

Emergency Management Australia

Guidelines for Psychological Service Practice

MENTAL HEALTH PRACTITIONERS GUIDE





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Manual 10

**MENTAL HEALTH
PRACTITIONERS GUIDE**



EMERGENCY MANAGEMENT AUSTRALIA

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The first publication in the original AEM Series of mainly skills reference manuals was produced in 1989. In August 1996, on advice from the National Emergency Management Principles and Practice Advisory Group, EMA agreed to expand the AEM Series to include a more comprehensive range of emergency management principles and practice reference publications.

The Australian Emergency Series has been developed to assist in the management and delivery of support services in a disaster context. It comprises principles, strategies and actions, compiled by practitioners with management and service delivery experience in a range of disaster events.

The series has been developed by a national consultative committee representing a range of State and Territory agencies involved in the delivery of support services and sponsored by Emergency Management Australia (EMA).

Parts I to III are provided as bound booklets to State and Territory emergency management organisations, students, community organisations, appropriate government departments for further dissemination to approved users including local government and over 70 countries around the world.

Parts IV and V (skills and training management topics) are normally only issued as training guides in loose-leaf (amendable) form to all relevant State agencies through each State and Territory Emergency Service.

AUSTRALIAN EMERGENCY MANUALS SERIES STRUCTURE AND CONTENT

Publishing Status
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PART I – THE FUNDAMENTALS

Manual 1	Emergency Management Concepts and Principles (3rd edn)	U/R
Manual 2	Australian Emergency Management Arrangements (6th edn)	A
Manual 3	Australian Emergency Management Glossary	A
Manual 4	Australian Emergency Management Terms Thesaurus	A

PART II – APPROACHES TO EMERGENCY MANAGEMENT

Volume 1 – Risk Management

Manual 1	Emergency Risk Management – Applications Guide	A
Manual 2	Implementing Emergency Risk Management – <i>A facilitator's guide to working with Committees and Communities</i>	A

Volume 2 – Mitigation Planning

Manual 1	Planning Safer Communities	A
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Volume 3 – Implementation of Emergency Management Plans

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PART III – EMERGENCY MANAGEMENT PRACTICE

Volume 1 – Service Provision

Manual 1	Emergency Catering	A
Manual 2	Disaster Medicine (2nd edn)	A
Manual 3	Disaster Recovery	A/R

Volume 2 – Specific Issues

Manual 1	Evacuation Planning	A
Manual 2	Safe and Healthy Mass Gatherings	A
Manual 3	Health Aspects of Chemical, Biological and Radiological Hazards	A

Manual 4	Post Disaster Survey and Assessment	A
Manual 5	Community Emergency Planning (3rd edn)	A/R
Manual 6	Urban Search and Rescue Concepts and Principles	A
Manual	Civil Defence	D
Manual	Lifelines	D
Volume 3 – Guidelines		
Guide 1	Multi-Agency Incident Management	A
Guide 2	Community and Personal Support Services	A
Guide 3	Managing the Floodplain	A
Guide 4	Flood Preparedness	A
Guide 5	Flood Warning	A
Guide 6	Flood Response	A
Guide 7	Emergency Management Planning for Floods Affected by Dams	A
Guide 8	Reducing the Community Impact of Landslides	A
Guide 9	Psychological Services: Emergency Managers' Guide	A
Guide 10	Psychological Services: Mental Health Practitioners' Guide	A
Guide 11	Disaster Loss Assessment Guidelines	A
Guide 12	Economic and Financial Aspects of Disaster Recovery	A
Guide	Community Development	D
Guide	Gathering Community Information	D
Guide	Disaster Victim Identification	D

PART IV – SKILLS FOR EMERGENCY SERVICES PERSONNEL

Manual 1	Storm Damage Operations (2nd edn)	A
Manual 2	Operations Centre Management	A
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Manual 4	Land Search Operations (2nd edn – Amdt 1)	A
Manual 5	Road Accident Rescue (2nd edn)	A
Manual 6	General Rescue (4th edn – formerly Disaster Rescue)	A
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Manual 9	Communications (2nd edn)	A
Manual 10	Flood Rescue Boat Operation (2nd edn)	A
Manual 11	Vertical Rescue (2nd edn)	A
Manual	Structural Collapse Search and Rescue	D

PART V – THE MANAGEMENT OF TRAINING

Manual 1	Small Group Training Management (2nd edn)	A
Manual 2	Managing Exercises	A

Key to status: A = Available A/R = original version Available/under Review
D = under Development; P = Planned; R = under Review/Revision
U/R = Unavailable/under Review

FOREWORD

This manual has been developed by the National Urban Search and Rescue Steering Committee, representatives of police, fire, State and Territory emergency services, ambulance services, and the New Zealand Ministry of Civil Defence and Emergency Management. The Steering Committee is sponsored by Emergency Management Australia.

The manual is issued in loose leaf form to facilitate amendment and insertion of individual organisational supplements.

As situations change and improved techniques are developed the manual will be amended and updated by the National Urban Search and Rescue Steering Committee.

Proposed changes should be forwarded to the Director General, Emergency Management Australia, at the address shown below, through the respective State/Territory Counter Disaster Authority.

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CHAPTER 1

Introduction

The need for guidelines for psychological services practice is evidenced by the different context in which psychological services need to be delivered to disaster affected persons. In the disaster context, psychological services are delivered within a community structure which is typically disrupted whereas these services are normally delivered within a functioning social structure in an orderly patterned existence. Where formal intervention is required it is usually delivered in a clinical, office based setting. Disaster generates varying degrees of chaos and renders many everyday systems and coping mechanisms dysfunctional or impotent. Service delivery therefore has to be flexible, mobile and creative.

As psychological services inform all aspects of disaster management services, guidelines for the delivery of psychological services have been developed in two publications – Psychological Services Emergency Managers Guide and Mental Health Practitioners Guide. This publication, Mental Health Practitioners Guide has been developed to assist the delivery of psychological services practice in the disaster context by appropriately qualified practitioners.

The purpose of these guidelines is to offer practitioners with insights, principles and strategies in key facets of assessment and delivery of psychological services in the disaster context. They aim to facilitate recovery, ensure ethical practice and to protect victims and support workers in their respective roles and have been endorsed by the Australasian Society for Traumatic Stress Studies.

These guidelines have been developed to supplement the information available in the Australian Emergency Manual – Disaster Recovery and the Community and Personal Support Guidelines within the Australian Emergency Management series.

While the overviews in these documents provide adequate information on recovery processes and likely helpful activities, further information is considered necessary for those involved in the provision of psychological services. Because of the increased amount and sophistication of such information, it was deemed necessary to develop these guidelines.

To that effect, the Disaster Recovery Sub-committee of the Community Services Ministers Advisory Council (then the Standing Committee of Community Services and Income Security Administrators) and The Australasian Society for Traumatic Stress Studies, with funding under the National Studies Program of Emergency Management Australia, formed a steering committee which identified key areas to be addressed. Participants at a subsequent workshop represented a cross-section of managers and service providers from the range of government and non-government agencies involved in the delivery of psychological services in the disaster context. Professional disciplines represented included psychiatry, psychology, social work and related fields.

The steering committee collated the data from the workshop in development of these guidelines. In addition, they draw on the Mental Health National Action Plan, the Royal Australian and New Zealand College of Psychiatrists Position Statement 35 on the Role of Psychiatrists in Disasters, the Victoria Disaster Support and Recovery Unit discussion paper on Personal Support Guidelines and the World Health Organisation project on disaster management.

These guidelines should be read not only by those providing psychological services, but also by all involved government departments, agencies and individuals. Although these guidelines have been produced to encourage consistency in the delivery of psychological services in an Australian context, that is, across the boundaries of States, government and non-government organisations and professional disciplines, the prevailing management systems must be respected. It must be understood too, that psychological services are but part of a broader recovery process with which they need to integrate.

It is acknowledged that the body of knowledge in these Guidelines is in the process of development and consequently this document is a dynamic document intended to be reviewed and updated periodically or as new information comes to light.

Key topics addressed in these guidelines include:

- The role of psychological service providers in disaster management;
- The basis for the provision of psychological services;
- Assessment and appraisal;
- Interventions;
- Service Provision; and
- Research.

In these guidelines the terms “disaster” and “emergency” are synonymous.

CHAPTER 2

Basis for the Provision of Psychological Services

This chapter addresses the basis for the provision of psychological services to individuals and communities affected by disaster. It first defines the term “psychological services” as used in this publication and then deals with the aims and rationale of specialist psychological services, the logistics of service delivery in the disaster context, its integration with emergency management and self-monitoring by psychological service providers.

2.01 Psychological Services

For the purposes of this publication the term “psychological services” refers to those specialist psychological services which apply skills ranging from psychological first aid to long term clinical treatment provided by personnel trained to the level appropriate to the task.

2.02 Aims and Rationale

Psychological services in disasters aim to encourage “wellness” by addressing psychological vulnerability in order to limit the development of psychopathology. Alternately, they help affected populations to shift the balance from maladaptive or traumatic responses to adaptive ones. In each case the aim is to preempt later pathology and to alleviate it should it occur.

Psychological services need to be specialised, because disasters generate varying degrees of chaos and render many of the everyday systems and coping mechanisms dysfunctional or impotent. Responses to disasters need to be conceptualised differently to orthodox responses.

Orthodox psychological services usually deal with established problems and are customarily delivered within established diagnoses, frameworks and social structures. Disaster responses are acute, varied, fluid and require specialised conceptualisations to assist assessment, diagnosis and help and in particular, prevention of established responses. While orthodox treatments see “clients” and “patients” as needing cures from pathology, psychological services in early disaster phases emphasise normative responses and aid in pre-empting illnesses.

Established professional and institutional attitudes can even be quite unhelpful. People struggling with the effects of threats to their lives may resent being seen as “crazy”, ill, or “pathological”. They experience such judgements as additional stressors.

2.03 Logistics of Service Delivery

While orthodox treatments often take the form of patterned, office-based, clinical therapies, in the disaster context social structures and patterns may be disrupted, there may be a rapid increase in client numbers and the psychological service resources may themselves be overtaxed. Therefore, service delivery needs to be flexible, mobile, creative and extensive, while at the same time being capable of prioritisation.

The outreach approach to all in the affected community can identify the need to prioritise services to the vulnerable and those with established dysfunctions. Secondly, outreach may be able to prevent widespread distress and help prevent dysfunctions by providing information about the nature and sense of common stress responses and what can be done about them.

Psychological services should be a special but integral part of established response and recovery services. The logistics of service delivery is in the context of disaster management as a whole. Special skills include flexibility, mobility and creativity, “seeing the bigger picture”, the ability to communicate along hierarchical lines and across services, liaison with them and integration into response and recovery services as a whole, as well as having consultancy and healing roles toward the service network.

Special skill is required to communicate with those who may previously have had no contact with any aspect of psychological services. Skill is also needed to distinguish the majority of people who do not require professionally based formal psychological support but may simply benefit from information, those who may require help in the future and those who suffer current fresh and open wounds. Professional sensitivity, skill, ethical standards and self-monitoring must be of an exceptional order.

2.04 Nature of Specialist Psychological Services as Integral to Emergency Management

Emergencies and disasters typically have a wide range of impacts on individuals and communities. These may include the impacts of evacuation, damage to community infrastructure, personal loss and financial hardship. There is a psychological component to each of these impacts which may require local attention as well as attention at the management level.

Reciprocally, the planning, management and delivery of emergency services by disaster managers in many areas in all disaster phases have the potential to have serious psychological consequences for individuals and affected communities as a whole.

Therefore positive consequences can be enhanced and negative ones avoided, or at least alleviated, through disaster managers being informed by specialist psychological consultancy of the psychological consequences of their decisions.

Indeed, it is critical that the psychological dimension informs understanding, planning, training, assessment, decision making and service delivery components of emergency management. This should occur in an integrated way, from local to regional state national and international levels as required. In addition, psychological services may be utilised by managers to deal with secondary stresses within their own sub-systems.

2.05 Capacity of Psychological Service Providers to Self-monitor

Special skills are required of psychological service providers to self-monitor their own feelings, stresses and functioning. This ensures maintenance of their own health and effectiveness and of the principle “First do no harm”.

Specialist training is required to discern and appropriately act on the wide range of biopsychosocial stress responses evoked in providers during assessment and interventions. For instance, intense emotions and sensations may need to be appraised either as information about other persons’ states, or as reflecting one’s own stress responses. Such appraisals facilitate measured professional intervention rather than acting on unprocessed instinctive responses.

Because empathy requires receptivity, openness and reverberation with others, monitoring of one’s responses by self, peer group and supervisors is necessary. This can prevent being over-identified, over-committed and overburdened and thus becoming a secondary victim and a burden on those supposed to be helped.

The intense relationships developed with those being helped in disasters also requires ethical monitoring, in addition to the usual mental health professional ones. (See Appendix C for the code of ethics of the Australasian Society for Traumatic Stress Studies.)

In summary, specialist psychological services are needed in disasters, in order to:

- Recognize, assess and deal with different dimensions of biological, psychological and social stresses outside the usual paradigms
- Deal with unstructured and exacting logistical and organizational demands
- Be able to liaise properly with other workers and interact advantageously with management
- Be able to productively self-monitor oneself and one’s organisation

CHAPTER 3

Concepts of the Psychological Effects in Disasters

This chapter introduces the three dimensional biopsychosocial framework (Triaxial Framework) and the process, parameter and depth axes. Appendix A depicts this framework.

3.01 Psychological Disaster Effects

Disasters cause major environmental, societal and personal upheavals. Most disturbances are in the nature of strains and distress and are often called *stresses*. Situations which give rise to stresses may be called *crises* or *critical incidents*. Stresses may be curtailed or reversed by adaptive *stress responses*. Stress responses may be parts of *survival and preservation strategies* such as fight, flight, rescue and attachment. When stress responses are insufficient or inappropriate, stresses may “give” and irreversible disruptions of various magnitudes called *traumas* may develop. The event in which traumas develop is a *traumatic event*, and the situation in which this occurs is a *traumatic situation*. *Stressors* are particular agents in disasters which lead to stresses and traumas. Those which lead to traumas are called *traumatic stressors*. As disasters are stressors which, almost by definition, lead to trauma, disasters are often implied to be traumatic stressors.

Stresses and traumas have biological, psychological and social (actually integral biopsychosocial) ripple effects. Like ripples from a pebble in the pond, they radiate through the different dimensions of disasters.

3.02 Conceptualising Disaster Effects

Stress responses of various strategies of survival, both adaptive and maladaptive, biological, psychological and social, may be conceptualized to ripple along three dimensions. The three-dimensional ripple view of disasters informs the view of disaster effects.

3.03 Three-Dimensional View of Disasters (the triaxial framework) (Refer Appendix A)

The first dimension or axis (called the **parameter axis**) describes the “what” of the disaster (the event), the “when” (the disaster phases) and the “who” it struck and who was affected (the social system levels). Disaster phases and social system levels will be used in these guidelines as points of departure for assessments and interventions.

The second dimension or **process axis** describes the ripple process and makes sense of how and why various biological, psychological and social stress responses progress either to fulfilling results or symptoms and dysfunctions.

The third dimension, the **depth axis** orientates responses along human developmental levels, ranging from instincts to spirituality. Examples of these levels include moral judgements, identity, beliefs, meanings and purpose.

3.04 *Survival Strategies*

The choice of survival strategies determines the specific nature of stress responses and their particular adaptive and maladaptive biological, psychological and social ripples. The variety of survival strategies and their various ripple effects across the three dimensions, determine the great variety and complexity of traumatic stress responses in disasters.

Nevertheless, sense can be made of such responses by orienting them on the triaxial framework and tracing them back to specific survival strategies evoked in the context of traumatic events.

Specific survival strategies are fight, flight, rescue/caretaking, attachment, assertiveness/goal achievement, adaptation/goal surrender, competition and co-operation.

The table in Appendix B indicates how survival strategies may be used to classify adaptive and maladaptive biological, psychological and social responses in disasters.

CHAPTER 4

Psychological Service Providers

Psychological service providers need to be able to conceptualise the needs of affected communities and to deliver the services according to the three dimensional framework.

Psychological service providers should be able to assess:

- The adequacy and capacity of existing community agencies to undertake necessary tasks;

- The capacities and dynamics of the service provider community; and

- The capacity of available resources to meet identified and emergent needs.

Integration of psychological services needs to be maintained by regular network meetings with management. Integration of proven and trusted service providers may reduce convergence by a multitude of service providers unfamiliar with specific requirements in disasters.

Critical to the success of any aspect of the recovery process is effective inter and intra agency coordination, communication and role clarity. To facilitate effective communication between agencies, providers of psychological services need to meet regularly to undertake a range of tasks, including:

- Coordinating and streamlining assessments and intervention outcome information;

- Ensuring effective coordination of ongoing services; and

- Planning for timely withdrawal of services.

In the absence of current accreditations for specialised psychological service providers and the frequency of unsolicited groups and individuals who offer psychological services in disaster areas, the following guidelines are offered to assess the suitability of psychological service providers for disaster work. The guidelines should be used by organisations and individuals who contemplate offering psychological services to disaster areas and by managers who may need to determine the suitability of those proffering help at disaster sites. In the latter situation managers should also consult senior psychological service personnel trained in disaster work.

Broadly, similar principles apply to assessment of psychological service providers as to those who offer other specialist emergency management services.

As a guide, the following questions should be answered satisfactorily with respect to those wanting to help:

To what extent have they had prior experience, training and ability to perform the specialised psychological services in disasters described in these guidelines?

If not specially disaster trained, to what extent do individuals/groups have a secure professional identity (such as psychiatrist, clinical psychologist, social worker, etc.), matured professional experience and skills, knowledge of their own limitations and a secure supportive agency and work-base which will enable the workers to stay as long as needed?

Will they have sufficient rosters and supports to give continual service? Will they have capacity to travel to disaster sites and work out of hours in less than optimal conditions?

What are their coping styles, defences and blind spots? How have they coped in previous disasters and with personal disasters? Have their own traumas been attended?

Do they have the necessary flexibility, ingenuity, and capacities to prioritise?

To what extent will they fit with the culture of the population, other emergency and recovery service workers and with the community and established psychological services?

To what extent do they have group process skills?

Will they accept lines of responsibility and accountability within the disaster management framework? Do they understand the prevailing State Emergency Management arrangements?

Do they accept self-monitoring concepts (debriefs, supervision)? Will they have supervision by more senior people suitably trained and experienced in emergency and trauma work?

Will they maintain proper duty of care in the context of informed consent and confidentiality? Can they balance the need to communicate with other services and avoid duplication, yet maintain the privacy rights of their clients? Can they curtail imposition of unwanted help?

Are they bound by professional ethics of their own association? Will they accept the ethics of the managing agency and the ethical guidelines for trauma work?

Do they accept that their prime responsibility is to the affected population, not third parties?

Will they declare other interests and their source of remuneration?

These considerations will help to assess the extent to which the potential service providers' skills capacities and attributes can fulfill needed roles and match the needs of particular disaster populations at particular times.

If it is assessed that those offering their services can be utilised for psychological services, they should be assisted to establish themselves into existing networks with their skill levels matched to appropriate tasks. All service providers should be monitored, supervised and given opportunities to deal with their stresses during their tours of duty.

CHAPTER 5

Assessment

In this section general principles and modes of assessment are provided and are followed by descriptions of specific means of assessment of different social system levels at different disaster phases.

5.01 Definition of Psychological Service Assessment

Psychological service assessment may be defined as evaluation of the impact of a disaster at a particular time on individuals, families and communities, with the purpose of determining needs for psychological service interventions.

Assessment is a continuing process from pre-impact to healing. It is a complex, dynamic multidimensional inquiry which takes into account adaptive and maladaptive biological, psychological and social responses to threats of survival and to what is cherished in life.

5.02 General Principles

The following key considerations apply to assessments generally:

FIRST DO NO HARM. Assessments are in themselves interpersonal interventions which have an effect on those assessed. It cannot be assumed that assessments are necessarily positive experiences or helpful for affected persons. Service providers should continuously monitor whether their assessment is helpful or causing distress. For instance, a pathological bias may be self-fulfilling and assessment of vulnerabilities may be exposed and aggravated.

Affected individuals must be given the opportunity to express their most pressing needs in their own language without preconception, judgement or need to straitjacket communications into prior paradigms.

Service providers must assess the situation in which they are assessing and adapt to the unique requirements of interviewees, local issues and dynamics.

Assessors' understandings need to be that most people respond normally, not pathologically in disasters. In this sense assessments are like in epidemics where all are potentially vulnerable, but only a sizable minority become ill. Assessments are directed to ascertaining best methods for prevention of pathology and discerning the vulnerable and those already ill.

Resilience and coping skills within individuals, families and communities should be assessed and supported. Vulnerabilities should be identified but not be aggravated or exposed without support.

Assessments should continue in all disaster phases, include all social system levels (that is, communities as a whole, groups and organisations, families, individual adults and children and emergency service personnel and other workers), embracing biological, psychological and social aspects and include levels from instinctive to spiritual.

Nevertheless, assessments may need to be tailored to the phase of the disaster (for instance, relatively more “triage,” in the immediate aftermath of a disaster, relatively more emphasis on assessment of life meanings in later phases).

Different types of assessments have their windows of opportunity of acceptability, both of the inquiry and the assessors. For instance, if the initial windows are missed, trust, bonding and integration of service providers into a disaster affected community may be compromised.

Many acute stress responses are similar in the initial stages, whether they eventually go on to resolution or post-traumatic stress and post-traumatic stress disorder. Assessments may need to be done at different stages to note the evolution of responses. The gauging of the likely direction of the progress of responses requires specialist expertise.

Concurrent education should be given to affected people on different social levels about the nature and purpose of assessments.

Assessments must be coordinated to ensure there is no unnecessary repetition.

Where feasible, review assessments should be undertaken by the same assessor.

Assessments should always be informed by the complexity of the process and readiness to assuage any distress inadvertently evoked by the assessment.

Assessors must assess themselves. Their assessments may be distorted in traumatic situations. For instance, excessive impulses to help may result from needs or overidentification with victims. Defences such as dissociation, denial, blind spots, or resorting to old secure paradigms may result in too little or inappropriate help.

Assessments of needs and resources, capacity to match the two and deliver what is needed in the way it is needed must be made. This includes determination of when specialised assistance is not required.

Finally, there is also a need to assess the assessment. Is the assessment appropriate, is it likely to lead to meeting affected persons’ needs, or is it potentially creating additional trauma?

5.03 The Why, How, What, When, and by Whom of Assessments

The reasons for assessment

Assessments are undertaken to determine:

- the range of communities affected by a disaster;
- what impacts and consequences there have been on the various communities;
- and
- the various community needs.

Means of assessment

Means of assessment include targeting sources from which to collect data. As well as individuals and families the following community sources may provide especially relevant information:

- Emergency service managers who can supply information about the nature and scope of the disaster and any special features;
- Disaster recovery managers;

Community leaders, members/services;
Health/welfare system; and
Local Government.

Prior history of disasters in the area may be obtained from these or other sources.

The above sources may be accessed by attending briefings, visiting places/people in formal and informal meetings, by convening meetings and by accessing previous community evaluations including socio-demographic profiles.

Modes of assessments

Given the complexity and variety of psychological responses to disasters there can be no simplistic pro-forma model for assessment. Assessors whole person as well as specialist skills must be available to communications from affected people.

The following modes are available for assessments. *Verbal* and *nonverbal* means of communication are assessed within each mode. Nonverbal means include facial expressions, postures, body language and artistic expressions.

Telling the disaster story. People are facilitated to tell their stories fully and in their own words. Stories are filled in from other social systems, such as communities reporting about individuals and vice versa. Assessments are non-judgemental, yet take into account defensive distortions. For instance, parents and teachers often underestimate children's distress, while people may project their own distress on others. In such cases they may say that their neighbours are worse off than themselves.

Professional histories. These include personal and family histories of disasters and means of handling them, assessment of past illnesses, personalities, strengths and vulnerabilities. Again others may shed light on such histories.

Re-enactments (Transference). Trauma stories may be "transferred" from the traumatic situation to the assessment situation and re-enacted or dramatised in the latter. For instance, anger in the assessment situation may reflect anger from the disaster event.

Assessors own responses (Counter-transference). An assessors own responses may be empathic identifications or reactions to other people's feelings, even if the latter are unexpressed. For instance, their own despair or denial may reflect the way interviewees feel, while the impulse to protect and provide may stem from others' attachment needs.

What to assess

All dimensions of disaster consequences need to be assessed. Failing to assess any aspect of the triaxial framework may lead to ignoring potentially useful interventions.

Assessments include:

A sweep of the "ripples in the pond" in all triaxial dimensions to see what effects the disaster caused;

Diagnosis of salient points on the ripples by orienting the points and tracing their manifestations back to their original contexts;

Assessments include adaptive and maladaptive, biological, psychological and social aspects of each ripple point which shows disturbance.

It is useful to do a checklist to see whether all the components of the three axes have been assessed.

Parameter Axis

Components of the parameter axis describe what happened, when to whom. The following are assessed:

The details of the particular stressor and the extent and nature of devastation.

Details of when it happened and over what period.

The details of the affected community – demographics, social system groupings and networks, special groups which may be of help or are vulnerable, those secondarily affected.

Ages of those affected – children, adults, and elderly.

Process Axis

The process axis assesses the nature of the ripple effects, including the what how and why of disaster consequences. Each of the components which follows has biological, psychological and social (functionally biopsychosocial) aspects.

Stressors

Assessment of the noxiousness of stressors includes the number dead and injured, degree of mutilation, presence of human motivation in the causation of the disaster, youth of victims, closeness to the epicentre of the event, extensive destruction, suddenness of the event and unpreparedness.

The more of these factors that are present the more stressors are likely to lead to trauma, and be *traumatic stressors*. Lesser stressors which may be resolved and even lead to better adjustments are called *crises*. Lesser stressors again may be “*daily hassles*”. Disaster stressors usually have a cascade of a mixture of stressors.

Stress responses

Assessment and making sense of stress responses relies on assessing which survival strategies (fight, flight, rescue, attachment, goal achievement, goal surrender, competition, cooperation) were evoked to deal with stressors. Stress responses may be adaptive, in which case they provide satisfaction. If insufficient or maladaptive, they may lead to stress and trauma.

The wide range of fluctuating and often opposite (e.g. altruistic and selfish) manifestations is due to the multiplicity of survival strategies used in disasters and their adaptive and maladaptive, biological, psychological and social aspects.

The presence of even intense stress responses in the initial stages may not indicate bad prognosis, as they may lead to adaptive dealing with stressors.

Stresses and Traumas

It is important to assess and distinguish adaptive, maladaptive/stress and trauma responses. While adaptive responses lead to satisfaction, unsuccessful/maladaptive ones are associated with a sense of strain stress or distress which are nevertheless still reversible. On the other hand, trauma responses are associated with a sense of overwhelming threat of death and irretrievable disruption. Severe stress and trauma responses (often called traumatic stress or critical incident stress responses) need to be assessed and monitored for their potential long term entrenchment and evolution of symptoms and illnesses.

Stress and trauma responses are biological, psychological and social. Psychological stress responses include a variety of intense emotions and cognitive difficulties experienced as difficulties in concentration, poor memory, sense of mental overload and fatigue with decreased mental functioning. Psychological trauma responses include intense helplessness, powerlessness, aloneness, abandonment, engulfment, constant danger and disintegration. Cognitive responses include shock, dissociation, inability to sequence and have

insight and perspective. (For classification and specific diagnosis of biological, psychological and social adaptive, stress, and trauma responses see table in Appendix B.)

- **Strengths and Vulnerabilities**
Strengths are assessed in terms of training and successful past disaster experience, relevant coping skills, supportive networks and ability to use them, personal and financial resources and resilience. Vulnerabilities to be assessed include past traumatic events and illnesses, past fragility and lack of resilience, current noxious stressors, losses of people and resources (see Stressors above), lack of coping skills and supportive networks, and having young or elderly dependants.
- **Defences**
Defences mitigate stresses and traumas by diminishing awareness of them. Assessment involves identifying particular defences and the benefits and costs of the tense coping equilibrium of which they are part. Dissociation may manifest as a sense of unreality, out of body experiences or numbing. Fragmentation of responses may emphasise only one of biological, psychological or social responses. Disconnections (such as suppression or repression of awareness and memories) distortions of memories (such as projection, displacement) avoidance of anxieties (such as denial, withdrawal, overwork and substance abuse) all have benefits and costs in particular circumstances.
- **Symptoms and Illnesses**
Though both affected people and workers naturally reject illness models while they are trying to reconstitute normality and in fact to prevent pathology from occurring, it must be recognized that traumas and defences do lead to a wide variety of biological, psychological (including PTSD) and social symptoms and illnesses, which account for well known increases in morbidity and mortality after disasters. Assessments include diagnosis of these dysfunctions, and assessments of past and present vulnerabilities and strengths which compound with current stress and trauma consequences.

Depth Axis

Assessment of the depth axis (see also Appendix A) is often forgotten as it does not deal with immediate survival issues. However, depth axis components include what makes life meaningful and survival worthwhile. Thus disturbances to these components may actually cause more suffering than struggles for survival. Checking for these components and diagnosing them when they present themselves, is therefore very important.

- **Judgements**
Positive judgements include pride, worth, goodness and loveliness for actions in different disaster phases. Negative judgements include anger, guilt, shame, and a sense of injustice at one's own and others' actions. Assessment includes understanding the specific sources of both positive and negative judgements.
- **Beliefs**
Beliefs include basic assumptions about oneself and the world. They include values, ideals, principles, rights and codes of conduct. Assessment includes identifying both upheld values and ideals and beliefs which were shattered. Assessment also includes noting the source of false beliefs and basic assumptions which arose in the disaster.

- **Identity, self**
Assessment includes enhanced and compromised aspects of identity. Enhanced self-respect may stem from having acted altruistically or effectively according to expectations, or even beyond one's prior self-estimation. Loss of self-esteem may arise from a sense of failed roles and having acted outside one's ideals. Dignity may be maintained in adversity through maintenance of self-respect. It may be lost through loss of self-respect and its symbols and denigrating treatment by others.
- **Spirituality, sacredness, beauty**
Disasters may shatter assumptions about God, consequences of good and bad actions and connections with an ordered purposeful universe. Disasters may also be seen as having destroyed beauty and harmony. On the other hand, survival and its accompaniments may come to be seen as sacred and meaningful. As well, inventiveness may spring from necessity and creative impulses may flourish with regeneration.
- **Existential meaning, purpose**
It is important to assess the balance of existential hope and despair and the meanings, fulfillment and purpose which have been derailed. The latter can be central motifs of distress. Hope of positive meanings and purpose provide energy for recovery. Disasters may reshape past meanings of life in the context of increased wisdom and maturity.

When to Assess

The aim and mode of assessments may vary and might need to be tailored according to the phase of the disaster (from initial "triage," in the immediate aftermath of a disaster, through to detailed clinical assessment) and the impact of it on the individual.

Each person's response will be individual and may be complex, dynamic and variable over time. Reactions/responses to the event need to be assessed in terms of their appropriateness to particular disaster phases.

Assessment is an ongoing process which is necessary to determine immediate, intermediate and long term community needs. It is also necessary to continually review and reassess the adequacy and appropriateness of service provision throughout the recovery process.

Throughout all disaster phases assessments are directed to ascertaining needs for interventions and their specific types, e.g. psychological support, defusing and debriefing, crisis counselling, trauma therapy, longer term counselling.

Who Should Assess

Assessment being a complex specialist process, it should be done by service providers skilled to do so. Skills required by service providers have been described in chapter 4 (Psychological Service Providers). Having considered general aspects of assessments they will now be applied to specific situations.

5.04 Assessments of Different Social System Levels at Different Disaster Phases

The following section provides guidelines on assessment procedures for specific social groups at different disaster phases.

It should be noted that:

The underlying intention is to assess needs at any given time at any given level so as to specifically match them with appropriate interventions.

This can only be an approximation as both phases and social systems overlap and impact on each other in a dynamic system. For instance, events in one phase influence those in subsequent ones and social systems impact on each other.

Disaster Phases

For the purpose of these guidelines the following definitions of disaster phases and social system levels will be used. (They are consistent with those in the AEM Disaster Recovery). The phases considered are broadly preimpact, impact, postimpact and recovery and reconstruction.

Preimpact Phase

Preimpact phase is the time before the disaster strikes. It is the time for putting into effect lessons from past disasters and for training and preparation. As the disaster approaches, it is the time for warnings and possible evacuation.

Impact Phase

Sometimes called the heroic phase, it is the time during and immediately after the disaster strikes when people use strategies of survival to save themselves and others and to preserve possessions.

Postimpact Phase

When the immediate threats of the disaster wane, the first part of the postimpact phase is characterised by joy of survival, strong egalitarian and generous bonds among survivors, strong sympathy and help from outside and a sense of optimism about quickly returning to predisaster circumstances. This period is also called "the honeymoon phase".

The phase of disillusionment follows as the difficulties of coming to terms with losses and rebuilding become apparent. Much frustration with scarce resources, bureaucracy and diminishing help may be accompanied by community tensions. As people try to assimilate their disaster experiences they may have a sense of still being immersed, reverberating or being assailed by images, responses, judgements and meanings from the disaster.

Recovery and Reconstruction

Physical and environmental reconstruction and replacement is accompanied by passage of identity from victim to survivor where individuals and communities resume responsibility for themselves and their disaster story. Disaster responses, their judgements and meanings are worked through into overarching wisdom. Yet unresolved griefs, entrenched stress responses, maladaptive defences, may evolve in this stage into symptoms and illnesses or may emerge in a delayed form in previously apparently well functioning people.

Definition of Social System Levels

The groups to be assessed are communities, families, adults and children. workers are a special group which needs assessment and help (see Section 7). Other secondary victims, such as family members outside the disaster area, nearby communities, media reporters, body handlers, hospitals to which the injured are transferred, should be remembered and assessed.

Social system levels merge and overlap and assessments within particular social groups use information from other social groups. For instance, individuals and families give information about communities and vice versa and adults give information about children and vice versa.

Although these guidelines refer only to the Australian context, the same principles of preparedness and response apply when helping in disasters internationally.

Communities

Communities are generally defined by all those affected directly by a disaster. Yet communities include a variety of intersecting groups which may be defined by geographic location, cultural, ethnic, socioeconomic, institutional accidental visitor criteria or by their functions in disasters (e.g. police, firefighters). Disasters may also create new groups such as evacuees and bereaved groups.

Community groups cohere through social networks, hierarchies, established codes and institutions and channels of communication.

Assessment therefore includes strengths and vulnerabilities of the community as a whole, its groups, networks, leadership, hierarchies, communication and capacities of its institutions especially of its emergency services, local government and health and welfare systems. Assessments are made of vulnerable parts of communities, such as hospitals, retirement villages and ethnically and personally isolated groups. Their special needs and how they may be met are assessed.

Special sources of information for community assessments include prior sociodemographic profiles and other community assessments and current disaster command post and community leaders.

The following points should be noted in community assessments:

- It is important to develop an assessment style that is relevant to the particular community (such as civilian/military, urban/rural) its current tone, mood, morale and culture (such as psychological mindedness and capacity to deliver services in a psychological framework).

- Assessments may be undertaken through visiting places and people formally and informally, attending briefings and by convening meetings.

- Assessments are made by different people at different hierarchical levels. They need to be integrated by persons who do not have operational responsibilities and have requisite experience and knowledge to make overall "meta assessments".

- Assessments should be mapped over time and carefully integrated in the overall management process.

- Assessments should be monitored for potential adverse consequences.

Families

Families need to be assessed multi-dimensionally, which includes their general and specific culture, group contexts, lifestyle, value base and developmental stage. Information about families may be obtained from their local networks and community services.

Families include parents, children and grandparents. Other members in the same household including relatives and friends, extended households and even close family members who were not in the disaster area at the time may form parts of assessments. Pets and toys should also be included whenever practicable.

Assessments must balance the family as a unit and its members as individuals. Special importance of family assessments rest with the information which they supply about children.

A critical aspect of the assessment process is to identify and support a family's normal recovery processes and identifying ways in which they can identify their own needs, recognise need for specialist assistance and be aided and supported. Assessment may be used to guide families in their own recovery and to prevent future difficulty.

The following points should be noted in family assessments:

It is critical to ensure that all members of the family and other residents in the household are included in assessments from infants to the older generations.

Families may 'protect' vulnerable members from scrutiny or use them as projections of their own distress.

Wider family networks, which suffer secondary stress, should be assessed in their own right.

The same ethics, such as of privacy and confidentiality (Appendix C), apply to family assessments as for those of individuals.

Adults

While adults are assessed as parts of communities and families, who may give information about individuals, adults should be assessed individually as well. Similarly, adults' subjective assessments and self-assessments depend both on their perceived roles and execution of their responsibilities within them, as well as on highly subjective experiences and responses. These will be influenced by age, family status and specific capacities and vulnerabilities.

Losses of social support and networks may influence individual responses adversely, while their presence may ameliorate severe responses.

During assessment the following points should be noted:

Affected individuals do not always recognise or report their difficulties and may need encouragement to do so. For instance being given information about common stress reactions may lead to people realising that they too are experiencing them.

Assessment must be undertaken in a manner space and setting congenial to the person. Privacy, confidentiality, dignity and rights as well as special needs of the person should be respected at all times (Appendix C).

Individuals may fluctuate in their functioning at different times in different roles and in different circumstances. For instance, an individual may help others at one point in time but at another focus on themselves.

Assessments should include adaptive and maladaptive biological, psychological and social responses. Diagnosis of these responses may be attempted by tracing them back to their origins in specific situations in the disaster (Appendix B).

Past strengths and vulnerabilities, especially in similar past situations may help predicting future coping and planning for special needs.

Continued unabated distress or total cutting off of feelings (dissociation) for more than a week may be predictive of longer-term adjustment difficulties.

Children

Assessment of children often utilises information from adults (parents, child carers, teachers, guidance officers). Such informants can also be affected by the disaster and account must be taken for skewing of their judgement. Adults especially when stressed, often underestimate and even suppress knowledge of children's' distresses.

Therefore, most importantly, each child should also be assessed individually. This may require specialist knowledge of child/adolescent/family developmental stages, as well as how children communicate, e.g. through play, drawing, and nonverbal family communication.

During assessment the following points should be noted:

Children express their distress relatively more in physical symptoms and in actions. They are relatively more likely to associate events with atavistic and personalised meanings such as that a monster or a monstrous parent caused the disaster; alternately they may believe that they caused the disaster or it was a punishment for their misdeeds.

Children express their own vulnerabilities and distress, but they may also act as vehicles to express family distress.

Children's assessments should take similar care as in assessments of adults for dignity, confidentiality and rights of clients and for monitoring of assessments.

Assessments in the Preimpact Phase

Community

Assess the culture, groupings, information networks, strength and disaster preparedness of institutions and leaders. Examine community demographics and past history with disasters. Review whether current information and warnings are dispersed in a credible manner and whether consequent preparations are congruent with the likely danger or whether people are acting on denial, rumours and myths.

Assess capacities and needs for support, especially of vulnerable institutions such as retirement villages, hospitals and schools and vulnerable groups such as the ill, frail, old, marginalised and non-English speaking.

Families

Assess family structure and culture.

Is the family prepared, does it have contingency plans?

Is the family prepared especially for its vulnerable members?

Does the family need education, training, slotting into community and communication networks?

Are there imminent needs for evacuation, of whom and what will be the cost in potential separation stresses?

Adults

Assess personal strengths (such as training, previous experience), vulnerabilities (such as physical and psychological illnesses, social isolation), and insight into the needs of the incipient situation.

Do denial or inappropriate beliefs prevent appropriate action?

Children

Assess the child's maturity and capacities to understand safety precautions. Assess suitability of protective networks (including at school) prepared for the child should the child be evacuated.

Assessments in the Impact Phase

Community

Assess the probable extent of loss, destruction and disruption in the community, its groups, leaders, hierarchies, networks, institutions and communications.

Is correct information available to and from the community?

Are existing emergency services effective?

Are new organizations and leaders emerging and how effective are they?

Are vulnerable groups safe and catered for?

Is spontaneous outside help appropriate, effective or are there unhelpful convergence phenomena?

Assess the extent to which the community is coping or needing professional help.

Families

If psychological service providers are present in the impact phase of disasters, their assessments revolve on how to survive and preserve themselves and those around them. Assessments involve urgent issues around which strategies of survival to use, such as retrieval and saving family members, neutralising the disaster and escaping.

When not concerned with immediate survival needs, assessments and prioritisations are made of those in need of psychological first aid – the injured, shocked, stunned, confused, the isolated those who feel abandoned and those behaving inappropriately.

Usually assessments of impact phase are retrospective.

What family losses occurred?

What threats to life and destruction were experienced and witnessed?

How did the family survive?

To what extent did family members become separated?

How were separations handled?

What life saving, competent, altruistic acts occurred with what gratitude, within families and between families (e.g., neighbours)?

What strains in rescue and protection occurred with what anguish or resentment?

Adults

Assess survival needs and which survival strategies were attempted from moment to moment.

Were they successful or not?

To what extent did the individual believe they or their loved ones would die?

What strains were present regarding the “survival calculus” that is calculations balancing personal and others’ survival needs?

What were the eventual losses?

How much shock and dissociation (disbelief, denial, derealisation, depersonalisation) were experienced?

Which physical, cognitive, emotional social or spiritual experiences stand/stood out from others and how were they interpreted?

Children

Attachment is the major survival strategy available to otherwise helpless children.

How secure is/was attachment?

Did the child think that it, its parents or others would die?

How much separation is/was there physically and emotionally from protective figures?

What other survival strategies did the child attempt?

Did the child try to rescue parents, pets or toys?

Did the child help and how effectively?

What are/were the ultimate losses, including pets, dolls and toys?

How much did the child absorb of what was happening or to what extent was it defended, for instance dissociated?

What were the salient events the child witnessed and how were they interpreted?

In the child’s eyes, were monsters causing the havoc?

Did the child interpret that its parents had abandoned it, that the child had caused the traumatic event, or that aspects of the events were a punishment for the child’s misdeeds?

Assessments in the Postimpact Phase

Communities

Many impact phase assessments apply also to the postimpact phase. Assessment needs to take account of the extent of destruction and loss, functioning of leaders, institutions and communication channels, caretaking for vulnerable groups, effectiveness of local groups, outside workers and further need for help.

In addition, assessment includes how post-disaster euphoria (honeymoon period) and subsequent disillusionment are handled.

Is the phase of generosity and mutuality facilitated adaptively and the state of subsequent disillusionment anticipated and mitigated?

How is the community dealing with new stresses?

How is the community accessing, rejecting and generally dealing with helper bureaucracies?

Assessment includes the extent and nature of cohesion and disruption within and between old and new hierarchies, community groups and outside services.

Are information networks efficient or are rumours and misinformation rife?

What assistance can be given to facilitate communication of correct and credible information?

Is there high community morale with mutual goals and cooperation or low morale with tensions, envy and greed?

Are old tensions and conflicts being reactivated and even deepened?

What can facilitate the establishment of helpful cooperative networks?

How is the community assessing its losses, including of community symbols and icons?

Is there a need to facilitate public mourning ceremonies?

How is the community apportioning blame and guilt, esteem and shame?

Are individuals or groups being scapegoated?

What community values, symbols and identity beliefs have been enhanced or disrupted and what meanings are made of the events in relation to these values and views of self?

What information is available to provide understanding in terms of survival needs in the disaster context, of the multitude of biological, psychological and social responses and of judgements and meanings reverberating from the disaster?

Is there circulation of advice about the balance between containing emotions for continuing survival needs and needs to express them for the sake of coming to terms?

Are there warnings that as a result of strain and imbalance people should be wary of accidents, physical ailments, of not taking their regular medications, of anxieties and depressions, alcohol and drug abuse, marital problems and problems with children?

Is priority help reaching the most vulnerable and the worst affected?

Is the community adaptively accessing help and evolving new goals?

Families

To what extent has the family reconstituted with resumption of adaptive roles or has become disrupted and dysfunctional?

Is the family availing itself of available information, social networks and available help?

Is the family mutually loving, supportive, open to each other's physical emotional and social needs, grieving together and setting new mutual goals or is the family splintered and competing for emotional needs?

Is the family tense, with suppressed emotions expressed in irritabilities, withdrawal and absent or overactive sexual needs?

What positive judgements and meanings have evolved from disaster experiences and what angers, guilts, shames, sense of injustice and negative meanings are smouldering?

Are vulnerable family members such as children, the elderly and frail cared for properly?

To what extent have family strengths and vulnerabilities come to the fore?
How can the former be encouraged and the latter be supported?

Adults

Following the euphoria of survival, how are people coping with the realisation of what happened and how hard it will be to rebuild?

How are they coping with their various roles and how are they able to access social networks and help?

Which adaptive and maladaptive biological, psychological and social responses of which strategies of survival are still fluctuating and reverberating with the disaster?

How are these responses being expressed? (e.g., relived, suppressed, transferred to new situations, projected on others).

What current stressors are present and are the responses to them adaptive or maladaptive?

Are insufficient or maladaptive means of dealing with new stressors due to faults in provision of help, still active disaster responses and/or past vulnerabilities?

How have predisaster, disaster and postdisaster events, strengths and vulnerabilities compounded?

Have past fitness, resourcefulness, and sociability paid off, or have prior say, heart conditions, depressions, and social isolation worsened?

What judgements and meanings have been evolving? (For instance, "I didn't know I could be so effective." "I am a bad mother." "People come good in disasters." "People let you down when the crunch comes.")

In the latter part of this phase are people starting to come to realistic terms with events or are they still (re)living traumatic events very vividly and consistently, stunned, oblivious and dissociated or overoptimistic, overimmersed, or have lost too intensely their life path and purpose and in need of continued assessment and help?

Children

Attention needs to be given to how the child is managing changes and how much care, attention and understanding is being provided. Because children respond to adult expectations such as to not complain and have greater cognitive difficulties to sequence, make sense and express events, distress of children may go unnoticed. Therefore, extra patience is required to give individual attention to listen to children and assess their needs. Assessment takes into account adult reports, though it must be remembered that these may be overoptimistic or skewed.

Children tend to express their survival relivings relatively more than adults through actions, emotions and physical manifestations. As well as relivings of anxieties of the actual disaster, children are likely to reflect attachment and protective anxieties and angers and guilts around parents. Assessments in children require skilled reading according to their developmental ages of their behaviors, body language and their expressions in play and drawing.

Assessments need to be made of personalised meanings which children are more likely to make of events, such as that they caused them and were punishment, such as for being unlovable.

Persistence of the following may require monitoring and possible intervention – physical symptoms, sleep problems and nightmares, clinging, demanding, regression to earlier behavior, decreased function, overactivity or withdrawal and anxious or aggressive play or acting out in the environment.

Assessments in the Recovery and Reconstruction Phase

Communities

To what extent is the community progressing or is it stuck in its recovery and reconstruction of its environment, groups and networks?

Is the community well informed and able to access help?

Are insurances and compensations being distributed quickly and fairly?

Has the community adequate advocacy?

To what extent and how appropriately, is the community self-reliant and assuming responsibilities for itself and to what extent is it dependent on others?

Is the community being commercially exploited?

Are new balances harmonious with high morale or with low morale, smouldering with conflict, blame and sense of injustice and if so, what are the factors causing this?

Have significant memorials been held, the causes of the disaster resolved and justice achieved?

Are heroes and workers, as well as all survivors being recognized?

Are creative integrations of the event into community history and meaning being achieved, values, identity and existential meanings re-established or is there lasting disillusionment, discontent, splintering and people leaving the community?

Are those identified as vulnerable earlier progressing well, or are their earlier responses becoming entrenched into symptoms and illnesses?

Are delayed biological, psychological or social symptoms and illnesses coming to the fore and are they being attended to by service providers?

Have contacts with referral services been made and maintained?

Are communities, schools, helper agencies, informed to look out for disaster consequences for even up to years into the future?

Families

To what extent has the family directed its efforts constructively and regenerated new lives, or are struggling or even given up, e.g. become dependent on welfare?

Are family relationships harmonious, or have earlier tensions worsened or new ones developed?

Has the family created a family narrative of the disaster, in which they all feel esteem, or are they bearing secret wounds in a 'conspiracy of silence'?

Are families energies creative or diverted to maintaining a facade and absorbed in maladaptive preoccupations?

Is any member of the family vulnerable or suffering symptoms and illnesses and to what extent are they symbolic of family stresses and strains?

Adults

Is the individual readjusting to new circumstances reconstructing a new life and fulfilling roles in family and community or is the individual still under the influence of the disaster, past vulnerabilities and subsequent stressors?

Are defences still active and are they adaptive or have they turned into compulsions (e.g. overwork, substance abuse, sexual cravings), phobias (of triggers symbolic of the disaster), depressions in the absence of grief and to gaps in memory and of parts of self?

Have maladaptive and traumatic responses solidified into biological, psychological and social symptoms and illnesses and if so, which ones?

Can these responses be made sense of by tracing them to particular survival strategies in particular disaster contexts?

Finally, have new and fulfilling self narratives of the disaster experience evolved, with deepening wisdom of one's own human capacities and frailties or is the person consumed with anger, guilt, sense of injustice and shattered beliefs?

Is there creativity and spurt to new life or is the person disconnected externally and internally, wasting and decaying?

Children

Have children recovered their expected developmental phases and their sense of security, belonging and future? Have they grieved their losses and readjusted to new relationships, homes, friends, schools and routines? Have they done so on a deep level, or only superficially to please adults? Have their earlier symptoms resolved, are they more chronic, or have new ones developed? What sense can be made of the symptoms, relating to which manner of survival in what context?

Ultimately, have the children absorbed the story and meaning of the disaster into their lives in a way which is no longer threatening? Or has it radiated fear into their lives?

Having made assessments of disaster affected populations one can plan and execute interventions.

CHAPTER 6

Interventions

The purpose of psychological service interventions in disaster affected populations is to enable affected people to maintain and retrieve their biological, psychological and social selves and to emerge with existentially meaningful lives.

Dealing as providers do in disasters with fresh wounds, gives opportunities to preempt serious pathology and excessive scarring. Further, even if pathology develops, its recent onset and relatively clear causation may lend themselves to efficacious healing.

While psychological services are provided in a manner which empowers individuals and communities in the management of their own recovery, effective service delivery is also reliant upon recognition and understanding of the impacts of disaster on adults, children, families and communities in their various social and cultural contexts.

Expert advice and consultancy are provided throughout all aspects of the disaster recovery process. This ensures that services are delivered in a psychologically informed manner to facilitate and enhance overall community recovery.

Expert advice and consultancy need to be provided at all hierarchical levels, including to emergency managers, particularly recovery managers.

Types of interventions thus range from psychological first aid and support, to long term clinical treatment. The means of delivery of such interventions should be preplanned to be delivered through a seamless, holistic service.

The following sections will consider some general principles regarding intervention, ingredients common to different types of interventions and then overviews of some particular treatment interventions. Subsequent sections will elaborate their applications to different disaster phases for different sections of the population, in accordance with the schema used for assessments.

6.01 General Principles

The following principles include and extend those in the Community and Personal Support Services Guidelines.

FIRST DO NO HARM. Interventions can have negative as well as positive effects and therefore they should be continually monitored.

Interventions should favour self management and autonomy. They should empower those they help in the management of their own coping, recovery and “wellness”. In this regard psychological services must support growth and be careful not to pathologise inappropriately. Rather, education emphasises the normalcy in disaster situations of responses which in other situations appear abnormal.

Interventions should maintain the dignity of affected people and should be delivered in a tactful, flexible, paradigm free, fair, equitable and ethical manner (see also Appendix C).

As with the process of assessment, the timing of services is critical, as the community dynamics immediately following a disaster provide a limited opportunity for service providers to connect with a disaster affected community.

Because recovery from disaster is a complex, dynamic and protracted process, interventions must be provided in a coordinated, timely and culturally appropriate manner, tailored to the prevalent needs of affected people in different phases, throughout the entire recovery process.

Services should be available not only in all disaster phases but at all social system levels, take into account biological, psychological and social aspects and all human levels from instinctive to spiritual.

Psychological services should integrate within affected populations and share information, understanding of issues, policies, goals, decisions, arrangements and management.

Personnel should be selected for their specialist expertise, group skills and ability to integrate with disaster management and other service providers.

Psychological services must be properly integrated into disaster management arrangements. Psychological service managers should be involved consistently at all service hierarchy levels from initial briefings through all disaster phases.

Interventions should be coordinated to avoid multiple approaches, and follow ups should be carried out preferably by the same people.

Interventions should be documented professionally and confidentiality of the documentation maintained. Plans for availability of documentation should take into account translocations of affected people. Such translocations should also be documented.

Pathways of referrals should be established and maintained through all disaster phases.

Providers should receive concurrent help and supervision.

Knowledge and experience gained should be utilized in future preemption. Preparedness should be increased through exercises, training and research.

6.02 Common Ingredients in Stress and Trauma Mitigation and Healing

Preventive interventions are described in this section in the different disaster phases.

When internal networks, adaptive responses and preventive measures are insufficient to prevent occurrence of stress and trauma, the goal of intervention is their mitigation and promotion of healing. Mitigation includes the preservation of as much biopsychosocial integration and meaningful life as possible, while healing involves finding new integrated, meaningful, self-conscious life paths.

The following ingredients apply in all interventions ranging from psychological first aid through various crisis interventions, debriefings, trauma counselling, to clinical therapy. Different techniques use different weightings of the following ingredients.

Recognition includes of who or what group is affected in what way, how and why. It involves diagnosis of inappropriate current responses and beliefs which may make sense when traced back to their biological, psychological and social survival response origins in the disaster context. Recognition thus includes assessments made in Section 5.

Psychological support; counter-trauma environment. Psychological support characteristics include a safe space with boundaries within which one can absorb, think, feel, express fully, communicate and put one's experience in context. Listening to a distressed person, offering empathy and understanding, enables them not to feel alone and helps to place their personal experience in a context which helps them come to terms with it. However, the support person is required to make a sensitive and appropriate contact, to retain an objective and non-judgemental approach and to refrain from giving advice or commenting on their emotions. Support is gained from acceptance and the opportunity to express oneself in as full a way as necessary. Often this is not in accordance with normal conversations where people tend to pass judgement on what they hear, compare it with their own experience or evaluate it. In particular, it is inappropriate to expect an untrained person to listen to painful or distressing experiences while still retaining an objective and supportive attitude.

Therapeutic relationship is a very important feature of psychological support. As well as empathic listening and tuning into affected people for the purpose of being able to offer skilled help, the relationship is reliable, punctual, objective and non-judgemental. It provides a template for hope, trust, bonding and faith that the world can provide kindness, comfort and reliability.

Relief of specific distress; symptomatic treatment. Intervention may mitigate specific distress or symptoms. This includes mitigating creature distress, such as by facilitating provision of warmth, shelter, food or toiletries. People may be *taught skills in asking* for such items by understanding helping networks and know how to ask for what, where and how. Empowerment may also be facilitated by learning *physical skills* to improve one's *external environment*, while ventilation of feelings and skills to *manage tension, anxiety, anger* and other intense emotions facilitates taking control over one's *internal environment*. Drugs may also be helpful in controlling symptoms such as anxiety and depression . . . **Education**, provision of **information** and **clarification** are key components which relieve distress. For instance, it can provide great relief to have clarified that what people are experiencing is typical of *normal people who experienced an abnormal event* and thus their responses are *not pathological* and people are *not crazy*.

Assimilating the trauma requires full understanding of the nature of the traumatic events, the biological, psychological and social survival responses to them, judgements, meanings and beliefs which arose from them and ripples emanating from them to current times. Each response and its ramifications are made sense of in terms of the original context and its ripples and is contrasted with current less turbulent and hopeful contexts and the nature of appropriate responses to them.

Correct understandings of both the disaster circumstances and of the present are merged cognitively and emotionally in a chronological story with new meanings which incorporate both past and present. The wisdom which includes past experience facilitates adaptive responses to the present and the future.

It must be seen that:

Disaster intervention is a sophisticated process of many sensitive components, which can help greatly if properly applied, but if improperly applied, can do harm.

This may be most evident in simplistic applications of packaged interventions to affected populations, especially when they are still in traumatised, distressed or disorganised states.

6.03 Some Particular Treatment Interventions

Psychological support, crisis counselling, defusing and debriefing and long term counselling have been considered as special types of trauma therapy in the AEM – Disaster Recovery. These terms are explained below. However in these guidelines aspects of the above treatments are elaborated in a more sophisticated manner as they are tailored in different disaster phases applied to different social systems.

Psychological Support

Psychological support has been variably used as empathic listening and emotional attunement. This can be provided by relatives and friends and nonclinical support staff. However, psychological support is a sophisticated recognition and reverberation to affected people.

Crisis Counselling

Counselling provides a relationship in which the affected persons' disaster experiences are able to be examined in detail together with other issues in their lives in order to assist them to understand the effects the experiences have had and the meaning they have given them. It can then provide them with an alternative set of understandings. This may also extend to other aspects of the recovery process, such as the impact of change and stress on relationships, personal identity and values. Counselling involves a structured relationship which is provided by someone trained to understand the nature of the difficulties the person is presenting and can anticipate the needs and the methods necessary to assist them. Most crisis counselling is focussed on some specific aspects of the crisis situation and seeks to provide immediate remedies.

Defusing, Debriefing and Worker Support

These special techniques have been developed to assist recovery workers who have been affected by their experiences and have developed potential or actual traumatic stress, sometimes called critical incident stress. Debriefings may use structured methods by those with specific training whose aims are to ensure that the details of the experience are reviewed, together with the thoughts, emotions and behavioural reactions they have caused.

Services whose workers are offered debriefing include police, firefighters, hospitals, nursing homes and community service agencies.

Debriefing has also been offered to victims, not only service personnel. People affected by a disaster caused by known and expected hazards are more likely to benefit from debriefing than people who have not had any expectation of the trauma they have suffered and are in a traumatised, distressed or disorganised state. In such cases it may be of assistance in a modified form as part of a network of other services.

Debriefing has come under critical scrutiny in recent times, as many inexperienced providers applying debrief packages have converged on disaster sites causing distress rather than mitigation of stresses. It is important to understand that no treatment is a panacea and that knowledgeable professional sensitive tailoring of good principles is more important than prescribed techniques.

Traumatic Stress Treatment; Longer Term Counselling

Post-traumatic stress and post-traumatic stress disorder are complex and potentially severe and disabling conditions. They need to be carefully assessed and treated by clinicians trained in the field. Usually these conditions become compounded with pre-existing and subsequent problems and form a complex set of difficulties.

Even without traumatic stress illnesses, complex personal and family problems often emerge during the recovery period. Emotional problems which may have been adequately managed in normal circumstances may become major difficulties in the context of the disaster stresses. These often require more extensive counselling or other forms of psychological treatment provided by experienced clinicians.

6.04 Interventions in different Social System Levels at different Disaster Phases

The following section provides guidelines for interventions at different social levels at different times, using the principles in 6.1.

Because assessments and interventions overlap, many principles applicable to assessments at different social levels also apply to interventions. For instance, interventions in communities need to be applied taking into account the nature of the community, its mood, morale and culture and organised and applied at different hierarchical levels. Similarly, interventions are applied as necessary to all family members, even if one member is chosen to symbolize family distress and techniques with children may use play and drawing.

Like assessments, interventions are informed by the triaxial framework. Thus interventions in all groups which follow are tailored to adaptive and maladaptive biological, psychological and social responses and include dimensions ranging from the survival strategy responses to spiritual issues.

Interventions in the Preimpact Phase

Community

Between disasters it is important that links with communities and other services are maintained. Denial that disasters will happen is countered by pointing out the denial process and its reasons and providing information and education about preventive measures, training and exercises. Mandatory preventive measures such as compulsory fire alarms and exercises may be introduced.

These measures intensify as a disaster looms. Education and information become more specific and measures are taken for them to be effective. For instance, help may be given to provide information and warnings in simple language(s), making sure messages are not overwhelming and give people means to take action. Trusted communication networks, both formal and informal are identified and utilised. Rumours, and myths (such as it can't happen twice) are countered with facts.

Advice may be given about evacuation, its benefits but also psychosocial consequences of separation from community and families. If evacuation is required, advice may be given as to what to take, such as family photos and videos, pets, favourite toys and family heirlooms.

Vulnerable institutions, groups and individuals should be identified and extra provisions made for them.

Psychological services may aid crystallisation of clear leadership, hierarchy of command and a network of rescue services with clearly identified roles, territories and channels of communication. Psychological service providers may help maintain high morale and preparedness.

Families

All members of the family should have clear information and education about potential disasters and their effects and complacency countered by emphasising simple cost-effective preventive means. Protective measures of home and property are helped to be put in place. Emergency drills, contingency plans and role assignments are encouraged.

These measures are intensified when a disaster looms. Vulnerable members are identified and plans made for them. Pros and cons of evacuation and family separation are discussed.

Adults

Help may need to be given to clearly identify individual adults' different roles and places in helping and communication networks. Any potential conflicts between roles (e.g. fire fighter and family protector) should be clarified and prioritisation of roles rehearsed.

Individual denial should be countered by information and education about prevention and training and exercises provided for different potential disaster eventualities.

These measures increase as disasters are impending. Information and warnings intensify and help given to make them easier to absorb. Help is given to assist in difficult choices and to prioritise what may be abandoned or sacrificed and what should be preserved.

Information is needed to be provided about expected emotions such as fear and their effects so they can be anticipated, e.g. tendency to abandon rehearsed procedures when in states of fear.

Children

Children's developmental phases and parental filters greatly influence their understanding and responses to safety precautions and preparation for disasters. Roughly, children under 3 years old are totally dependent on adults. Children aged 4-7 can obey by rote, while children over 7 act ever more like adults with increasing age.

Psychological service provision can help to educate parents and schools about how to provide information, education, preparation and exercises to children of different ages.

If separation from parents is required, this information should be prepared, measured and explained. Separation anxieties may also be mitigated by contact with trusted adults other than parents and by retaining pets, toys, photos and transitional objects such as teddy bears and security blankets.

Interventions in the Impact Phase

In this phase psychological service personnel are participant observers. That is, as well as being concerned to survive and preserve themselves, they should help others do the same. In the process they may use their professional skills for psychological first aid, such as help to reunite missing family members. Helpful interventions which enhance (not reflect on) adaptive strategies of survival, may lead to trust and acceptance in future interventions. Premature interventions, such as, "It is normal to feel anxious about your missing child" may be felt as quite unhelpful.

Psychological service providers can provide a "mind" where impulse to action is predominant. They can help clarify and resolve some impulsive and inappropriate actions and conflicts, such as excess guilt making people expose themselves to unnecessary danger.

Community

Psychological services have uses at all hierarchical levels. At higher levels they may hold in mind prior protocols, communication networks and help to maintain or re-establish them. Lower down emergent helping networks should be encouraged and linked with standing rescue teams. Workers need encouragement to not stand on pride and territory, but help each other, as well as to make clear requests for necessary help from outside.

Leaders who may be wavering need encouragement. They should be helped and empowered to fulfill their roles such as to communicate orders, raise morale, provide information and scotch rumours. Leaders who know the bigger picture should be encouraged to take responsibility for prioritisation. This can relieve rank and file workers of much potential guilt and obsessive needs to provide "perfect" treatment, albeit to only a small section of the population.

Central registers and information on people's whereabouts and their states of being may be facilitated.

Workers may check that vulnerable groups are being attended.

Psychological understanding of apparently "irrational" people, whose inappropriate actions for the circumstances may be directed by desires to search for or care for relatives, may dispel "difficult" behavior and preempt frustrated workers from using force.

Workers may themselves be helped such as by bringing to their notice their exhaustion, need for rest and instituting rosters.

Families

Physical help to facilitate survival and look after vulnerable members may be offered. Psychological service personnel may help to realistically appraise priorities and strategic options and facilitate them. They may help relieve paralytic inaction.

Reuniting family members who were separated or torn apart, or providing information about missing family members and rescue efforts on their behalf, can provide much relief and allow family members to get on with their own necessities.

Helpers may help activate and access rescue and service networks and help maintain reliable channels of information.

Adults

With correct information most people do naturally what is most adaptive under the circumstances. Therefore facilitating correct information and aiding adaptive survival strategies may be the most effective interventions. Correct information confirms choice of priorities and most effective survival strategies.

For those who are injured, alone, who are frozen with fear, are stunned or are paralysed, who suffer psychic shock and dissociation, psychological first aid may be provided or facilitated. Such states may be reversed or mitigated by physical contact such as holding the hand especially with relatives and friends and verbal contact (even if only by mobile phone). Other aspects of psychological first aid include provision of and reassurance about safety and by providing shelter, warmth and normality, often symbolised by a warm cup of tea. It also includes allowing people to express their recently frozen horrors and traumas, possibly allowing them to thaw. Shock may be relieved by giving people control, such as by finding them useful tasks, including looking after others.

Children

Children as well as adults should be given as much information, reassurance and instructions about what is happening in the disaster as possible. Their adaptive strategies of survival, too, in their case especially attachment, need to be supported. Their pets and toys should be safeguarded. Unnecessary separations should be avoided, but if inevitable, children's morale may be maintained by hopeful adult spirits, singing, playing and activities. Useful tasks can ameliorate their fears.

As in adults, shock and terror in children is also mitigated by personal contact and warmth, reassuring words (which need to be truthful however), allowing children to express their feelings, and relieving their guilt and responsibility.

Interventions in the Post-impact Phase

It is in the postimpact phase that organised psychological service providers have traditionally started their work. Yet starting only in this phase may be associated with initial lack of trust and credibility. More ideally, in this phase prior networks have been activated and integrated into a seamless effective service with community and emergency service agencies.

Communities

It is desirable that all service interventions be psychologically informed. Expert advice and consultancy needs to be provided at all hierarchical levels, ranging from government, through emergency and recovery managers, to affected communities. Information should be dispersed about usual post-disaster community responses such as post-disaster euphoria, tendency to find scapegoats and convergence phenomena. Myths about the frequency of panic, looting, unbounded heroism and capacity to recover, as well as pessimistic assessments of permanent damage need countering with proper information. Special care should be taken that media reporters are properly informed and that they themselves are not overoptimistic or on the other hand overwhelming.

Information is widely distributed about the ubiquity, normality and sense of many biological, psychological and social responses, negative judgements such as guilt, shame and sense of injustice, as well as emergence of negative meanings. All means of communication are utilised, including radio, television, newspapers, internet, telephone hotlines, newsletters, pamphlets (such as the Red Cross pamphlets distributed at Australian disasters), posters, community meetings and interpersonal communication.

In this phase realistic causes of the disaster and realistic stocktaking of losses and public mourning for them should be facilitated, helping progress in the assimilation of the disaster.

In this phase many aid agencies and individuals stream into the area. Help is much appreciated if well tailored, but may have adverse effects if part of convergence and competition for victims. Psychological service providers may counter these phenomena by bringing them to the attention of managers and helping them to be discerning about the aid offered. They may help to coordinate quality aid and to halt inappropriate help and voyeurism.

Communities and workers need to have a mutual understanding of losses, needs, available resources and knowledge of the systems by which to access and distribute them. Aid workers should be facilitated to tailor distribution of resources according to need, priorities and to help expeditiously and efficiently. Consultation will ensure that aid is given with compassion yet generosity of spirit, with grace, maintaining dignity and respect for the helped. This may preempt later community tensions, anger, envy, greed and sense of unfairness and injustice.

Vulnerable groups such as orphans, bereaved, homeless, isolated, non-English speaking, should be identified and early specialist treatment (e.g. crisis counselling, bereavement counselling) provided. Secondarily affected groups, such as relatives, should be identified and catered for, as are those who have left the district.

Aid workers and the communities they cater for need to be educated about the natural ambivalence to aid. Truly unfeeling unsympathetic and unjust services may be stressful and even traumatogenic. Their effects may compound with earlier states and add to states of helplessness and rage. Psychological service providers may diagnose and ameliorate these interactions, build helpful bridges, educate, resolve conflicts or advocate on behalf of some victims.

Communication channels should be used and enlarged to increasing empower communities to seek their own help and eventually to help themselves. This decreases a sense of dependency and increases self-esteem.

Aid workers should themselves be educated about secondary stress effects and their prevention and help is given them as required.

Families

Psychological services to families are most efficiently provided on an outreach basis. All families should be visited in their homes or in other shelters.

Two workers with different fields of expertise may visit families together as part of a "buddy system". Together they should make sure that the biological, psychological and social needs of all family members are catered for and that the family dynamics are fully absorbed.

Family needs must be attended both on the level of the family as a whole and on the basis of all their individual members.

If stress responses are due to ongoing stressors, they need to be identified and if possible ameliorated. This may involve arranging for creature comforts such as food, shelter, warmth, toilet facilities and medicine. Reuniting families is still very important. So is reuniting families with familiar social and helping networks and new networks.

If it has been assessed that the family is tense and dysfunctional since the disaster, stress responses still active from the impact phase of the disaster need to be ameliorated. Support and crisis counselling should be instituted in a family setting using principles described in Section 6.1.

Thus, in a safe environment facilitated by the therapeutic relationship, detailed cognitive emotional and behavioural recognition of what the family went through is achieved. Which survival strategies worked when in what interaction and which did not, why, and with what consequences, is ascertained and validated with family members. The sense and normality of their responses in the disaster context is pointed out, as is the reason for lack of need to maintain such responses currently.

Family members may express to each other how they saw the disaster from their personal perspectives and express feelings to each other from such perspectives. Understanding of each other may resolve guilts and angers and strengthen mutual esteem and bonds. Family dignity and identity are preserved, or even enhanced. Adaptive meanings of the experiences may well emerge. Vulnerable family members need special attention. Nevertheless, if the individual's symptoms are used as vehicles to signal family distress, this needs attention.

Adults

The same principles apply to individual adults as for families and may occur contiguously with family healing. Thus reuniting with families and with social networks is beneficial to individuals as well as to whole families. However, intimate one to one counselling relationships allow more personal issues to be addressed in more depth.

While stress responses experienced by individuals may be able to be placed in logical context to ripples from disaster, personal counselling often deals with situations where the connections to such contexts may be hidden. Then people may appear to suffer irrational biological, psychological and social manifestations or symptoms. Reasons for the disconnections may be protection against reliving traumatic events (e.g. sense of imminent death, deaths of others, helpless abandonments), accompanying negative judgements (guilt, shame, rage, outrage), or unacceptable meanings of oneself and the world. The connection may be retrieved through offering skilled and deep recognition of the symptoms, their origins and deep empathic understanding as to why memories of the event are disconnected. Connections of symptoms to the original event are retrieved through reassessment of traumatic feelings, cognitions, judgements and meanings and seeing that they are not warranted today. Retrieval of connections to the traumatic event then allows once again understanding the symptoms in terms of rational biological, psychological and social survival responses in abnormal situations. With reconciliation of past and present, individuals tend to develop new realistically positive meanings and views of self and the world.

Such acute trauma therapy may prevent long term fragmentations of the mind and development of many entrenched symptoms and illnesses. Therapeutic skills need to match the complexity of how the mind deals with trauma. They need to be able to additionally include dealing with past vulnerabilities and meanings, defences personality styles and cultures, all of which compound with the way affected people present.

Note that it may not be enough to simply reassure that symptoms are normal. Such reassurance may only be meaningful when all healing principles are in place, resulting in full cognitive and emotional awareness of causes, consequences, connections and reasons. This results in a narrative story of the disaster and its consequences.

Children

Reuniting with parents and family and provision of creature comforts are even more urgent for children than for adults. Next, it is important to establish an environment of security, routine, education, contacts with peers and opportunities for play and drawing to express the children's experiences.

As for adults, it is important to give children opportunities to express themselves in one to one situations. Their physical and social reenactments may then be connected to particular child versions of traumatic events, judgements and their meanings. For instance, children may feel that the disasters, deaths and subsequent parental strains and irritability are due to their badness. They may combine their concerns with atavistic meanings of predatory worlds, and monsters and witches.

Again acute therapy, this time tailored to children, may prevent such symptoms and meanings becoming entrenched. Interventions need to be congruent with children's developmental phases and using their special modes and means of communication such as play and drawing.

Interventions in the Recovery and Reconstruction Phase

This phase is prolonged and may last even years. Because many delayed symptoms and illnesses become manifest in this phase, it is essential to maintain some level of psychological service provision for a long time.

Communities

Consultation and education at all hierarchical levels of the community and of recovery agencies should be maintained from previous phases. Consultation needs to be provided on the process of handing over management to the local community. While self-reliance and empowerment are encouraged, premature withdrawal of aid and services is discouraged.

Information is provided to the communities, strained relationships and bureaucracies about the real and significant hardships, challenges and costs of this phase, as well as the continued ripples from earlier phases. The latter may manifest in continued and even amplified and multidimensional stress responses and in jelled, frozen, delayed and intermittently manifest responses. Local doctors, marriage counsellors, welfare agencies should be alerted to likely increased workload stemming with different degrees of obviousness from the disaster experience.

Previously identified vulnerable groups should be followed up. Those who were especially shocked (dissociated) during the disaster and who were overimmersed in (re)living the disaster also need follow up, as such groups have been found to be vulnerable to developing future traumatic stress syndromes.

While capacities for self-recovery and independence are acknowledged and facilitated, appreciation must also exist for continued strain, fluctuating tendencies to be disillusionment, dependency, irritability, blaming, competition and division (along both old and new lines). Facilitating networks, bridging communication and advocacy may facilitate more sensitive solving of needs and speedy dignified and equitable insurance and compensation payments. Conflict resolution may resolve enmity between competing groups for the benefit of the whole community.

Community vulnerability from commercial exploitation can be countered by issuing warnings and encouraging protective laws.

Absorption of the disaster into community history and culture may be facilitated through mourning and memorial rituals, commemorations of the dead and the heroes, but also of all survivors and celebration of the community's achievements. Regeneration ceremonies, creative and aesthetic remembering (plays, books, paintings, sculptures) and consolidation of communal wisdom should be facilitated.

Families

Most families may forge new self-respectful identities which include their disaster experiences and reconstructed lives. However, for others, earlier difficulties may become entrenched or new ones become evident. Interventions may include expediting various needs and referrals to various community agencies and networks.

Education and advice may be given about the frequently occurring marital and sexual tensions. They may be seen on the basis of extra personal needs which partners cannot fulfill. Similar education may be given about the meanings of symptoms in children, in terms of their extra needs.

Influences on families of maladaptive coping strategies such as overwork, increased alcohol and coffee intake and substance abuse may be brought to notice and addressed. Similarly education paralleling that in earlier phases about the sense and origin of delayed stress responses may provide much relief.

More entrenched and deeper problems may require trauma therapy as described in the postimpact phase. In this phase relatively more attention may need to be paid to prior vulnerabilities (e.g. marital problems), beliefs and entrenched defences, conspiracies of silence, avoidance of emotions and more overt symptoms and illnesses. Special attention may be paid to identified "sick" members, but the whole family needs also to be seen in its entire system.

Much skill and sensitivity are required in choosing and dosing the various prongs of treatment. For instance, the family's strengths and vulnerabilities must be assessed and balanced with the costs in different family members of leaving defences intact, with the potential pain of exposure of traumas, emotions and unacceptable judgements and meanings.

Once the disaster has been encouraged to be brought to full awareness, painful silences within the family are replaced with voices of understanding of various members' experiences and of the family itself. A self-respecting mutually affectionate story is integrated in the family's history.

Adults

Interventions with individual adults may have taken place within family contexts. Individuals' adaptive roles in families and community networks are facilitated, but referrals are also effected to various helping agencies according to need.

While clarification of the sense of long term or new symptoms and/or symptomatic treatment such as medication may offer sufficient relief for some, one to one trauma counselling or therapy may be required to heal more entrenched and longer term effects of stress and trauma.

As in previous phases, biological, psychological and social symptoms and illnesses, as well as distresses associated with negative judgements, meanings, shattered beliefs and ideals of self and the universe, are traced back and made sense of in their original contexts of stressed survival attempts and lost fulfillments. As in the postimpact phase, this may require working through defences and past vulnerabilities (perhaps more so in this phase than previous ones). Trauma ripples are then reworked in terms of past and current realities and adaptive meanings and views of self and the world.

New meanings evolve which include wisdom of the frailties, yet also capacities for resilience and fulfillments of human nature.

Children

While many children will have assimilated the disaster as a learning experience into their developing lives and even gained confidence in their capacities to overcome adversity, others may have lost confidence and a sense of security.

Children may need extra attention and explanations and help to readjust to new relationships, schools, friends and routines. They may need help to grieve and express their fears and emotions.

Trauma therapy may be required, using the same principles as for adults, but using special methods for children, as in earlier phases. Parental and school collaboration should be enlisted. Ultimately the child makes realistic sense of its disaster experiences according to its developmental phase and is able to creatively use them within its life's trajectory.

CHAPTER 7

Disaster Management Workers

EMERGENCY SERVICE WORKERS

RECOVERY SERVICE WORKERS

COMMUNITY WORKERS

Disaster management workers are themselves a vulnerable group in disasters because of their intense commitments and emotional involvement over a long period of time often without sufficient breaks. They are especially vulnerable where the disaster has been particularly overwhelming, if they thought they might die, if they have lost comrades, attended dead people especially if mutilated or killed through human action or if they reminded them of loved ones. Additional strains include poor communication, failure in equipment, lack of organisational support and territorial disputes with other organisations.

These workers may suffer from burnout, compassion fatigue and secondary stress disorders. They may also develop their own stress disorders, post-traumatic stress disorder and the variety of biological, psychological and social symptoms and illnesses, as described for primarily affected people.

Because disaster management workers are themselves affected in disasters, similar assessments and interventions need to be applied to them as to other affected groups. Psychological service organisations and personnel must be especially aware of the needs for monitoring and self-monitoring of service providers and themselves. (See also Section 4 Psychological Service Providers).

Psychological services which should be made available are peer support (including sound operational policy, standards and procedures, recognition for work done, rostering), feedback, defusing, debriefing, supervision, mentoring and counselling. Psychological help draws on the same principles as for primarily affected people.

The worker groups overlap with each other and with community groups already considered. Therefore what follows should be read in conjunction with community assessments and interventions in different phases described earlier. However, the following assessments and interventions highlight special helper cultures and needs.

7.01 Community Workers

Community groups may be established prior to disasters, or may emerge during disasters. As one of the principles of helping disaster communities is to help them to help themselves, it is an important priority that community self-help groups are identified, assessed for their capacities to function, empowered to function as far as possible and helped to function if their capacities are compromised.

Preimpact

Assessment. Formal and informal leaders and groups should be identified, communication channels opened between them and psychological service providers and their capacities to deal with disasters assessed.

Interventions include education, training and exercises which help to prepare for future disasters. Community and outside psychological services groups may be used as two way conduits of information and as a disaster approaches, for warning and preparation of the threatened community. Networks between community groups and other groups are facilitated and prospective roles apportioned.

Impact

Community workers are helped in whatever way possible to survive and preserve life and property. Prearranged lines of communication may facilitate outside agencies to assess the nature and extent of community destruction and needs. Preparations for postimpact intervention should be instituted at all hierarchical levels.

Postimpact

Assessment includes identification of available community workers, their leadership, cohesion, morale and networks. They need to be assessed for burnout and secondary stress.

Intervention. Community workers need assistance and encouragement in their reclamation of their networks and in their work with affected people. Those who have been compromised themselves by the disaster may be given priority assistance so that they can then assist the rest of the community. The nature of the assistance is as described above for other affected people. Workers are cautioned for burnout and secondary stress and treated for them if they occur.

Seamless co-operation between community and other groups is facilitated at all hierarchical levels, while potential tension between them may be mitigated through activation of prior plans and two way sharing of current information and goals.

Recovery and Reconstruction

Assessment. Functioning of established, emergent and reforged groups, their cohesion, leadership and morale, as well as functioning of their members needs to be assessed. Occurrence of delayed stress responses, burnout and secondary stress disorders are monitored.

Interventions. If necessary, self-empowered efficient local networks are supported in their work. At the same time, as established long term groups take over from emergent ones, the latter groups and their leaders are acknowledged for their achievements. Some may be redirected to new tasks groups and responsibilities.

Leaders and their groups are monitored for delayed stress reactions and helped for them as well as continued burnout and secondary stress phenomena.

7.02 Emergency and Recovery Service Personnel

Emergency and recovery service personnel, as well as staff members of hospitals, nursing homes, community and human service agencies and the media, may be secondary victims in disasters.

Preimpact

Assessment. Emergency and recovery services may already include psychological service providers at different hierarchical levels and in coalface teams. As trusted members, they can more easily assess and monitor implementations of lessons from previous disasters.

Interventions include countering denial and facilitating implementation of lessons from past disasters in preparations and exercises for future ones. Education and training in biopsychosocial and personal responses in disasters encourages the addition of psychosocial and “human” dimensions to physical concepts.

In recently reported disasters psychological services form part of the briefing process. They help to highlight define and facilitate clear roles, territories, cooperation with other services, lines of communication and responsibility (such as for prioritization of rescue efforts). Psychological services facilitate morale by support for leaders, encouraging humour and confidence, as well as realism and preparation for some disappointment as to what will be able to be achieved.

Impact

Psychological service providers may be part of emergency teams, for instance mental health workers in medical teams. They may provide “psychological first aid” to rescue teams as well as to affected populations.

Assessment. Assessment includes that of the efficacy and quality of leadership, group interactions, worker-victim interactions and of emergency personnel functioning.

Interventions aid survival and preservation activities of the team. Psychological first aid may be applied while physical first aid is administered by others. The former may include holding victims’ hands, explaining procedures, giving reassurance for instance by reinterpreting excessively fearful appraisals. Victim “uncooperativeness” may be quickly clarified and resolved, by dealing with fear for relatives or special life meanings.

At the same time staff need support in their stresses, such as recognition of needs to prioritise and thus leave some victims without ideal help. They may be reminded that it is the disaster, not they, which necessitates action according to the “survival calculus”, where scarce help is given where it is most efficacious.

Other help may include reminding workers of the need for breaks, during which salient problems may be quickly discussed (decompression) and rosters facilitated. At the end of rosters or of rescue work, food and drink and short sharing of experiences and feelings can be facilitated and workers reminded about possible later responses and warned about potential for accidents (demobilization, defusion).

Postimpact

This is a time of taking stock, appraising achievements and losses and repairing dints in morale. Personnel need to feel particular and continued support from their managers at this time. They require personal needs arising from the work to be sensitively managed and to have ready access to consultation and counselling.

Assessment. Group and individual achievements and failed objectives, gains and losses, are assessed objectively and subjectively. This is often done in team debriefs. Debrief assessments have operational and psychosocial components. Operational components make objective assessments of services provided and where improvements may be made in the future. Psychosocial components contrast objective assessments with subjective sense of achievements and failures. Psychosocial aspects of debrief assessments are also interventions in which objective and subjective assessments are realigned. Knowing the culture of the group, as well as individual members' strengths and vulnerabilities is very helpful in both assessments and interventions.

Intervention. The same principles of tailored provision of psychological services and of stress and trauma mitigation as is provided to primarily affected people must also be applied to service personnel.

As noted, correct application of these principles requires sophisticated psychological service skills and training which cannot be compressed into simple packages or didactic lessons such as, "Your responses are normal for abnormal circumstances".

Psychological services in this phase include **supervision** where client problems are ironed out. This may include **support** for service providers who may be stressed and burnt-out, or making them aware of personal blocks. **Mentoring** includes discussing personal problems with a designated experienced person who maintains confidentiality, **counselling** may extend the above into dealing with more entrenched secondary stress and triggers to earlier vulnerabilities.

Psychosocial **debriefing** mentioned earlier involves assimilating disaster experiences and responses into professional and personal histories.

Debriefing

Debriefing may be routine for some service provider teams. When applied, debriefing for service personnel may be seen as the equivalent of outreach to affected populations. It is intended that in the process the group achieves homogenous understanding of the disaster and people's personal roles in it and that personal biological, psychological and social stress responses and maladaptive judgements and meanings can be resolved and incorporated into adaptive alternatives.

Like in family counselling it is hoped that the team emerges with deeper and wiser self-respect, cohesion and knowledge of itself and its limitations. The event is absorbed into an esteemed part of the history of the team.

Tailoring of psychological services to service personnel debriefs may involve the following:

Especially difficult disaster stressors (critical incident stresses), should be recognized as requiring debriefs. They may include multiple deaths, mutilations, death of family and friends, severe role conflicts, priority conflicts and failed equipment.

All service personnel should be included and be able to communicate safely across hierarchical lines.

The client is both the group as a whole and all its individual members. This is reminiscent of families. As with them too, at times certain members highlight group dysfunction, at other times group dynamics reflects individuals' characteristics, especially of leaders.

Service personnel are especially concerned about whether they saved as many lives and prevented as much damage as possible and whether they did a good professional job. In this context group tensions may reflect role blame or guilt. This

may need to be ironed out for group and personal morale to be reestablished. It is therefore important to go over the disaster in detail and make sense of what was done and what could not be done. In the process especially maladaptive rescue (e.g. feeling burdened and resentful) and goal achievement (e.g. feeling frustrated and powerless) survival strategy stress responses (Appendix B) are identified. They and associated guilts, shames, angers, sense of injustice and negative meanings, are identified, made sense of, and alleviated by placing them in their realistic contexts.

Positive meanings and morale are facilitated by coming to terms with all things considered, personnel did as well as possible under the circumstances. Personal and group pride in the context of deeply purposeful professional endeavours emerges. Grief over losses is mitigated by the lessons learned which will make future disaster interventions still more efficient.

Additional debrief sessions may be arranged as necessary and individuals who are still affected or otherwise suffering may receive individual attention.

Recovery and Reconstruction

Personnel need to be followed up long term especially if they were traumatized in the disaster. This is because delayed responses may arise over a long period.

Assessment. Includes checking for stress responses which are not settling after some time, stress responses which may arise as symptoms after variable delays and maladaptive defenses such as withdrawal, cutting off feelings, alcoholism and substance abuse.

Professional assessments are made as for other affected populations. Post Traumatic Stress Disorder and compassion fatigue are particularly looked for, but so are a variety of biological, psychological and social stress responses, symptoms illnesses, maladaptive coping, defenses and meanings. Vulnerabilities which may be taken into subsequent disasters are assessed.

Interventions include counselling and stress and trauma therapy tailored to the particular needs of the affected worker.

7.03 Psychological Service Providers

Psychological service providers are perhaps more prone to secondary traumatic stress effects than other personnel, because of their openness to others' wounds. Therefore much of what has been said for emergency and recovery service personnel applies even more so for the psychological service providers.

Preimpact

Assessment. Psychological service providers need to be assessed organisationally as teams and individually for their training and preparedness for disaster work. This is done according to the criteria in Chapter 4. Assessment of needs and resources are made to ensure best possible matching.

Intervention. If denial is present about the importance of training and preparedness for disaster work, it should be addressed organisationally and individually by the various mental health disciplines offering specialist education and training. Practical organisational preparations include readiness for release of appropriate groups and individuals, preparing their rostering for service and making provisions for others to do extra duties without complaints in their place.

Preparation for action in a current disaster includes activation of communication networks, obtaining as much briefing as possible and rehearsing procedures. Interventions ensure most appropriate matching of resources with needs.

Potential stresses and stress responses in the team and oneself are anticipated individually and in group settings.

Impact

Psychological service personnel who are impacted like the rest of the affected population, need help in similar ways to other members of the population.

Those who are serving with other rescue personnel may themselves need support with breaks, rostering, decompression, demobilization and defusion.

Postimpact

Psychological service groups will include those who have been involved in the preimpact and impact phases and those who have mobilised only in the postimpact phase.

Assessment. Those who have mobilised in the pre-impact phase now monitor their preparations and assess how they matched impact needs. They assess successes and failures, costs on themselves and resources to match further needs.

Psychological service groups and individuals who present their services in this phase are assessed as others were in the preimpact phase for specialist organisational and individual skills. Criteria for assessment are those described in Chapter 4. Personnel are now deployed or rejected according to their skills and matching needs.

Once deployed, assessment of secondary stress and trauma effects following work in this phase is carried out as for other personnel.

Interventions. The same principles and methods of delivery are provided for psychological service providers as they provided for other services. Such interventions include breaks, rosters, defusion, supervision, mentoring counselling and debriefing. This is organized by higher levels of psychological services and management and is built into psychological service self-monitoring. These higher levels must also ensure maintenance of group and personal morale through support and recognition and reward for effort.

As for other workers, debriefing includes operational review as well as personal and group review of subjective responses to caretaking efforts and professional roles. Biological, psychological, social responses and moral and existential concerns are reviewed and placed into realistic contexts.

Individual workers are also monitored and catered for according to their needs, for instance by one to one counselling.

Recovery and Reconstruction

Assessment. Psychological service personnel need similar follow up to other service personnel for entrenched or delayed maladaptive responses. Burnout, Post Traumatic Stress Disorder, secondary traumatic stress disorder, vicarious traumatisation and other biological, psychological and social symptoms and illnesses and defences are assessed in relation to the disaster and other traumatic events, earlier vulnerabilities and subsequent stressors.

Interventions. Personnel must have available, according to need, supervision, debriefs, support, mentoring, morale enhancing measures and personal counselling and therapy like other service providers.

The experiences of helping others and of being helped oneself may enable psychological service personnel to meld their disaster experiences with their everyday professional work in new creative ways, both individually and institutionally.

CHAPTER 8

Research

Research into the effects of disasters and the benefits of various psychological assessments and interventions is critical to the continued development of best practice in service delivery. In particular, sound research contributes to the development of the knowledge base and will inform intervention at all levels.

One goal of research may be the development of minimum national data on the profile of psychological responses in Australia and development of standardised and comparable assessment, intervention and outcome measures. Nevertheless, research must be well considered and not interfere with current recovery. The following principles are offered as a guide in any consideration of research in the disaster recovery area:

FIRST DO NO HARM. Like assessments and interventions, research may involve interpersonal interaction which may burden stress or retraumatise affected people. Even non-personal research instruments may cause much distress. Therefore,

Research must recognise the needs of affected people and disaster workers and must never compromise their healing or disaster management.

Disaster managers should be apprised of the advantages of the research and their cooperation enlisted. They should consider potential convergence of researchers seeking access to affected communities and ensure minimal disruption to individuals, families and the community through multiple researchers and their projects.

Research ethics and procedures need to be explicitly specified so that proper standards are maintained. Researchers must adhere to guidelines and procedures of all organisations, government departments, tertiary education institutions or non-government organisations which may be involved in the research. General professional and specific disaster codes of ethics (see Appendix C) must also be adhered to in research.

Subjects of research must give informed consent and their confidentiality must be maintained.

Research goals should be informed from a base of current knowledge and existing literature on all aspects of disasters.

Research should occur through established ethical research channels such as the Australian Emergency Management Institute and universities or at least be supervised by them.

Results of research should be freely available, including to the subjects themselves, other researchers and agencies and to bodies building up data profiles in Australia.

Research should be subject to quality assurance, best practice standards and scrutiny as to whether they help to improve assessments and effectiveness of interventions.

APPENDICES

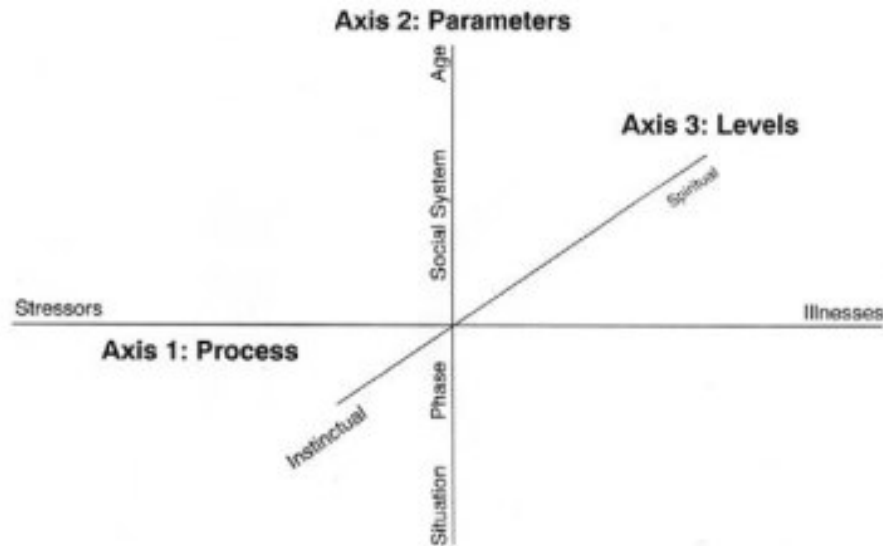
Appendix A

Three Dimensional (Triaxial) Biopsychosocial Framework

The three dimensional view of traumatic stress includes three axes. The three axes are depicted in Figure 1

Triaxial View of Traumatic Stress

Figure 1



The components of the three axes or of the triaxial framework are depicted in Table 1.

Triaxial View of Traumatic Stress

<i>Process axis</i>	<i>Parameters axis</i>	<i>Depth axis</i>
1. Stressors	1. Factors in traumatic situations	1. Basic instincts, drives
2. Appraisals	2. Phases of traumatic situations	2. Survival Strategies
3. Stress Responses	3. Social system levels including helpers	3. Judgements and Morality
4. Strengths & vulnerabilities	4. Developmental phases	4. Basic meanings
5. Trauma		5. Ideals, values and principles
6. Defences		6. Codes, dignity, rights
7. Memories		7. Spirituality, religion, ideology, beliefs
8. Illnesses		8. Identity
9. Secondary spirals		9. Symbols
		10. Creativity, esthetics
		11. Sacredness
		12. Wisdom, knowledge, truth

Table 1: Components of the Triaxial Framework

Process Axis Components

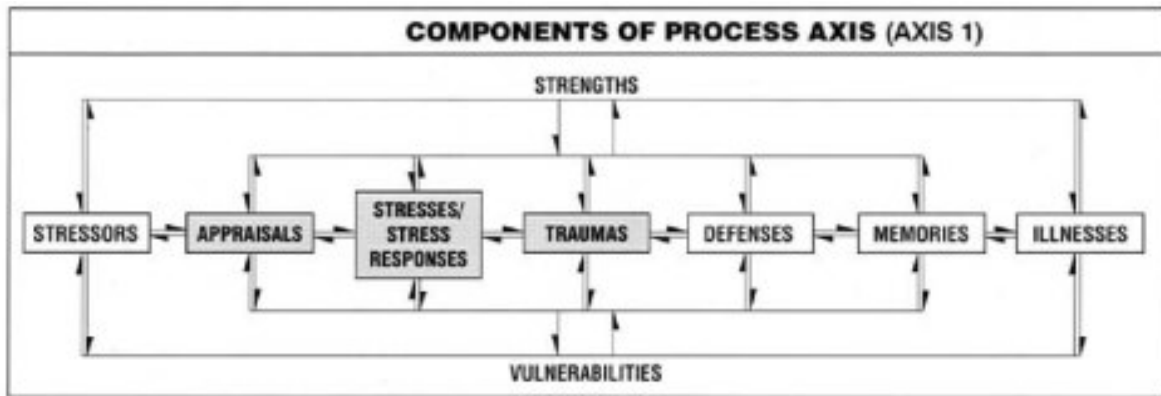


Figure 2

Appendix B

Survival Strategies

The variety of survival strategies, appraisals which evoke them and their adaptive and maladaptive manifestations are depicted in Table 2. Judgement columns indicate the potential of classifying adaptive and maladaptive ramifications of survival strategies along human function levels on the depth axis (Table 1).

<i>Appraisals</i>	<i>Survival Strategies</i>
1. Must rescue others	1. Rescuing
2. Must be rescued by others	2. Attaching
3. Must achieve goals	3. Asserting
4. Must surrender goals	4. Adapting
5. Must remove danger	5. Fighting
6. Must move from danger	6. Fleeing
7. Must obtain scarce essentials	7. Competing
8. Must create scarce essentials	8. Cooperating

Table 2: Survival Strategies and the appraisals which evoke them

Appendix C

Australasian Society for Traumatic Stress Studies Code of Ethics

Definition

Trauma therapy is help administered by professionals to traumatised people in order to help them with the prevention, amelioration, healing and reduction of the consequences of trauma.

Traumatised people have experienced threat of any or all of physical, mental or social annihilation. Trauma sequelae result in an indefinite loss of a previous equilibrium for a less life enhancing one. They result in biological, psychological and social symptoms and illnesses.

Professionals are people trained to help traumatised victims. Their prime motive and obligation is to apply their expertise for the welfare of their clients or patients. They put the latter's interests before their own or the interests of any other third party(ies). The rewards for their efforts are fees, or payments in some other culturally agreed to currency. Professional here will mean professional trauma therapists.

Specific Ethical Principles

In Relation to Clients, Patients.

1. **First do no harm.**
2. **Primacy of clients' or patients' welfare.** Whatever is best for clients should take primacy. In particular the vulnerability of their traumatised state should not be exploited for financial, academic, organisational or personal rewards. The impulse to help should be balanced by likely benefits and disadvantages to victims.
3. **Collaboration with clients or patients.** To the degree possible trauma therapy should be collaborative and reciprocal, clients being able to control the occurrence of the therapy and having equal power in it. When clients are approached as part of an outreach process, its rationale should be explained very early and permission to continue be asked for. If clients are unable to give informed consent to therapy, a prime goal should be to help them to be able to do so. The rights as well as special needs of children, the elderly, the ill and ethnically unassimilated should be respected.
4. **Confidentiality.** Whatever knowledge or information a professional derives during therapy remains confidential unless it involves threats to the lives of others or is subject to criminal law. Any divulgence of information must be with the written consent of the client or guardian.
5. **Length of therapy.** This should be determined by clients' welfare and mutual negotiation. To the extent possible, it should not be curtailed or extended for the benefit of therapists or third parties.
6. **Rewards.** Payments should be through mutual negotiation.
7. **Third parties.** It should be clear that the welfare of clients and patients is paramount, even if third parties pay. If therapists' motivation or obligation is toward an organization this, as well as any potential conflicts of interest with the individual client must be declared. If therapy is not agreed to by clients under such circumstances or if their benefit from therapy is curtailed, therapy should not occur.

In Relation to Peers.

1. **Collegial Respect.** Due respect and deference should be given to colleagues' skills. These should not be denigrated to other clients or in public.
2. **Respect for Service Networks.** Practitioners need to know local government and non-government helper networks and rules and cooperate with them as much as possible.
3. **Advertising and Competition.** Practitioners have the right to let potential clients know of their skills, but these should not be exaggerated or plied in a commercial manner. Similarly, others' skills should not be denigrated and territoriality should be avoided. Benefit to clients is again primary. Skills, training and references should be shared and supplied on request.
4. **Limitations on Unprofessional Conduct.** If it comes to the notice of practitioners that others are acting in unethical and dangerous manner, education, personal approach and as a last resort legal avenues should be taken to protect clients and patients.

In Relation to the Community.

1. **Trauma Prevention.** The community should be educated about what makes it vulnerable to trauma, how to prevent it, and how to prepare for it.
2. **Education.** The community should be educated about trauma, trauma therapy, its skills and ethics. Advice may be given about tailoring needs and available skills. Training of trauma therapists should be set in train.
3. **Ethics Education.** Interchange with the community about dilemmas in trauma therapy should take place. Ethics committees should be set up by professional trauma associations whose members practise trauma therapy in order to learn, teach and update knowledge on ethical issues.

In Relation to Self.

1. **Recognition of Skills of Trauma Therapy.** The professional recognises that trauma therapy requires special knowledge and skills which are not fulfilled simply by having a mental health professional qualification. Practitioners ensure that they acquire such knowledge and skills to whatever degree possible.
2. **Tailor Skills and Type of Trauma Therapy.** It should be recognized that there are many types of traumatic situations and types of therapy. Skills may not generalise across all situations. Practitioners are obliged to make sure that best available skills are applied to specific situations, and assess whether they are the best people to fill them.
3. **Limitations of Skills and Referrals.** When professionals are the best placed persons under the circumstances to help, they are obliged to do so, but also to declare to the degree appropriate their limitations. Otherwise they should alert clients to other options and be willing to refer clients to them, ask them to help, or ask them for second opinions.
4. **Declaration of Skills through Professional Network.** Professionals should declare their skills through a professional trauma network, so that they may be asked to help in appropriate situations.
5. **Maintaining Professional Skills and Fitness.** It is incumbent on professionals to keep up with their knowledge, make sure their standards are maintained and their mental health remains adequate. To this effect professionals should take part in peer group education, supervision, debriefing and have a good understanding of their own traumas.

In Relation to Research.

1. **First Do No Harm.** Because traumatised people are in a highly vulnerable state, they are open to exploitation of others' interests. Welfare of victims must always precede the interests of professionals. Research should in no way prejudice healing.
2. **Research Goals.** The goal of research must be the obtaining and free dispersion of knowledge which will help future generations of victims. The goal should not be partisan to a particular form of therapy, drug, method, person or group. Lack of benefits, side effects and negative effects should be reported as much as positive ones. Potential biases such as funding bodies and institutional and relevant group attachment should be declared.
3. **Consent.** Client or guardian consent should always be obtained. The nature of the research, its goals, benefits and risks, should be explained.
4. **Informed Research.** Because research always siphons some energy from patient welfare, its value over and above knowledge already available should be assessed. Repeating previous research on the one hand and on the other not paying attention to established principles should be avoided.
5. **Confidentiality.** People's identities must be preserved from recognition. This is particularly important in high profile disasters involving high profile identities.

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GLOSSARY

- assessment.** Psychological service assessment may be defined as evaluation of the impact of a disaster at a particular time on individuals, families and communities, with the purpose of determining needs for psychological service interventions. Assessment is a continuing process from preimpact to healing. It is a complex, dynamic multidimensional inquiry which takes into account adaptive and maladaptive biological, psychological and social responses to threats of survival and to what is cherished in life.
- community.** A group with a commonality of association and generally defined by location, shared experience or function.
- comprehensive approach.** The development of emergency and disaster arrangements to embrace the aspects of prevention, preparedness, response and recovery (PPRR). PPRR are aspects of emergency management not sequential phases.
- convergence.** The propensity for emergency services personnel and others to be physically drawn to an emergency site and the over-use of communications near the site.

crisis counselling. Counselling provides a relationship in which the disaster affected persons' experiences are able to be examined together with other issues in their lives in order to assist them to understand the effects the experiences have had and the meaning they have given them. It can then provide them with an alternative set of understandings.

critical incident. Any situation faced by emergency workers (or others) that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later.

critical incident stress. An acute stress reaction caused by exposure to a traumatic event.

critical incident stress debriefing. The process of ensuring the welfare of emergency service and other personnel following a potentially traumatic event.

defusing, debriefing and worker support. These special techniques have been developed to assist workers who have been affected by their experiences and have developed potential or actual traumatic stress. Debriefings may use structured methods by those with special training whose aims are to ensure that the details of the experience are reviewed, together with the thoughts, emotions and behavioural reactions they have caused.

disaster. A serious disruption to community life which threatens death or injury in that community and/or damage to property which is beyond the day-to-day capacity of the prescribed statutory authorities and which requires special mobilisation and organisation of resources other than those normally available to those authorities.

disaster affected persons. People. Other than emergency management personnel, who experience losses or injury or are affected by a disaster. Usually understood to exclude the deceased.

disaster management. The body of knowledge and administrative decisions and operational activity which pertain to the various stages of a disaster at all levels.

personal support services. The process of assisting the diverse, immediate as well as longer-term personal needs of persons affected by a disaster. Such needs may encompass provision of information, practical advice on a range of issues and emotional support.

post traumatic stress disorder. An anxiety disorder, beyond the normal response to stress, caused by exposure to a highly traumatic event that has been excessively demanding.

psychological services. The specific forms of assistance, ranging from initial support through to longer-term clinical treatment, provided by trained personnel within this framework.

psychological support. Psychological support is used as empathetic listening and emotional attunement and can be provided by relative, friend and non-clinical support staff. It is a sophisticated recognition and reverberation to affected people.

stressors. Particular agents in disasters which lead to stresses and traumas.



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