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DISASTERS MANAGEMENT

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The objective of the National Health and Medical research Council is to advise the Australian community on the achievement and maintenance of the highest practicable standards of individual and public health and to foster research in the interests of improving those standards.

RESERVED

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What are disasters?

Disasters are events which overwhelm individuals and communities. Such events may be sudden and unexpected, or may come on after a period of warning, for instance in the case of a flood or cyclone. They may be 'natural' i.e. a result of natural forces such as storm, wind, earthquake, forest fire. Or they may be termed 'man-made' - occurring as a result of failure of human technologies such as in a transport accident, or a result of human action, for instance a terrorist bombing.

Clearly in many instances there may be an overlap of such categorisation - for instance where a plane crashes as a consequence of bad weather, or a dam breaks under the force of excessive rains.

The word disaster means 'ill-starred' so that there are usually implications of threat and dread, and negative connotations and consequences of such events.

When a disaster occurs affecting a whole community, many community systems may be rendered inactive or at least temporarily overwhelmed by the impact of the disaster. The disruption of systems of organisation, communication, and response may add further to the problems of dealing with the impact and aftermath of the disaster, and increase the likelihood of adverse outcomes.

Some disasters do not come on rapidly, or as a single event, but rather **gradually**. They may nevertheless be just as adverse and overwhelming for communities and individuals affected by them. **Drought, toxic waste sites, famine** as in Africa, are all instances of 'slow' disasters with profound effects.

While disasters are usually seen as those events affecting communities at large, the term **personal disaster** is often used to describe events affecting individuals - for instance the loss of several family members at the one time, severe injury and life threat, or loss of job and home, and so forth.

Another important issue of terminology relates to the fact that there may be **formal definitions** of when an episode is officially called a 'disaster'. This may depend on level of disruption, severity of impact, numbers of threatened or injured and so forth. So while an event may be perceived as a disaster by those experiencing it, it may not officially be recognised as one - and this may lead to a sense of injustice and distress. Call-out for emergency services may relate to such definitions as well. Furthermore some events are not called disasters, but **incidents** by some groups - e.g. a bus crash. These factors may create confusion, and may also lead to feelings that what individuals have suffered is not adequately recognised by others.

Phases of disaster

It has been useful to consider the phases of disaster and the common reactions of individuals and communities throughout these. This model is useful for acute events, e.g. a cyclone or flood and their aftermath, but is not so appropriate for longer term slow disasters, which affect communities in different ways and may 'creep up' in terms of their disastrous impact.

Threat and warning

Threat and warning refer to the time before a disaster impacts when there may be either a general recognition that such a disaster could occur (threat) or a specific warning that a disaster is approaching (warning). Some communities may expect certain disasters because they know they are vulnerable, or have experienced them before - for instance areas that have been repeatedly flooded, or where there have been previous bushfires, or cyclones. In such communities a **disaster culture** may develop, with a set of beliefs about the likelihood of an episode and what should be done, or what may be effective. Several points are important with respect to the phase of threat and warning.

- Understanding the **background of a community** and its **disaster culture** helps to identify likely responses to disaster threat. This background may range from a perception 'it can't happen here', to 'the new dam will prevent it', to 'there's nothing we can do so why bother'.
- Reactions amongst those at risk of disaster may range from active **planning to prevent and mitigate** any possible catastrophe - to a denial of the reality of threat for this individual and this community. People may believe it is the responsibility of others, of 'they', the authorities, and thus fail to take effective steps themselves. It is important to ascertain what preventive actions have been taken, rather than asking generally if people are prepared. If the latter question is asked most people respond positively. Whereas if people are asked what actual actions they have taken it may become clear that they have done little to prepare themselves.
- Responses to warning that a **particular disaster** is imminent may be ignored, or not responded to adequately. It may depend on who provides warning and if this source is seen as being accurate; it may also depend on the content having meaning - for instance if river levels are given without reference points, they may have little meaning for those at risk. Technical descriptions of natural forces may not help those threatened to work out the likely effects for them, and what they should do.
- If there have been false alarms, or inaccurate warnings, especially in the recent past, this may diminish the likelihood that a new warning will be responded to. This happened for instance with the Darwin Cyclone, where a previous warning was followed by a cyclone veering away, not long before the major cyclone struck, so people did not take the next warning so seriously. Furthermore timing of events, for instance Christmas Eve, may make them less 'believable'.

- Most Australian communities have little pre-disaster **training and preparation in what to do** should a disaster occur. Cyclone affected communities, those which regularly experience bushfires and other disasters, may be better prepared for impact than others, but as earthquakes are rare, few communities in this country would have the sort of preparatory training which is an 'everyday' response for people in Japan for instance. As training and preparation can mitigate both impact and after effects, it is increasingly important that vulnerability to disaster is addressed and people and communities become involved in relevant planning and training.
- **Specific warnings** should be provided at the time of an emergency by recognised **reliable and trusted authorities**. They should be simple and comprehensible, and should specify appropriate actions to be followed. Television and radio are appropriate media, but also **local networks** of people who can, for instance, warn others in their neighbourhood. Bearing in mind the multicultural nature of Australian society, warnings must also access ethnic groups, be provided in community languages, and address the needs of those who may not have access to mainstream sources, e.g. Aboriginal communities.
- **Accurate information** is helpful to people. It should cover what to expect and what to do. Authorities often fail to provide warnings for fear that panic will occur and lead, of itself, to adverse consequences. Panic is rare and usually occurs only in specific circumstances, as when an escape route is closing, or potentially blocked, for instance in a smoke filled building. Calm direction, accurate information and appropriate leadership can help people to take effective action in response to a disaster threat and lessen the severity of consequences.
- Naturally people are **anxious** when a disaster threatens, especially if they have had no previous experience with one. The above actions help to diminish anxiety. It is true to say that under-response, i.e. inadequate anxiety and failure to protect the self, is more often a problem than over response. One source of anxiety is about the well-being of the self, the threat to one's own life. There is often also major anxiety about the safety and well-being of others for example partners, children and so forth. Wherever possible it is important to keep families together, especially children with parents, or to identify where they may meet after the impact is over. Threat to property, home or treasured personal possessions may also lead to anxiety and protective behaviours. For those whose baseline response to threat is high, i.e. that are easily made anxious, there may be an excessive response, but this is not usual and most people handle threat well and behave appropriately.
- Some disasters have **little or no warning**. The impact is virtually immediate. Those affected may not realise what has happened, and the shock and confusion may be greater in such circumstances.

Impact

The impact of a disaster is the time when its greatest force and disruption occur. With natural disasters there may be extraordinary wind or water forces, great heat from fires, fracturing forces of earthquakes and so forth.

Damage and destruction of homes and community are likely in any major natural disaster affecting areas of human habitation, and there may also be severe threat to human life. Peoples actions are usually geared to protection of the self and others, especially children, family members and those who are in any way weak and helpless.

There are not many studies of behaviour during impact, for often all people can do, once they have attained safety or shelter, is to wait for the force to pass. People may be uncertain about what is actually happening. For instance in the Darwin Cyclone, some people thought Darwin might be being bombed again. In the Newcastle earthquake, a disaster that was totally unexpected in the Australian community, many people thought that an explosion had occurred in the local steel works. Several important issues arise with respect to impact.

- People often experience the **illusion of centrality**, especially if they are isolated from others. They may feel as though the disaster is happening just to them and may not realise that others have also been affected.
- **Altruism** is frequent and people often place their own lives at risk to help or save others, sometimes even people who are strangers to them.
- The **shock** of impact, especially if very sudden and unexpected may temporarily paralyse the individual's response. It may also add to feelings of helplessness and powerlessness, and the individual may need to come to terms with these after it has passed,
- Some people respond in a way that is **disorganised, stunned** and may not be able to respond appropriately to protect themselves. Such **disorganised** or alternatively apathetic behaviour may be transient or may extend into the post disaster period, so that people are found wandering helpless in the devastation afterwards. This probably occurs in no more than 25 per cent of people and is usually transient. Some others may be slightly disorganised, or lose a sense of time, but many, if not most, will act purposely and appropriately. Knowing what went on during the impact is useful for two reasons: it may help explain people's reactions afterwards as they may feel in some way that they could have or should have 'done more' during this time, or may feel quite distressed by ways in which they did behave, which they do not see as fitting with their image of themselves. The second reason is that it may help to explain the nature of any traumatic experiences that affect the individual during this time and which may need to be dealt with subsequently.
- **Survival behaviours** Most people respond appropriately during the impact of a disaster and react to protect their own lives and the lives of others. They also protect children and their loved ones and those who are helpless. This is a natural and basic reaction. A range of such behaviours can occur, and these may also need to be dealt with and understood in the post-disaster period.
- **Stresses during impact** Several stresses may occur during impact which may have consequences for the person subsequently:
 - Threat to life or encounter with death. The person's own life may be threatened, or he may see others die or dead. When someone thinks 'this is it' - or 'I've had it' then it is likely that this threat has reached its height. Mutilating or gruesome deaths and the deaths of children are very traumatic.
 - Feelings of **helplessness and powerlessness**. These may be frightening in themselves as they destroy the individual's feelings of personal invulnerability. They may be difficult to come to terms with later, especially for those who need to feel they are in control at all times.
 - **Loss**. Many losses may occur during the impact - loved ones, home, possessions. This may be obvious immediately, or not realised till later when full realisation of the extent of what has happened has occurred.

- **Dislocation.** A person may be additionally stressed by being separated from loved ones, home, familiar settings - e.g. if in a foreign country, with strange people and different languages. Separation and dislocation from parents and family may be particularly stressful for children.
- **Responsibility.** During impact or subsequently the individual may feel that he or she is somehow responsible for others who have been hurt or died, or some aspects of the disaster or its effects; or that he or she should have done more or acted differently. This trauma may be realised during impact, or subsequently.
- **"Inescapable horror".** Sometimes the impact is so profound and prolonged as to constitute what seems to the individual to be a situation of inescapable horror. Being trapped with ongoing life threat, for instance in a sinking boat, or being tortured in a prolonged way would constitute such trauma.
- **Human malevolence.** When the impact has been the **result of human actions** e.g. a bombing, or mass shooting, then the trauma that results and the horror of the experience are likely to be particularly difficult for those affected. It seems an "act of God" terrifying as it may be, may be easier to deal with than an "act of man".

Recoil or inventory

This phase refers to the time immediately post-impact when people realise the worst has passed, that they have survived. They start to take stock of what has happened. People may swing from the view they may have felt during the disaster that it was happening to them and them alone (the illusion of centrality) to the view that the whole world have been devastated. People are sometimes further stressed and shocked by what they see and the realisation of the extent of the death, damage and loss.

Sometimes there is a sense of elation that one has survived. This may be rapidly followed by guilt, survivor guilt, that the person has had such feelings in the face of what has occurred. Nevertheless there tend to be persisting feelings of relief and even laughter and release, now that life seems assured.

Because communication is usually disrupted at this time, **misinterpretations, myths and rumours** may spread rapidly. Accurate information and the rapid re-establishment of communication are essential to help correct such problems. Local sites for information about others, about appropriate actions, shelter, health etc are of great value in providing reassurance and guidance, as well as points for people to gather.

Gradually there is recognition of what has happened, the extent of loss and people rapidly respond to become involved in rescue and related activities. The phase of inventory and recoil merges into rescue.

Rescue

Early rescue activities in any community affected by a major disaster are usually carried out **by members of that community** - who may themselves be to varying degrees directly affected by what has happened. People may start to gather in shelters or other neighbourhood or central places, as they come together to assist, to talk and to make meaning of what has happened. The usual social barriers may cease to exist, as people share their relief at having survived and their differing experiences.

This coming together and affiliative or attachment behaviour and helping of others constitute the **therapeutic community** effect which may commence during this phase and continue into the early part of recovery. This gathering together, sharing and mutual concern, and talking through what has happened may be helpful to people in working through their own experience, and should be encouraged by workers at shelters and other such sites. It seems to represent a spontaneous and informal 'debriefing' process.

These spontaneous groups often replace traditional groups at this time because of the powerful **bonds** of the shared experience, the crisis, and the increased affiliative behaviours. **Natural** leaders may arise and help mobilise appropriate actions for rescue and to meet other needs. Traditional groupings of course re-establish themselves in time, but the 'special' experience of having gone through the disaster together is likely to remain important, as are friendships formed at that time, and the sense of achievement.

In these contexts it is important to recognise that **evacuation** may further disrupt important social groupings that would otherwise facilitate recovery. The stereotype of evacuating women and children is unhelpful, in many instances resulting in family disruption and subsequent vulnerability. Evacuation was found to add to risk of stress and adverse outcomes after the Darwin cyclone. As noted above, the initial rescue activity will generally be made by those within the affected community. In addition, however, this phase is characterised by the arrival or convergence of a large number of people external to the community who enter the disaster area for a number of reasons, both official and unofficial. There may be the wish to help, concern for those affected or anxiety for family members who may be at the site. As well there is the natural curiosity about death and destruction. While people converging intend to be helpful, they may create further problems; for instance, they may congest the site; disrupt communication; or develop problems themselves; or they may respond in an overly dramatic way, exaggerating problems or become angry that their help is not needed. Managing or preventing this convergence is important in overall response at this time.

Activity at this stage can be **productive or non-productive**. Productive activity is oriented to the reality of the situation and involves the affected persons taking an increasing and active role in their own return to function. In contrast, those involved in the disaster and those who have converged in the disaster area may become overwhelmed by their reactions to what has happened. Some may demonstrate a 'staring reaction'; a contemplation of the enormity of the disaster damage which they need time to come to terms with. Another relatively nonproductive behaviour pattern which may be seen at this time is the **counter-disaster syndrome**. Here people are overactive, overconscientious but with loss of efficiency. Bustling activity of a purposeless nature is characteristic of this syndrome. People may be unwilling to finish their tour of duty, be over-involved and believe they are indispensable, even though their efficiency is in fact diminished

Emotional reactions to the stresses of the disaster impact and aftermath **may now start to appear**, although these will be variable and depend on the individual's perceptions and experience of the different stress or elements noted above. Necessary activities of the rescue phase may mean these reactions are delayed, appearing more as recovery processes get under way.

Reactions include the following.

- **Numbness**, denial or 'shock' may continue and the individual may seem to have shut down feelings or to be very stoical, or even inappropriate, by lack of reaction. This may be because he or she is so overwhelmed, or is still struggling to survive, physically and psychologically, or simply because personal style, other demands, or social circumstances do not allow response.
- **Traumatic anxiety and stress reactions** If there has been severe threat to the individual during the disaster, it is natural for anxiety to continue or return. Arousal, and heightened responsiveness are protective in times of threat, gearing the individual to rapid action. Usually this anxiety settles when it becomes apparent that the threat no longer exists, but it may continue for days or even weeks. Sometimes the person stays in this situation of heightened arousal, as though locked in, and is vulnerable to the development of psychological problems such as post-traumatic stress disorder. This may be associated with **re-experiencing** the horror of what has happened in flashbacks and nightmares, excessive reaction to reminders, and avoidance and anxiety. It is critical that this reaction is monitored as it may be the precursor for the development of Post Traumatic Stress Disorder and this condition has the potential to be severely disabling and prolonged when it develops. Early detection and effective intervention may help prevent the development of this problem which will be discussed in further detail below.
- **Grief** reactions to loss may start to appear even as rescue is still progressing or they may seem to be held in check by those who are bereaved, till the emergency is over, or because they are still dealing with the trauma of their experience or the necessary tasks of survival.

Anger, feelings of anguish and despair, sadness and hopelessness may come in waves if there has been the loss of a loved one, and the bereaved person may be preoccupied with thoughts of the person who has died. There may even be great difficulty in believing the reality of the loss, especially if the bereaved has not had an opportunity to see the body of the dead person, or if they have not been found. It is particularly important that those involved in recovery of bodies try to ensure that the bereaved have an opportunity to see their loved ones and say their good byes.

Active roles are very important for those who were affected during the disaster, as playing a part in rescue and later recovery may help to undo the feelings of powerlessness and helplessness that occurred during impact. A sense of mastery may be achieved, provided those affected are fit enough and psychologically able to do so, but such active involvement, and the common and dangerous stereotype of the passive and helpless 'victim' is thus avoided.

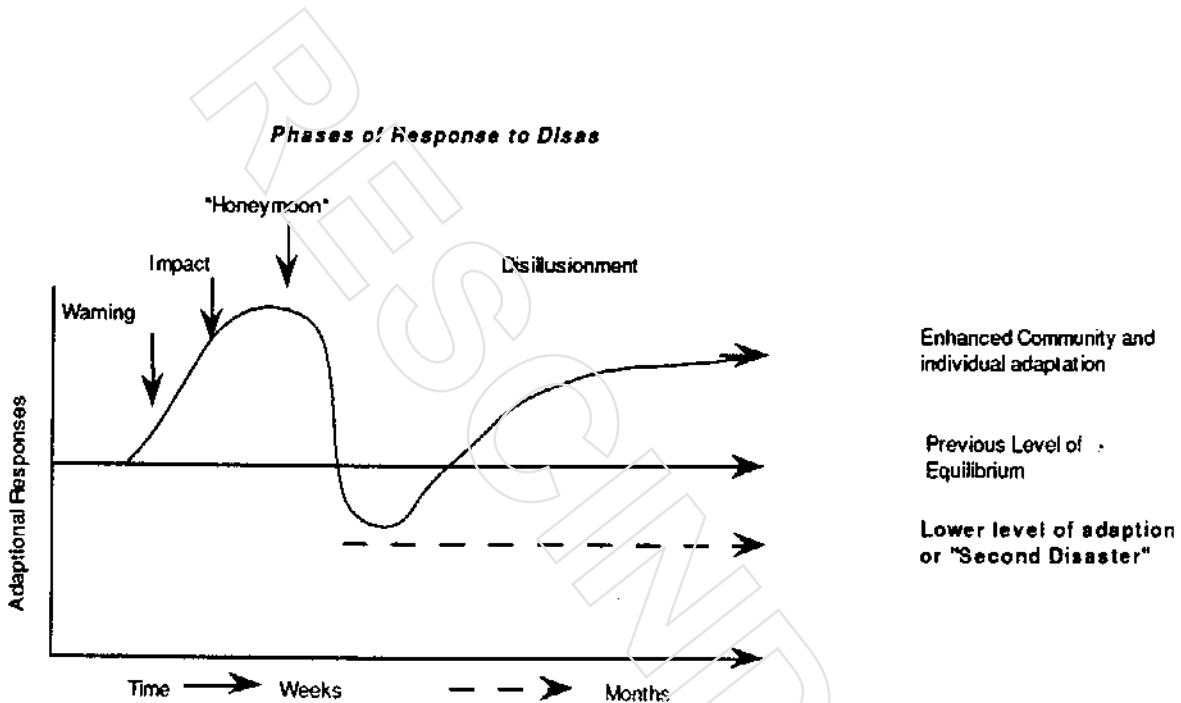
Recovery

The recovery phase commences once rescue is completed and individuals and communities face the task of bringing their lives and activities back to normal. Much will depend on the extent of devastation and destruction that has occurred as well as injuries and lives lost.

During the emergency the surrounding community responds, everyone is supportive, the 'honeymoon phase' follows and many promises are made. It is as though everyone wants to make up for what has happened and return things to the way they were before the disaster. Of course this is not possible.

The extent of costs, the problem of who will pay, the time that will be required, the ongoing problems that will continue, all start to impact on those affected, bringing chronic stress which is often more difficult to deal with than the original acute experience. This period is often called the phase of **disillusionment**, or if it becomes entrenched and severe, the 'second disaster'.

Figure 1



Recovery will inevitably take time and it is true to say things will never be quite the same again because this disaster has occurred. Several important themes emerge and continue during the recovery phase:

- **Active involvement** in and ownership of the recovery process is essential for members of the affected community, both as individuals and a group. When others take over, control funds, or seem to demand ongoing helplessness and gratitude, it is likely that disorganisation and helplessness will predominate — continuing into a 'second disaster'.
- **Community organisation** passes from the emergency phase back to regular systems. These may need new groups and structures to cope with the additional tasks of recovery and reconstruction. Old systems may be adequate or inadequate for the task. Support for community development is essential in the recovery phase, to strengthen positive outcomes, to prevent scape-goating and splitting, and to ensure ongoing community growth in the face of the challenge.

- Convergence may be an ongoing issue or the support may vanish at this stage, when it may be most needed. Community organisation may need to address issues such as the appropriate mobilisation of volunteers, or utilisation of resources which have been donated, i.e., factors from outside, as well as systems, needs and responses within the community.
- **Practical** issues including resource needs may predominate. These must be dealt with, but do not by themselves meet emotional needs. People often find it difficult to ask for practical and financial assistance, especially if they have previously been very independent, so that assistance may need to be made available in a supportive way. People may also be overwhelmed and fatigued by the many tasks they face and may need government and other agencies to come together at 'one stop shops' so that they can get all their practical tasks done at the one time and place.
- It is particularly important to remember that **emotional needs are** likely to be profound, for at least those who have been severely affected and often for many others. They may only start to appear at this time. All workers need to be trained and aware of particular emotional reactions, so that they can behave supportively. People may also be hesitant to express distress or concern, or dissatisfaction, feeling they should be grateful for the aid given, or because they have suffered less than others. It should be noted that sometimes emotional reactions may present as physical health symptoms, e.g. sleep disturbance, indigestion, fatigue and this may need to be understood, as well as social effects such as relationship or work difficulties.
- **Debriefing, counselling and other mental health support** services should be available in readily accessible places in the community, or through outreach programs. Stresses and grief impact on individuals and families, including children and place them at considerable risk. Good support and counselling services, as well as opportunities to talk through problems in groups with others who have gone through the same experience, will do much to facilitate emotional recovery. These provisions should not interfere with the natural support processes, such as family and friends, and local professionals, but should be developed to assist these and to liaise with them to meet additional needs in ways that are accessible and acceptable.
- **Maintaining social networks** is also important in the recovery process. If people have been dislocated from home and community, evacuated, moved in with friends or relatives, they face additional strain. Social network support plays a vital role in the recovery from adversity, and acts as a buffer against negative outcomes. Every effort needs to be made to continue networks of neighbourhood, friends and confidants so that stresses may be dealt with in such groups.
- If a **phase of disillusionment** supervenes, more active processes may need to come into play to help people deal with their sense of anger and injustice and to promote fresh hope and energy for reinvestment in recovery goals. Support and recognition from others can help this process. Social groups representing community stakeholders may be valuable in helping to identify sources of difficulty and seeking active consultation and solutions. Dealing with difficulties in this active way is helpful to the community, empowering and relevant to local needs and culture.

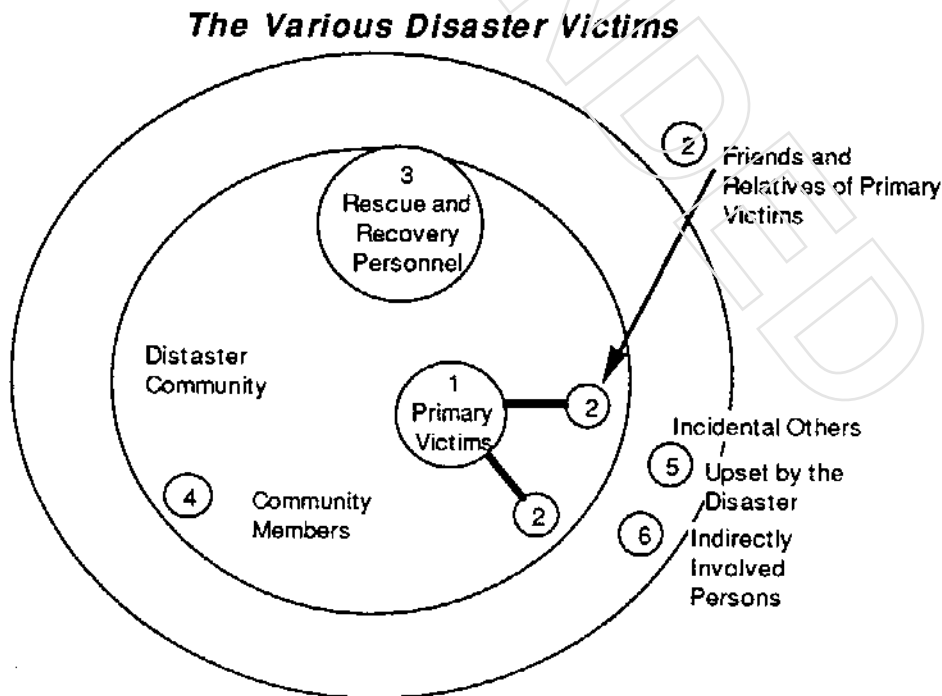
- **Communication and information systems** are central at every stage of the disaster, and continue to be so during the recovery process. Here they help counterbalance myths, provide feedback and promote recognition of individual and community achievements. Newsletters, television and radio are all useful, as are public meetings and forums.
- **Community rituals** may evolve as symbolic and important steps in the recovery process. Memorial services and renewal projects, testimony of suffering and courage in art and literature all constitute ways of externalising and making meaning of the disaster. They help individuals and communities come to terms with what has happened, memorialise and pay tribute to the living and the dead, and set the experience in the past so that it may be integrated and all may move on from it.
- **The role of the media.** The media are intensively involved in any disaster and their roles may be positive or negative. Intrusions on individual acute distress and grief for 'human interest' stories are often seen as very destructive and inappropriate.
- On the other hand, presentations about what has occurred and the experiences of different people can help people see their own in context, and furthermore, give testimony and information to the wider community. The media can also provide a very positive contribution in informing those affected, the wider community and others, both in the acute phase and over time, and may be the only channel for such communications in some instances. Those managing the recovery process should liaise with the media to ensure that these positive collaborative arrangements can develop to the benefit of those affected. Most media professionals follow an ethical approach in this period, and only a few do not. It would be hoped that the development of professional standards will help to ensure positive as opposed to negative media contributions. It should also be noted that members of the media may themselves be traumatised and stressed by their work in disasters and may need debriefing and mental health support programs to be available for them.

Who are affected by disasters

It is often difficult to define just who is most affected by a disaster. Included are those at the centre as well as periphery; those whose lives were directly threatened, as well as those who were a "near miss"; those who have lost loved ones and who may or may not have been present in the disaster themselves; the wider community, and so forth.

Workers responding to disaster include formally trained professionals, used to emergency work, such as police, ambulance, fire and other care-giving service workers, medical and health care professionals, and in some instances other counter disaster teams such as the military. Volunteers may also be a significant group, and may be willing but ill prepared to help as they converge on the disaster site. While they may assist greatly they may also require care themselves if overwhelmed by the disaster stress. Community leaders are another group who are often forgotten yet may be affected in a major way.

Figure 2



SOURCE: Adapted from A. J. W. Taylor and A. G. Frazer, Psychological Sequelae of Operation Overdue Following the DC-10 Air Crash in Antarctica (Wellington, New Zealand: Victoria University of Wellington Publications in Psychology, No. 27, 1981)

People in communities subject to disaster may experience the stressors of the disaster differentially as well, and may perceive even a shared stress quite differently. Thus in identifying who might be in particular need of help or support afterwards, ie **who may be most affected**, several different factors need to be taken into account.

The traumatised

Those who are severely stressed by exposure to traumatic stressors (as outlined above) or who are vulnerable are likely to need assessment and support. There is a need to enquire about the following:

- What **particular stressor** or group of stressors was this person exposed to and how was it perceived - for instance what level and severity of exposure was there to life threat, or death encounter, loss, personal injury, dislocation and so forth.
- Were there **particular vulnerabilities** for this person in terms of **developmental stage** (eg childhood), **belonging to a disadvantaged group, concurrent stressors, past experience**.
- Were there particular social processes for instance support or lack of support, recognition and lack of recognition, that facilitated or interfered with the recovery environment.
- Were there secondary effects for people who might be seen as **indirect** victims of this disaster, e.g. rescuers, helpers.

Children

Children show a variety of reactions which, as a general rule, depend on their age. The very young child may find it difficult to comprehend what is happening and simply mirror his parents' reactions. For example, if the parent is frightened or upset, the child shows a similar response.

It is the parents emotion that the child is tuned in to, not the verbal message. A mother may say 'Don't be frightened', but if she is frightened herself, it is the feeling, not the words, which are responded to. The predominant fear at all ages is separation from the parents. If separation does occur, it may add to the child's traumatic experience.

In the impact phase of the disaster, the child may be excited by what is going on. The dramatic events that occur then are often linked to fantasy and play. Children may often work through the experience afterwards in games, even in make-believe burials, train crashes and cyclones. This is the child's equivalent to the adults' talking-through, something to be encouraged, not suppressed. Sometimes however these repetitive games do not help the child, but represent ongoing effects of the traumatic experience. In such circumstances, the child may need specialised referral and assistance.

From about 7-8 years of age onwards, the child becomes aware of the reality of his or her own death. This naturally may add to the stress of children from this age upwards. Often this awareness goes unrecognised, particularly as the child's apparent unconcern may hide his inner distress. If there is a bereavement, the child needs to share the reality, to be comforted, to be given an honest and simple explanation ;and to be reassured that, although the dead person cannot return, others in the family will remain and continue to love him.

Children often regress in the face of stress. That is to say, they go back to earlier patterns of behaviour such as thumb-sucking, bed-wetting and terror at sleeping alone or at separation. Usually this settles quickly with reassurance, love and understanding.

Adolescents may show more clearly than adults the mood swings (from elation to despair) during the disaster. It is often the case that they are scapegoated for the elation - 'They're carrying on as if nothing happened'. Although adolescents may be less concerned by the material losses that a family sustains, they have special problems should the family suffer bereavement. If they do not show overt grief, they are condemned as being unfeeling. If they are distressed they are criticised as childish and not offering support to the bereaved parents. They too are acutely aware of the reality of death and much of their behaviour may represent attempts to shut this reality away.

When families are forced to move from home and familiar neighbourhood to new areas or schools the stress of dislocation may have further adverse effects for all members. Research studies with children affected by disasters have now clearly shown how greatly they may be affected, both through effects on parents and their own traumatic experience. They may show traumatic stress effects, including repetitive play and re-enactment, as well as fearfulness and avoidance. These traumatic effects and grief may have ongoing negative effects on their adjustment and development.

It is important that disaster plans and response take into account the needs of children. Wherever possible they should stay with their parents. Schools need to have special policies to manage children if a disaster strikes during school hours and to reunite them with parents as soon as possible, as well as programs to assist them in their recovery and integration of the experience subsequently.

The elderly

For many older people life focuses on their immediate family, their home and their treasured possessions. There is often a disengagement from other social involvement during this period of life. For such old people the loss of their home is particularly distressing. There is more reluctance to leave home in response to warnings and they may thus be at greater risk of their lives. During the recovery phase there may be a deeper sense of deprivation reflecting the real improbability of restoring things to their former state.

Studies show that the elderly are unlikely to complain or seek help after a disaster, so that their vulnerability and need for support may not be recognised. Furthermore the loss of needed appliances such as spectacles, hearing aids, false teeth and so forth may make them especially sensitive to approaching others and at the same time leave them further out of touch and at risk in terms of physical health. In most instances a special outreach program that is sensitive to the elderly can help overcome these problems.

People of non-English speaking background

People who do not have English as their first language may be particularly disadvantaged by disasters. They may have difficulties with disaster response guidelines if these are not available in community languages. If recently arrived migrants they may be still experiencing psychological distress in adjusting to their new community.

Different ethnic groups may not feel fully identified with the community affected by the disaster and may feel and be vulnerable to the scape-goating which often occurs in this post disaster period.

If they have suffered trauma in their country of origin for instance in war, or have come as refugees from political repression, or even torture, they may be particularly vulnerable to new trauma. Culturally sensitive support and counselling services should be available to them.

Losses may also be especially threatening to them. For instance they may have few resources, only a limited number of treasured personal mementoes from the old country, and be very anxious about loss of documentation about their status in Australia. Rituals about grief and mourning from their culture may not be understood by disaster authorities, again creating further stress for them.

Aboriginal people

Aboriginal people may be adversely affected by disasters as may other groups. Because their communities are often suffering with marginal status, poor physical health and housing, problems of cultural loss and grief, disasters may bring immense further distress and trauma. They may also be dislocated from traditional places of importance to them. As well they are often scapegoated in the post disaster period, reflecting ongoing community discrimination and too often racism. It is critical that where Aboriginal communities are affected by disaster that their leaders are involved in the development of culturally appropriate recovery and support processes.

The injured

There is now evidence that people who are injured in disasters are at greater risk of psychological problems afterwards. This may not be apparent initially for much personal energy is likely to be taken up with responding to the physical problems associated with the injury. Thus it is important that outreach programs provide support for them in relevant health care settings. Similarly these issues can apply to those who are physically ill when affected by a disaster, or who lose a loved one while attempting to deal with their own injury.

Mothers of young children

It seems likely that women with small children or women who are pregnant may suffer special stresses for fears of threat to their children. They may require assessment and care because of this.

Indirect victims - helpers

The 'helpers', be they emergency service workers, or rescue workers, support personnel, volunteers or counsellors may all be affected by the disaster trauma.

Emergency service workers, such as police, ambulance, fire, rescue, SES (State Emergency Service), and related workers, medical teams, disaster victim identification workers and others, may all be likely to be affected. The degree of training and preparation may mitigate effects, as may specific briefing **to help them to deal with**

the particular episode. The level of exposure to death, especially gruesome and mutilating deaths and mass deaths, the deaths of children, the degree of helplessness and frustration, or threat to the worker's own life are likely to contribute to the development of stress effects in such workers. Patterns of pathology, over and above initial distress, occur and are similar to those outlined below. Debriefing programs, which will be discussed later, are aimed at preventing such outcomes, and are usually perceived as helpful, although not all people benefit and they may not prevent posttraumatic problems from developing. There needs to be education about normal reactions to such stressors, how to manage them and where to seek help, as well as adequate support and counselling services for workers who do become affected. Organisational backing is very important as workers may fear they will be seen as weak or inadequate for their jobs if they seek assistance. They need reassurance and support from management to do so.

Where workers in such services are adversely affected there are increased sick leave rates, job changes and loss of personnel as well as negative impacts on family life. So costs may be substantial, both to individuals and organisations, unless a positive approach is developed.

Support workers may have less clear cut roles and tasks and may be stressed by being uncertain what they can do to assist. Clarifying of roles and goals can be useful. Counsellors may carry 'second hand' as it were, a great deal of empathic distress as they hear victims' tales of horror and loss. Depressive symptoms are not uncommon, and workers may find themselves overwhelmed, 'burnt out' or suffering from 'compassion fatigue'. Case review, case limits, and education and support programs can help deal with these issues.

Volunteers are a group who may miss out on support programs. They are likely to be even more vulnerable to the stresses of disaster aftermath as they are often untrained and unprepared, and uncertain of their roles. Debriefing programs should be available for this group and the impact of stress on them may be mitigated if their contribution is well coordinated by a supportive leader or leaders.

Community leaders may shoulder an enormous burden of distress, both for themselves and their communities, as well as feelings of helplessness and frustration at the enormous tasks of recovery. Others turn to them but they may have no-one they can turn to at such a time. Furthermore they are likely to be blamed for what cannot be fixed or what goes wrong. They are vulnerable to over-involvement and excessive activity (a form of the counter disaster syndrome) as they try to make things right again. Recognition of their needs for support and backup will be helpful to them and their communities in the post-disaster period, particularly in view of the political pressures that are likely to intensify during this time.

Mental health consequences of disasters

Careful and systematic studies of a number of natural and man-made disasters have shown that a range of psychological and psychiatric outcomes may occur and adversely affect the mental health of those who have been exposed. Nevertheless the majority of people will recover even if the disaster is never forgotten and their experience always remains a reference point in their lives.

It is clear that the degree of distress experienced in response to the disaster and its aftermath will vary amongst individuals. Many, if not most people, will show at least transient reactions to their experience. The number of people affected in this way and the severity of this initial distress will be closely related to the severity of the traumatic exposure. For instance between 70 per cent and 90 per cent of people may experience some distress and anxiety in the early days after a disaster, but twelve months later distress levels in such an affected group may be back near baseline levels, ie comparable to everyday distress levels found in communities which have not been exposed to a disaster.

Nevertheless studies of Australian and other disasters all indicate that many people do experience adverse mental health consequences and may develop post traumatic morbidity in the form of post-traumatic stress disorders, adjustment disorders, depression and anxiety disorders and substance abuse problems. The frequency and extent of such problems after a disaster with many dependent on the number of individuals exposed to stressors and their severity, as well as secondary traumatisation that occurs. Rates, for instance, may vary from being near to the rates in populations who have not been affected to levels as high as 20-30 per cent or even more. Man-made disasters, unpredicted events with many deaths may be followed by rates as high as 70-90 per cent. Several factors may influence whether or not a person develops such problems. These include severity of exposure to traumatic stresses such as personal encounter with death; losses; personal injury; dislocations; support available to the person to help mitigate these effects; opportunities for active mastery and coping both at the time and subsequently; opportunities to 'work through' and come to terms with what has happened; concurrent or multiple or further stresses adding an additional psychological burden for the affected person; personal psychological vulnerabilities of the individual with which the stressful experience interacts to contribute to ongoing pathology.

Levels of morbidity after some disasters may be as high as 30 per cent of the population or occasionally, particularly after 'man-made' disasters, even higher, as noted above.

The ways in which such problems may present are variable but could include the following:

- **Ongoing distress, fearfulness, dread and arousal** which do not settle. The person may feel as though the disaster may return, or some further catastrophe is imminent. There may also be difficulty sleeping, irritability and problems concentrating. Such distress usually settles in the first few days or weeks, but if it continues or increases, these are signs that the trauma is still having ongoing effects and that the person may need counselling or specialised help. When such

distress stays at a high level, or reliving and numbing are profound and lasting, the person may be at risk of developing Post Traumatic Stress Disorder which will be described in more detail below. This is likely to need specialised mental health assessment and early, effective treatment.

- **Reliving the experience.** This may occur in the form of **flashbacks**, vivid visual experiences of some particularly distressing part of the experience, often where the person's life was under threat, or the lives of others, or the deaths of others occurred. **Nightmares** where the affected person wakes from sleep, reliving what has happened, occur initially for many but usually settle. If they do not, this is also evidence that the person may need further assessment. Sometimes reminders - e.g. sounds or smells, may bring back the full intensity, fear and helplessness of what happened, or the person may feel as if he or she were back there.
- **Numbness, avoidance and shutting out feelings.** Naturally people hope to forget harrowing experiences and try to put them out of their minds. However, for most people this does not really work in the long run, and the event has to be come to terms with, before it can fade and take its place with other memories. While some shutting out and rest from distressing feelings, as well as avoidance is natural initially, and may alternate with the re-experiencing of the event, if it (ie numbing) becomes the total response it has many adverse consequences. For instance people avoid talking about what has happened and thus do not receive the social support and opportunity to come to terms with their experience. Feelings related to other things become shut off as well, so there is a loss of capacity for enjoyment, and often a negative impact on relationships with partners and children, as feelings cannot be shown in these close personal interactions. Numbing is also difficult to treat when it becomes a long established pattern of dealing with the traumatic experience. Thus if numbing is prominent extends to other areas of life, or continues after the first few weeks, specialised assistance is necessary.
- **Depression and despair.** As time goes on after the disaster, people may confront great feelings of hopelessness as the extent of loss, devastation and change have to be dealt with on a daily basis. Massive changes to the physical environment, destroyed neighbourhoods, collapsed buildings, loss of familiar meeting places, blackened forests muddied homes, may all contribute to these feelings. This is likely to be aggravated if people have lost their own homes, have had to move in with others, or to temporary accommodation, or have lost their social networks of neighbourhood and friends. The difficulties of recovery and reconstruction may be aggravated by bureaucratic requirements, failures of insurance or aid, and a multitude of other practical problems. Ongoing feelings of despair, depression and hopelessness may mean that the person has developed a depressive illness in response to these stressors, so careful assessment should be made by family doctor or specialised mental health professionals in such cases. It should be noted that some people may feel so despairing and overwhelmed that they contemplate suicide, and those providing assistance should be aware of and respond rapidly to any communication where the person suggests that life is not worth living.
- **Continuing grief.** Grief may be delayed, but when it does appear, is a natural and healthy emotional response to loss. The nature of disaster deaths - the fact that they are sudden and unexpected and often untimely and possibly multiple and may have occurred in very traumatic circumstances, all mean that it may be more difficult for the bereaved person to come to terms with the loss. As well there are the additional stresses and losses faced both during the disaster, and its aftermath, and the very struggle for survival that some may face, for instance if themselves injured, or battling to keep home and family together. When grief does not appear

after weeks, or if it does appear but does not seem to settle gradually over the months that follow, instead becoming chronic, then specialised counselling and assistance may be required.

- **Changes in behaviour.** Sometimes the effects of trauma are more obvious in changed patterns of behaviour such as the following:
 - Heavy drinking, or self medicating.** People may attempt to dampen distress, and shut out memories by drinking heavily or taking excessive amounts of sedatives or tranquillisers.
 - Withdrawal and changes in personal relationships.** Some individuals deal with their shocking experience by withdrawing - this is often a form of avoidance. Others may find relationships disrupted by irritability or chronic stress.
 - Victim status** may be taken on as an identity and the person's whole life seems to centre around the importance and gain they get from being seen as a victim of the disaster. Other changes may also occur, but most of the behaviours listed above represent ways in which the person fails to deal with the psychological experience of the disaster and are thus blocks to moving beyond it. The aim of counselling or support is to help him or her do so.
- **Health changes.** The stress of the disaster experience may impact on health. Studies have shown that there may be, for some, effects on blood pressure, cardiovascular system, diabetes, miscarriage, and possibly even on vulnerability to cancer. Some people with mental illness may also be vulnerable to such stress. For most people such adverse outcomes do not occur, although there may be a heightened vulnerability to infection, accidents and so forth. Nevertheless, where whole populations are studied there are small, but significant effects, for example on cardiovascular deaths, and so forth. It should also be noted that physical symptoms may be an indirect indication of underlying psychiatric disorder and the possibility of such co-existing disorders or somatic manifestation should be thoroughly assessed. A preventive approach emphasises the importance of careful attention to nutrition and exercise, avoidance of smoking and excessive alcohol intake, plus medical check-ups.

Management

There are some key themes which should determine management throughout.

A preventive approach

The aim of all management should be the humane care of those affected, with the goal of preventing adverse outcomes for health, and enhancing the well-being of individuals and communities. In particular, it is vital to use all endeavours to prevent the development of chronic and disabling problems such as post traumatic stress disorder, depression, alcohol abuse or strain and break-up of family relationships. There is much evidence to suggest that the factors described below will help to facilitate positive outcomes and prevention. However, this always needs to be monitored and support and other mental health services mobilised if long-term adverse effects become obvious.

- At all times those affected should have a **recognition of their strengths, as well as the suffering** they have experienced. While their suffering must be acknowledged, and they need compassionate and empathic understanding of what they have been through, they also need those who care for them to believe in and support their capacity to master this experience.
- **Information and education** help people's understanding and should be available as part of the support and care systems. Preparation beforehand, information about what has happened, education about normal responses to such events, training in what to do to help psychological recovery, information centres and ongoing information feedback to affected communities, for instance in special newsletters, all help people's mastery and recovery.
- **Telling the trauma story.** There seems a general need for people to tell the story of their experience, to give testimony, both to externalise it, to obtain emotional release, and to gain understanding and support from others. All management and interventions should support, or at times encourage, this process.
- Supportive networks are critical and should be retained, reinforced and rebuilt. These networks help people in the ongoing recovery process, both through the exchange of resources and practical assistance, and through the emotional support they provide to deal with the disaster and its aftermath. Community groups may develop to facilitate support, and should be encouraged.
- **Community processes** as well as individuals, need to be recognised and developed. For instance leadership, rituals of memorial, and later renewal, as well as theatre, and art can contribute positively. Community splits, scape-goating, political power-broking post disaster may interfere with recovery. Interventions need to recognise, support and develop community strengths, while also recognising community suffering.

Training and preparation

This is more likely to be available for disaster workers than general community members. Nevertheless the more knowledge available to people before-hand about what to expect and what to do, the less likely it is that they will be severely traumatised by their experience.

Such preparation needs to acquaint people with likely outcomes as well as actions, needs to identify sources of warning, provide information on physical and psychological survival. Knowledge that one's responses are normal can prevent a great deal of secondary distress and help one to get on with the business of dealing with the disaster and aftermath.

General training is helpful, but it is also most helpful to have preparation or briefing about the specific trauma that will be faced, if this is possible. Obviously some disasters have no warning and there is nothing one could have done to prepare. Preparation may also be futile at times, reinforcing a sense of powerlessness.

Psychological first aid and triage

All disaster workers should know the principles of psychological or emotional first aid to assist people in the acute period. These involve:

- **Offering human comfort and support** is the most important component of psychological first aid. Being with those affected, protecting them from further harm, ensuring basic needs are met, conveying your recognition of what they have been through in a respectful and compassionate way, all assist.
- **The person should be allowed to talk freely**, reliving particularly the frightened, helpless and angry feelings that were experienced. Such ventilation will enable him or her to come to terms with such feelings. This may appear distressing to him and may be painful for the listener, but will often prove of the utmost value. One aspect that may require ventilation is the terror that has been evoked for the person by the close encounter with death. If they can talk about how this was "nearly it" either at this early time or later when they may feel more safely distanced from it, it will be likely to lead to their better acceptance and adjustment.

This is the first stage of the **telling of the trauma story** and if dealt with in a supportive and caring manner, may help set the person on the path of psychological recovery.

In this context a range of feelings may appear and need to be dealt with:

- Feelings of helplessness may constitute a special problem, since many people feel ashamed of such feelings, seeing them as a weakness. It is important to recognise this as it may interfere with people's capacity to get over other aspects of the experience. It is also helpful for people to realise that such an experience would have induced helpless feelings in most people, and thus to see their own feelings in context.
- The person who is known to have gone through traumatic disaster experience but who **appears unaffected** and extremely competent may also need support in spite of an outward show of calmness and confidence. It may be hard for such a person to acknowledge a need to ventilate distressing feelings and accept the comforting of others.

- Angry feelings too may appear and may need to be recognised and talked about: 'Why did it have to happen to me?'; Victims and helpers alike may see this anger as being irrational for what is the point of being angry with a cyclone:- when it is not possible to change or attack it. It is easier to be angry with God, the Government, 'they', or with people on the disaster scene who may irritate one, unduly. Just recognising that **it is both natural and acceptable to be angry** can help in this sort of situation.
- Guilt is another upsetting feeling which might appear at this time and can also be distressing. Guilt may be about not listening to the warnings, following advice, taking precautions, etc., or the fact that one has oneself survived, uninjured, when others have not. All these things may be a source of **painful feelings which need to be talked about.**
- **Behaviour varies enormously** and is influenced by individual psychological makeup as well as group needs. Sometimes the individual who is most emotional may only be expressing what others wish they could show but cannot. Very basic and simple behavioural patterns often appear briefly in the time of acute stress, for instance the curling up in a child-like position, the wish to be cuddled, whimpering or wetting oneself. No judgement should be made about such behaviours for they represent natural 'regressions' in the face of severe stress, but the person may feel ashamed about them and may require support to be able to accept such responses comfortably into their concept of themselves.
- **Relationships with others are extremely important** at any time of crisis. Relationships with one's own family and friends are of prime importance when one is especially susceptible. Thus it is important that families be kept together or brought back together, or kept in communication with one another as much as possible. It is important to ensure the person is with others and not left isolated and alone.
- **Human dignity** is an important issue throughout. The loss of personal possessions, clothes, even glasses, the overwhelming dehumanisation of the disaster experience, the subsequent dependence on others for even the simple basics of everyday life may all be threats to the individual's personal dignity. Whenever possible those helping should be sensitive to these issues. Handouts of old clothes for which the victims are expected to be grateful may be the sort of thing that highlights such vulnerability, making the victim feel ashamed, humiliated or even angry.
- Identifying those who are particularly stressed or at risk and ensuring that they are followed up by counsellors or mental health outreach workers is another important aspect.
- Immediate assistance and protective care should be provided to persons who have decompensated - e.g. wandering dazed and stunned and unable to look after themselves, or showing extremes of anxious, agitated, or disordered behaviour.

These basic principles of psychological first aid can be carried out by any workers or volunteers. Their primary aims are to ensure safety and that no further harm occurs.

Debriefing

Psychological debriefing, or critical incident stress debriefing as it is now called, is a formal process designed to help groups of emergency workers, or others involved with the disaster, including those who have been direct victims. It may be preceded by other processes, such as 'defusing' which refers to the opportunity for brief support for workers as they come off a shift. Debriefing is usually provided in the first 24-72 hours after the disaster, although it is now also used flexibly in the first few days or weeks. Its goal is to help people to debrief - i.e. review and 'unload', their disaster experience, and to learn about normal reactions and how to deal **with them - ie there is also** an education component.

People who carry out debriefing should be fully trained in the technique, as well as knowledgeable about group processes and reactions to trauma. Mental health professionals **are expected to perform this role but may need** additional training to do so. Those being debriefed are seen together as a group and ideally the group should include groups of people who have been through the experience together, or for instance, teams of workers. It may take 2-3 or even more hours and starts with information sharing and setting rules about confidentiality etc. People are encouraged to present their experiences, and a picture gradually emerges of the over-all experience. Thoughts, feelings and reactions are discussed and may be ventilated, although there should be no demand that this need occur. The meeting closes with an educational input, drawing together what has happened, describing it in terms of normal reactions to abnormal events, and providing information on ongoing positive coping techniques. People are usually offered opportunities to talk further if they wish and personal counselling may also be made available. Follow-up debriefings may also be offered, depending on need - for instance a week or so later.

In a way debriefing allows for a group telling of the trauma story, plus the mobilisation of support. It allows people to make meaning of what has happened, often a shared meaning, and it provides information and education. Inherent in it is the recognition of both suffering and strengths. It has proved to be a useful and supportive process and while it has not been systematically evaluated in terms of outcome, is perceived positively by many people. Its acknowledgment of people's experience is a symbolic as well as a real aspect of its value.

Nevertheless there are significant numbers of people for whom it will not be adequate - it may not be at the right time, and it may not meet their needs. Studies have shown that some people will continue to be highly stressed, despite receiving such support, and that for many, even though it is perceived as helpful, it may not lessen their symptoms of distress or numbing. Some may not be able to use it because of shock or denial. For those who are bereaved it may not meet needs for grieving in the weeks and months that follow.

It is therefore critical that debriefing is not seen as the cure-all, but rather it is available to people in association with a safety net of back up services. These should include information (e.g. particularly about normal reactions), personal counselling, and follow-up outreach to check how people are going. Such a safety net may need to operate for a period of time after the disaster as some effects may be delayed in their appearance. It needs to link to and include specialised mental health services to assist with prevention and provide rapid and effective intervention for those where significant problems arise.

Counselling

Specialised counselling services should be developed, in collaboration with the mental health services of the affected region. Extra resources may be necessary to support existing services,

and additional personnel and special training for the disaster-related work which is quite different from the usual roles of mental health workers. Counselling aims to help people come to terms with the trauma, loss and other trauma they have suffered in the disaster and its aftermath, with emphasis on enhancing positive coping and facilitating active mastery and involvement in the recovery process. Counselling may need to deal with a single traumatic component and its effects, or with multiple stressor effects, including things that have been reawakened from the past.

- **Counselling to deal with the traumatic encounter with death.** This will involve encouraging the person to talk through the particular aspects of the experience, to tell their story, to deal with the feelings that were and are aroused, including fear and helplessness. There is often a great sense of release when the person is able to do this. However, sometimes the experience is still too frightening and painful, so this must be taken gradually, in amounts that are manageable for the individual. What was or was not done, what could not be done, the naturalness of the feelings in terms of what was experienced, the nearness to death, are all issues that may need to be confronted. If the person is intensively preoccupied with re-experiencing the trauma, then they may need to be helped to lessen emotional distress, whereas if their response is essentially numbing, then they may need help to get in touch with and express their feelings. The person may also need education about normal reactions and how to gradually confront the feared experience to gain mastery in retrospect. They may also be helped by writing down their experience. There may be a need for several sessions. If high levels of arousal continue, the person may need referral to a psychiatrist for specialised assessment and treatment, which may include medication.
- **Counselling for loss.** The bereaved person initially needs comfort and support to accept the news and reality of the death. Wherever possible the bereaved should be supported to see the body of the dead person and say their goodbyes. If there is gross mutilation of the body or the body cannot be found then special support to talk through fears about the nature of the death and the possible suffering of the deceased may be critical. Thus the person needs to be gently encouraged to talk of the lost person, if this is a personal bereavement. Grief counselling involves reviewing the relationship with the person, talking over and sharing memories about it, both positive and negative, and expressing the complex feelings that are evoked, including anger, guilt, sadness and so forth. The bereaved needs support to talk of the circumstances of the death for these may have been personally traumatic and this trauma component may have to be worked through as well. Memorial ceremonies may be especially helpful allowing public acknowledgment and support for those bereaved. Counselling over loss of home, property or intangibles involves similar processes of sharing memories and regrets, expressing sadness and so forth.
- **General counselling** is often needed to deal with stresses such as the effects of personal injury, dislocation, uncertainty, chronic problems of recovery, family friction, difficulties with children's behaviour and so forth. General principles of establishing an empathic relationship, encouraging identification of problems,

expression of feelings and positive coping and solutions will be helpful, as well as identifying sources of ongoing support in the community.

- **Support groups.** Self-help and other support groups are often formed in communities affected by disaster. They provide valuable roles in practical assistance, information, lobbying and often considerable counselling in interpersonal interaction which assists the working through processes.

Special aspects of counselling in disasters

Counselling at such times involves a different pattern of relationship and work from traditional counselling settings where those affected present themselves as people with problems needing help from professionals. Counsellors in disasters often work alongside those affected in dealing with practical problems, and need to be able to provide counselling for emotional needs in such frameworks. Furthermore there is likely to be much greater identification with those affected, so counsellors may more readily find themselves overwhelmed and feel a need to withdraw, or alternatively may become too enmeshed in victims' problems to be helpful. It is also very important that they do not erode the sense of independence and attempts at active mastery, but rather assist and facilitate these in nonintrusive ways, while at the same time pursuing goals of helping the person to confront and integrate their experience. Case review and supervision are useful backup for counsellors in these settings, especially as they may themselves become stressed.

Long term management issues

Although not all disasters are accompanied by long term management problems, these frequently exist on a much larger scale than is generally appreciated. Although difficulties may be largely social or largely psychological, the word 'psychosocial' best expresses the concept that, for most with long term problems, both sorts of issues exist together and are related to each other in complex ways.

These longer term problems encompass issues such as place of living, restoration of home, living with relatives or in temporary accommodation such as caravans etc, pursuing insurance settlements, seeking aid and financial support, work if workplace or job is destroyed, schooling in unfamiliar environments, drain on family resources from care of an injured family member, community disorganisation, lack of neighbourhood and networks, loss of interest from others who provided support, shortcomings of government or other agencies - to name a few. This mix of social and practical problems, and the psychological stresses involved in dealing with them, as well as the original trauma, all heighten vulnerability.

Most communities attempt, at least initially, to provide a coordinated welfare and recovery response, drawing together necessary agencies for the emergency period. This is particularly important as different groups of helpers may converge on those affected either overwhelming them, or competing for them, with risk of negative consequences. The appointment of disaster relief workers, often from social work, welfare or psychology backgrounds, to provide a single point of contact and follow-up, is one solution. This person is meant to provide both practical assistance and necessary counselling, and most achieve this in supportive and valuable ways. However, it is sometimes difficult to 'fit in' counselling with the multitude of practical tasks yet essential that it be provided as necessary. There is also often unfortunately a reluctance to recognise, and refer on to mental health specialists, people suffering from psychological problems or psychiatric disorders after the disaster. It is essential that

such referral is made and made in a supportive manner, otherwise there may be undue and prolonged suffering for those affected.

Care for serious mental health problems

As noted earlier, serious problems may arise for some people after a disaster, especially if there have been particularly horrific experiences. Man-made` disasters may be more likely to lead to such difficulties, particularly if human malevolence has contributed.

Who needs more specialised support?

Specialist referral is necessary in some instances and should be carried out supportively. The problems outlined previously, or indications as below, are times for such referral

- **Extreme agitation**, particularly if it leads to actions that are life-threatening to the self or others.
- **Prolonged disaster syndrome** beyond the first couple of days.
- **Overt psychiatric disturbance** requiring care in its own right, for example, 'psychotic' decompensation where the affected person appears out of touch with reality and perhaps even responding to hallucinations or delusions. Fortunately this is rare but may occur.
- **Prolonged denial of reality**. Some shutting out of what has happened is natural initially but the person who continues, for example, to talk about somebody killed in a disaster as if he or she were still alive is likely to need specialist care.
- Persons distressed by **overwhelming bouts of anxiety**, dread, or panic when the danger has long since passed. Some panic is natural in the beginning, but when this does not gradually fade and lessen in intensity as the weeks and months progress, then specialised assistance is probably necessary.
- Although some **depression** is very likely in the aftermath of disaster a picture of severe depression, accompanied by hopelessness, unremitting despair and a loss of belief in any worthwhile future indicates a severe response. When in addition self-esteem is low, sleep severely impaired, there is marked weight loss and loss of interest in the world, and a general slowing down of all activities, then a depressive illness should be suspected and specialist assistance urgently sought.
- Although **suicide** is by no means common after a disaster, one should be alert to the possibility that feelings of hopelessness may be associated with this level of despair. Similarly a bereaved person preoccupied with thoughts of reunion with someone who has died in the disaster should be of concern.
- **Body complaints**, particularly mild, ill-defined and chronic complaints such as listlessness and headache, often accompanied by irritability and sleep disturbance, may reflect chronic, hidden and unresolved psychological distress that requires assessment overt psychiatric disorder, or risk developing physical W-health.
- **Disturbed interpersonal relationships** appear as a severe and prolonged disturbance of the capacity for interpersonal relationships (for instance in family or marital breakdown, rejection, or the formation of only transient relationships). In this situation, specialist assistance may be required.

- **Post traumatic stress disorder.** Symptoms of prolonged arousal, re-experiencing and numbing are also indicators of unresolved psychological distress in the form of post traumatic stress disorder. In the early days and weeks, sometimes even months, nightmares often occur for those who have been in any way involved. These may be of particular scenes of the disaster and the person may wake up, re-experiencing repeatedly the horror and the terror, often sweating or cold and shaking. Flashbacks of similar memories may also recur during the day or with reminders of the disaster. Startle reactions, irritability, difficulties concentrating, problems in personal relationships, difficulties with work, numbing and withdrawal may also be indications that post traumatic stress disorder is developing or is present. Post traumatic stress disorder is a serious and disabling condition and often becomes chronic unless treated early in its course and with the most effective form of treatment. People with such indicators should be referred to a psychiatrist for specialised assessment and care. Medication may be a necessary part of treatment, as may in depth counselling or behaviour therapy, or other techniques. Furthermore, people with this condition are at increased risk of other psychiatric problems such as severe depression or alcohol and other drug problems and thus may develop a series of chronic conditions needing care.
- **Alcohol or medication abuse** may be another symptom of the person's attempts to deal with unresolved psychological distress related to the disaster experience. Many attempt to shut out or deaden painful experiences in this way, but such coping devices usually only lead to further difficulties. If this cycle cannot be broken by the support being provided, specialist referral is suggested.

Referral to mental health specialists and psychiatrists

When reactions as noted above are unduly severe, or continue unabated, and disrupt the individual's personal functioning and life, then it is essential that they are referred for specialised assessment and care. Often they will need to be assessed and treated by a psychiatrist, especially when problems are severe. There is sometimes a reluctance to refer people on to such specialists, for fear of upsetting them. The evidence is however that many people who could be helped, do not have their problems recognised, and suffer unnecessarily and in a prolonged way, from mental disorders which could be rapidly and effectively treated. Thus it is important, where problems persist, and the person does not respond, that the individual is supportively referred for appropriate care.

Conclusions

Much has been learnt in the past decade about disasters, their outcomes and their management. Appropriate training in mental health aspects of disaster management should be part of all disaster plans, and mental health workers should be trained to contribute appropriately. Much can be done to prevent adverse psychological and social outcomes if the disaster is managed appropriately. Australian workers have contributed substantially to the understanding and management of disasters, and the readings listed below note some of their work in this field. For those who seek to extend their knowledge, this following reference may be helpful.

RESEARCH
RECOMMENDED

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