

**Maintaining the Balance:
A Strategic Support System
For Operations Personnel and Survivors**

NDMS Basic Training Course

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A CLEAR AND PRESENT DANGER

Compared with the significant concerns presented by death, destruction, injury, and the challenges of managing a disaster, psychological support services for operations personnel and survivors is a frequently neglected topic. Disregard for the psychological needs of operations personnel can hamper team cohesiveness as well as unit and individual functions under field conditions. Ultimately, skilled members of the team may suffer long-range consequences of such neglect. Post-traumatic stress disorder (PTSD) or other psychological reactions may evolve as a result of inadequately managing the stress responses caused by the intensity of disaster work. Unresolved psychological reactions produce further team dysfunction and fragmentation. People may depart prematurely from service or cease to perform to their maximum potential. For some, marital discord is a direct result of work at a disaster. Some people suffer from frustration, feelings of abandonment, anger, irritability, and survivor guilt. A few become so depressed that they contemplate suicide.

Overlooking the psychological needs of victims and survivors is equally devastating. Lack of psychological support complicates the management of cases in the field and impairs recovery in the months and years following a disaster. Victims and survivors then suffer two forms of trauma: the impact of the disastrous event itself and then “secondary traumatization” caused by the lack of care expressed by helpers when they fail to provide adequate psychological services.

Consider these findings from the field of traumatic stress research:

- 90% of adults in the United States will be exposed to a traumatic event during their lifetime (Breslau et al., 1998).

- About 40% of children and adolescents in the United States are exposed to trauma before their eighteenth birthday (Ford, Ruzek, and Niles, 1996).
- In 1997, there were 304 acts of international terrorism; one third of them were directed at targets in the United States.
- The risk of developing post-traumatic stress disorder (PTSD) among people exposed to traumatic events was 13% for females and 6% for males (Breslau et al., 1998).
- Suicide rates increase 62% in the first year after an earthquake; 31% in the first two years after a hurricane; and almost 14% in the four years after a flood (Krug et al., 1998).
- The prevalence of PTSD was 13% in a sample of suburban law enforcement officers (Robinson, Sigman, and Wilson, 1997).
- Law enforcement officers are 8.6 times more likely to die from suicide than from homicide and 3.1 times more likely to die from suicide than from accidental circumstances (Violanti, 1996).
- 62% of a sample clinical health care staff reported being exposed to traumatic stressors at work (Caldwell, 1992).
- The prevalence of PTSD ranged from 15% to 31% among urban firefighters, based on a traumatic exposure rate ranging from 85% to 91% (Beaton, Murphy, and Corneil, 1996).
- More than 15% of paramedic personnel experience PTSD in the course of their career (Ravenscroft, 1994).
- Symptoms of distress and PTSD correlate with exposure to traumatic stressors (Weiss et al., 1995; Corneil, 1993; Wee et al., 1999).

Obviously, there is a “clear and present danger” for the personnel who work at a disaster as well as for those who are victims or survivors of such an incident. It must be noted, however, that the needs of operations personnel are quite different from the needs of victims and survivors. Therefore, intervention programs must address the specific issues and needs of each group.

Effective steps must be taken to implement a crisis intervention program that includes a multi-component Critical Incident Stress Management (CISM) system for operations personnel. The old assumptions that operations personnel are exempt from being affected by traumatic events or that they have been trained to be unscathed by the destruction, death, and injuries around them have been disproved by research and experience.

Consideration must also be given to establishing effective linkages that enable victims to tap appropriate crisis intervention and mental health resources beyond the limited emergency interventions that can be provided under field conditions. Mental health programs must be tailored to assist victims and survivors of a disaster during the long-term recovery period that often follows.

This chapter focuses on the needs of operations personnel deployed to a disaster site. In addition, information is provided about the needs of victims and survivors as well. As appropriate, the two groups (operations personnel and victims/survivors) are addressed in separate sections to avoid confusion. Some crisis intervention tactics are

used specifically for operations personnel; others are likely to be useful only for victims and survivors; and some may be applied to both groups.

DISASTER PSYCHOLOGY

Psychology is the study of the human mind and the behaviors that originate in the mind. There are two broad branches in the field of psychology: 1) the study of normal behaviors and functions and 2) the study of abnormal behaviors and functions. Disaster psychology is a branch of psychology that focuses on the normal aspects of psychological reactions to disastrous events and seeks to refer people with abnormal conditions for additional intervention and psychotherapy.

The word “psychological” is built on two major *normal* human functions—intellect and emotion. Some people falsely attach an implication of “abnormality” to it. This is unfortunate because it produces confusion and reluctance on the part of disaster workers to discuss anything “psychological.” They fear they are expressing weakness or abnormality if psychological issues are discussed openly or if anyone suggests that a plan needs to be established to manage psychological issues in a disaster. Yet, failure to do so places operations personnel in a precarious position. First, they are far more vulnerable to significant abnormal reactions when no plan or program exists to appropriately deal with their normal psychological responses to a disaster. Second, their ability to adequately assist the victims and survivors of a disaster is severely impaired because they lack essential skills and protocols to intervene on behalf of the victims. Without knowledge of the typical responses of human beings to a highly stressful event such as a disaster, operations personnel are incapable of determining whether or not the reactions are in the “normal” or “abnormal” range. Appropriate intervention or referral is therefore impossible.

The issue of psychological response to disasters is further confused when people falsely assume that a stress reaction is an abnormal condition. In fact, a stress reaction to a disaster is typically a normal response of normal people to an abnormal event. If the stress reaction is handled properly, the vast majority of people can recover from the experience and may even grow stronger. If the stress reaction is mishandled, ignored, or misunderstood, it may later turn into post-traumatic stress disorder (PTSD), an abnormal condition. It should be clear, however, that a stress reaction ordinarily starts in the normal range of human behavior.

CRISIS INTERVENTION

Severe stress reactions, like those encountered in disasters, can be managed with Crisis Intervention (CI). CI is the active, temporary and supportive entry of into a person’s or group’s situation during a period of stress. CI is based on principles of human behavior from the field of psychology, but it is not therapy. The principles of CI are discussed below.

A specialized system of crisis intervention procedures for emergency workers and others in high-risk populations was formulated in the mid-1970s. It is called Critical Incident Stress Management (CISM), and it has a proven track record in preventing or mitigating significant stress reactions among crisis and disaster workers. The program is

particularly successful in assisting individuals and groups as they recover from the impact of traumatic stress.

The table below provides an overview of disaster psychology as it is applied in disaster situations. The field of disaster psychology ranges from preparing a community to cope with the stressors of a disaster through the crisis intervention phases associated with impact and immediate aftermath of the disaster. It also includes the treatment of powerful psychological reactions to the disaster such as PTSD long after the disaster is over. Most mental health professionals do not function in the disaster realm alone. They hold disaster psychology as a specialty, but they usually provide a number of other services, including general psychology or stress management services.

The functions marked with an asterisk must be provided by mental health professionals only. All other functions may be provided by peer support personnel, by mental health professionals, or by teams of peers support personnel and mental health professionals.

Disaster Psychology

Functions/Primary Tasks	Providers	Usual Recipients
Prevention Team/family/community preparation Policy development Planning Education Training	MHP/Peers	Team/family/victims
Crisis intervention Prepare, educate Stabilize situation Mitigate impact Motivate Problem solve Mobilization of resources Normalization of experience Restoration to function Referral	Peer/MHP	Victims/team members
Critical Incident Stress Management Support team members before, during, and after crisis events	Peers/MHP	Staff/team members
Follow-up services Team/family/survivors/community Post-incident education Community meetings Assessment and referral for PTSD treatment Lessons learned Preparation for next disaster	MHP/Peers	Team/victims/survivors

Emergency psychology/psychiatry* people Assessment Immediate care Medications Referral Hospitalization Follow-up	MHP	Severely disturbed
Re-establishment of local mental health system* Needs assessment Resource assessment Linking of available resources to NDMS Transfer of functions back to local resources	MHP	Community/survivors

MHP, mental health professional; peer, a person who is not a mental health professional but who has received special training in crisis intervention and CISM (examples: firefighters, paramedics, police officers, nurses, communication specialists, and other disaster response personnel); PTSD, post-traumatic stress disorder; NDMS, National Disaster Management System

**Must be provided by mental health professional*

Stages of a Disaster

Seven distinct phases can be identified in most disasters. These phases offer a psychological road map through a disaster for those who have to provide services. The phases can assist disaster workers in providing the right kind of emotional support services at the right time. The table below describes the stages of a disaster and the emotional reactions that are usually associated with them.

Disaster Stage	What is Happening	Emotional Reaction
1. Warning	Signs emerge; authorities warn	Denial, vague anxiety
2. Alarm	Situation imminent; avoidance	Anxiety, denial, fear
3. Impact	Event occurs, hiding, shelter	Shock, anxiety, fear, denial
4. Inventory	Evaluation of losses, resources	Shock, denial, anxiety, fear
5. Rescue	Citizens help each other, call for help	Relief, euphoria, disillusioned
6. Recovery	Danger down, basic services restored	Relief, apprehension
7. Reconstruction	Rebuilding lives and community	Anger, frustration, rage, grief, depression, apprehension, resentment, hope

Prevention Tactics

Operations Personnel. Prevention programs are the best investment any administration can make in its people. Prevention efforts pay huge dividends in actual field performance and subsequent unit recovery. Prevention may be looked upon as costly, but no organization that works in a disaster can afford the higher costs associated with not being prepared. Ill-prepared organizations are less effective in field operations;

they suffer the effects of impaired morale and are more vulnerable to guilt feelings and psychological distress in the aftermath of a disaster.

In the field of disaster psychology, prevention encompasses four important factors: 1) policy, 2) planning, 3) education, and 4) training. National Disaster Management System (NDMS) teams must be engaged in all of them; otherwise, the success of an entire disaster intervention program can be thrown into jeopardy.

Policy. NDMS teams should incorporate operations support programs into a standardized policy. Maintaining the healthy functions of a team should be paramount in the minds of administrators. It is inappropriate to leave decisions regarding the health and welfare of NDMS team members up to individual field commanders without the benefit of a carefully developed national policy. Experience indicates that when policy is absent, support services for operations personnel are either non-existent or haphazard in their applications.

It is recommended, therefore, that NDMS policy be stated clearly on issues relating to support of field teams. For example, all members of NDMS teams should be provided with at least several hours of education on traumatic stress and its impact on the provision of service in disaster work. Next, NDMS teams should incorporate CISM support services for team members while they are engaged in operations. This can be done by having CISM trained personnel as part of an NDMS team or by connecting with existing CISM teams to utilize their resources while in the midst of disaster operations. The section on CISM below details what a CISM program can do under field conditions. In addition, NDMS policy should require a minimal amount of post-deployment assessment and intervention for any NDMS team and its members. Members should commit to attend at least one group critical incident stress debriefing and one brief one-on-one follow-up session to ensure recovery after field operations cease.

Planning. Once a standard NDMS policy has been established, then, for mission readiness, it is necessary to plan a system of support services for operations personnel. Without a plan, the policy will be difficult to implement. It is important to know, for example, who is responsible for the acquisition of CISM resources to serve operations personnel. Are there plans to incorporate the services of one or more of the 400 CISM teams already functioning in the United States for the benefit of emergency personnel? Are there links to the International Critical Incident Stress Foundation (ICISF), a non-profit organization that trains and coordinates these teams? Are there people on NDMS teams who are cross-trained in CISM? Are protocols and procedures in place to effectively utilize CISM support? Have internal and external medical and psychological referral resources been identified for use if team members should encounter someone who needs more than what CISM services can accomplish?

Education. Every person who serves on an NDMS team should have at least the general information contained within this segment of the course. They should know what causes stress and how human beings generally react to it. It is helpful to know the common signs and symptoms of stress. Team members should also be aware of the differences between normal and abnormal reactions to stress. Stress is not generally harmful unless it becomes prolonged and/or intense. Flyers and handout material can be very helpful reminders of the normal responses of normal people to abnormal events. They can also be helpful in warning people of reactions that are disruptive to effective performance or to one's mental and physical health.

Training. NDMS team members tasked with the provision of specific crisis intervention services to their fellow team members or the general public should have considerably more information, training, and skills. Crisis intervention is a specialized field and it requires specialized training. No provider should be chosen for the task of providing crisis intervention services unless he or she has been properly trained. Course work should include but not be limited to the following:

- Assisting individuals in crisis
- Crisis intervention
- Basic CISM group processes
- Advanced CISM group processes
- CISM and disaster response

General Population. Preparing the general population for the emotional impact of a disaster is a very difficult task. Most people do not even consider the potential for a disaster to occur in their community. They assume that “the authorities” will take care of them should a disaster ever strike. Denial is the strongest emotional reaction in regard to the potential for a disastrous event in their lives. Disaster studies indicate that in 75% of the situations, warnings were generally ignored by the public, even in the face of impending impact.

Despite the general population’s tendency toward denial, emergency management personnel must make every effort to forewarn and prepare the community. Booklets, flyers, radio talk shows, television reports, fire station visits, magazine articles, and public lectures are a few methods that might be used to suggest at least minimal preparations. Emergency personnel and civic leaders should not fear initiating panic. Panic, an emotional state of over-arousal which may produce irrational and/or dangerous behavior such as running, hiding and irrational acts, is rare in disasters. It has occurred in only 10% of disasters, and then only when there was intense imminent danger and no visible means of escape.

The general population tends to listen more to messages that are delivered by well-known people in the community and by their friends and neighbors. They also listen when information is

- Repeated
- From multiple sources
- Consistent between the various sources
- Accurate and verifiable
- Uncomplicated
- Practical

Informative flyers that give people in distress practical information and guidelines for managing disaster-related stress can cut down the chaos that typically occurs in disasters. Such flyers should be stockpiled and ready for distribution when the need arises.

Principles of Crisis Intervention

Whether they are applied to the victims of a disaster or for the benefit of the personnel who are working at a disaster, the principles of crisis intervention provide useful guidelines for mitigating the psychological impact of a disaster. They also encourage a return to adaptive functions in both victims and operations personnel.

Crisis Definition. “Crisis” is a state of emotional turmoil produced by an excessive demand on an individual, a family, or a group. It has been called an upset of the “steady state.” It is also used to refer to a period of strain or emotional pain.

The best definition for use in this course segment is that a crisis is an acute disruption of the state of psychological balance. This disruption causes emotional distress and impairment in one’s usual abilities to cope emotionally or to function intellectually or physically. The normal, healthy coping mechanisms that normally help people deal with most situations do not work in the midst of crisis. The existence of a crisis reaction does not indicate weakness or psychopathology.

In summary, a crisis is an acute state of emotional distress that has the following characteristics:

- 1) Disruption of the psychological balance of an individual, a family, or a group
- 2) Failure of the usual coping mechanisms
- 3) Evidence of impairment

Nature of Crisis. A crisis is a crisis to the one who is in it. The person’s *perception* of the crisis holds the most meaning. You may not look at a situation as a crisis, but the person who is experiencing the situation may certainly feel that it is one.

Any person could experience a crisis at practically any time, since crisis situations frequently evolve without warning. No one is exempt from the experience of crisis.

People encounter two main types of crisis as they move through life: The first is “maturational.” These are crises that happen as people grow from childhood to adulthood. Reaching the age of reason, becoming a teenager, becoming a responsible adult, reaching middle age, and growing old may all present periods of emotional turmoil.

The second type of crisis is “situational.” These are crises associated with accidents, injury, illness, death, threat, loss, danger, violence, and disruption of normal life conditions. The reactions of human beings to these types of events depend on a wide range of factors, which include, but are not limited to, the following:

- Age of the person experiencing the crisis
- Nature of the crisis
- Length of exposure
- Intensity of the impact
- Mental attitude
- Amount of time between the warning (if there was one) and the crisis
- Pre-crisis preparation
- Availability of resources and support

- Ability to control the circumstances of the crisis
- Previous experiences with crisis management

Phases of Crises: Crises generally have five main phases:

1. Pre-crisis phase. This is the phase of stability and routine before the crisis develops. In some circumstances, early warning signs of an impending crisis appear and, if heeded, the crisis might be avoided.
2. Crisis phase. The event that causes the crisis state occurs. The crisis reaction is initiated and progresses through the next two phases.
3. Disorganization phase. The crisis reaction produces emotional pain, mental confusion, and disorganized attempts to adapt to the situation.
4. Reorganization phase. Attempts to deal with the situation become more organized, and some efforts are now being successful. More order and less confusion are apparent. People in the crisis are recovering gradually. The immediate dangers recede.
5. Post-crisis phase. Those who have worked through the crisis must now adjust to the aftermath of the experience. They may have to grieve their losses, rebuild their homes or businesses, and cope with long-range psychological effects. The post-crisis phase is the longest and may last months to years. Some crises leave permanent physical and emotional scars that never resolve entirely.

Crisis Intervention. Crisis intervention, or “emotional first aid,” is the active and temporary entry into a person, family, or group’s situation during a period of extreme distress. Its primary focus is prevention, not cure. It is not psychotherapy, and it is not a substitute for psychotherapy. People who need psychotherapy should be referred to competent mental health professionals.

Crisis intervention must be active to be effective. Some action must be taken quickly, or the crisis has the potential to deepen and cause more harm. Those who intervene in a crisis must understand that their intervention is only temporary. Most people are quite capable of managing their own situations, and they need only temporary assistance when a crisis arises. If the helpers do not realize the temporary nature of their interventions, they may foster unnecessary dependence in those who need their help. In addition, over-helping people tends to generate feelings of anger and resentment. People who provide help need to enter the situation, do what is necessary, and then withdraw from their supportive roles when the situation resolves or when sufficient appropriate resources have been organized and deployed.

Core Principles of Crisis Intervention. In 1917, during World War I, Dr. Thomas Salmon developed the seven core principles of crisis intervention. Those principles, which proved their value in the midst of war, form the foundation of all modern crisis intervention services. They principles are listed below:

1. Simplicity
2. Brevity

3. Innovation
4. Pragmatism
5. Proximity
6. Immediacy
7. Expectancy

Simple interventions work better than more complex interventions in the midst of crisis. Cognitive processes are disturbed in a crisis, and people cannot focus on complicated instructions or procedures.

Crisis intervention is provided in short bursts of time (unlike psychotherapy). Short interventions of just a few minutes can make a substantial difference. Sometimes a single contact of less than one hour is sufficient to improve a person's ability to cope with a crisis. At other times, a few contacts may be necessary. These are also brief in nature. If improvements are not achieved within a few days, referral for psychotherapy is generally the recommended course of action.

Crisis intervention requires innovation. The work is done in unstable, often volatile circumstances that are changing constantly. There is no one single technique that is applicable to each person, under every circumstance, with equal success. What works well in one circumstance will not work in others. Crisis workers must be willing to make changes to accommodate their interventions to fit the requirements of a particular set of circumstances.

Crisis intervention services have to be practical. It is not helpful to suggest that people engage in activities that have no realistic value. Telling people to get exercise to manage their stress is not helpful if they are very ill or seriously injured.

Crisis intervention services are typically provided reasonably close to the work environment, but in a safe zone. This helps rescue personnel feel connected to their usual work groups. They also feel less disabled since they are more likely to return to work if they have not been removed too far from the work zone.

Immediacy is key in crisis intervention. Waiting allows the crisis to spiral out of control and cause greater disturbance. One key to recovery is the speed of onset of help.

People who are helped to develop expectations that they will recover are far more prone to achieve a full recovery than are people who expect to fail in their efforts to recover. Debilitating conditions are more a condition of one's mental attitude than physical capacities.

Goals of Crisis Intervention. As "emotional first aid," crisis intervention has five major goals:

1. To stabilize the current situation
2. To mitigate the impact of the crisis on those exposed to it
3. To mobilize appropriate resources to assist those in the crisis state in their efforts to recover from the emotional turmoil
4. To normalize the crisis response
5. To assist people return to adaptive functions

In addition, the techniques of crisis intervention may be used to

1. Educate people about crisis and stress management
2. Motivate people to take control of the situation
3. Assist in problem solving
4. Assess people for additional assistance
5. Refer people who need more help

Crisis Intervention Techniques. Many specific crisis intervention techniques can be used to assist people in crisis. The following segments list some of these techniques and the order in which they are often applied:

Stage One

- a) Establish rapport – introduce helper; develop relationship
- b) Rapid assessment – determine the level of distress; identify problems
- c) Stabilize situation – take some control of the situation; protect person
- d) Contain situation – remove antagonists; set boundaries; avoid spread
- e) Lower stimuli – cut visual, auditory, and olfactory stimuli
- f) Reduce symptoms – calm the person; provide reassurance that help is there
- g) Lessen impact of event – be active, calm and in control; inform victim

Stage Two

- a) Active listening
- b) Emotional ventilation
- c) Reflect feelings
- d) Get the person to tell his or her story
- e) Reframe the experience
- f) Explore alternative solutions
- g) Assist person in returning to adaptive function
- h) Assist in resolving crisis
- i) Help the person develop a sense of cognitive mastery over the event
- j) Achieve recovery or refer the person to the next level of care

Steps in Managing a Crisis.

1. Make a flexible mental plan of how the intervention should go.
2. Introduce yourself and establish a positive relationship.
3. Assess – What is the main problem? What is the immediate cause of crisis?
4. Have the person tell his or her story. Ask questions. Listen carefully.
5. Allow feelings to be expressed. Validate the person's feelings.
6. Develop a list of possible alternatives and resources.
7. Pick the best possible alternative under the circumstances.
8. Develop an appropriate action plan to resolve the crisis.
9. Implement the plan immediately and ensure it is working.

10. Follow-up – Determine if the person has recovered or needs referral for additional care.

The Successful Crisis Plan. The most successful plans in crisis intervention have the following characteristics:

1. Focus on the immediate situation the person is facing
2. Carefully thought out by the crisis intervener
3. Practical
4. Short term
5. Immediately applicable
6. Developed with the cooperation of the person in the crisis state
7. Developed in light of the resources immediately available
8. Likely to produce at least some positive effect instantly
9. Developed in cooperation with other agencies
10. Contain a mechanism for follow-up or referral

Assisting Disaster Victims With Crisis Intervention

Disaster victims generally fall into one of three primary groups. They may be:

- Anxious and agitated
- Shocked, depressed and subdued
- Functioning adequately under the circumstances

The largest group is typically the adequately functioning group. Depending on the magnitude of the disaster, more or less 50% of disaster victims will appear to be doing “okay” for a short time during and even after the disaster. They may help rescue their own family members and friends and often assist other members of the community. It is not unusual in disasters to find these community members, who are actual victims of the disaster, working side by side with emergency service and other official disaster workers to clear debris and search for and rescue the wounded or recover the dead. Some are able to maintain a positive attitude and encourage others during the course of the disaster and for some time thereafter. Others, after a few hours or so, may begin to fatigue and then lapse into either the anxious and agitated or shocked and subdued categories.

People in the adequately functioning category usually suppress their own feelings of loss and distress until well after the disaster experience. While busy with the demands of a disaster, they are often distracted from their own issues and needs. Psychological recovery for some those in the adequately functioning group may be accelerated because they worked hard during the disaster and feel that they made valuable contributions to their community. They may develop a strong sense of control or mastery over the disaster experience. They may be quite proud of a new found inner strength that helped them to handle their exposure to the disaster. Keep in mind that although they are destructive forces, disasters can also be opportunities for enormous growth for some individuals.

On the other hand, some who are in the adequately functioning group of disaster victims might end up with an impaired recovery. They may regret that they did not do more to help their families or friends. They may have witnessed too much destruction to both human beings and to property. Their actions in a disaster may have masked their need to grieve their losses and focus on their own needs. When the overwhelming nature of the disaster finally becomes apparent to them, they suffer emotional breakdowns and long-term psychological distress. A disaster, like any crisis event, can be one person's destruction while simultaneously being the basis for another's growth.

A few suggestions may be useful for managing the adequately functioning victims.

1. Relieve them of their efforts to help out and rescue others as soon as reasonably possible. Remove them to rest areas where they can be medically evaluated. Many of these people have injuries but become so caught up in rescue efforts that they ignore their pain and continue to work. Reassurance and basic supportive care is very helpful for people in this victim category.
2. If it is not possible to completely remove them from the disaster site or if their help is useful to the official rescuers, adequately functioning victims should be assigned to lighter tasks in staging or treatment areas. Helping others, in some instances, helps to keep these victims from "falling apart."
3. Further evaluation and a wide range of support may be required for these victims. Do not be fooled by people in this group. Just because they have a positive attitude or were helpful to others does not mean that they do not have needs of their own. Some need help rebuilding homes and businesses. Others will need grief support or other forms of intervention.

Roughly 25% of disaster victims fall into each of the other two primary categories. Those in the anxious and agitated category display many fairly obvious signs and symptoms. They are in a state of emotional volatility and extreme anxiety. They are clearly distressed and let people around them know it. They may cry loudly, scream, wring their hands, faint, pace rapidly, run, and panic. Some express their anger, experience nausea, dizziness and mental confusion. Some may become hysterical and histrionic. They may, on occasion, wander about aimlessly or actually interfere with rescue efforts and focus entirely on their own needs. Unfortunately their obvious distress may cause others to become more upset. Hysteria tends to spread. Newly distressed victims will then increase their demands on operations personnel who are busy trying to mitigate danger and assist the critically wounded.

Here are some suggestions for managing the anxious, agitated and hysterical victims.

1. Remove them from the scene immediately.
2. Transport to a hospital or aid station for further evaluation.

3. Find a “buddy” who can stay with the highly anxious person and help to calm him or her.
4. Use a kind but firm tone of voice and give clear, direct and simple instructions and directives.
5. Avoid force or threats.
6. Restrain only if absolutely necessary for the safety of the disaster workers or for the person’s own safety.
7. Reassure the victims that they are safe and help is available or on the way.
8. Sedation is the last resort. It has been known to make matters worse in some victims.

Victims in the shocked and subdued category attract the least amount of attention. They are quiet, inactive, shocked and may wander aimlessly or sit and stare. They may be feeling terrorized and “frozen” in over-control. Victims in this group often feel dizzy, nauseous and thirsty. Low blood pressure is common along with shallow respirations and a rapid, weak pulse. Shaking and trembling is very common as is profuse sweating and pale, moist skin. They are frequently mentally confused and disoriented. They speak little and usually only report that they are stunned or numb.

It is wise to manage victims in the shocked and stunned group as if they were high priority medical cases. In fact they often are. The symptoms they display are those associated with shock in medical terms. Their physical systems are depressed and some may experience cardiac and respiratory problems. Shocked and subdued victims should be stabilized and transported first. Their physiological needs are greater than victims in other groups.

Some of these suggestions will help the shocked and subdued victims.

1. Immediate removal from the scene
2. Block the view of horrible sights; remove from hearing disturbing sounds; reduce exposure to unpleasant odors
3. Medical evaluation
4. Have the victim lie down or at least sit
5. Treat for shock
6. Keep the victim warm (not hot)
7. Assign a “buddy” to continue care for the victim
8. Avoid sedation. Remember, Physical systems are already depressed
9. Provide plenty of reassurance and encouragement
10. Provide accurate information and let them know the plan for their care

Crisis intervention in disasters is essential for the immediate care of the victims. It can make a real difference between a rapid and effective psychological recovery and a slow and ineffective recovery process. One of the goals of a crisis interventionist is to turn a victim into a survivor. In addition to the specific suggestions made for the victim categories above, there are numerous other crisis intervention tactics that can be helpful in disaster situations. All of the following

suggestions are based on the core crisis intervention principles noted earlier (innovation, pragmatism, brevity, simplicity, proximity, immediacy and positive expectancy).

Assess the situation. Crises are easier to manage if disaster workers know what is happening with the victim. Background information is helpful in determining the type and amount of assistance needed for the victims.

Call in resources. Once victim needs are apparent, call in the resources required or move the victim to the location where those resources can be found.

Stabilize the situation. Prevent further casualties (do not allow adequately functioning victims to become hysterical or shocked victims).

Sort the victims into categories for intervention purposes. Uninjured victims with no apparent medical complications should be evaluated with a medical priority system in mind. Shocked and subdued victims or highly anxious and agitated victims may, in fact, suffer physiological complications. Shocked victims are most in danger, followed by anxious victims and finally by those in the adequately functioning victims.

Keep victims with their natural groups. Family members should be grouped with other family members (unless there is extreme antagonism between them). Friends generally should be sheltered with their friends. Neighborhoods should be grouped with people from the same neighborhoods.

Assign a spokesperson. A primary NDMS spokesperson should be assigned to individuals or groups of survivors. This person provides the information updates to the assigned groups until those groups are moved to other areas for more definitive care and assistance.

Assist in victim identification. Family members and friends should never be allowed to view the dead in a temporary or permanent morgue without direct support from NDMS team members.

Develop a systematic information approach. People who come into the area seeking information on loved ones should be handled carefully. Accurate information should be provided regarding their loved ones or they should be told how and where they might obtain that information.

Do not rush people in a crisis. Allow people to say “goodbye” to their damaged homes or property before bulldozing. If the facilities are dangerous, then at least let them look from a safe perimeter.

Control the perimeter. Perimeter control personnel need to be firm, fair and professional. They should avoid being insensitive, heavy handed, bored or angry.

Limit exposure. Do not allow victims to see gory sights or be exposed to awful sounds or horrible odors.

Give bad news cautiously. If bad news regarding relatives or friends has to be given, it should be done gradually and gently. Let people know what they need to know, but do not dump it on them all at once or with an unconcerned attitude.

Provide security. Grieving relatives and friends need to be sheltered in a secure area away from the media. Insensitive interviews can cause great pain for disaster victims. Media should never be given access to victims without their permission. Likewise, bystanders should be kept at a distance from the victims.

Do not give false hope. Be supportive and encouraging, but never give false hope (“Do not worry, everything will be okay”).

Inform the families and friends. People involved in a crisis need a steady supply of accurate and up-to-date information. Accurate information tends to lower anxiety and allows people to make better decisions and take action that is in their own best interest.

Be honest. When victims or their families ask questions they want and deserve honest answers. Insensitivity and overloads of details should be avoided.

Check credentials. Not all mental health professionals are equally trained or experienced. A master’s degree or a doctorate does not mean that the mental health professional has training or experience in crisis intervention. Do not allow poorly trained or inexperienced mental health professionals to have access to the victims or their families. Poorly executed help may produce a greater negative impact than no help.

Notify appropriate others of victim status. Help the victims to notify their relatives in other areas of the country as to their status, health, safety and other pertinent information.

Assist the victims in any way possible. At times even simple tasks appear to be monumental for people in the midst of a crisis. NDMS team members should be prepared to assist distraught victims in anyway possible. Be innovative and creative and try to anticipate problems that might be encountered by the victims.

Be kind. Professionalism and kindness in whatever you do for the victims is essential. They will remember kindness for years to come if not for a lifetime. They will also remember insensitivity.

These suggestions will not substitute for a full crisis intervention course. When applied properly, however, they will go far toward the goals of stabilizing a crisis situation and mitigating the emotional impact of a disaster. They will also enhance a team member’s ability to identify resources for the victims, normalize the experience and restore people to adaptive function.

Critical Incident Stress Management: Taking Care of Our Own

Critical Incident Stress Management (CISM) is a comprehensive, systematic, and multi-component crisis intervention approach to the management of traumatic stress. The CISM system was developed in the mid 1970s and has been improved and upgraded since then. Today, CISM is the most widely utilized crisis intervention program in the world and the only one with substantial positive outcome research evidence to support its utilization in a wide range of crisis situations, including disasters.

CISM has wide applicability to many populations who are involved, in one way or another, in traumatic events. It is used to support people deployed to work at a disaster site—police officers, fire fighters, emergency medical services personnel, nurses, dispatchers, Red Cross workers, Federal Emergency Management Agency (FEMA) teams, military personnel, and NDMS personnel. CISM programs have likewise supported people who work in businesses and at industrial settings. During the past decade, CISM services have been employed in many school systems around the world. The system also has been utilized for community support purposes in numerous disasters. In this section, the emphasis is on NDMS team members and other emergency workers. That is, this section discusses how we can care for our own people and keep them healthy and functional during and after deployment to the scene of a disaster.

It is easier to understand how CISM is useful for NDMS team members if we understand what the CISM system is designed to do. This understanding can be based on an awareness of the meaning of the words that constitute the term. The word “critical” means a point of change or a turning point. It can also be used to imply something vital to the success or failure of a project or an operation. It also implies seriousness or a threatening condition. Sometimes the word is used in a darker sense, with the implication of something ominous. The word “incident” simply means an event, an occurrence, or a situation. A “critical incident” therefore is any event that produces considerable psychological disturbance in anyone who encounters it. It can also be defined as a significant event that has a sufficient amount of emotional power to overwhelm the coping abilities of the people involved.

The word “stress” means a state of physical, emotional and intellectual *arousal*, resulting in response to some significant demand on the person, family, or group. Stress is a normal condition of life. It can help us to be creative, to make discoveries, and to change our world. Stress can be a positive, driving force within us. When stress becomes prolonged or excessive, however, or when a combination of prolonged or excessive stress arises, it then becomes dangerous and destructive. Reactions to the stresses associated with experiencing a disaster typically start as normal but turn destructive in many cases because they become prolonged and excessive.

“Critical incident stress” is a *normal response of normal people to an abnormal event*. “Normal,” however, does not imply an absence of pain. A reaction to an experience can be normal but very uncomfortable and distressing. That is typically the case with Critical Incident Stress (CIS). It can cause people to experience mental

confusion, disruption in performance, and a heightened level of physical and psychological arousal.

Common Signs and Symptoms of CIS. The symptoms and signs of critical incident stress can be grouped in four main categories—cognitive, physical, emotional, and behavioral. They do not necessarily indicate a problem in and of themselves. These symptoms are to be expected in light of experiencing an overwhelming event such as a disaster. Any intense or prolonged symptoms, however, may indicate a need for medical or psychological evaluation. The symptoms and signs marked with an asterisk require immediate corrective action such as an immediate break from a task or medical evaluation and/or treatment

Physical

Chest pain*	Nausea
Difficulty breathing*	Upset stomach
High blood pressure*	Lip and hand tremors
Collapse from exhaustion*	Profuse sweating
Cardiac arrhythmias*	Chills
Severe shock*	Diarrhea
Excessive dehydration*	Rapid heart beat
Dizziness*	Muscle aches
Excessive vomiting*	Dry mouth
Blood in stool*	Vision problems
	Body shakes
	Fatigue

Cognitive

Decreased alertness to surroundings*	Mental confusion
Severe difficulties in making decisions*	Lowered attention span
Being hyper-alert*	Calculation difficulties
Generalized Mental Confusion*	Significant memory problems
Disorientation to person, place, or time*	Poor concentration
Serious disruptions in thinking*	Repetitive thoughts about the event
Problems in naming familiar items*	Distressing dreams
Problems recognizing familiar people*	Disruption in logical thinking
	Blaming someone

Emotional

Panic reactions*	Anticipatory anxiety
Shock-like state*	Denial
Phobic reaction*	Fear
General loss of emotional control*	Survivor guilt
Emotions that do not match the situation*	Uncertainty of feelings
Suicidal/homicidal feelings*	Depression
	Grief
	Feeling hopeless

Feeling overwhelmed
 Feeling lost
 Feeling abandoned
 Worried
 Wishing to hide
 Wishing to die
 Anger
 Feeling numb
 Identifying with the victims

Behavioral

Significant change in speech patterns*	Change in activity levels
Excessively angry outburst*	Withdrawal from others
Uncontrollable crying spells*	Suspiciousness
Anti-social acts (violence)*	Change in communication patterns
Extreme hyperactivity*	Change in interactions with others
	Increased or decreased food intake
	Increased smoking
	Increased alcohol intake
	Excessive humor
	Excessive silence
	Unusual behaviors
	Being hyper-alert

Post-Traumatic Stress Disorder. Most people recover from critical incident stress. In most cases, the stress reaction is relatively short in duration. Most people experience lessening symptoms within about a week of exposure to the incident. When stress is managed properly, people can recover quite well from the traumatic experience. In fact, a critical incident experience can be an opportunity for learning and growth.

If it is not resolved, however, critical incident stress has the potential to turn into post-traumatic stress disorder (PTSD), a pathologic or maladaptive result of an unresolved stress reaction. Some authors describe a condition of “universal vulnerability” in regard to PTSD. That is, anyone can develop PTSD if they are exposed to a horrific event. It is quite common in warfare and in disaster situations, but many other circumstances can cause it as well. It also occurs in cases of severe threat, violence, and exposure to gory sights.

The treatment of PTSD is beyond the capacities of crisis intervention programs. Its resolution requires therapy provided by competent mental health professionals. The goals of crisis interventions, such as those included in a CISM program, are assessment, stabilization, prevention, and referral, not therapy.

PTSD criteria. There are six primary criteria for the development of PTSD:

1. A traumatizing event
2. Intrusive symptoms (see, hear, taste, smell, feel it repeatedly or an inability to stop thinking of the event repeatedly)

3. Avoidance symptoms (avoid people, places, conversations, situations or reminders of the event)
4. Arousal symptoms (sleep disturbance, restlessness, lack of concentration, limited attention span)
5. Symptoms last longer than 30 days
6. Significant disruption in normal life pursuits (job, relationships, family, hobbies, activities)

Preventing PTSD. The fact that anyone can develop PTSD does not mean that we are helpless in the face of critical incidents that can cause it. We can all develop PTSD, but that does not mean we are destined to develop it. Many steps can be taken to prevent or mitigate PTSD. Pre-exposure knowledge of stress reactions coupled with a comprehensive Critical Incident Stress Management strategy as well as a set of effective CISM tactics can reduce the risks for both disaster operations personnel and victims.

CISM Teams. The provision of proper support to NDMS and other disaster workers requires a team approach. Fulfilling this task is beyond the capabilities of any one person. Different skills must be brought together to achieve the goals of CISM. Well-trained peer support personnel can provide most of the support services. Peers are people drawn from fire service, law enforcement, emergency medicine, communications, nursing, and other response organizations. They are trained in basic and advanced group crisis intervention procedures as well as in assisting individuals in crisis.

Mental health professionals also serve on the teams. They provide consultations for the peers and direct crisis intervention services to people who are distressed by their exposure to the disaster or by their work to alleviate human suffering.

Many teams include members of the clergy, who have received the same training as other team members. They know that a crisis situation is not a time to preach, but a time to listen and provide support. They focus on people while working with a CISM team and remain a good resource for spiritual issues when they arise.

CISM Tactics. CISM teams have a range of tactics built into their strategy. There is no one single tactic that will be applicable to all people under all circumstances, and no single tactic can be equally effective for all people. A CISM program is by nature a multi-component program.

A variety of CISM tactics are used before, during, and after a critical incident occurs. CISM is therefore involved in the preparation, mitigation, and response recovery aspects of crisis intervention and disaster management.

Core Components of CISM. A well-planned CISM program has seven primary components:

1. Pre-crisis preparation and education
2. a) Demobilization for operations personnel in large-scale incidents
b) Crisis management briefing for civilian populations
3. Defusing for small groups immediately after a traumatic event

4. Critical incident stress debriefing (CISD) a few days to a few weeks after the event
5. One-on-one crisis interventions
6. a) Family support services
b) Organizational advisement
7. Follow-up services and referrals for those who may need more help

CISM Interventions .

- a) Individual interventions
 - education
 - on-scene support
 - one-on-one crisis intervention
 - phone contacts
 - work site visits
 - contacts at home
 - referrals
- b) Group interventions
 - education
 - demobilization for large groups immediately after the first exposure to a disaster
 - defusing on the same day as the event
 - CISD, usually several days to a few weeks after an event
 - pre-deployment briefings
 - crisis management briefings for civilian populations
- c) Environmental interventions
 - family education
 - family crisis support
 - family death or injury notification
 - organizational support
 - advise command/supervisors
 - support good management practices
 - enhancement of unit cohesion and function

It is not the purpose of this chapter to provide training in specific CISM tactics. A full training course in CISM requires many hours. An overview of the components of a CISM system is sufficient here. More than 400 specially trained CISM teams in the United States regularly provide crisis support services to emergency personnel after a wide range of traumatic events. Their services are generally voluntary. Many members of those teams are also members of NDMS teams. They already know how to apply the specialized interventions mentioned above. Their training is far beyond what can be offered in this chapter. NDMS teams would be wise to link with local and regional CISM teams or with the International Critical Incident Stress Foundation (ICISF) to

provide direct services to NDMS team members or to supplement CISM services for NDMS teams that already have properly trained CISM team members.

Methods of Coping with Stress during NDMS Team Deployments

Be well informed. All available information about the deployment and the circumstances in the field should be provided to disaster response personnel. Frequent informative updates are also important. Be clear on the mission before setting out to complete it. The fewer surprises the situation contains, the better the chance that field personnel will be able to complete their mission without negative consequences.

Be realistic. Do not expect too much of yourself. Take on only the responsibilities that you can actually handle. Do not make unrealistic demands of others. Set achievable and practical goals. Expect to be successful in the things you do best.

Keep a positive attitude. Be cheerful and enthusiastic. Recognize that even in difficult circumstances, you are making a difference in the lives of others. Help others and ask for help when you need it. Avoid resenting others.

Do not take on personal blame for the incident. The situation occurred before the disaster response personnel were called out. Unrealistic guilt feelings will only sap one's energy and cause dysfunction in disaster work.

Manage your time. Plan your work. Break the work into "bite-sized" pieces. Checklists can be helpful. Allow some time for the unexpected, which, of course, is likely in a disaster.

Orient everyone to time. In a critical or highly stressful situation, a person's time frame is altered. People under pressure often lose track of time. They may not realize that many minutes or even hours have passed since they were assigned to a task. A lack of time awareness can lead to many problems such as overwork, failure to take breaks, missed meals, and excessive fatigue. As fatigue builds, physical and emotional efficiency decreases, and there is increased risk for mistakes and injuries. Supervisors should make sure that a time announcement is made every 20 to 30 minutes. The current time and the time elapsed since task assignment should be announced to work groups.

Take frequent breaks. Relax when you can. Get up; move around a bit. Stretch your muscles. Move away from the distressing stimuli. Talk to a colleague. Take a shower. Eat a snack or get a full meal if you are hungry. Drink non-alcoholic, non-caffeinated fluids. A half hour of personal down time now and then can keep you going for the long haul.

Allow work teams to rest. Several "rules of thumb" should be structured into standard operating procedures when people are involved in highly stressful work. For example, 2 hours of work, then 30 minutes of rest. The maximum time on any shift

should be 12 hours. The goal is a maximum of 12 hours on and at least 12 hours off in a 24-hour period.

Heed some cautions on resting. Do not rest work teams too frequently. For example, an arbitrary decision to rest teams every 20 minutes whether they need it or not is considered too frequent a rest schedule. The personnel will feel that their leaders are interfering with their work. Similarly, forcing rest breaks when teams are only minutes from completing a task causes team members to feel extremely frustrated, angry, and more stressed by the “rest break” than they would have felt if allowed to work until the task was completed. If supervisors do not set some example by resting themselves, they will find it harder to convince their workers that they need a break.

Rotate teams. Teams that normally work together should generally be assigned to tasks and rotated to other duties or to rest areas as a team. Structured rest breaks are more efficient when the rotation goes from intense work to lighter work and finally to rest. Likewise, the rotation into assignments is easier to adapt to when units move from rest to less intense tasks to more difficult tasks. The process from rest to light work to heavy work should be followed whenever possible. Final disengagement from a disaster deployment should, in most cases, be done as a unit. It is also best to keep work teams together with their regular leaders. People become more stressed when they feel they have either new leadership or an absence of leadership. They also typically trust their usual leaders and work best when led by them. These efforts support team cohesiveness.

Periodically assign teams to new assignments. Most NDMS team members have specialties and are required to perform within those specialties. It is helpful, however, to assign team members to brief out-of-specialty assignments (less stressful than their usual job) for short periods of time.

Avoid rigidity. Disaster work is difficult and changeable. Plans and procedures are very helpful, but they can cause stress if the rule becomes more important than the objectives and the work and the people doing the work. Too rigid an application of specific rules and regulations or procedures can cause irritability, frustration, anger, resentment, and a sense of unreality. The message, although not intended that way, may be implied that the supervisors care more about their procedures than they do about their people. Innovation and flexibility are important factors to keep NDMS teams from becoming stuck on procedural issues alone.

Be safety conscious. One area with no room for flexibility is safety. Always follow proven safe procedures. Safety procedures cut down on accidents, losses, mistakes, injuries, and deaths. Safety must be everyone’s concern, not just the concern of supervisors.

Eat well. Eat healthy. Cut sugars, fats, white breads starches and junk foods. Your system needs proteins, complex carbohydrates, vitamins, and minerals.

Re-hydrate yourself. Cool water is the best re-hydration agent. Fruit juices can also be helpful.

Avoid stimulants. Stimulants tend to drive the stress reaction along and intensify it. Caffeine is among the most serious offenders. It has its greatest stimulant effects on the amygdala and the hippocampus, the two parts of the brain that are most sensitive and reactive to the body's natural stress chemicals. The use of caffeinated products during a disaster may actually increase the potential for response personnel to develop post-traumatic stress disorder (PTSD) in the aftermath of the event.

Be cautious with soft drinks. Many people see soft drinks as "innocent"; however, they do present some hazards and should be used with some caution. They are loaded with sugar and most contain a great deal of phosphorus. Too much phosphorus disrupts the body's calcium/phosphorus balance. Disruption of that balance makes a person more vulnerable to the development of kidney stones and bone diseases. Diet soft drinks cause reactions such as elevated blood pressure in some people.

Avoid the use of alcohol. Alcohol interferes with and suppresses rapid eye movement (REM) sleep patterns and thus deprives the brain of nature's most effective mechanisms for processing the traumatic experiences of the past 48 hours. Alcohol should be avoided during the first week following the completion of a disaster deployment

Get some exercise each day. This exercise should not be related directly to the work one is doing at the disaster site. Disaster work can be strenuous, but it is not the kind of exercise that relieves tension and stress. So, take a walk, jog, swim, or do calisthenics. Do something physical to burn off the chemicals of stress in your body.

Shelter yourself. Human behavior and one's capacity to cope with stress can be changed significantly by exposure to heat, cold, altitude, and dehydration. Appropriate shelter is a high priority in a prolonged deployment, especially in foul weather conditions. Keep warm and dry between assignments.

Get at least 7 or 8 hours of sleep whenever possible. Aim for this amount of sleep at least 3 to 4 times per week. At least 6 hours of sleep a night is minimal for top-notch performance under field conditions. Certainly, no one should work with less than 4 hours sleep in a period of 24 hours, except in extreme emergencies. People who attempt to work regularly with less than 4 hours sleep in 24 hours are typically working in an impaired state.

Do not expect to be the same as always once you are in a disaster. During a disaster, you eat different foods, drink different water, and endure higher levels of tension than you would in everyday life. Your mind and your body will let you know that you are different. Pay attention to yourself and be prepared for a variety of adjustments. For example, your digestive system can be affected by stress. Many people experience an increase in bowel secretions when undergoing the stress of change. Those secretions may

lead to diarrhea and abdominal cramps. More rolls of toilet paper are used during a disaster than by the same number of people in a non-disaster gathering of equal duration. Menstrual cycles can also be disturbed by stress.

Refer the media. Just because a camera or a microphone is put in front of you does not mean that you have to talk to the media. Refer all media contacts to the NDMS team's spokesperson or public information officer.

Know the signs and symptoms of distress. The signs of stress are difficult to recognize in oneself but are easier to see in others. A key factor in recovery from stress is getting early supportive intervention. That is very difficult to achieve if one is unaware of the common signs and symptoms of stress.

Talk to a colleague when the pressure gets high. Just knowing that others have similar feelings can be reassuring. Some of your colleagues have had previous experiences and may be able to relate to your current circumstances. Opening up can do much to keep good people functioning in the field. If you are on the receiving end of someone else's ventilation, remember that listening is a powerful tool that can greatly assist your colleagues and help them stay healthy and balanced while under pressure. So, make time for others when they need to talk.

Connect with a CISM team and use their services. These teams can be invaluable during and after a disaster deployment and can be enormously instrumental in helping team members recover from the stresses of the disaster. There is strong evidence that stress symptoms are diminished and personnel return to normal duties in a mentally and physically healthy state when CISM services have been applied properly.

FOLLOW-UP SERVICES

It is easy to forget to follow-up after a disaster. With the exception of the actual disaster victims, most people want to put it all behind them and get back to their routine lives. In reality, however, a disaster changes people. They simply cannot turn off a switch and make it all go away. Some people may actually get stuck in the misery and the pain if appropriate follow-up steps are not taken.

The victims need many things: insurance services, loans, counseling, guidance, rebuilding, or relocating. No one individual, no matter how well trained or motivated, can ever keep up with all of the needs of the victims. Many agencies and organizations have to combine their efforts to return survivors and their communities to a reasonable degree of healthy function.

One of the follow-up services should focus on the psychological aspects of recovery. Most people look good on the outside but hurt terribly on the inside. Unless someone asks how they are really doing, they may not be identified as in need of additional psychological services. Most hurting people are unsure how to ask for psychological support, or they are simply too embarrassed to ask for help.

One of the ways to reach them is to offer community-based post-incident education programs and/or community meetings. These stress education programs often

tell people what they need to know about stress reactions that are not subsiding. The education helps them identify the problems they are encountering, and it points them toward appropriate resources that can help them recover.

Operations personnel can also benefit from a wide range of post-deployment services. They include, but should not be limited to, the following:

- Critical Incident Stress Debriefings
- Individual consultations
- Post-incident education programs
- Family support services
- Follow-up meetings
- Referrals for those who are having difficulty recovering
- Post-incident critiques to develop a list of lessons learned
- Preparation for the next deployment

Typically, by the time the final reports are written and the referrals for follow-up care are made, the role of crisis intervention diminishes. The role of crisis intervention services also diminishes when severe psychological disturbance is identified in either victims or, on rare occasions, in operations personnel. Additional psychological support services then become the domain of mental health practitioners.

Emergency Psychology/Psychiatry

During a disaster deployment, field workers may encounter survivors who are displaying signs or symptoms of severe psychiatric disturbance; acute psychiatric disturbances might include severe panic attacks that cannot be brought under control with crisis intervention skills. Another form of acute disturbance is psychomotor retardation. In this condition, people move extremely slowly and only with great effort. Under conditions of extreme stress, some victims develop amnesia and may be found wandering around aimlessly. The shock of the disaster could also initiate a shutdown of some bodily functions. Disaster workers may also encounter people who have not taken their prescribed medications for any number of reasons. Those people may be exhibiting psychiatric symptoms such as hallucinations, illusions, delusions, serious thought disorder, and significant behavioral change. In some cases, the stress of surviving a major disaster and losing family members or cherished property may trigger a psychotic reaction.

Preexisting psychiatric conditions are typically exacerbated by a disaster. Although some people show considerable psychological improvement in face of a disaster, a deterioration in thinking and behavior is the more likely scenario. Alcohol consumption and the use of drugs of abuse may increase after a disaster experience.

Some people may become violent or a considerable threat to themselves. Some are so severely disturbed that they become completely dysfunctional and unable to make decisions or take actions in their own best interest. In the face of danger, they may do nothing to care for themselves.

All of these people need emergency psychiatry. They need an assessment by competent mental health professionals (usually psychologists or psychiatrists). It is not

unusual for them to need to be contained or restrained in the field as well as to need medications to bring their behavior under control. Transfer to hospitals capable of managing psychiatric patients is indicated. Additional medications and psychotherapy may then be employed to help these people regain control and balance. Long-term psychiatric follow-up care is frequently required.

Re-Establishment of Local Mental Health Capabilities

A very real problem in disaster areas is that local mental capabilities are severely disrupted. Mental health professionals may have lost their office space if the buildings in which they worked were destroyed. Records may be lost or inaccessible. Staff may be coping with their own losses and unable to come to work. Some mental health professionals may have been killed or injured in the disaster. Others may have become homeless or may be suffering the loss of loved ones or close friends.

Many mental health professionals have little or no knowledge of how to assist members of their community, since they have not been trained in providing disaster mental health services. Another factor that demands serious consideration is that the client load after a disaster may far surpass the capacity of available mental health resources within a given community.

Crisis intervention teams may be helpful in the early stages of assessing community needs and in providing crisis intervention support as a stopgap measure until mental health resources can be mobilized, but they cannot replace trained mental health professionals who can provide psychotherapy and psychiatric treatment.

Once needs and resources have been assessed, temporary mental health resources must be brought into a community to supplement local resources. Then plans need to be drawn up to link resources coming from outside of the community with those still available within the community. Eventually a smooth transition of functions back to local mental health services must be worked out. All of these tasks can be daunting and should be performed by mental health professionals, who work in coordination with administrative personnel familiar with the organization and management of community psychological and psychiatric services.

CONCLUSION

This chapter tackles the complexities of a disaster psychology response to a catastrophe. It thoroughly covers the issues of crisis intervention and the tactics used within a critical incident stress management system. It identifies the common signs and symptoms of critical incident stress as well as the impact of post-traumatic stress disorder. Many helpful suggestions are presented toward maintaining the health and performance of operations personnel during and after a disaster deployment.

The best resources in any disaster are people. Utilization of the crisis intervention strategies and tactics outlined in this chapter can do much to ensure peak performance of NDMS teams and to maintain the mental and physical health of disaster workers. Many of the principles of crisis intervention and disaster psychology that are useful for emergency personnel can also enhance the services provided to the victims of a disaster.

This chapter provides many tools to diminish the clear and present danger that threatens the victims of disasters and the workers who help them.

ADDITIONAL INFORMATION

For additional information about CISM contact:

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