



Helping Survivors in the Wake of Disaster

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What are normal stress reactions in the wake of disaster?

Most disaster survivors (children and adults as well as disaster rescue or relief workers) experience normal stress reactions after a traumatic event. These reactions may last for several days or even a few weeks and may include:

- Emotional reactions: shock; fear; grief; anger; guilt; shame; feeling helpless or hopeless; feeling numb; feeling empty; diminished ability to feel interest, pleasure, or love
- Cognitive reactions: confusion, disorientation, indecisiveness, worry, shortened attention span, difficulty concentrating, memory loss, unwanted memories, self-blame
- Physical reactions: tension, fatigue, edginess, insomnia, bodily aches or pain, startling easily, racing heartbeat, nausea, change in appetite, change in sex drive
- Interpersonal reactions: distrust, conflict, withdrawal, work problems, school problems, irritability, loss of intimacy, being over-controlling, feeling rejected or abandoned

What are some more severe reactions to a disaster?

Studies show that as many as one in three disaster survivors have severe stress symptoms that put them at risk for lasting Posttraumatic Stress Disorder (PTSD). Symptoms may include:

- Dissociation (depersonalization, derealization, fugue, amnesia)
- Intrusive reexperiencing (terrifying memories, nightmares, or flashbacks)
- Extreme emotional numbing (completely unable to feel emotion, as if empty)
- Extreme attempts to avoid disturbing memories (such as through substance use)
- Hyper-arousal (panic attacks, rage, extreme irritability, intense agitation)
- Severe anxiety (debilitating worry, extreme helplessness, compulsions or obsessions)
- Severe depression (loss of the ability to feel hope, pleasure, or interest; feeling worthless)

What aspects of disaster are especially traumatizing?

Certain aspects of disaster are particularly likely to be traumatic. The following are likely to put survivors at risk for severe stress symptoms and lasting PTSD if the survivor directly experiences them or witnesses them:

- Life threatening danger or physical harm (especially to children)
- Exposure to gruesome death, bodily injury, or dead or maimed bodies
- Extreme environmental or human violence or destruction
- Loss of home, valued possessions, neighborhood, or community
- Loss of communication with or support from close relations
- Intense emotional demands (e.g., rescue personnel and caregivers searching for possibly dying survivors, or interacting with bereaved family members)
- Extreme fatigue, weather exposure, hunger, sleep deprivation
- Extended exposure to danger, loss, emotional/physical strain
- Exposure to toxic contamination (e.g., gas or fumes, chemicals, radioactivity)

Which individuals are at risk for severe stress responses?

Some individuals have a higher than typical risk for severe stress symptoms and lasting PTSD, including those with a history of:

- Exposure to other traumas (e.g., accidents, abuse, assault, combat, rescue work)
- Chronic medical illness or psychological disorders
- Chronic poverty, homelessness, unemployment, or discrimination
- Recent or subsequent major life stressors or emotional strain (e.g., single parenting)

Disaster stress may revive memories of prior trauma and may intensify preexisting social, economic, spiritual, psychological, or medical problems.

What are the priorities for helping disaster survivors?

Helping disaster survivors, family members, and emergency rescue or disaster relief personnel requires preparation, sensitivity, assertiveness, flexibility, and common sense.

- The first priority is to be a team player by respecting and working through the site chain of command. Being a team player also means pitching in to provide basic care and comfort to survivors and workers.
- A close second priority is to make personal contact in a genuine way with survivors and rescue workers. Listen; don't give advice. Ask the survivors how they and their children are doing and find out what you can do to help. If they need it, provide them with food, beverages, practical supplies (e.g., clothes, blankets, sunscreen, magazines, writing implements, telephone), and a comfortable place to sit.

- A third priority is to help them "defuse" by encouraging them to tell their story. Ask: "Have you ever been through anything like this before?" "How's it going finding a place to stay and getting the assistance you need?" "Is there anyone I can help you get in touch with?" "What do you find yourself remembering most since this all happened?" "Where were you when this started?" "What are your top three main concerns for the next few hours or days?"
- A fourth priority is to carefully assess the risk factors and symptomatic problems for PTSD or other health problems. Identify and set up referrals for the persons or families most likely to be in need of further care.

What are the goals of mental-health providers in response to a disaster?

The goals of on-site mental-health care in the wake of disaster are: *

PROTECT:

Help preserve survivors' and workers' safety, privacy, health, and self-esteem.

DIRECT:

Get people where they belong; help them to organize, prioritize, and plan.

CONNECT:

Help people communicate supportively with family, peers, and service providers.

DETECT:

Screen, triage, and provide crisis care to those at-risk for severe problems.

SELECT:

Refer people to health, spiritual, mental-health, social, and financial services.

VALIDATE:

Use formal and informal educational opportunities to affirm the normalcy and value of each person's reactions, concerns, ways of coping, and goals for the future.

What are the recommended interventions in the wake of a disaster?

- People have their own pace for processing trauma. It is important to convey to them that they should listen to and honor their own inner pace.

- People should be encouraged to use natural supports and to talk with friends, family, and co-workers - at their own pace. They should follow their natural inclinations with regard to how much and with whom they talk.
- If someone wants to speak with a professional in the immediate aftermath period, it would be helpful to:
 - Listen actively and supportively, but do not probe for details and emotional responses. Let the person say what they feel comfortable saying without pushing for more.
 - Validate normal, natural recovery.

Conclusions drawn from outcome studies of Psychological Debriefing (PD) are mixed. Overall, the conclusions do not confirm the efficacy of a one-session intervention shortly after the trauma. Psychological Debriefing does not necessarily decrease psychological disturbances after a trauma. Some studies found that, in the long run, a single session of psychological debriefing may hinder natural recovery. Accordingly, we do not recommend intervention in this initial aftermath period. If people do present to clinics or counselors requesting help, single-session contact should be avoided. In these instances people should be scheduled for 2-3 visits over 2-6 weeks.

- For those who have previously experienced traumatic events, subsequent traumatic experiences may stir up memories and exacerbate symptoms related to previous traumas. Thus, some people will feel like the most recent trauma is opening old wounds. These symptoms should also be normalized and are likely to abate with time. It may be helpful to ask people what strategies they have successfully used in the past to deal with trauma reactions, and encourage them to continue using these techniques.
- Individuals who continue to experience severe distress that interferes with normal functioning after three months are at higher risk for continued problems. These individuals should be referred for appropriate treatment.
- The construct "Protect, Direct, Connect, Select" was developed by Diane Myers, unpublished manuscript.