Mass Disasters and Psychosocial Support: Resources

Compiled by Kelly O'Donnell 2.05

We know the recent tsunami story well, with its disturbing images of destructive mounds of ocean, bloated bodies, and human misery. A massive earthquake of magnitude 9.0 occurred off the west coast of Northern Sumatra on 26 December 2004 at 00:58 hours GMT. Another earthquake of magnitude 7.3 occurred 81 kilometres west of Rulo Kunji in the Nicobar Islands. These two earthquakes triggered tsunamis. Aftershocks were reported frequently in this region. Well over 150,000 people were killed. Many are missing. Those countries most affected were Indonesia and Sri Lanka, as well as Thailand, India and eight other nations.

"This tsunami is not the biggest recorded in history, but the effects may be the biggest ever because many more people live in exposed areas than ever before…" (Jan England Emergency Relief Coordinator, United Nations OCHA). Imagine what the situation would have been like if something like the Krakatoa volcanic explosions of 1883, off the coast of Java and Sumatra, happened again—with its 40 meter (130 foot) tsunami! The response with financial help to rebuild has also has been unprecedented with over five billion dollars pledged from public and private sources.

Mass disaster situations create massive wounds, and many are less visible, emotional wounds. Empowering communities to help themselves is key to seeing people become active survivors rather than passive victims. Consider these core community-based principles, in the aftermath of mass disasters: Stay busy and help others, to help stay sane; establish routine and a schedule for a greater sense of control; attend to physical needs and medical care to prevent disease and epidemics; control looting and human trafficking; listen and just be there for others; use local capacity and re-establish social structures for giving and receiving help.

Many of us in the mission and member care communities have been involved in helping and consulting, providing different types of what the humanitarian sector calls "psychosocial care" to both relief workers and survivors. And very importantly, our prayers have gone out as the world joins together, for the long-haul, to help rebuild families and communities.

In the midst of the initial responses, several core resources were circulated by MemCa to the mission and member care community. Here is a summary of some of the main ones. We encourage you to explore these resources, with a view towards how you can be further equipped to help survivors and relief workers involved in the current and future critical events—including natural, technological, and human-made disasters.

- There are several core handouts on crisis/trauma care principles for helping individuals at the end of this two page introduction.

- Mental Heath Workers Without Border offers a free handbook to download on how relief workers can provide community-based trauma care

www.mhwwb.org

- International Federation of the Red Cross offers three free and very helpful publications, available to download at: www.ifrc.org

a. A short booklet for workers called "*Managing Stress in the Field*" (English Spanish, French)
b. *Best Practices for Psychosocial Support* includes brief case summaries illustrating the psychosocial support offered in several humanitarian disasters)
c. *Community-Based Psychological Support* is a training manual that overviews six topics, providing key principles for understanding and helping in communities that have experienced extreme stressors
(in the "search" area of the web site, type in "psychosocial support best practices" to get these publications, and for the last one, click on the *Best Practices for Psychosocial Support* publication and in the column on the right click on the term "training manual"

- World Health Organisation gives regular updates and information on a variety of health-related issues and programmes
www.who.org

- Centers for Disease Control has good information on public health issues and materials related to disasters. The materials on "Health Information for Humanitarian Workers" and "Traumatic Incident Stress" are good.
www.cdc.gov

- Office for the Coordination of Humanitarian Assistance (OCHA) is the United Nations body to help joint efforts in times of human and natural disasters. See the material in the Future Directions section of this *Briefing*.
www.opchaonline.un.org

- Reuters Alertnet service provides updated information on crisis areas in the world www.alertnet.org

- Aid Workers Network links international relief and development staff to share support, ideas, and best practice; lots of good material on life as an aid worker
www.aidworkers.net

- Humanitarian Practice Group has produced a briefing note covering some of the humanitarian aspects of the Indian Ocean catastrophe. It provides a series of links to relevant papers, websites ,and other sources, including research conducted by UK's Overseas Development Institute. www.odi.org.uk

- National Center for PTSD is a gold mine of material and helps on crisis care and PTSD. Articles, research summaries, handouts, and information for both the public and health care professionals.
www.ncptsd.org

- International Society for Trauma and Stress Studies has four short pieces linked to its home page on mass trauma, helping children, the indirect effects of trauma etc.; also conference and training information
www.istss.org

Health Briefing: After A Disaster

Ruth Fowke, Interhealth, London (*www.interhealth.org.uk)*

You have been through a very distressing time and your experience is very personal to you. We want you to know that you are not alone in your anguish, and that help is available. It may help you to know what has been gleaned from survivors of other traumatic situations.

HEALING comes through expressing your thoughts, feelings and reactions over time. **IT IS NOT ACHIEVED** by allowing them out **ONCE** and then locking them away again. **Allowing your feelings expression will not lead to loss of control.** Bottling up your feelings may lead to problems later on. It is **NORMAL** to experience some or all of the following which will vary in intensity and intrusiveness, and slowly fade over time.

*Numbness. The events may seem unreal, like a very bad dream which you cannot shake off.

*Weariness, lack of energy, restless activity, disturbed sleep, nightmares.

*Irritability, poor memory and concentration, lack of interest.

*Palpitations, nausea, shakes and muscle tension.

*Change in appetite, sexual interest, menstruation.

*Disturbed relationships, unaccustomed conflict.

*Fear: a) of breaking down or losing control; b) of being left alone, or leaving loved ones; c) of almost anything.

*Grief: a) for deaths. Feelings about losses earlier in your life may reawaken; b) for other losses, sometimes trivial by comparison.

*Shame: a) for your reactions; at the time, and now; b)for needing others.
Guilt: a) for things not done, for 'wrong' decisions made; b) for relationships left strained; good-byes not said; c) for leaving, especially leaving others who are still suffering; d) for having so much; e) for surviving.

*Anger: a) at the atrocities, injustice and senselessness of it all; b) at the trivia preoccupying people at home; c) at the materialism, plenty and indifference of friends; d) at God for not stopping the disaster.

*Feeling in limbo, not knowing what is happening, who's alive or dead, whether or not you'll ever return. Just not knowing. Memories and feelings return at unexpected and inconvenient times, and can be overwhelming.

CHILDREN

Children experience similar feelings which they may express through changed behaviour rather than words. They may become unusually destructive or aggressive in their normal play and relationships, and may need to invent new games to act out their fears and experiences. Some become withdrawn, quiet and uncommunicative. Some blame themselves (however irrational this may seem) and behave in a way likely to bring the punishment they feel they 'deserve.'

*Children may become disinterested in normal pursuits, lacking in energy and concentration, or become hyperactive.
*Tummy aches and headaches are common, as is a return to an earlier pattern of behaviour such as clinging, crying, bedwetting. They are likely to be extra sensitive to correction or criticism.
*Bad dreams are common. Hear them out if they are able to talk about the dream, and/or encourage them to draw the scary dream in order to help defuse it.

*Let them talk about their experiences, memories and feelings. Encourage expression through drawing and games.
*Let them hear you discuss your feelings, thoughts, reactions and plans but do be sensitive and guard them against over-exposure. Even though they may seem to be absorbed in play they will pick up your feelings as you talk on the phone or in person.
*They will need more hugs, cuddles, reassurance and comfort than is normal for them for a long time to come. These should be given within the security of clear boundaries and accustomed firmness. Indulgence and 'spoiling' because they are upset will not help.
*Encourage their return to school, play with peers and other normal activities as soon as possible.
*Be encouraged yourself that, given the understanding and help described above, children are enormously resilient.

PROFESSIONAL HELP
Professional help should be sought if after one month you are:
1. Persistently re-experiencing the traumas in any of these ways:
   a) Distressing, recurrent and intrusive recollections of events.
   b) Suddenly acting or feeling as though the event is now happening again.
   c) Recurrent distressing dreams of the events.
   d) Intense distress at anything that resembles some aspect of the events.

2 Persistently avoiding reminders of the trauma, or numbing your general responsiveness in more than one of these ways:
   a) Avoiding associated thoughts, feelings, activities and people.
   b) Inability to recall important aspects of events.
   c) Consistently feeling distant, detached or estranged from people.
   d) Consistently lacking interest in usual activities.

3 Persistently aroused, indicated by two or more **NEW** symptoms such as:
   a) Difficulty falling, or staying asleep.
   b) Difficulty in concentration.
   c) Irritability, or outbursts of anger.
   d) Persistently heightened watchfulness.
   e) Exaggerated startle response.
   f) Sweating whenever there's symbolic or actual reminder of the trauma.

NB: Post Traumatic Stress Disorder as described above can develop at a much later date, sometimes years, after the trauma, and even following a totally symptom free period of successful life and relationships. If this does happen to you don't hesitate to arrange to talk it through with one of the InterHealth staff [or mental health/medical professionals] who are there to help you. **EFFECTIVE HELP IS AVAILABLE** : do not suffer on your own.

Finally a word of warning. **AVOID** increasing your intake of alcohol, and resorting to non-prescribed or 'recreational' drugs. They prevent your readjustment. Far better to talk your experience through with friends, and with those professionally qualified to help.

BELIEFS ASSOCIATED WITH RESOLUTION OF CRISIS
Mobile Member Care Team (MMCT www.mmct.org)

Beliefs Controlled By Fear
The world is dangerous, hostile, and/or rejecting
People intend harm for me
God is a harsh and unmerciful God who will punish me and will not protect me
I am weak and vulnerable
In order to cope 1 must hide, run, and stay constantly alert
Scriptural example Numbers 13.27-33

Beliefs Controlled By Anger
The world is bad and ugly
People are dishonest, cruel, evil, untrustworthy
What has been done to me is unforgivable
God has betrayed me and abandoned me and I hate Him or do not believe He exists
I am a victim
I have been treated unfairly
In order to cope I must fight., attack and be strong and defensive. I must not show any weakness or vulnerability.
Scriptural example. Jonah 4

Beliefs Controlled By Sadness
The world is an unkind place that has nothing to offer me
There’s no point in being involved with others because I will lose them too
I can never be happy again
God is distant and does not care for me
I am despicable and unlovable
1 don’t really need anybody else
In order to cope I must depend only on myself and keep distant from others
Scriptural example: I Kings 19:1-10

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A PERSON’S INNER AND OUTER WORLDS HAVE CHANGED:

Am I am safe?

Are others safe?

Is the world safe?

Is the future is safe?

Is God safe?

WAYS TO COPE AFTER A TRAUMA

MMCT (www.mmct.org)

There is no one right way to cope. Each person has unique strengths and vulnerabilities. The key is to come up with a plan that will give God room to bring healing to your wound.

DO:

Relax and rest
Eat nutritiously (Avoid sugar)
Exercise
Get more than enough sleep
Talk about what happened (to God and others)
Write about what happened (journaling, letters, e-mails)
Laugh when you can
Set small goals
Keep some sort of routine
If safe, stay in familiar environment
Spend time with those who are supportive and helpful
Cry if you can
Pray and reflect in the Word
Sing or listen to music
Educate yourself about traumatic reactions
Anticipate difficult times to come
Search and find perspective and meaning in the event
Ask for help

DON'T:

Make major decisions
Set up an active travel or speaking schedule
Drink alcohol
Drink caffeinated drinks
Take sedating drugs (i.e., valium, sleeping pills)
Talk publicly about sensitive details soon after trauma
Make broad generalizations about yourself, future, others

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Coping Suggestions

Los Angeles County Department of Mental Health

* Give yourself permission and TIME to grieve.
* Focus on your strengths and coping skills.
* Ask for support and help from your family, friends, church or other community resources. Join or develop support groups.
* Redefine your priorities and focus your energy and resources on those priorities.
* Set small realistic goals to help tackle obstacles. For example, re-establish daily routines for yourself and your family.
* Clarify feelings and assumptions about your partner. Remember that men and women react differently. Women tend to be caretakers and put others first. Men have difficulty acknowledging and expressing feelings of helplessness and sadness and believe in 'toughing it out'.
* Eat healthy meals and exercise.
* Get enough rest to increase your reserve strength.
* Continue to educate yourself and family about normal reactions to disaster.
*Talk to your children. Be supportive. Set an example by expressing your feelings and showing problem solving skills in dealing with family problems.
• Remember that you are not alone.

SO, YOU'D LIKE TO HELP

MMCT (mmctintl@aol.com), 1999

Traumas are life changing events. The person you know and want to help will experience normal trauma responses that can be confusing and distressing (See the handout entitled Common Post-Trauma Reactions and Symptoms). Below you will find some guidelines for ways to support and help someone who has been through a trauma.

Be present and available

Invite them to share what happened without pressuring

Listen well without offering solutions, advice, or "quick fix"

Help them to establish routine, set small goals, and engage with others

Allow them to express fear and anger without judgement

Allow them to ask searching spiritual questions without feeling the need to provide an answer (you don't have it)

Educate yourself about traumatic reactions

Provide loving feedback when they are unrealistic, engaging in risky behaviours, making unwise decisions, or not taking care of themselves

Be a buffer between them and those who are merely curious or who cannot offer legitimate help (though it may be sincere)

Say things like "I went through something similar and I felt _______ How is it effecting you?" rather than "I know how you feel."

Instil hope, but don't give false promises

Avoid minimising or making light of what has happened

Finally, get support for yourself It is very stressful and difficult to see someone you care about hurting. You may hear about traumatic details that "stick" with you. Make sure that you have a good support and care plan for yourself.

HELPING CHILDREN IN THE MIDST OF CRISIS

These suggestions are taken from pp. 165-1 76 in Sojourners: The Family on the by Ruth J Rowen & Samuel F. Rowen (1990). Farmington, Michigan: Associates of Urbanus.

DON'T...

1. laugh and tell him it is silly to feel that way.
2. ignore it and just hope that it will go away.
3. fuss over the fear and give it lots of attention.
4. compare him with the younger brothers or sisters who may not be afraid.
5. instil fears in your child by telling them about all the tragedies which are happening in the world every day.
6. allow him to see your fears uncontrolled. Fears are mimicked.
7. display a great measure of apprehension in ways which would substantiate his or her fears.

DO...

1. listen intently to him when he casually mentions his fear or wants to talk about it.
2. accept the fact that the fears are real to him, even the imaginary ones. Allow him to have those feelings. The real and the imaginary need to be given the same consideration.
3. educate him regarding the situation. He may just be lacking complete information. Inform him of the situation if it has to do with schooling, friends, food, wild animals, etc. The unknown causes fear. Get books, slides, or films from the public library to help him understand.
4. comfort him and give him the support he needs during the period of these fears. Many of them will be overcome in a few weeks to several months; however, during this period, be extra sensitive to his feelings and give extra support.
5. teach him that God promises to be with us. Isaiah *43:5* says, Have no fear, for 1 am with you." The promise is that God will be with us at all times--even in difficult situations.
6. pray with your child regarding his fears.
7. give an extra measure of love and security during this time--even extra family time together would be beneficial.
8. look for positive experiences in relationship to that fear which will help it to dissipate. If his fear is of dogs, spend some time with a friend's dog that is gentle and friendly. Allow the child to begin playing with the dog at his own pace.
9. be sure both parents are agreed on how to handle the situation.
10. talk with other parents whose children may have experienced similar fears and find out how they handled it.
11. consult your paediatrician if necessary. He can help determine the best way to overcome certain fears which cause sleeping or eating disorders. Often bedwetting and nightmares are a result of fears deep-seated in children.
12. remember that all children develop fears while growing up and whether they develop into more serious problems or not, depends largely on how parents handle the situation.
13. debrief children after a crisis to let them tell their story and reveal any wrong assumptions, fears, personal blaming, etc. Parents can reframe the crisis for their children.

HEALTH BRIEFINGS

Advice for Societies Dealing with DISASTERS & TRAUMATIC INCIDENTS

Dr Ruth Fowke Consultant Psychiatrist (June 1994)

Disasters are sudden calamities outside normal experience involving groups of people, or whole communities.

Traumatic incidents are those which cause mental, emotional or physical injury to the individuals subjected to them. While outside daily experience they are not necessarily rare in the culture. Some examples are burglary, armed hold-up, road traffic accident, rape, mugging.

There are **FIVE PHASES to consider.**

1. **DEFUSING**. Immediate response to the crisis, first 24 hrs - hand holding
KEEP THE GROUP TOGETHER. Let people just be; shock and numbness are common, though some need to talk a lot or react with over activity.
Ensure:

a) Physical safety. In shock some may be unaware of common dangers such as moving traffic.

b) Basic needs. Maintain fluid intake, temperature and food.

c)Information re. incident needs to be accurate and adequate.
Include whereabouts/welfare of significant others separated from the group.
Keep individuals informed of what is being done, who has been informed and by whom, what the next steps in handling the situation are likely to be and who will take them.
Rumour and conjecture increase distress.

d) The vulnerable are considered. Children need to talk, question, move around, play, rest with familiar people. They should not be excluded from all discussion and sharing but may need to be protected from over exposure to parental talking through experiences.
The sick, convalescent, exhausted, recently bereaved, those who have been through previous traumas, have had past emotional distress or are separated by the disaster from their immediate family are more at risk than average.

NB: Crises are best handled by someone with whom people have already built up a relationship, using prearranged channels of communication with designated individuals.

2. **CONTINUING EMERGENCY**. Special care needed for workers welfare.

a) Regular group debriefing to share emotional and intellectual impact eg I 5 mins daily after the first 36 hrs.

b) Organised pairing--the ‘buddy’ system. So each can monitor the other for signs of continuing stress. Each must be able to insist the other leave the operational area for regular rood, fluid, rest exercise and relaxation, setting the time limit before return is allowed.

c) On return to UK allow sufficient RECOVERY TIME. Placement in a less stressful role or zone maybe beneficial for a period before further exposure to trauma.

3 **CRISIS DE-BRIEFING**. 36-72 hrs after event, or on return to UK.
Emphasis throughout is on normalisation of normal people after an abnormal experience, not on illness, weakness or abnormality.

A structured approach by an experienced, trained worker or workers is recommended. They do not need to have a pre-existing or on-going relationship with survivors.

Experience gathered by those dealing with survivors from such disasters as Lockerbie, Zeebrugge, Kegworth and the Gulf War suggest that an un-timed, unhurried, unrecorded and totally confidential group debriefing for ALL survivors as a matter of course is desirable. They can have the option to opt out, but must not be left to opt in. This debriefing needs to be arranged by the responsible employer or organisation and made available to all survivors together.

InterHealth are prepared to offer this service to client organisations.

4 **ASSESSMENT** not less than 6 weeks post event.
The purpose of this is to see how people are doing and to pick up IN ORDER TO REFER ON any who have progressed from the entirely normal post traumatic stress reaction and have developed post traumatic stress disorder.

This disorder may present after many months, even years, or well-being and coping. It does not *occur* at neatly timed intervals. Survivors need to know this, and that they are welcome to seek help at any stage that they need it. They must be informed who to contact, and how.

Routine assessment will probably be done by the line manager or personnel officer who will be looking for any evidence that the worker is stressed, irritable, edgy, humourless, dispirited, abusing alcohol or drugs, unduly tired, has lost interest or whose memory and concentration are impaired. These are signals that the worker needs to be encouraged to seek professional medical advice.

Such help is a normal part of the work of InerHealth.

5. **CONTINUING CARE**. 3-I8 months post event.
Follow-up should be pro-active and planned for survivors who remain in your organisation. It should not be left for an individual to seek help, many will not ask for it but may accept an opportunity to talk through the stages of readjustment if it is offered by phone or letter. One such offer at three months and two or three at six monthly intervals might be considered.

Again the line manager or personnel officer may be the designated person to undertake this care. They will be looking for any of the signs and symptoms outlined in 4 above, and will be on the lookout for undue anxiety, phobic behaviour, depression, personality change, preoccupation with or avoidance of the subject of the disaster.

It is important to remember that delayed post traumatic stress disorder may present for the first time after a lapse of many years since the disaster.

Effects of Disasters and Reactions to Disasters

The **effect of a disaster** is likely to be worse if it involves:

1. Personal loss or injury (including property; loss of function)
2. Traumatic sights e.g. mutilated bodies (especially children)
3. Human error was perceived to have caused the disaster
4. Threats to basic beliefs about the meaning of life; justice; God's existence etc
5. Having to make major decisions e.g. to deny medical care to those who are nearly dead in favour of those with a better prognosis; to save one person's life and leave another to die

NB: Contacts with traumatised survivors may lead to vicarious traumatisation., especially if you identify the survivor with a loved one ('it could have been my son'). High expectations (e.g. of helping many others survive) can lead to a sense of failure if not fulfilled., or guilt.

How someone **reacts to a traumatic event** is influenced by many factors, including:

1. Nature of the event
2. Degree of warning (and therefore preparation)
1. Coping style (active problem solving vs passive ete)
2. Prior mastery of a particular experience
3. Proximity to event
4. Concurrent stressors
5. Social support
6. Interpretation of the event, or your response to it (e.g. 'It was my fault'; 'I should have done more'; 'The world is random and meaningless'; 'The world is not safe'; 'God does not care'; 'I'm over-reacting', 'I'm going crazy'. See handouts 16 & 17 on beliefs and assumptions associated with trauma)
7. Whether it reminds them of something experienced previously
8. Training and preparation
9. A history of PTSD (increases vulnerability)
10. Media coverage (can increase anger and stress)

Principles of Crisis Intervention

A crisis is a time-limited event that demands a response or some sort of intervention. It is usually temporary, accompanied by mental or cognitive uncertainty, disequilibrium, perhaps even immobilizing some of the participants, causing paralysis of thought and will (Laura Mae Gardner, "Crisis Intervention in the Community", p. 137 in M. Care).

<u>Some Do's and Dont's for Helpers</u>

- 1. Stay as calm as possible. Distinguish (in your own mind) between minor problems vs. actual crises, and the severity and duration of these. Make sure the person is out of physical danger. Are drugs and any medication involved? Should you receive information or help from any one else to help assess and provide immediate care? Who else could be affected in this situation?
- 2. Be realistically supportive through active listening, reflecting back what you hear, and letting the person freely express both positive and negative feelings, without evaluation or criticism.
- 3. Normalise the person's reactions if possible--in as much as you sense it is a normal reaction to an abnormal situation. Reassure them that their feelings are manageable and they are not going crazy.
- 4. Help the person define the problem as they see it. Redefine it for them in manageable bits (if relevant--may need to just listen and offer support if someone has been traumatised significantly). Start with those aspects that can be worked on most directly or immediately. Is it possible to help the person see the problem in a new light? Explore with the person what they have done to get help and what has helped work through similar problems in the past. Define some alternative coping mechanisms. Pay attention to personal strengths. Reinforce with verbal feedback any appropriate coping mechanisms and helpful decisions he/she made in the current crisis.
- 5. Help the person make connections between other stressful events in their life and the present crisis/symptoms. What precipitated the problem? Are there any eating, sleeping, health, or weight changes/difficulties? Any previous psychiatric treatment? Describe to the person how you understand the problem and any connections between the current situation and patterns or previous events in his/her life. Any symbolic links with things in the past?
- 6. Let the person know the limits of confidentiality (usually danger to self, others, elder or child abuse, and in some settings any problem that significantly incapacitates the person or compromises the integrity of the organisation, such as moral failure, severe marital conflict, and major depression). Assess suicide or homicide potentiality by asking "SALSH" questions concerning: (specificity of any plan, availability of method chosen, lethality, significant others present to support the person, and history of such behaviour).
- 7. Remember that being directive at times (in addition to and following active listening) can be very supportive when someone is feeling out of control.
- 8. Help the person identify sources of support within his/her social world, and discuss how to use these.
- 9. Encourage the person to choose among the alternatives and to set manageable goals. Refocus on the person's responsibility for decisions and behaviour.
- 10. Direct the person to act on his/her choices. Set up a contract, role play future situations, and advise them of the consequences of not doing anything, if necessary.
- 11. Follow up by phone or visit within a few hours to a few days, depending on the severity of the crisis. Exchange names, phone numbers, and addresses.
- 12. Do not hesitate to consult with someone else or refer if necessary (respecting confidentiality).
- 13. Document what you do, and reasons for your decisions.
- 14. Debrief and reflect on what has just transpired, your own reactions, and how you handled the situation. Perhaps do this with a friend or on your own.
- 15. Include prayer, Scripture, and add the ingredients of your compassion and personal stability.

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