Field Manual for Mental Health and Human Service Workers in Major Disasters

Publisher: SAMHSA

Publication date: January 2000

Publication ID: ADM90-0537

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U.S. Department of Health and Human Services

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INTRODUCTION

This Field Manual is intended for mental health workers and other human service providers who assist survivors following a disaster. This pocket reference provides the basics of disaster mental health, with numerous specific and practical suggestions for workers.

Essential information about disaster survivors' reactions and needs is included. "Helping" skills are described with guidance for when to refer for professional assistance. Strategies for worker stress prevention and management are presented in the last section.

The Field Manual condenses and focuses material contained in the *Training Manual for Mental Health and Human Service Workers in Major Disasters, second edition* (Publication No. ADM 90-538). Separate publications on children, older adults, people with serious and persistent mental illness, rural communities following disasters, and disaster mental health services are available through the Substance Abuse and Mental Health Services Administration's National Mental Health Information Center.

KEY CONCEPTS OF DISASTER MENTAL HEALTH

The following principles guide the provision of mental health assistance following disasters. The truth and wisdom reflected in these principles have been shown over and over again, from disaster to disaster.

Key Concepts

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Most people do not see themselves as needing mental health services following disaster and will not seek such services.

- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

Most people who are coping with the aftermath of a disaster are normal, well-functioning people who are struggling with the disruption and loss caused by the disaster. They do not see themselves as needing mental health services and are unlikely to request them. This is why disaster mental health workers must ***go to*** the survivors and not wait and expect that survivors will come to them. Survivors often find terms like “assistance with resources” and “talking about disaster stress” to be acceptable, and services described as “psychological counseling” and “mental health services” to be for someone else.

Going to survivors means using community outreach strategies. Soon after the disaster, survivors gather in shelters, at mass feeding sites, at disaster recovery centers, at disaster information meetings, and in their neighborhoods to clean up and repair their homes. Churches, senior centers, local cafes, schools, and community centers are also likely locations where survivors congregate. A considerable amount of psychological support can occur informally over a cup of coffee.

Most importantly, survivors respond to genuine concern, a listening ear, and help with immediate problem-solving. Survivors find brochures and information about “normal reactions to disaster stress” and “how to cope” to be extremely helpful. Disaster mental health services must actively fit the disaster-affected community. This means workers are culturally sensitive, provide information in the languages spoken, and work with local, trusted organizations and community leaders to better understand survivors’ needs.

SURVIVORS’ NEEDS AND REACTIONS

Floods, tornadoes, hurricanes, earthquakes, hazardous materials accidents, terrorist acts, and transportation accidents cause many similar and predictable reactions. While there may be specific disaster-related stressors, underlying concerns and needs are consistent. These are:

- A concern for basic survival
- Grief over loss of loved ones and loss of valued and meaningful possessions
- Fear and anxiety about personal safety and the physical safety of loved ones
- Sleep disturbances, often including nightmares and imagery from the disaster
- Concerns about relocation and the related isolation or crowded living conditions
- A need to talk about events and feelings associated with the disaster, often repeatedly
- A need to feel one is a part of the community and its recovery efforts

In the days and weeks after a disaster, the most common types of problems encountered are problems in living. These might include transportation problems, unemployment, loss of child care, inadequate temporary accommodations, inability to locate a missing loved one, filling prescriptions, lost eyeglasses, difficulty applying for disaster relief loans, or public health concerns. Disaster workers often find that as they assist a survivor with the immediate problems at hand, they earn the survivor's trust and are told about his or her unique struggles and emotions.

DISASTER COUNSELING SKILLS

Disaster counseling involves both listening and guiding. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem-solving and referral to resources. The following section provides "nuts-and-bolts" suggestions for workers.

Establishing Rapport

Survivors respond when workers offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

Active Listening

Workers listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

- ***Allow silence*** — Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.

- ***Attend nonverbally*** — Eye contact, head nodding, caring facial expressions, and occasional "uh-huhs" let the survivor know that the worker is in tune with them.

- ***Paraphrase*** — When the worker repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good leadins are: "So you are saying that …" or "I have heard you say that …"

- ***Reflect feelings*** — The worker may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared, etc., does that fit for you?" This helps the survivor identify and articulate his or her emotions.

- ***Allow expression of emotions*** — Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Workers should stay relaxed, breathe, and let the survivor know that it is OK to feel.

Some Do's and Don'ts

Do say:

- These are normal reactions to a disaster.

- It is understandable that you feel this way.

- You are not going crazy.

- It wasn't your fault, you did the best you could.

- Things may never be the same, but they will get better, and you will feel better.

Don't say:

- It could have been worse.

- You can always get another pet/car/house.
- It's best if you just stay busy.
- I know just how you feel.
- You need to get on with your life.

The human desire to try to fix the survivor's painful situation or make the survivor feel better often underlies the preceding "Don't say" list. However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers allow survivors their *own* experiences, feelings, and perspectives.

Problem-Solving

Disaster stress often causes disorganized thinking and difficulty with planning. Some survivors react by feeling overwhelmed and become either immobilized or unproductively overactive. Workers can guide survivors through the following problem-solving steps to assist with prioritizing and focusing action.

- **Identify and define the problem**

  Describe the problems/challenges you are facing right now.

  Selecting one problem is helpful, identify it as the most immediate, and focus on it first. The problem should be relatively solvable, as an immediate success is important in bringing back a sense of control and confidence.

- **Assess the survivor's functioning and coping**

  How have you coped with stressful life events in the past?

  How are you doing now?

  Through observation, asking questions, and reviewing the magnitude of the survivor's problems and losses, the worker develops an impression of the survivor's capacity to address current challenges. Based on this assessment—the worker may make referrals, point out coping strengths, and facilitate the survivor's engagement with social supports. The worker may also seek consultation from medical, psychological, psychiatric, or disaster relief resources.

- **Evaluate available resources**

  Who might be able to help you with this problem?

  What resources/options might help?

  Explore existing sources of assistance and support such as immediate and extended family, friends, church community, health care providers, etc. and how the survivor might obtain their help. Refer the survivor to the appropriate relief agencies and assess if the survivor is able to make the calls and complete the required applications. Assist with accessing resources when necessary.

- **Develop and implement a plan**

  What steps will you take to address this problem?

  Encourage the survivor to say aloud what he or she plans to do and how. Offer to check in with the survivor in a few days to see how it is going. If the worker has agreed to perform a task for the survivor, ***it is very important to follow through.*** Workers should promise only what they ***can do,*** not what they would like to do.

A Word of Caution

When confronted with a disaster survivor's seemingly overwhelming needs, workers can feel the understandable impulse to help in every way possible. Workers may become overinvolved and do too much for the survivor. This is usually not in the best interest of the survivor. When survivors are empowered to solve their own problems, they feel more capable, competent, and able to tackle the next challenge. Workers should clearly understand the scope of their role in the disaster relief effort and recognize that empowering survivors is different from ***doing for*** them.

Confidentiality

A helping person is in a privileged position. Helping a survivor in need infers a sharing of problems, concerns, and anxieties—sometimes with intimate details. This special sharing cannot be done without a sense of trust, built upon mutual respect, and the explicit understanding that all discussions are confidential and private. No case should be discussed elsewhere without the consent of the person being helped (except in an extreme emergency when it is judged that the person will harm himself or others). It is only by maintaining the trust and respect of the survivor that the privilege of helping can continue to be exercised.

WHEN TO REFER FOR MENTAL HEALTH SERVICES

Referrals to mental health and other health care professionals are made as workers encounter survivors with severe disaster reactions or complicating conditions. The following reactions, behaviors, and symptoms signal a need for the worker to consult with the appropriate professional and, in most cases, to sensitively refer the survivor for further assistance.

- ***Disorientation*** — dazed, memory loss, inability to give date or time, state where he or she is, recall events of the past 24 hours, or understand what is happening

- ***Depression*** — pervasive feelings of hopelessness and despair, unshakable feelings of worthlessness and inadequacy, withdrawal from others, inability to engage in productive activity

- ***Anxiety*** — constantly on edge, restless, agitated, inability to sleep, frequent frightening nightmares, flashbacks and intrusive thoughts, obsessive fears of another disaster, excessive ruminations about the disaster

- ***Mental illness*** — hearing voices, seeing visions, delusional thinking, excessive preoccupation with an idea or thought, pronounced pressure of speech (e.g., talking rapidly with limited content continuity)

- ***Inability to care for self*** — not eating, bathing, or changing clothes, inability to manage activities of daily living

- ***Suicidal or homicidal thoughts or plans***

- ***Problematic use of alcohol or drugs***

- ***Domestic violence, child abuse, or elder abuse***

POTENTIAL RISK GROUPS

Each disaster-affected community has its own demographic composition, prior experience with disasters or other traumatic events, rural or urban setting, and cultural representation. Consideration should be given to the following groups, as well as additional groups with particular needs residing in the disaster-affected area:

- Age Groups

- Cultural and Ethnic Groups

- People With Serious and Persistent Mental Illness

- People in Group Facilities
- Human Service and Disaster Relief Workers

Age Groups

Each age group is vulnerable in unique ways to the stresses of disaster. Different issues and concerns become relevant during the progression of phases in the post-disaster period. Some disaster stress reactions listed below may be experienced immediately, while others may appear months later. The following table describes possible disaster reactions of the different age groups and helpful responses to them.

Disaster Reactions and Intervention Suggestions

Ages	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
1-5	● Resumption of bed-wetting, thumb sucking, clinging to parents ● Fears of the dark ● Avoidance of sleeping alone ● Increased crying	● Loss of appetite ● Stomachaches ● Nausea ● Sleep problems, nightmares ● Speech difficulties ● Tics	● Anxiety ● Fear ● Irritability ● Angry outbursts ● Sadness ● Withdrawal	● Give verbal assurance and physical comfort ● Provide comforting bedtime routines ● Avoid unnecessary separations ● Permit the child to sleep in parents' room temporarily ● Encourage expression regarding losses (i.e., deaths, pets, toys) ● Monitor media exposure to disaster trauma ● Encourage expression through play activities
6-11	● Decline in school performance ● Aggressive behavior at home or school	● Change in appetite ● Headaches ● Stomachaches	● School avoidance ● Withdrawal from friends, familiar activities	● Give additional attention and consideration ● Relax expectations of performance at home and at school temporarily

Ages	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
	● Hyperactive or silly behavior	● Sleep disturbances, nightmares	● Angry outbursts	● Set gentle but firm limits for acting out behavior
	● Whining, clinging, acting like a younger child		● Obsessive preoccupation with disaster, safety	● Provide structured but undemanding home chores and rehabilitation activities
	● Increased competition with younger siblings for parents' attention			● Encourage verbal and play expression of thoughts and feelings
				● Listen to the child's repeated retelling of a disaster event
				● Involve the child in preparation of family emergency kit, home drills
				● Rehearse safety measures for future disasters
				● Coordinate school disaster program for peer support, expressive activities, education on disasters, preparedness planning, identifying at-risk children
12-18	● Decline in academic performance	● Appetite changes	● Loss of interest in peer social activities, hobbies, recreation	● Give additional attention and consideration
		● Headaches		
	● Rebellion at home or school		● Sadness or depression	● Relax expectations of performance at home and school temporarily

Ages	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
	● Decline in previous responsible behavior ● Agitation or decrease in energy level, apathy ● Delinquent behavior ● Social withdrawal	● Gastrointestinal problems ● Skin eruptions ● Complaints of vague aches and pains ● Sleep disorders	● Resistance to authority ● Feelings of inadequacy and helplessness	● Encourage discussion of disaster experiences with peers, significant adults ● Avoid insistence on discussion of feelings with parents ● Encourage physical activities ● Rehearse family safety measures for future disasters ● Encourage resumption of social activities, athletics, clubs, etc. ● Encourage participation in community rehabilitation and reclamation work ● Coordinate school programs for peer support and debriefing, preparedness planning, volunteer community recovery, identifying at-risk teens
ADULTS	● Sleep problems ● Avoidance of reminders	● Fatigue, exhaustion ● Gastrointestinal distress	● Depression, sadness ● Irritability, anger ● Anxiety, fear	● Provide supportive listening and opportunity to talk in detail about disaster experiences

Ages	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
	● Excessive activity level ● Crying easily ● Increased conflicts with family ● Hypervigilance ● Isolation, withdrawal	● Appetite change ● Somatic complaints ● Worsening of chronic conditions	● Despair, hopelessness ● Guilt, self doubt ● Mood swings	● Assist with prioritizing and problem-solving ● Offer assistance for family members to facilitate communication and effective functioning ● Assess and refer when indicated ● Provide information on disaster stress and coping, children's reactions and families ● Provide information on referral resources
OLDER ADULTS	● Withdrawal and isolation ● Reluctance to leave home ● Mobility limitations ● Relocation adjustment problems	● Worsening of chronic illnesses ● Sleep disorders ● Memory problems ● Somatic symptoms ● More susceptible to hypo- and hyperthermia	● Depression ● Despair about losses ● Apathy ● Confusion, disorientation ● Suspicion ● Agitation, anger	● Provide strong and persistent verbal reassurance ● Provide orienting information ● Use multiple assessment methods as problems may be under reported ● Provide assistance with recovery of possessions ● Assist in obtaining medical and financial assistance

Ages	*Behavioral Symptoms*	*Physical Symptoms*	*Emotional Symptoms*	*Intervention Options*
		● Physical and sensory limitations (sight, hearing) interfere with recovery	● Fears of institutionalization ● Anxiety with unfamiliar surroundings ● Embarrassment about receiving “handouts”	● Assist in reestablishing familial and social contacts ● Give special attention to suitable residential relocation ● Encourage discussion of disaster losses and expression of emotions ● Provide and facilitate referrals for disaster assistance ● Engage providers of transportation, chore services, meal programs, home health, and home visits as needed.

Cultural and Ethnic Groups

Workers must respond specifically and sensitively to the various cultural groups affected by a disaster. Ethnic and racial minority groups may be especially hard hit, because of socioeconomic conditions that force the community to live in housing that is particularly vulnerable. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values can present challenges for workers in gaining access and acceptance.

Cultural sensitivity is conveyed when disaster information and application procedures are translated into primary spoken languages and available in non-written forms. Cultural groups have considerable variation regarding views of loss, death, home, the family, spiritual practices, grieving, celebrating, mental health, and helping. It is essential that workers learn about the cultural norms, traditions, local history, and community politics from leaders and social service workers indigenous to the groups they are serving. Establishing working relationships with trusted organizations, service providers, and community leaders often facilitates increased acceptance. It is especially important for workers to be respectful, well-informed, and to dependably follow through on stated plans.

People With Serious and Persistent Mental Illness

Many disaster survivors with mental illness function fairly well following a disaster, if most essential services have not been interrupted. They have the same capacity to “rise to the occasion” and perform as heroically as the general population during the immediate aftermath of the disaster. However, for others who may have achieved only a tenuous balance before the disaster, additional mental health support services, medications, or hospitalization may be necessary to regain stability. For survivors diagnosed with Posttraumatic Stress Disorder (PTSD), disaster stimuli (e.g., helicopters, sirens) may trigger an exacerbation due to associations with prior traumatic events.

The range of disaster mental health services designed for the general population is equally beneficial for survivors with mental illness; disaster stress affects all groups. Workers need to be aware of how people with mental illness are perceiving disaster assistance and services and build bridges that facilitate access where necessary.

People in Group Facilities

People who are in group facilities or nursing homes during a disaster are susceptible to anxiety, panic, and frustration as a consequence of their limited mobility and dependence on caretakers. The impact of evacuation and relocation on those with health or functional impairments can be tremendous. Dependence on others for care or on medical resources for survival contributes to heightened fear and anxiety. Change in physical surroundings, caregiving personnel, and routines can be extremely difficult.

Both the staff and patients/residents of evacuated or disaster-impacted group facilities are in need of support services. Interventions for these groups include reestablishing familiar routines, including residents in recovery and housekeeping activities when appropriate, providing supportive opportunities to talk about disaster experiences, assisting with making contact with loved ones, and providing information on reactions to disaster and coping.

Human Service and Disaster Relief Workers

Workers in all phases of disaster relief, whether law enforcement, local government, emergency response, or survivor support, experience considerable demands to meet the needs of the survivors and the community. Depending on the nature of the disaster and their role, relief workers may witness human tragedy, fatalities, and serious physical injuries. Over time, workers may show the physical and psychological effects of work overload and exposure to human suffering. They may experience physical stress symptoms or become increasingly irritable, depressed, overinvolved or unproductive, and/or show cognitive effects like difficulty concentrating or making decisions. Mental health workers may intervene by suggesting or using some of the strategies described in the next section.

STRESS PREVENTION AND MANAGEMENT

Working with disaster survivors is inevitably stressful at times. The long hours, breadth of survivors' needs and demands, ambiguous roles, and exposure to human suffering can affect even the most experienced professional. While the work is personally rewarding and challenging, it also has the potential for affecting workers in adverse ways. Too often, staff stress is addressed as an afterthought.

Preventive stress management focuses on two critical contexts: the organizational and the individual. Adopting a preventive perspective allows both workers and programs to anticipate stressors and shape crises rather than simply react to them after they occur. Suggestions for organizational and individual stress prevention and management are presented in the next four pages.

Organizational Approaches for Stress Prevention and Management

Dimension	*Response*
Effective Management Structure & Leadership	● Clear chain of command and reporting relationships
	● Available and accessible clinical supervisor
	● Disaster orientation provided for all workers
	● Shifts no longer than 12 hours with 12 hours off
	● Briefings provided at beginning of shifts as workers exit and enter the operation
	● Necessary supplies available (e.g., paper, forms, pens, educational materials)
	● Communication tools available (e.g., cell phones, radios)
Clear Purpose & Goals	● Clearly defined intervention goals and strategies appropriate to assignment setting (e.g., crisis intervention, debriefing)
Functionally Defined Roles	● Staff oriented and trained with written role descriptions for each assignment setting
	● When setting is under the jurisdiction of another agency (e.g., Red Cross, FEMA), staff informed of mental health's role, contact people, and expectations
Team Support	● Buddy system for support and monitoring stress reactions
	● Positive atmosphere of support and tolerance with "good job" said often
Plan for Stress Management	● Workers' functioning assessed regularly

Dimension	*Response*
	● Workers rotated between low-, mid-, and high-stress tasks
	● Breaks and time away from assignment encouraged
	● Education about signs and symptoms of worker stress and coping strategies
	● Individual and group defusing and debriefing provided
	● Exit plan for workers leaving the operation: debriefing, reentry information, opportunity to critique, and formal recognition for service

Individual Approaches for Stress Prevention and Management

Dimension	*Response*
Management of Workload	● Task priority levels set with a realistic work plan
	● Existing workload delegated so workers not attempting disaster response and usual job
Balanced Lifestyle	● Physical exercise and muscle stretching when possible
	● Nutritional eating, avoiding excessive junk food, caffeine, alcohol, or tobacco
	● Adequate sleep and rest, especially on longer assignments
	● Contact and connection maintained with primary social supports
Stress Reduction Strategies	● Reducing physical tension by taking deep breaths, calming self through meditation, walking mindfully
	● Using time off for exercise, reading, listening to music, taking a bath, talking to family, getting a special meal—to recharge batteries
	● Talking about emotions and reactions with coworkers during appropriate times
Self-Awareness	● Early warning signs for stress reactions recognized and heeded
	● Acceptance that one may not be able to self-assess problematic stress reactions
	● Overidentification with survivors'/victims' grief and trauma may result in avoiding discussing painful material

Dimension	*Response*
	● Understanding differences between professional helping relationships and friendships
	● Examination of personal prejudices and cultural stereotypes
	● Vicarious traumatization or compassion fatigue may develop
	● Recognition of when own disaster experience or losses interfere with effectiveness