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PSYCHOSOCIAL INTERVENTIONS IN THE EARLY PHASES OF DISASTERS

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Interest in the emerging field of disaster psychology has significantly increased after such events as the Oklahoma City bombing and the September 11th (2001) terrorist attacks. Consequently, a massive response has ensued from clinicians seeking to provide mental health services to disaster victims, highlighting the need to ensure timely and clinically effective service provision. The present article is directed toward clinicians and trainees interested in learning more about the disaster mental health field. It describes the impact of disasters on communities and individuals and the most commonly employed interventions. The authors emphasize the distinction between the fields of disaster psychology and traumatology and stress that expertise in treating trauma-related disorders is not sufficient preparation for conducting psychosocial disaster intervention. Finally, information is provided on how to obtain adequate training and experience as a disaster mental health professional.

The span of human history is punctuated by catastrophic events with monumental impacts upon social and political developments. Early historical accounts make it clear that cultures and religions have long employed disaster stories as teaching tools to impart lessons on the basic meaning of the human experience. From the ancient floods and plagues recorded in religious texts to the plagues of the Middle Ages and on through the global wars and genocides of the 20th century, such crises have shaped the course of history. While tragic events need not be epic in scale to prove traumatic for those individuals and groups who are most directly affected by them, what sets disaster apart from other forms of trauma is the stunning breadth of its collective impact.

Public awareness has recently increased regarding the psychological reactions that may develop among people affected by disasters, and mental health interventions have become a mainstay of the national and local disaster-response systems. After a decade that included the Oklahoma City bombing, the massacre at Columbine High School, and the terrorist attacks of September 11th, 2001, the expectation of psychological trauma and posttraumatic stress disorder (PTSD) in the aftermath of catastrophic events is now part of our national consciousness. News media coverage of disasters often includes references to grief or crisis counselors with the implication that these services may be crucial to the recovery of traumatized victims and bereaved survivors. Correspondingly, interest in disaster mental health (DMH) services has rapidly increased with a call for greater availability of graduate and postgraduate training and for establishment of guidelines for models of service provision and employment of evidence-based interventions.

While high profile incidents, such as the tragic acts of violence committed in the Oklahoma City bombing and the September 11th terrorist attacks, attract and deserve massive media coverage, disasters of lesser magnitude are altogether too

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common and easily overlooked. Statistics collected by the Federal Emergency Management Agency (FEMA) show that presidentially declared "national disasters" have increased to an average of 47 per year, up from an average of 27 in the previous 2 decades (FEMA, 2003). Moreover, it is estimated that only 10% of all disasters receive a presidential declaration, which first requires an official appeal by the governor of the affected state. Therefore, a conservative estimate of the total number of disasters annually in the United States could top 4,000. Nevertheless, public awareness of disasters and their human and financial tolls is understandably dominated by events characterized by images of carnage and massive destruction of property.

Long before the tragic events of September 11th, 2001, social scientists and mental health professionals had recognized the need to better understand the psychological and sociological effects of disasters (e.g., U.S. National Institute of Mental Health, 1953). Events such as transportation accidents (e.g., train wrecks, plane crashes), natural hazards (e.g., hurricanes, floods, tornadoes, earthquakes, and fires), community violence (e.g., school shootings, restaurant murder sprees), and bombings (e.g., Oklahoma City, U.S. embassies) have all been examined in a variety of published studies (reviewed in Norris, Friedman, Watson, Byrne, Diaz, & Kaniasty, 2002). While the lion's share of media and public attention has focused on trauma and PTSD, survivors of these events may exhibit a broad range of reactions, not all of which signify a trauma response.

Epidemiology of Disaster-Related Psychopathology

A recent empirical review of the disaster-psychology literature (Norris, Friedman, Watson, Byrne, et al., 2002) classified the psychosocial outcomes of disasters into categories labeled as (a) specific psychological problems (i.e., diagnostic disorders according to the *Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association, 1994), (b) nonspecific distress (i.e., elevation of symptoms associated with reactions to extreme stress), (c) health problems and concerns (e.g., somatic complaints, substance abuse), (d) chronic problems in living (e.g., increased daily hassles secondary to the disaster), (d) psychosocial resource loss (e.g., deterioration of personal hardiness and social support), and (f) problems specific to youth (e.g., separation anxiety, developmental regression, and externalizing behavior problems). These authors reported that a slight majority (51%) of 160 empirical studies that they analyzed reported moderate impairment among disaster survivors, while another 39% of those studied reported severe to very severe impairment, suggesting that a very substantial proportion of disaster survivors could benefit from DMH services (Norris, Friedman, & Watson, 2002).

Aggravating risk factors, such as mass violence (as opposed to natural disasters and technological accidents), the severity of individual exposure, severity and pervasiveness of the financial and social effects, threat of or actual loss of life, and physical injuries were associated with more severe psychiatric impairment. Categorical risk for severe postdisaster impairments was also higher among women, youth, and residents of less developed countries (Norris, Friedman, Watson, Byrne, et al., 2002). These findings demonstrate the complexity of interacting variables contributing to postdisaster psychological reactions and resiliency and may also be understood to caution against simplistic notions of massively traumatized populations attendant to every disaster regardless of its scale or characteristics. Moreover, given the reported rates of postdisaster psychosocial problems, there is an evident need for systematic intervention with people affected by disasters.

Emerging Field of DMH

Recognition of the need for mental health services to disaster victims dates back to the middle of the 20th century (e.g., Crawshaw, 1963; Mental Health Materials Center, 1955). Researchers and advocates identified the need for disaster interventions at the community level that provided outreach services in field settings (Heffron, 1977) and for specialized training in DMH response (Brownstone, 1977). As the DMH field began to develop a more distinct identity, a series of manuals and other training aids were published. We refer readers seeking further and more detailed elaboration of DMH practices to several resources (American National Red Cross, 1995; Cohen, 2000; Cohen & Ahearn, 1980; DeWolfe, 2000; Hartsough & Myers, 1985; Myers, 1994; Raphael, 2000; Simonsen & Reyes, 2003; Young, Ford, Ruzek, Friedman, & Gusman, 1998).

One effect of the September 11th, 2001, terrorist attacks has been growing governmental concern and support for DMH preparedness. Recent committee reports have stressed the need for expanding research, training, and fiscal resources dedicated to meeting the mental health needs of the American public following terrorist attacks and other massive violent events (Institute of Medicine, 2003; National Institute of Mental Health, 2002). Given the changing face of what may constitute disasters in the new century, with growing fears of extreme weather events (e.g., global warming) and mass violence (e.g., bioterrorism on a wide scale), it is difficult to anticipate what the DMH needs in the near future may be. The present article is intended to offer some guidance to members of the mental health community on becoming involved in providing DMH services and in formulating initiatives to improve the capacity of communities to respond to the mental health needs of their citizens in the aftermath of a disaster.

Approaches to Conceptualizing Postdisaster Psychosocial Needs

Traumatic stress and PTSD have dominated the public discourse on psychological reactions to disasters in the past decade or more. This is somewhat less true in the professional literature, which has also focused on issues of grief and bereavement, community disruption and reorganization, and the effectiveness of early interventions (e.g., critical incident stress debriefing) for reducing the long-term negative sequelae of disasters. Nevertheless, research findings support the notion that symptoms of acute stress and even PTSD are among the most commonly detected psychological reactions among disaster survivors (Norris, Friedman, Watson, Byrne, et al., 2002). It should also be noted that a short-term acute stress reaction is a relatively "normal" response to an abnormally challenging or life-threatening event (Horowitz, Stintson, & Field, 1991). Moreover, the most common outcome of an acute stress reaction is an adaptation that combines assimilating most of the experience into preexisting schemata and accommodating to those aspects for which redefining one's sense of self and worldview are the most functional solutions (Harvey, Stein, & Olsen, 1995).

However, it is important to recognize that, while trauma is a predictable constituent of psychological reactions to disasters, disaster psychology is not synonymous with traumatology. The emphasis on trauma and PTSD can divert attention from other important problems and lead to a mismatch between needs and services. Some social scientists and journalists have recently cautioned against the hysterical appeals of trauma zealots who exploit news media coverage to create an impression of "massive traumatization" and the urgent need for a correspondingly massive mental health response (Herbert et al., 2001). However well-intentioned such appeals may be, they have the potential to promote higher levels of societal distress than would otherwise exist. An alternative strategy is for mental health professionals to strike a balance between alarming and soothing public concern, emphasizing accurate information (e.g., psychoeducation), and facilitating functional coping strategies (e.g., crisis intervention).

A popular alternative to the posttraumatic stress framework focuses on the functioning of community resources in the postdisaster environment. This approach is more akin to a community psychology than to a clinical psychology perspective and advocates the use of community-based interventions (e.g., North & Hong, 2000). Rather than focusing on individual reactions and needs, community-based psychosocial interventions are directed toward strengthening the capacity of a disaster-affected community to provide adequate support to its citizens in ways that are locally available and culturally appropriate. The role of DMH workers in this model is to provide consultation and support to community leaders and local healers without usurping their authority or undermining their credibility. Intervening at the community level is designed to make a maximal contribution to the psychosocial recovery of the disaster survivors by strategic provision of information and supplemental resources to rapidly rebuild and augment local resources. Moreover, it is intended to be helpful in ways that avoid pathologizing or stigmatizing individuals or groups within these communities.

Whatever the approach, the most common goal of DMH interventions is to prevent the development of pathological adaptations. Initial psychological reactions to disasters are typically framed as normative reactions to nonnormative events (Jacobs, Quevillon, & Ofman, 1998). In essence, the message is that what might appear pathological under normal conditions is within the normal

range of reactions to extraordinarily stressful life events. An implication of the framework is that as the disaster situation evolves to resemble a more normal set of conditions, so too will the psychological reactions resolve to approximate baseline functioning. Therefore, to the extent that DMH interventions are successful, a greater proportion of survivors receiving these treatments should exhibit a relatively rapid return to "normal" functioning than would be achieved without the interventions.

Issues in DMH Intervention

Serving as a clinician under disaster conditions is challenging in a variety of ways. There are countless professional expectations that clinicians hold based upon our education, training, and experience that are inconsistent with the work of a "field clinician" at a disaster site. The most obvious differences have to do with the settings, which include temporary mass shelters, service centers, feeding sites, outreach centers, parking lots, and morgues. Home visits are also common, especially as a member of a multidisciplinary service team. In essence, field clinicians encounter disaster survivors where the survivors live, not within the controlled and insular confines of the clinician's professional domain. This can mean working in neighborhoods that the clinician would normally avoid, with people whose socioeconomic status is far below that of most mental health professionals, and across lines of sociocultural diversity that are outside the range of the clinician's professional or personal experience. For instance, many types of natural disasters (e.g., tornadoes, floods, wildfires) occur most frequently in rural areas, which are typically underserved by the mental health establishment. Since mental health services are more available in urban areas, rural inhabitants must typically travel to those urban centers to obtain assistance. Therefore, most clinicians have little or no experience working with rural inhabitants in these individuals' own backyard, especially under disaster conditions. While there may be a temptation to view a trip to the "country" or to an inner city urban neighborhood as something of an adventure, it is wrong-headed and dangerous to confuse DMH with tourism.

Other differences include working within an impromptu hierarchical command service structure as well as experiencing role ambiguity, minimal control over job assignments, and a need to work cooperatively with providers of other services (e.g., pitching in with manual labor). Among the greatest stresses that arise are instances of disagreement with the policies or practices either of one's own sponsoring agency (e.g., Red Cross, Critical Incident Stress Team) or of other important players (e.g., FEMA, the news media, political office holders). It is important to understand that most people in a disaster, including other mental health professionals, are operating outside their comfort zones and that their expectations have also been violated. Effective functioning under these conditions of low control requires clinicians to cope in an extremely flexible manner. Anyone with a relatively rigid cognitive style or a high need for control, predictability, and autonomy may be poorly suited to the challenges of DMH work.

Under disaster conditions, a formal therapist–client relationship is seldom established. Instead, it is more common for DMH workers to perform many of the nonclinical tasks of social work, such as helping to connect people with public and private resources. This means that the expectations on both sides of the relationship must be congruent with a short-term, emotionally supportive, but pragmatic interaction. The interventions often take place in public places with little hope of privacy, and therefore confidentiality is more limited than in a formal therapeutic relationship. Nonetheless, mental health professionals must obey the ethical codes of their discipline, the licensing regulations of the relevant states, and the laws of the state in which they are practicing at the time. Therefore, it is prudent for clinicians practicing outside their home state to familiarize themselves with the mental health laws of the disaster-affected state in which they will provide service. This is particularly salient around issues of mandatory reporting of child abuse, duty to protect, duty to warn, and involuntary hospitalization.

Many modes of intervention that were learned during graduate clinical training, then modified and refined during internship and independent practice, are less than suitable for a field clinician. For the most part, the basic skills and knowledge of a competent mental health professional will provide a sound foundation for DMH work, but the interventions employed often require some additional study and practice. For instance, while crisis intervention is a stalwart of

the social work curriculum, it is seldom taught in clinical psychology doctoral programs. Thus, some clinicians may be more prepared than others for fieldwork with people in crisis. Those with substantial expertise in trauma work may feel particularly well-prepared for disaster assignments, only to find that their advanced skills are less applicable than expected when working with people whose chief concerns revolve around the seemingly endless reams of red tape involved in applying for relief benefits. Therefore, it may best serve clinicians who are interested in providing DMH services to investigate the characteristics and skills necessary to perform the following interventions, which are presently among those most commonly employed in disaster settings (Litz, Gray, Bryant, & Adler, 2002).

Early Interventions in DMH

Time is among the most precious resources in any emergency. Minutes and seconds often spell the difference between success and failure for a lifeguard rescuing a drowning swimmer or paramedics defibrillating a heart attack sufferer. Psychological reactions to disasters are often viewed as analogous to medical emergencies and thus believed to merit the most immediate and intensive interventions available. Accordingly, just as heroic medical measures are understood to be appropriate under life-threatening conditions, so then must the correspondingly heroic psychiatric or psychotherapeutic techniques be applied to preserve mental health and prevent the development or exacerbation of psychopathology. This analogy can be understood to possess variable utility depending upon the specific characteristics of the situation and of those people affected by the potentially traumatic event. Moreover, evidence must be considered that supports or undermines the potential success of the proposed treatment. While it is understandable that the sense of urgency in a disaster compels a correspondingly urgent intervention, it is crucial and ethical for those providing DMH assistance to practice within the limits of their expertise and limits of their methods.

Early interventions have been developed to match the urgent psychological needs of people in crises and disasters, with varying levels of consideration for the types of events and the types of people involved. Among the most commonly practiced varieties of early interventions are crisis intervention, psychoeducation, psychological debriefing, and defusing. Another popular term, *psychological first aid*, describes the use of crisis intervention techniques by minimally trained nonprofessionals within the affected community. The common goals of these techniques are to relieve immediate distress and to prevent or minimize the development of pathological sequelae.

While the evidence for the clinical efficacy of these techniques varies, all are widely practiced and defended by their adherents. The purpose of the present article is not to resolve debates about the comparative efficacy of treatments but instead to survey and describe the most commonly employed interventions in the field of DMH. For the most part, the following techniques are well-established and their effectiveness and potential risks have been assessed and debated in the empirical literature (Litz et al., 2002). We have attempted only to clearly articulate the most salient characteristics of each technique and the conditions under which it is most likely to be practiced. However, given the controversial nature of some methods, we have cited pertinent references that may offer a more detailed analysis of these approaches.

A further complication involves the unresolved debate over whether early interventions should in fact be classified as "psychotherapies," since they are administered equally to people who are asymptomatic and those who exhibit noticeable signs of acute stress. For instance, advocates for critical incident stress debriefing/management (CISD/CISM) often counter their critics by claiming that the concerns raised about their methods are irrelevant because CISD/CISM does not claim to be a form of psychotherapy (Mitchell & Everly, 1996). However, given that many psychotherapists who work with disaster survivors employ these techniques and that any technique a psychotherapist uses to intervene tends to be perceived as "psychotherapy," the classification of CISD/CISM as a preventive approach to psychotherapy seems both rational and self-evident.

Crisis Intervention

Among the most basic and essential areas of competence in DMH are the knowledge and skills of crisis intervention. Texts on crisis intervention often date to the beginning of that field from the work of psychiatrist Erich Lindemann (1944) in the aftermath of the disastrous Boston

Coconut Grove Fire of 1942. This same event is often designated as the genesis of an awareness regarding the mental health impact of disasters, later leading to the emergence of the DMH field. What connects this event to the emergence of both DMH and crisis intervention is the recognition of the extraordinary emotional pain and enduring grief suffered by disaster survivors and the need for interventions that are substantially different from those employed under less dire circumstances.

People in a state of crisis have lost their sense of equilibrium and may exhibit a range of physical, emotional, and cognitive symptoms associated with extreme stress (Roberts, 2000). The primary goals of crisis intervention are to first assure the safety of the client and then to assist the client in regaining an adequate level of autonomous functioning. Accomplishing these goals requires the development of a supportive relationship, identification of the chief complaint, assessment of the client's personal and social resource base, articulation of viable alternatives for achieving proximal goals, and obtaining a firm commitment from all concerned (e.g., client, intervener, and any third parties) to follow through with an agreed upon plan. Follow-up contacts should be built into the crisis-reduction plan to allow evaluation and modification of goals and plans to take place over time (Roberts, 2000).

Crisis intervention differs from psychotherapy in a number of ways, not the least of which regards the fact that it is much more time sensitive and requires a more directive stance by the intervener. People in crisis typically feel overwhelmed and unable to cope by conventional means. They may exhibit signs of confusion, helplessness, shock, emotional lability, aggressive agitation, or inconsolable grief (Roberts, 2000). A common concern is for the potential lethality of the client, in terms of either suicidality or homicidality. Thus, it is understandable that the crisis intervener often needs to adopt a firm and directive stance, while providing the client with a sense of support and hope. By focusing on systematic problem solving, the intervener is able to model a deliberative process of goal setting, planning, and constructive coping (Abueg, Woods, & Watson, 2000). The "end" state of crisis intervention with severely distressed or impaired survivors is often a referral for ongoing services to an appropriate local provider who can provide access to a continuum of care that is responsive to the client's changing needs over time.

Crisis intervention with disaster survivors often focuses on palliating emotional distress, connecting the survivor to available community resources, and helping to structure a short-term recovery plan. Such a plan would focus on ensuring that basic survival needs are met and that the survivor has a realistic justification to feel hopeful about the course of future developments. Given the difficulty of achieving such ends, it is vital not to foster unrealistic expectations or false hopes. Thus, a pragmatic approach with relatively humble goals is least likely to fuel a sense of frustration and disappointment. The essential principle of this approach is to gradually build upon small successes or successive approximations of the ultimate goals.

Educational Interventions

Among the secondary stressors in a disaster are confusion and apprehension about what to expect. Many people find that being able to predict the course of events partially relieves anticipatory anxiety and supports the capacity for deliberation, planning, and constructive coping. *Psychoeducation* is designed to mobilize this predictive capacity and prepare disaster-affected individuals and communities to respond proactively and effectively to reduce the negative psychosocial impact that they might otherwise experience. The modes of intervention often include distribution of brochures describing common responses to acute and chronic stress, discussions with mental health professionals conducted in public forums, and public mental health advisories conveyed in the electronic media.

The purposes of educational interventions include reducing the confusion and perceived helplessness that often follow a disaster. Giving accurate and helpful information to public officials, teachers, parents, first-responders, and anyone else who bears some responsibility for the emotional welfare of others may equip these helpers to provide better care and leadership and to feel more confident in their ability to function effectively under difficult conditions. General messages address expectable reactions and contact information for mental health resources (e.g., toll-free hotlines). These messages are intended to encourage empathy, social support, and help-seeking as well as to decrease the social stigma

often associated with psychological support services. Accordingly, the spokespeople are often trusted public figures (e.g., celebrities or political or spiritual leaders), rather than mental health providers. More specific messages tailored for particular groups (e.g., children and elderly individuals) may also be developed and are often delivered in schools and other types of institutional settings.

Psychological Debriefing

On the basis of the widely held belief that disaster survivors need to relate the details of their experience to others, various approaches to structuring this process are employed and have come to be known collectively as *debriefing*. The most prominently employed modes of psychological debriefing are *critical incident stress debriefing* (CISD; Mitchell, 1983) and the American Red Cross (ARC) debriefing approach, sometimes referred to as the *multiple stressor debriefing model* (Armstrong, O'Callahan, & Marmar, 1991; Armstrong et al., 1998). Debriefing methods share the common core aspect of a structured discussion of a potentially traumatic event with the intention of relieving immediate stress and reducing the likelihood of long-term impairment. However, they also differ in terms of whether they emphasize the roles of peer support or mental health professionals, the specificity (preventing PTSD or other psychopathology) or generality (stress management and burnout reduction) of their goals, and the use of individual or group formats.

Given the ongoing controversy surrounding CISD in particular, it is understandable that proponents of other approaches to debriefing often wish to distance themselves from the derogatory emanations of that debate. A recent consensus-building conference (National Institute of Mental Health, 2002) recommended limiting the use of the term *debriefing* to those "operational debriefings" that have historically served to provide a detailed account to superiors about the successes and failures of an operation (e.g., debriefing astronauts to gather information for future missions). In this section, we attempt to describe some of the most salient characteristics and differences between the psychological debriefing techniques currently employed as early interventions with disaster survivors.

Critical incident stress management/debriefing (CISD). Since its development as a group-processing technique for relieving occupational stress among firemen, CISD has expanded and evolved in a variety of ways. Early on, this approach was adopted by other emergency-response professions (e.g., police, emergency medical technicians) who found it appealing as a method of assisting their personnel, who often work alongside firemen and are exposed to comparable levels of occupational stress (Mitchell, 1983). The precipitating critical incident is typically of a nature that goes above and beyond what people in high-stress jobs typically experience, such as the death of a child or the line-of-duty death of a coworker. For many emergency responders, the events surrounding the September 11th, 2001, attacks define the extreme end of their occupational stress continuum.

CISD, embraced nationally as a preferred technique for serving the stress-management needs of emergency responders, is often mandated from the highest levels. Problems arose, however, when researchers studying debriefing suggested that the technique was either ineffective or even harmful (Deahl, 2000). Proponents of CISD countered that those studies employed corruptions of the technique by adapting it to situations other than those for which it was recommended, often abandoning the group process and peer-support components while substituting one-on-one dialogue with a mental health professional, and were therefore invalid in their conclusions (Everly & Mitchell, 2000). Contemporaneously, the International Critical Incident Stress Foundation (ICISF), founded by the originator of CISD and several of its strongest proponents, was established to promote the dissemination of the technique and to assure a consistent quality of training and curriculum development. Additionally, it has served as a collective buffer to absorb and deflect some of the opposition and to maintain the momentum that has allowed CISD to become as popular internationally as it is in the United States.

As the debate grew more heated, CISD also expanded to become CISM (critical incident stress management), which is less episodic and offers a more comprehensive package of debriefing, stress management, and ongoing support. These developments and the associated arguments have done little to resolve the tension between proponents and opponents of debriefing, but some recent publications have sided unequivocally with the opposition to CISD as a

method either of crisis intervention or a prophylactic against the development of PTSD and other pathological outcomes (National Institute of Mental Health, 2002). Nevertheless, despite a mounting groundswell against debriefing in general and CISD in particular, the popularity and ubiquity of these techniques are remarkably resistant to dissuasion or disfavor.

American Red Cross debriefing. Perhaps the second most prominent use of psychological debriefing is in the American Red Cross (ARC) Disaster Mental Health Service (DMHS; Weaver, Dingman, & Morgan, 2000). The DMHS at present recognizes three categories of interventions: crisis intervention, defusing, and debriefing. The fact that ICISF and the ARC use these same terms to describe their techniques has resulted occasionally in an understandable confusion between the DMHS and CISD models, leading to numerous disclaimers and clarifications by both organizations. While there are in fact many similarities rooted in the promotion of "telling one's story" and "venting" as forms of social support for emotional healing, there are also clear distinctions between the models and applications of psychological debriefing between these two organizations.

In the ARC, debriefing is understood to be a stress-management technique for relieving distress by providing an empathic one-on-one discussion with a DMH professional, as opposed to the peer-processing and support model of CISD. The central goal of the ARC method is to provide practical support for coping constructively with the countless frustrations accompanying any disaster, rather than responding to a critical incident. The process itself is a relatively unstructured technique, blending a Rogerian stance (e.g., empathic, accepting, and actively listening) with attention directed toward coping strategies and maintenance of social support.

It is important to recognize that the mission of ARC's DMHS function includes providing stress-reduction services to that organization's own staff and volunteers, not just to the disaster survivors and their communities (Morgan, 1995). Consequently, the use of debriefing by the DMHS is primarily reserved for the support of disaster-services personnel. Most disaster-services workers receive at least one debriefing per assignment, especially upon departure from the field operation, and thus more DMHS staff time is dedicated to "staff care" than to interventions with the disaster-affected community. In this way, the relief workers and volunteers are treated with compassionate regard for their humanity and recognition of the highly stressful circumstances under which they have served. Given the risk of burnout and other stress-related impairments, debriefing and other stress-management services for disaster services personnel are clearly warranted and laudable.

Finally, it should be noted that in the disaster-services context of ARC DMHS, debriefing is but one of many stress-management tools and is not as highly emphasized as it is among CISM teams. Being present to help with stress reduction whenever needed is the main occupation of the DMHS workers, and they are most likely to encounter those needs under conditions and in venues (e.g., funerals, hospital rooms, home visits) where structured techniques like debriefing would be neither welcome nor helpful. Moreover, because of the broad variety of services offered by the ARC, DMHS clinicians often work in concert with health care nurses and other types of assistance providers. This promotes a team service approach with mental health support being subtly woven within the fabric of a complex service package.

Defusing

Defusing is a term that is strongly associated with CISM but that has also become a mainstay of ARC DMHS practices and literature (American National Red Cross, 1995). The metaphorical inference is that of a bomb which is in danger of exploding unless the fuse is removed. The justification for such a procedure requires an assessment indicating that conditions are favorable for an explosive outburst of stress-related frustration and hostility. The core technique in defusing is to verbally process the stress reactions within the group (i.e., ventilation) to facilitate constructive communication and motivate corrective adjustments, and it is typically more immediate, briefer, and less formal than debriefing. Moreover, while debriefing mainly focuses on processing reactions to a critical event that has already transpired, defusing may also focus on events that are present and ongoing with the goal of preempting a potential worsening of the situation.

Critical incident stress defusing. The definition of *defusing* for CISM purposes is fairly clear in regard to when and how it is used (Mitchell &

Everly, 1996). CISM defusing is most commonly administered within 12 hr of a critical incident to allow people to ventilate and process their thoughts, emotions, and experiences while providing them with appropriate validation or normalization of their reactions. The size of the group involved is typically smaller and more circumscribed than for a debriefing. The arrangements leading up to the meeting and during the group process are less structured and formal, and the duration of the meeting is shorter. The clinical goals of the defusing are to mitigate symptoms to any extent possible while assessing emotional distress and psychosocial needs among the group members so that triage decisions can be made.

American Red Cross defusing. ARC defusings are commonly directed toward rapidly relieving a stressful working situation (e.g., conflict among coworkers), and DMHS workers are often positioned in close proximity to first responders so that problem detection and response times are optimized. Because emotional "hot spots" can emerge rapidly and unexpectedly during a disaster operation, ARC DMHS defusings must be correspondingly fluid and opportunistic. In this process, victims or workers are given an opportunity to "ventilate" about their experiences during and after the disaster, as they share their memories of the events, their stresses and losses, and especially their methods of coping. It is important that the defusing process, which often occurs in informal and impromptu sessions, be done in settings that are both safe and supportive. For instance, a DMH worker who witnesses an unpleasant emotional exchange between a victim and a staff member might approach one or both of them soon afterward to initiate a constructive dialogue. This is intended to relieve people of thoughts and feelings that might otherwise compound their distress. In theory, suppressing or repressing such emotionally charged material increases the likelihood of developing stress-related symptoms and disorders.

Psychological First Aid (PFA)

The term *psychological first aid* (PFA) has been coined to capitalize on the analogy between bodily and psychological injuries. The main idea is that, just as people without extensive medical knowledge or training can be taught to provide immediate help without further injuring a person, so can people then be taught to provide palliative relief of psychological suffering without having been trained in practicing psychotherapy (Mental Health Materials Center, 1955; Pynoos & Nader, 1988). As with crisis intervention, the key ingredients of PFA are empathy and compassion, and the imperatives are to reduce the risk of harm, stabilize psychological distress, and provide practical assistance such as connecting the person with other resources (Litz et al., 2002). However, crisis intervention goes beyond PFA by emphasizing diagnostic assessment, lethality assessment, collaborative problem solving, mental health referrals, and follow-up contact to assess the efficacy of the intervention.

Another important difference between PFA and crisis intervention is that PFA requires no formal training in a mental health profession. In accordance with the analogy, just as first aid and CPR require no formal medical training, PFA can also be learned by average citizens for use in times of crisis when professional assistance is unavailable. In addition, just as the essential purpose of first aid is to stabilize the condition and preserve life until more curative care is available, so PFA can reduce emotional distress and improve the situation in a meaningful way until professional therapeutic intervention can be offered. However, just as in many cases of first aid, no further professional assistance may even be necessary or sought, so PFA may compose the only assistance and the only care needed in some situations. Thus, crisis intervention is a more formal technique to be practiced by trained and experienced crisis workers, while PFA offers the hope of harnessing the talents of compassionate individuals within a community as one of its indigenous healing resources. Moreover, just as teaching first aid and CPR lead to a small degree of "culture change," so might PFA spur changes in public attitudes about mental health and the nature of psychological services.

Distinguishing DMH Service Delivery From Treatment for PTSD

While older examples in the DMH literature suggest the need for crisis intervention and bereavement services, more recently the emphasis has shifted to the prevention of clinical disorders, most notably PTSD (Wilson, Raphael, Meldrum, Bedosky, & Sigman, 2000). The heavy emphasis on the traumatic aspects of disasters at times leads to treating DMH and trauma work as virtual

synonyms. In turn, clinicians who are qualified for work with trauma victims may then suppose that they are equally prepared to serve as field clinicians in disasters. Although this is an admittedly flawed analogy, it is somewhat like assuming that most successful surgeons are automatically qualified to operate in field hospitals. It seems obvious that the transference of skills from one context to another is sufficiently limited to require further preparation for the corresponding adjustments that must be made. Thus, it is important to recognize some of the most salient distinctions between DMH and trauma work.

One of the most crucial distinctions concerns the tendency for posttraumatic adaptations to develop over time and thus for both the clinical phenomena and modes of intervention to vary accordingly. Clinicians who are mainly familiar with the most problematic long-term outcomes of traumatic events may not be as well prepared for working with survivors in early phases of a posttraumatic response. Moreover, the incidence rates of PTSD in disaster-affected communities do not justify the assumption that DMH clinicians are encountering large proportions of people who are in the early stages of developing traumatic stress syndromes or PTSD (Norris et al., 2002). Rather, it appears that most disaster survivors will develop relatively resilient adaptations and will not require or benefit from trauma-focused interventions. Therefore, while most trauma clinicians are trained and experienced in working with clients who present with symptoms that are pathognomonic for trauma, those professionals are less qualified to work with people who present with normally aggravated stress reactions that are congruent with a recent catastrophic event.

A major premise of the CISD debate, and related claims for the importance of early interventions, has been the supposition that such services provide a means of PTSD prevention (Everly & Mitchell, 1995). However, the empirical findings from many of the studies testing the efficacy of CISD have drawn into question the validity of early interventions as preventive medicine against the development of disaster-related psychopathology (Litz et al., 2002). Thus, it may prove more realistic to shift the emphasis of early interventions in disasters away from PTSD prevention toward more general goals of reducing the intensity of immediate emotional suffering and promoting an accelerated resilient adaptation.

How Can Mental Health Professionals Become Involved With Disaster Work?

There are several ways in which mental health professionals can become active in helping disaster victims and/or relief workers. Some of the more widely accessible means for becoming involved are through the following organizations: (a) American Red Cross (ARC), (b) Disaster Response Network (DRN), (c) Disaster Psychiatry Outreach (DPO), and (d) International Critical Incident Stress Foundation (ICISF).

American Red Cross

Mental health counselors, psychologists, psychiatrists, psychiatric nurses, and social workers are among the licensed mental health professionals who may serve as volunteers with the ARC's DMHS function. Requirements include proof of current licensure and completion of both a 3-hr orientation course (Introduction to Disaster Services, ARC 3066) and a 2-day ARC course on DMH: Disaster Mental Health Services I (DMHS 1). While the orientation course is widely available through local ARC chapters, the DMHS course is more difficult to obtain and may not be frequently offered. Once training is complete, the professional can provide DMH services within ARC's framework in local disaster relief operations, organized through the local chapter.

The local chapter can also provide the professional with application materials to join the Disaster Services Human Resources (DSHR), a national ARC network of individuals from a variety of ARC functions in addition to DMHS. DSHR membership allows the mental health professional to communicate with the local chapter and/or state (or regional) chapter coordinator in order to be deployed nationally in times of disaster, to provide DMH services. An ARC DMHS volunteer starts at the rank of Technician and can advance through the ranks of Specialist, Coordinator, Assistant Officer, and Officer, through additional ARC disaster-related courses and disaster experience. Additional ARC information can be obtained by contacting the American Red Cross National Headquarters by mail at 431 18th Street, NW, Washington, DC 20006; by phone at (202) 303–4498, or on the Web (www.redcross.org).

Disaster Response Network (DRN)

Growing recognition of the need for DMH planning and coordination at the national level

led to the signing in 1991 of a statement of understanding between the American Psychological Association (APA) and the ARC (Jacobs, 1995). Through this understanding, state and provincial psychological associations (SPPAs) coordinate deployments of licensed mental health professionals to disaster sites. Since 1991, other organizations have signed statements of understanding with the ARC, such as the National Association of Social Workers, American Counseling Association, American Academy of Marriage and Family Therapists, and American Psychiatric Association. However, we focus here on the APA DRN.

At the time of this writing, 41 states had DRN coordinators, with more than 1,900 psychologists listed in the DRN database. Membership can be obtained by contacting one's local state psychological association or by contacting the Disaster Response Network through APA's Practice Directorate. However, once becoming a member, the DMHS 1 course is required for disaster response. More information on DRN can be obtained by contacting the American Psychological Association Practice Directorate by mail at 750 First Street, NE, Washington, DC 20002; by phone at (800) 374–2723, or on the Web (www.apa.org/practice).

Disaster Psychiatry Outreach (DPO)

The role of psychiatry in DMH has developed somewhat independently of other clinical professions in accordance with the particular characteristics of that discipline (Norwood, Ursano, & Fullerton, 2000). DPO trains, credentials, and deploys licensed psychiatrists to work with disaster victims and relief workers in the various phases of a disaster's aftermath. DPO psychiatrists work closely with ARC DMHS as well as other private and government agencies at disaster sites. The ARC DMHS 1 course, as well as the DPO Disaster Training Course, are requirements for deployment to a disaster through DPO. For more information, DPO can be contacted by mail at Disaster Psychiatry Outreach, 141 Fifth Avenue, 3rd floor, New York, NY 10010; by phone at (212) 598–9995; or on the Web (www.disasterpsych.org).

International Critical Incident Stress Foundation

The ICISF provides CISM to public safety and other disaster-relief personnel. Requirements vary depending upon the local CISM team but generally involve at least a master's degree in a relevant mental health field, employment in the mental health field, and CISM and other relevant training (e.g., crisis intervention, PTSD). One can participate by contacting a local CISM team or can obtain the training and information on forming one's own CISM team by contacting the International Critical Incident Stress Foundation by mail at 3290 Pine Orchard Lane, Suite 106, Ellicott City, MD 21042; by phone at (410) 750–9600, or on the Web (www.icisf.org).

Conclusions

For clinicians interested in the field of DMH, resources and requirements for becoming involved in disaster-response work have been described. Those resources include such agencies as the American Psychological Association, American Red Cross, and the International Critical Incident Stress Foundation, but this list is certainly not exhaustive. Countless other professional organizations and groups are involved with DMH service, and readers are encouraged to explore those alternatives that best match their needs and interests.

Practical experience and empirical findings are generating a growing consensus regarding several general principles that should guide the delivery of DMH service delivery. First, while early interventions after a disaster may be helpful, the evidence that this is the case is far from conclusive, and the vast majority of studies have focused on the debate surrounding CISD. Thus, there is a need to study the efficacy of other approaches to early intervention (e.g., American Red Cross debriefing, defusing, etc.) rather than simply generalizing conclusions from studies of CISD/CISM to these other methods. Moreover, most studies of early interventions lack adequate verisimilitude with actual field interventions conducted with disaster survivors and relief workers. Instead, these studies are often limited by the logistical and political difficulties of conducting field research during the early phases of a disaster relief effort. Therefore, it is important that researchers address these obstacles more effectively and proactively before firmly drawing conclusions regarding the efficacy of these interventions.

Second, early psychosocial interventions in disaster-affected communities tend to be episodic,

despite consistent recommendations for building a follow-up component into the intervention design. This approach appears to fit with the conceptualization of disaster stressors as "acute," rather than chronic and cumulative. The aftermath of the acute phase, however, may contain characteristics that are persistently stressful with chronic spikes of exacerbation (e.g., anniversary reactions). Therefore, it is important to provide ongoing monitoring and support during the acute phase as well as chronic monitoring of reactions at predictably difficult junctures.

Third, some emotional difficulties after a disaster may not emerge until several days or weeks later, and these problems may thus go undetected and unaided. Thus, disaster survivors' emotional conditions should be monitored for some time after a disaster. This is particularly important given the phasic nature of the postdisaster environment. For instance, once the temporary influx of human and material resources have subsided and the explicit and implicit promises of assistance with recovery are evaluated by the disaster-affected population in a less rosy light, a less optimistic or disappointed phase is common. During this phase, after many of the early-phase coping strategies have been exhausted, disaster-affected community members may require a very different approach to intervention than the early-intervention approaches afford. Ongoing interventions that follow up on early interventions and are responsive to the evolving needs of disaster survivors should be initiated and evaluated for their effectiveness.

Finally, it is important to evaluate the training needs of DMH clinicians across a variety of disciplines. While the ARC and ICISF organizations have made progress in the development and provision of training, the research base for understanding the important personal characteristics and skills of DMH professionals is very sparse and anecdotal. The persistent social emphasis on trauma may lead to the inference that training and experience with trauma victims is necessary or sufficient for DMH work. This is not the case. There are many other potentially helpful areas of knowledge and skill that less commonly receive attention, such as community mental health and social psychology, that could also prove important in the training curriculum of DMH professionals and in the design of interventions. Whatever the curriculum and training need may be, they are most likely to be accurately discerned through a persistent and reiterative process of testing assumptions without bias and accepting the most reliably obtained results as guidelines for concerted action.

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