide for Spiritual Care in Times of Disaster for Disaster Response Volunteers, First Responders and Disaster Planners.

National Voluntary Organizations Active in Disaster. <http://www.nvoad.org/mdocs-posts/light-our-way/>

Resource for Faith Communities. Faith Communities & Disaster Mental Health. National Disaster Interfaiths Network.

www.n-din.org/ndin_resources/tipsheets_v1208/11_NDIN_TS_DisasterMentalHealth.pdf

LGBT Community

Disaster Preparedness for Families with Parents who are LGBT. Family Equality Council.

www.familyequality.org/get_informed/advocacy/know_your_rights/disaster_preparedness/

Working with the Lesbian, Gay, Bisexual and Transgender Community: A Cultural Competence Guide for Emergency Responders and Volunteers. Human Rights Campaign.

http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/EmergencyResponders_-_LGBT_Competency.pdf

Special Needs Populations

Psychosocial Issues for Older Adults in Disasters. Substance Abuse and Mental Health Services Administration.

<http://store.samhsa.gov/product/Psychosocial-Issues-for-Older-Adults-in-Disasters/SMA99-3323>

Coping with Crisis- Helping Children with Special Needs. National Association for School Psychology

www.nasponline.org/resources/crisis_safety/specpop_general.aspx

Specific Disaster Resources

Community Violence: Reactions and Actions in Dangerous Times. National Child Traumatic Stress Network.

www.nctsn.org/products/community-violence-reactions-and-actions-dangerous-times

Coping With Grief after Community Violence. SAMHSA.

<http://store.samhsa.gov/product/Coping-With-Grief-After-Community-Violence/SMA14-4888>

Mental Health Response to Mass Violence and Terrorism. SAMHSA

<http://store.samhsa.gov/shin/content/SMA04-3959/SMA04-3959.pdf>

How to Cope With Sheltering in Place. SAMHSA.

<http://store.samhsa.gov/shin/content/SMA14-4893/SMA14-4893.pdf>

Traveler Health, Chapter 2, “The Pre-Travel Consultation” Natural Disasters and Environmental Hazards; Malilay, Batts, Ansari, Miller, and Brown.

wwwnc.cdc.gov

FEMA Trainings in Incident Command Incident Command System/ National Incident Management System

Note: These free online trainings explain the organizational structure used in all major emergency management activities, which is important information for novice DMH responders to understand.

IS-700.A: National Incident Management System (NIMS) An Introduction

This course introduces and overviews the National Incident Management System (NIMS). NIMS provides a consistent nationwide template to enable all government, private-sector, and nongovernmental organizations to work together during domestic incidents. Three hours.

<https://training.fema.gov/is/courseoverview.aspx>

IS-100.B: Introduction to Incident Command System, ICS-100

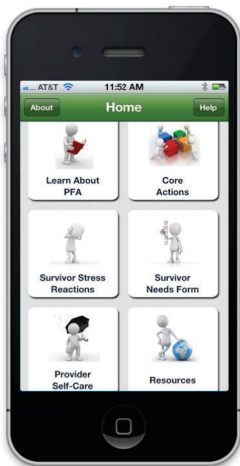
introduces the Incident Command System (ICS) and provides the foundation for higher level ICS training. This course describes the history, features and principles, and organizational structure of the Incident Command System. It also explains the relationship between ICS and the National Incident Management System (NIMS). Three hours.

<http://www.training.fema.gov/is/courseoverview.aspx?code=IS-100.b>

On the Go: The App Resource Guide

Anyone in possession of a smartphone or tablet knows there's been a virtual explosion of apps released to address every possible need—including many needs we never actually knew we had! There are a growing number of free or inexpensive tools that may be useful for DMH responders. Some are mental health specific, including a number of apps that will remind you of key Psychological First Aid and self-care actions you can take during a response. Others are intended to encourage emergency preparedness among members of the public, so they may be useful to recommend to clients and patients. We hope you'll find these recommendations useful in the field.

Psychological First Aid and Other Clinical Tools



PFA Mobile

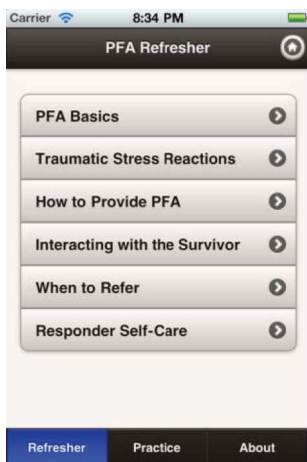
Price: Free

Platforms: Android, iOS

Useful for those using Psychological First Aid in the field, PFA Mobile offers interventions, tips and other resources to support responders. Developed by the VA's National Center for PTSD, National Child Traumatic Stress Network, and DoD's National Center for Telehealth and Technology, this app has an incredible breadth of information.

Download at:

- <https://play.google.com/store/apps/details?id=com.nctsn.pfa.mobile>
- <https://itunes.apple.com/us/app/pfa-mobile/id551079424?mt=8>



Psychological First Aid (PFA) Tutorial

By University of Minnesota School of Public Health

Price: Free

Platforms: Android, iOS

The Psychological First Aid (PFA) Tutorial provides a quick and thorough review for those who have previously received training to provide PFA. First responders, health care providers, mental health providers, MRC volunteers, students, and others will find this an easy to use resource while in the field following a traumatic event, natural disaster, public health emergency, act of terrorism, or personal crisis.

Download at:

- <http://itunes.apple.com/us/app/psychological-first-aid-pfa/id551424464?ls=1&mt=8>

- https://play.google.com/store/apps/details?id=com.umnsph.pfa&feature=search_result#?t=W251bGwsMSwxLDEsImNvbS51bW5zcGducGZhl10

SAMHSA Disaster App

Price: Free

Platforms: Android, Blackberry, iOS

With an ability to access and easily share important information such as tip sheets for survivors, how to get them support, coping information and pre- and post-deployment resources for the responder, this app is a true must-have for any responder in the field.

Download at:

- <http://store.samhsa.gov/apps/disaster/>



PE Coach

Price: Free

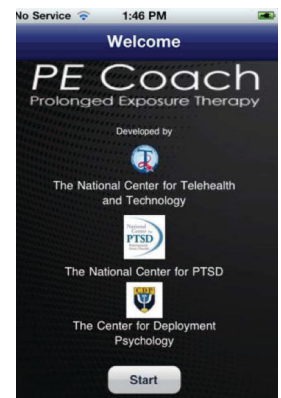
Platforms: Android, iOS

For clinicians working with clients in a long term setting, Prolonged Exposure (PE) is a highly recommended, evidence-based psychotherapy treatment for PTSD. PE Coach was designed as a tool for clinicians and their clients to maintain treatment goals.

*Please note: This is not a training tool in Prolonged Exposure therapy; clinicians should seek training in this model before attempting to use this therapy and app with a client.

Download at:

- <https://play.google.com/store/apps/details?id=org.t2health.pe>
- <https://itunes.apple.com/us/app/pe-coach/id507357193>



Tactical Breather

Price: Free

Platforms: Android, iOS

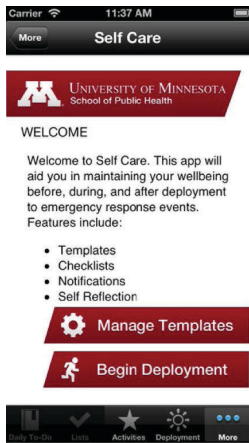
Another app created by the The National Center for Telehealth and Technology, Tactical Breather is an app that allows the user to practice breathing in a way that lowers their arousal levels. Useful in both disaster and other clinical settings to help an individual maintain calm.

Download at:

- <https://play.google.com/store/apps/details?id=t2.tacticalBreather&hl=en>
- <https://itunes.apple.com/app/tactical-breather/id445893881?amp%3Bmt=8&mt=8>



Self-Care



Responder Self Care

Price: Free

Platforms: Android, iOS

Released by University of Minnesota School of Public Health, Responder Self Care helps you keep track of your wellness as you respond to a disaster. From the app's description: "This mobile app aids those deployed to emergency response events in maintaining their own physical, emotional, and social well-being. It provides checklists for before, during, and after deployment that help responders pack for deployment, take care of daily needs, maintain important relationships, reflect on experiences, and more."

Download at:

- <https://play.google.com/store/apps/details?id=edu.umn.umnsc>
- <https://itunes.apple.com/us/app/responder-self-care/id708390024?mt=8>



Provider Resilience

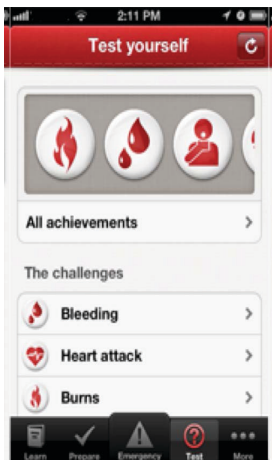
Price: Free

Platforms: Android, iOS

Offered by the National Center for Telehealth and Technology, Provider Resilience allows you to assess your burnout, secondary traumatic stress and compassion fatigue in a quick and easy app. Provider Resilience also allows you to keep track of how long it's been since you've had a day off and can give you tips on coping and maintaining compassion satisfaction.

Download at:

- <https://play.google.com/store/apps/details?id=org.t2.pr&hl=en>
- <https://itunes.apple.com/ca/app/provider-resilience/id559806962?mt=8>



Emergency Preparedness: For You and Your Clients

American Red Cross Apps

Price: Free to \$.99

Platforms: Android, iOS

The American Red Cross has put out a series of apps related to preparedness and recovery. Use these for your own needs or refer clients and survivors to them!

- First Aid
- Pet First Aid
- Hurricane
- Tornado
- Earthquake
- Wildfire

For a full list of American Red Cross apps and instructions on how to download them, visit:

- www.redcross.org/prepare/mobile-apps

FEMA App

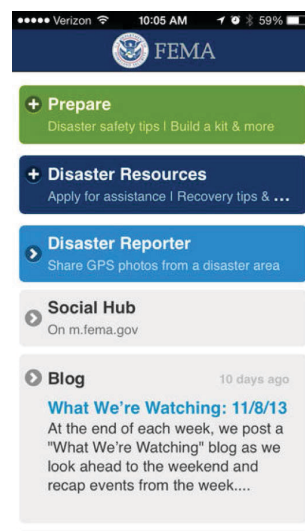
Price: Free

Platforms: Android, Blackberry, iOS

FEMA's disaster app has a tool for building an emergency kit, general tips on how to prepare for disasters and information for affected individuals on how and where to apply for assistance. This app is another that can be both useful to you in the field and for survivors.

Download at:

- <https://play.google.com/store/apps/details?id=gov.fema.mobile.android>
- <https://itunes.apple.com/us/app/fema/id474807486?ls=1&mt=8>



Pocket First Aid & CPR

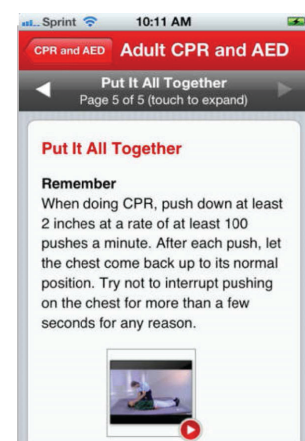
Price: \$1.99

Platforms: Android, iOS

Released by the American Heart Association, this guide provides you with step-by-step information about how to perform CPR and other basic first aid. From an emergency preparedness perspective, this app also provides the user a place to store medical information for themselves and family members and can place wallpaper on their phone that tells medical personnel where to find information about allergies, pre-existing health conditions, and emergency contact numbers.

Download at:

- <https://play.google.com/store/apps/details?id=me.jive.firstaid>
- <https://itunes.apple.com/us/app/pocket-first-aid-cpr-from/id294351164>





Information Tracking

Disaster Alert

Price: Free

Platforms: Android, iOS

Purely informational, this app gives you the opportunity to stay abreast of any occurring disasters around the globe.

Download at:

- <https://play.google.com/store/apps/details?id=disasterAlert.PDC>
- <https://itunes.apple.com/us/app/disaster-alert-pacific-disaster/id381289235?mt=8>

HealthMap: Outbreaks Near Me

Price: Free

Platforms: Android, iOS

Use this app to get information about disease and health outbreaks in your area and set the app to alert you with a notice when an outbreak occurs.

Download at:

- <https://play.google.com/store/apps/details?id=com.duethealth.healthmap>
- <https://itunes.apple.com/us/app/healthmap-outbreaks-near-me/id328358693?mt=8>



Other Useful Apps

Google Translate

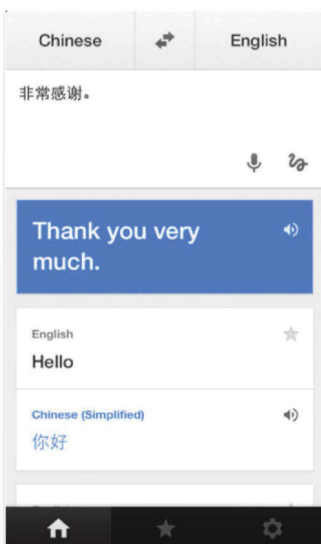
Price: Free

Platforms: Android, iOS

Google's translator app offers the ability to communicate in more than 70 different languages. For disaster responders, the ability to break through language barriers to give timely, accurate information and support to survivors is invaluable. Android users can download languages ahead of time to access translations without 3G and can even take photos of signs and documents for easy translations.

Download at:

- <https://play.google.com/store/apps/details?id=com.google.android.apps.translate&hl=en>
- <https://itunes.apple.com/us/app/google-translate/id414706506?mt=8>



NIMS ICS Guide

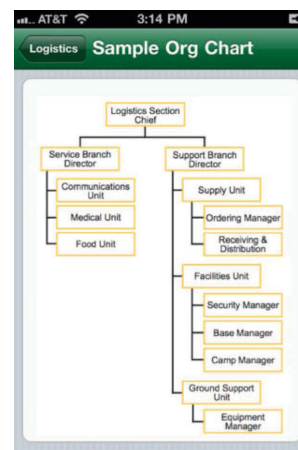
Price: \$6.99 to \$14.99

Platforms: Android, iOS

Though it has a much higher price tag than the other apps, the NIMS ICS Guide is recommended for responders working in Emergency Operation and Incident Command Centers.

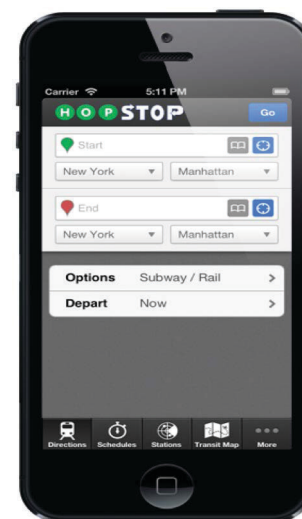
Download at:

- <https://play.google.com/store/apps/details?id=com.informedpublishing.NIMS>
- <https://itunes.apple.com/us/app/nims-ics-guide/id406880725?mt=8>



A final tip: What are the locals using?

If you're deploying to an unfamiliar location, it could be useful to ask local volunteers or staff members if there are any region-specific apps they find helpful, especially as some counties, states, and organizations move towards developing their own disaster information and operations apps. For example, HOPSTOP became a very valuable navigation tool for Hurricane Sandy recovery volunteers who were unfamiliar with New York City public transportation.



Sample OMH Deployment Communications

DISASTER MENTAL HEALTH GUIDANCE Disaster Recovery Centers

BUREAU OF EMERGENCY PREPAREDNESS AND RESPONSE

BEPR is the bureau which coordinates OMH emergency planning and disaster response activity including DMH.

Phone 24/7: 518.860.2146
Email: DMHOMH@omh.ny.gov

OVERVIEW

Disaster Recovery Centers (DRCs) are established to provide information and referral services to individuals and families affected by a disaster. They run as a joint operation between FEMA and NYS agencies. Many state and federal agencies, as well as, volunteer organizations will be present offering both information and immediate assistance across a wide range of areas from insurance to FEMA registration to housing. ***DMH responders support the DRC operation by ensuring that visitors &/or staff at the center are provided immediate emotional support if needed.***

LOGISTICS

Assignments

Your DRC assignment will usually come directly from a BEPR coordinator at OMH. That assignment will include the location of the DRC you are to staff, the shift you are expected to fulfill, and the length of your assignment.

To accept the assignment for deployment to a DRC you must follow all required authorization at your current job site relating to procedures for travel, including vehicle use and overnight accommodations. Remember, if overnight accommodations are needed and made, a tax-exempt form will be required by the hotel/motel.

The DRC site

- ◆ The **DRC Site Manager** coordinates all activities at the Recovery Center. If this is your first day on the site, locate and check in with the **Site Manager** and let them know who you are.
- ◆ Shifts are from 8AM to 8PM, unless told otherwise by the Site Director or BEPR coordinator. Please be prompt. You must complete your entire shift unless released by a supervisor. If a Site Manager releases you, contact BEPR via phone or email so the information can be logged.

- ◆ Meals are generally provided on-site (lunch and dinner) however, you should be prepared to manage meals on your own should they not be available.
- ◆ There is usually a briefing at the beginning and a “debrief” at the end of each day.
- ◆ While most agencies have clearly marked tables where staff waits to serve DRC visitors, Mental Health *may* have a table, but there **should also be a segregated area assigned for you** to meet with individuals who are distressed or are in need of privacy (see *Mental Health at the DRC* below).
- ◆ You need to be reachable at the site which means having access to telecommunications via a cell phone or landline. If you do not have a cell phone, or do not have service where you are located, another phone number must be provided to BEPR, as soon as possible. Each DRC is *usually* equipped with computer access and has its own phone and fax numbers.
- ◆ **Do not assume your belongings are secure at the site.**

MENTAL HEALTH AT THE DRC

- ◆ The primary role of the mental health presence at the DRC is to provide emotional support to visitors as they begin their efforts in the recovery process and to triage any significant mental health challenge that may occur at the center. Because DRCs are usually established days or weeks following an event you will **most likely** not encounter individuals presenting acute emotional trauma. However, the very process in which survivors are engaged will often be very challenging—stressing their already overwhelmed capacity for coping and for some, triggering memories of recent trauma.
- ◆ One of your first objectives at the DRC should be to introduce yourself to the other workers at each table at the center. Let DRC staff know who you are, what your primary role at the center is, and that they can look to you for assistance should someone they are working with appear to be in need of emotional support.
- ◆ You should plan to stay mobile when not working directly with an individual or group, circulating throughout the center watching for situations which might benefit from your assistance. If someone appears to be in distress, assess the situation and provide necessary assistance. **A discreet and private counseling area should be available should you need such space to work with an individual(s).** In keeping with DMH principles, you should not address acute psychological situations but be prepared to refer such situations to local outpatient services or a hospital if necessary. Referrals or the need to contact emergency services should be coordinated with the Site Manager.

CONFIDENTIALITY

All DMH services at the center should be considered as CONFIDENTIAL.

If you have questions, contact the BEPR coordinator.

- ◆ The environment at DRCs may be chaotic. You can assist the staff of the DRC by being a calming presence checking in with them about their own situations and responses to the event and educating about Self-Care.

NOTE: It is possible that Mental Health staff from either the local county or the Red Cross is present at the Center. Should this occur please work to coordinate roles at the Center and notify the BEPR coordinator as soon as possible for possible redeployment.

YOUR DMH ROLE

- ◆ **Familiarize yourself with the local mental health services.** If material is not available on-site, contact the local mental health department to obtain information. Educational material on coping skills, stress management, grieving, working with children, etc. should also be available. If not, contact the BEPR coordinator. If you have access to materials in advance of your deployment, you may want to make copies of material prior to deployment and bring them with you.
- ◆ There may be times when it's necessary to make a referral for long-term treatment. ***Upon arrival at your assigned DRC you should take steps to identify where and how to make a referral for follow-up care.***
- ◆ Learn what services are offered by each federal, state, and local agency at the Recovery Center. This will assist you in providing advocacy and direction to the clients.
- ◆ Circulate throughout the center but keep a special eye on key places where survivors might become emotionally challenged like the **Registration/Greeting** area and any of the desks/tables where they need to fill out paperwork.
- ◆ Don't forget the value of **Active Listening** as a tool to assist those in emotional distress. Remember, survivors may have histories of socio-economic, physical and mental health needs prior to the disaster and these challenges may be exacerbated by the loss and trauma experienced in this current disaster.
- ◆ Wear comfortable shoes; no jeans or shorts. Bring your official identification, carry a cell phone (if possible), and remember a phone charger.
- ◆ Assess the needs of the other site workers and offer advice &/or assistance as necessary.
- ◆ There may be significant down time. Some sites may have free internet capabilities whereas others may not. Feel free to bring laptop with air card, books, magazines, radio, or personal food. Note: There are no refrigerators at sites.
- ◆ It is OK if no one comes in to access services.

DMH ROLE

Remember...DMH does not engage in traditional clinical interventions.

No records are created other than the daily report form.

REPORTING

A summary of DMH support provided is required at the end of each day. The **DRC Daily Report** provides information critical for the maintenance of Situational Awareness. An electronic version of the form will be provided to you in advance of your deployment. If necessary print a sufficient number of copies for use during your assignment.

The information requested includes...

- The number of families received at the Center (this can be obtained from the registration desk).
- The number of individuals seen by mental health staff, general description of the mental health services provided, the nature of challenges being encountered, the methods you employed to address those concerns and any other noteworthy events/issues occurring that day.

Email your summary each day to: DMHOMH@omh.ny.gov

DISASTER MENTAL HEALTH GUIDANCE

Preparing for Deployment

PERSONAL PREPARATION

Typically, when a disaster event leads to the need to utilize OMH resources the event is large in scale and affects large numbers of people across numerous communities. When that occurs, you may be contacted by the OMH Emergency Preparedness and Response office which coordinates disaster Mental Health deployment requesting your availability to provide disaster mental health services and informing you of where to respond for duty. You may be asked to respond to a volunteer staging area for registration and assignment to a specific service site or, more frequently, assigned directly to an Assistance Center.

In the event you are asked to deploy, you should make sure that you have sufficient information to get you to the assigned location effectively and adequately prepared to engage in your DMH work. Some *must have* information should include:

- ◆ Where am I being assigned?
- ◆ How do I get there?
- ◆ Will I require any specific identification to gain access to the site?
- ◆ Will I need any specialized protective clothing?

- ◆ Are there health hazards associated with this service site of which I should be aware?
- ◆ How long are you expecting me to work?
- ◆ Who is my supervisor? Does he or she have a telephone or mobile phone number?
- ◆ Is there anything specific I need to bring with me (i.e., brochures, forms, etc.)?
- ◆ What are the reimbursement procedures for expenses?

What to expect upon deployment

Coping with what may be a chaotic and seemingly disorganized process calls for extreme patience and flexibility. You may spend the better part of a day or a significant number of hours with no one utilizing the DRC's resources or you could find the DRC overwhelmed with anxious survivors. Your ability to tolerate this environment may be the first test of how you will succeed in your newfound position as a disaster mental health professional.

You should also be prepared to have some pertinent information on hand for the registration process. This would include having a copy of your professional license, your driver's license, next of kin contact information, and healthcare insurance information.

Just as there is no loss of basic energy in the universe, so no thought or action is without its effects, present or ultimate, seen or unseen, felt or unfelt.

– Norman Cousins

What to bring

It is important that you have any personal items or professional supplies prepared ahead of time. Having a **Go-bag** packed will ensure that you have not forgotten important items that invariably are left behind in the chaos of responding to a disaster assignment.

Depending upon the location of your assignment and the circumstances of the disaster, there may be a number of personal items you may wish to bring in addition to the items you prepared ahead of time in your disaster Go-bag. These items may differ depending upon whether or not you will be assigned away from home or in your local vicinity. For example, if you are assigned away from your home community, having sufficient clothing, medication, and other supplies will be essential.

Go-bag Checklist

This checklist provides some suggestions for what to pack for a disaster assignment. You might also consider luggage with wheels and an integrated and removable backpack.

PROFESSIONAL MATERIALS AND WORK SUPPLIES	CLOTHING	PERSONAL ITEMS	EQUIPMENT HEALTHCARE AND MEDICAL ITEMS
Copy of professional license	Easy-care clothing (enough for days)	Inexpensive watch	Flashlight and batteries
Copy of driver's license	Casual slacks	Water bottle	Prescriptions/medication
Other professional identification	Casual shirts or tops	Extra pair of glasses/ Sunglasses	Travel alarm clock
Pens / pencils	Sweater/Jacket	Leisure time materials	
Steno pad of paper	Toilet articles	Facial tissues	
Envelopes for expense receipts	Rain gear	Antibacterial hand wipes	
Crayons/ Paper for drawing	Comfortable shoes	Credit card	

DMH PRACTICE

Evidence-based Principles of Early Intervention

REMEMBER... in order to improve the lives of survivors of disaster or mass trauma, there are a few basic principles that should be followed. Each of these recommendations is supported by research.

The five essential elements for early interventions recommended are:

❖ Safety

First steps after a disaster require the removal of actual or perceived threats to reduce the physiological responses to fear and anxiety

❖ Calming

Anxiety and distress are common responses to disasters, but once the immediate danger has passed, heightened anxiety or arousal can become dysfunctional.

❖ Efficacy

Promoting self-efficacy can begin with restoring one's ability to regulate negative emotions and solve practical problems. It can also include facilitating community activities like mourning rituals, getting children back in school, or rebuilding economic infrastructure.

❖ Connectedness

Connecting children with parents and neighbors with neighbors provides social support and Current Best Practices increases the chances for longer-term recovery.

❖ **Hope**

Hope is a belief that one’s actions can bring about a positive outcome. For some, hope involves a belief that luck or the government will address needs. For many, hope arises through a belief in God.

Key Components of Early Intervention

The following is a description of the key components of early intervention. Some of these components would be provided by mental health professionals while other components with mental health implications would be delivered by service providers other than mental health professionals.

BASIC NEEDS	OUTREACH AND INFORMATION DISSEMINATION
<ul style="list-style-type: none"> • Provide food and shelter. • Orient survivors to the availability of services/ support. • Communicate with family, friends, and community. • Assess the environment for ongoing threats. • Provide survival, safety, and security. 	<ul style="list-style-type: none"> • Offer information/education and “therapy by walking around.” • Use established community structures. • Provide information and foster communication and education. • Use effective risk communication techniques.
PSYCHOLOGICAL FIRST AID	NEEDS ASSESSMENT
<ul style="list-style-type: none"> • Protect survivors from further harm. • Reduce physiological arousal. • Mobilize support for those who are most distressed. • Keep families together and facilitate reunions with loved ones. 	<ul style="list-style-type: none"> • Assess the current status of individuals, groups, and/or populations and institutions/ systems. • Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed.
RESCUE AND RECOVERY ENVIRONMENT OBSERVATION	TRIAGE
<ul style="list-style-type: none"> • Observe and listen to those most affected. • Monitor the environment for toxins and stressors. • Monitor past and ongoing threats. • Monitor services that are being provided. • Monitor media coverage and rumors. 	<ul style="list-style-type: none"> • Conduct clinical assessments, using valid and reliable methods. • Refer when indicated. • Identify vulnerable, high-risk individuals and groups. • Provide for emergency hospitalization.
FOSTERING RESILIENCE AND RECOVERY	
<ul style="list-style-type: none"> • Foster but do not force social interactions. • Look after the bereaved. • Provide coping skills. • Foster natural social supports. • Provide education on stress responses, traumatic reminders, coping, normal versus abnormal functioning, risk factors, and services. 	

SELF CARE

- ◆ Vicarious Traumatization
- ◆ Secondary Traumatic Stress
- ◆ Burnout
- ◆ Compassion Fatigue

THE COST OF CARING
The negative impacts of helping traumatized others on helpers...

- ◆ Effective self-care begins prior to disaster response
- ◆ Includes evaluating one's personal readiness to respond to a disaster
- ◆ At least three primary considerations prior to disaster deployment:
 - Could my family cope well in my absence (ethical considerations to family)?
 - Was there anything so important in my work that I could not respond immediately (professional obligations)?
 - Could I be useful and was I volunteering for the right reasons (ethical consideration of self)?

SELF CARE PREPAREDNESS
An ounce of prevention

- ◆ Regardless of amount of time spent in the trenches, returning from a disaster can be stressful:
 - Significant difference in tempo
 - May be hard to share unique experiences
- ◆ Important to take time to decompress
- ◆ Attempt to find balance and enjoy other activities and people unrelated to the disaster
- ◆ Extended involvement in disaster response may have more consequences

POST-DISASTER SELF-CARE

- ◆ The sustained practice of self-care—before, during, and after a disaster—is a critical skill for mental health practitioners
- ◆ Risking exposure to vicarious trauma is an inherent risk in disaster work
- ◆ Self-care may help responders stay strong in the face of disaster's stresses

SELF-CARE SUMMARY



Contact Information (Day job)			
Name		Title/Role	
Work Phone		E-Mail	
Mobile Phone		Home Phone	
OMH Bureau		Supervisor	
Office Location			

Disaster Recovery Center Data			
Identify which DRC you were deployed to			
Date of Deployment		Time In/Out	
Number of Adult Visitors you interacted with:	Male	Female	
Number of Children Visitors (under 18) you interacted with:			
Total number of Visitors you interacted with:			
Total Number of Visitors to the DRC (from Site Director):			
Total number of fellow DRC staff you supported			

Narrative Feedback	
<p>If using a computer the table will expand to accommodate your response so please express your thoughts fully. When complete save the report with your initials in the document name and email to _____ If completing by hand please use as many sheets as necessary and fax to 518.473.7926.</p>	
DRC Facility	DMH Services
Organization	DMH Counselor Role
Was the Site Director available?	Was your role as mental health support discussed with the Site Director and agreed upon with you?
Were there resources for community mental health services available?	Describe specific tasks or activities you completed.
Was there an orientation in the morning and/or group summary at the end of the day? If so, describe.	DMH Work
Were other DRC staff aware of your presence and role at the DRC?	Describe the most common presentations you responded to.
Logistics	Do you have any particular concerns related to the individuals you served?
Did you receive directions to the DRC, were they accurate?	Where any referrals made and to whom?
How were the physical conditions at the DRC?	Did you serve any DRC staff? If so, can you briefly describe the circumstances?
Was there private space for you to use if needed?	Did you encounter situations that were problematic?
Recommendations for improved response from OMH?	Situations the next volunteer should know?
	Any requests or issues that need OMH follow-up?

