PSYCHOLOGICAL SERVICES IN DISASTERS

AUSTRALIAN EMERGENCY MANAGEMENT INSTITUTE

and

AUSTRALASIAN SOCIETY FOR TRAUMATIC STRESS STUDIES

Psychological Services

1. Introduction

Purpose of this Guideline

The Guidelines for the delivery of Psychological Services in the Disaster Context (henceforth called "the Guidelines"), have been endorsed by the Standing Committee of Community Services and Income Security Administrators (SCCSISA) and the Australasian Society of Traumatic Stress Studies (ASTSS). They have also been commended by the National Emergency Management Committee (NEMC).

In addition, the Guidelines draw on the Mental Health National Action Plan, the Royal Australian and New Zealand College of Psychiatrists Position Statement 35 on the Role of Psychiatrists in Disasters, March 1996 DSRU discussion paper on Personal Support Guidelines, and the World Health Organisation project on disaster management.

The purpose of the Guidelines is to incorporate and update information and knowledge previously available in two documents within Emergency Management Australia's Australian Emergency Manuals Series:

- The Australian Emergency Manual – Disaster Recovery, and
- Community and Personal Support Services Guidelines.

The Guidelines have been developed to offer service providers, managers and practitioners with insights, principles and strategies in key facets of assessment and delivery of psychological services in the disaster context. Their aims are to facilitate recovery, ensure ethical practice, and to protect victims and support workers in their respective roles.

As psychological dimensions inform all aspects of disaster services, the Guidelines should be read by all involved government departments, agencies and individuals. At the same time, as psychological services are but part of a broader recovery process, it is essential that psychological service providers and their agencies are aware of the specific recovery management system in which they operate, and to integrate within it.

Although these Guidelines have been produced to encourage consistency in the delivery of psychological services in an Australian context, that is, across the boundaries of States, government and non-government organisations, and professional disciplines, in any given situation the prevailing management systems must be respected.

Key topics addressed in the Guidelines include

- Need for and process of production of this Guide to psychological service provision in the disaster context,
- Rationale and principles for the provision of psychological services in disasters,
- Assessment of particular needs for psychological interventions at different times for different disaster populations,
- Nature of particular interventions at different times for different populations,
- Assessment of service provider needs and nature of interventions to help them, and
- Research.

It is acknowledged that the body of knowledge in these Guidelines is in the process of development. Consequently this document is intended to be reviewed and updated periodically or as new information comes to light.

2. Need for, and Process of Production of the Guidelines

Psychological service provision in a disaster context has been addressed previously in the Australian Emergency Manual – Disaster Recovery, and in Community and personal Support Services - Guide 2. While these publications provided reasonable overviews of the principles and practice of psychological recovery processes, more up to date and sophisticated approaches have evolved since their publications. It was therefore considered necessary to combine and update the previous publications for use by all levels of planning, training and operations personnel.

Consequently, a submission to conduct a workshop on the topic as part of EMA's National Studies Program was prepared by the Disaster Recovery Coordinators sub-committee of the Standing Committee of Community Services and Income Security Administrators, in conjunction with the Australasian Society for Traumatic Stress Studies.

Following the acceptance of the proposal by EMA a steering committee was formed to identify key issues to be addressed and develop the workshop program and content. Participants invited to the workshop represented a cross section of managers and service providers from the range of government and non-government agencies involved in the delivery of psychological services in the disaster context, and the best available disaster traumatologists and academics in the field. The steering committee then compiled the workshop's suggestions and used them to update the previous publications.

3. Definitions and concepts of psychological effects in disasters

The definitions and conceptualization of psychological effects described in this section will be applied through the rest of this manual. The reader is also referred to Appendices A and B.

3.1 Definition of disasters

For the purposes of this publication the term "disasters" refers to events which cause or threaten death within an identifiable and relatively circumscribed community. Natural disasters include floods, bushfires, cyclones and earthquakes. Man made disasters include mass shootings, hostage taking, major crashes and industrial accidents.

3.2 Definitions of disaster effects

Disasters cause major environmental, societal and personal upheavals. Most disturbances are in the nature of strains, often called *stresses*. Situations which give rise to stresses may be called *crises* or *critical incidents.* Stresses may be reversed, or stopped from

worsening, by adaptive *stress responses.* Stress responses may be parts of *survival and preservation strategies* such as fight, flight, rescue, and attachment. When stress responses are insufficient or inappropriate, stresses may “give”, and irreversible disruptions called *traumas* develop. The event in which traumas develop is a *traumatic event,* and the situation in which this occurs is a *traumatic situation. Stressors* are agents which lead to stresses and traumas. Those which lead to traumas are called *traumatic stressors.* Because disasters are stressors which almost by definition lead to trauma, disasters are often implied to be traumatic stressors.

Stresses and traumas have biological, psychological and social (actually integral biopsychosocial) ripple effects. Like ripples from a pebble in the pond, they radiate through the different dimensions of disasters.

3.3 Conceptualising Disaster Effects

Stress responses of various strategies of survival, both adaptive and maladaptive, biological, psychological and social, may be conceptualized to ripple along three dimensions. The three dimensional ripple view of disasters informs much of what follows.

3.3.1 Three dimensional view of disasters (the triaxial framework) (See also Appendix A)

The first (*parameter*) axis describes the what of the disaster, when it struck and who was affected. Disaster phases (when) and social system levels (who) will be used in this manual as primary bases for further exploration of the dimensions of assessments and interventions.
The *process* axis describes the ripple process, and makes sense of how and why which biological, psychological and social stress responses make their way to fulfilling results or symptoms and dysfunctions.
The *depth* axis orientates responses along human levels ranging from instincts to spirituality. The levels include moral judgements, identity, beliefs, meanings, and purpose.

3.3.2 Survival strategies (See also Appendix B)

The choice of survival strategy(ies) determines the specific nature of stress responses and their adaptive and maladaptive biological, psychological and social ripples. The variety of survival strategies and their various ripple effects in three dimensions determines the great variety and complexity of traumatic stress responses in disasters.
Nevertheless, one can make sense of such responses by orienting them on the triaxial framework and tracing them back to specific survival strategies evoked in the context of traumatic events.
Specific survival strategies are fight, flight, rescue/caretaking, attachment, assertiveness/goal achievement, adaptation/goal surrender, competition and cooperation. A table in Appendix B indicates how survival strategies may be used to classify adaptive and maladaptive biological, psychological and social responses in disasters.

4. Rationale and principles for the provision of psychological services in disasters

This section will consider the rationale for specialised psychological services, and requirements of psychological service providers

4.1 Definition of psychological services

For the purposes of this publication the term “psychological services” refers to those services which apply specialist psychological skills of a level appropriate to the task, to psychological assessments, diagnoses and interventions in disasters in all their dimensions.

4.2 Rationale for specialised psychological services in disasters

Psychological services in disasters are needed to help affected populations to shift the balance from maladaptive or traumatic responses to adaptive ones, and to preempt later pathology.
Psychological services need to be specialised because in disasters responses need to be conceptualized in ways different from orthodox ones. Further, delivery of service requires special skills and cooperation with others, including informing other services with the psychological perspective. Lastly, because personnel deal with fresh and open wounds professional sensitivity, skill ethical standards and self-monitoring must be of an exceptional order.

4.2.1 Special nature of psychological responses in disasters

Orthodox psychological services usually deal with established problems and are customarily delivered within established diagnoses, frameworks and social structures. Disaster responses are acute, varied, fluid, and requiring specialised conceptualizations (3.3) to assist assessment, diagnosis and help, so that they do not become established. While orthodox treatments see “clients” and “patients” as needing cures from pathology, psychological services in early disaster phases emphasise normative responses and aid them, preempting illnesses.

Established professional and institutional attitudes can be quite unhelpful. People struggling with effects from threats to their lives may resent being seen as “crazy”, ill, or “pathological”, and experience such judgements as additional stressors.

4.2.2 Logistics of service delivery

While orthodox treatments often take the form of patterned office-based clinical therapies, in disasters social structures and patterns are may be disrupted, there may be a rapid increase in client numbers, and the psychological services may themselves be strained.

Therefore service delivery has to be flexible, mobile, creative, extensive, while at the same time being able to prioritise.

The approach is outreach, with all in the affected community contacted. Such coverage can identify the need to prioritise services to the vulnerable and those with established dysfunctions. Secondly, outreach may be able to prevent widespread distress and help prevent dysfunctions by for instance providing information about the nature and sense of common stress responses and what can be done about them.

Psychological services should be a special but integral part of other established emergency and recovery services. The logistics of the service delivery is in the context of disaster management as a whole. Special skills are required to "see the bigger picture", communicate along hierarchical lines and across services, liaise with them, integrate into emergency and recovery services as a whole, as well as have consultant and healing roles toward the service network.

4.2.3 Special nature of psychological services as integral to Emergency Management

The planning, management and delivery of emergency services by disaster managers in many areas (such as evacuation, manner of dealing with personal loss and financial hardship) have the potential to have serious psychological consequences for affected individuals and communities.

Positive consequences can be enhanced and negative ones avoided through disaster managers being informed by specialist psychological services of the psychological consequences of their decisions.

Indeed, it is critical that the psychological dimension inform understanding, planning, training, assessment, decision making and service delivery components of emergency and recovery management.

Lastly, managers may avail themselves of psychological services to deal with secondary stresses within their own sub-systems.

4.2.4 Self-monitoring of psychological services to ensure effectiveness of the "First do no harm." principle, and maintenance of own health.

Specialist training is required to discern, and appropriately act on the wide range of biopsychosocial stress responses evoked in oneself during assessment and interventions. For instance, intense emotions at the professional level may be used as information for assessment and measured professional intervention rather than instinctive response. Nevertheless, because empathy requires openness to and reverberation with others, monitoring of one's responses by self, peer group and supervisors is necessary. This can prevent being overidentified, overcommitted, and overburdened, becoming a secondary victim and a burden on those one is supposed to help.
The intense relationships developed with those one helps in disasters also requires ethical monitoring, in addition to the usual mental health professional ones. (See Appendix C for the code of ethics of the Australasian Society Traumatic Stress Studies.)

In summary, specialist psychological services are needed in disasters, in order to

- recognise, assess and deal with different dimensions of biological, psychological and social stresses outside the usual paradigms
- deal with unstructured and exacting logistical and organizational demands
- be able to liaise properly with other helpers, and interact advantageously with management
- be able to productively self-monitor oneself and one's organization.

4.3 Psychological Service Providers

Psychological service providers should be able to deliver the services described above in section 4.2. Integration of proven and trusted service providers may reduce convergence by a multitude of service providers unfamiliar with specific requirements in disasters. Integration of psychological services needs to be maintained by regular network meetings with management.

In the absence of current accreditations for specialised psychological services, and the frequency of unsolicited groups and individuals who offer psychological services in disaster areas, the following guidelines are offered to assess suitability of psychological service providers for disaster work. The guidelines should be used by organizations and individuals who contemplate offering psychological services to disaster areas, and managers who may need to determine suitability of such people at the disaster site. In the latter situation managers should consult senior psychological service personnel already trained in disaster work.
Broadly, similar principles apply to potential acceptance and disposition of psychological service helpers as to those who offer help to other specialised services (such as firefighters).
More specifically, the following questions can be asked of those wanting to help -

- To what extent have they had prior experience, training and ability to perform the specialised psychological services in disasters described above?
- If not specially trained, to what extent do individuals/groups have a secure professional identity, matured professional experience and skills, knowledge of own limitations, and a secure work base which will enable the workers to stay as long as needed, be rostered, and be supported?
- What is their coping style, defenses and blind spots? How have they coped in previous disasters, and with personal disasters? Do they have capacities to prioritise?
- To what extent will they fit in with the culture of the population, other emergency and recovery services, and with community and established psychological services? To what extent do they have group process skills?
- Will they accept lines of responsibility and accountability within the disaster management framework?
- Do they accept self-monitoring (debriefs, supervision)?

- Are they bound by professional ethics? Will they accept the ethical guidelines for trauma work (Appendix C)? Do they accept that their prime responsibility is to affected populations, not third parties? Will they declare other interests and who pays them? Do they accept remuneration as conveyed by the disaster management authorities? Will they maintain proper duty of care in the context of informed consent and confidentiality?
- These questions will help to assess to what extent can service providers' skills, attributes, capacities to fulfill roles, match needs of particular disaster populations, particular available resources, at particular times.

If it is assessed that those offering their services can be utilised by specialised disaster psychological services, they should be helped to establish themselves into existing networks. If it is assessed that they cannot be of help, they may be treated as other well meaning people in convergence phenomena.

5. Assessment

5.1 General

In broad terms psychological service assessment may be defined as evaluation of the impact of a disaster at a particular time on individuals, families and communities, with the purpose of determining needs for psychological services. Assessment is a continuing process from pre-impact to healing. It is a complex, dynamic three dimensional enquiry which takes into account adaptive and maladaptive, predictable and unpredictable, uniform and fluctuating biological, psychological and social responses to threats of survival and of what is important in life.

In this section general principles and modes of assessment will be followed by a description of more specific means of three dimensional assessment. The general and specific ingredients of assessment will be applied to specific populations at specific times in later sections.

5.2 Some general principles

The following key considerations applicable to assessments generally may be noted.

- FIRST DO NO HARM. Assessments are in themselves interpersonal interventions which have an effect on those assessed. It cannot be assumed that assessments are necessarily positive experiences or helpful for affected persons. One should continuously monitor whether one's assessment is helping or causing distress. For instance, a pathological bias may be self-fulfilling, and assessment of vulnerabilities may expose and aggravate them.
- Assessments understand that most people respond normally, not pathologically in disasters. In this sense assessments are like in epidemics where all are potentially vulnerable, but only a sizable minority become ill. Assessments are directed to ascertaining best methods for prevention of pathology, and discerning the vulnerable and those already ill.
- Service providers must assess the situation in which they are assessing, and adapt to the unique requirements of interviewees, local issues and dynamics.
- Assessments should continue in all disaster phases, include all social system levels (that is, communities as a whole, groups and organizations, families, individual adults and children, and emergency service and helper), include biological, psychological and social aspects, and include levels from instinctive to spiritual.
- Nevertheless, assessments may need to be tailored to the phase of the disaster (for instance, relatively more "triage," in the immediate aftermath of a disaster, relatively more emphasis on assessment of life meanings in later phases).

- Different types of assessments have their windows of opportunity of acceptability, both of the enquiry and the assessors. For instance, if the initial windows are missed, trust, bonding with, and integration of service providers into a disaster affected community may be compromised.
- Affected individuals must be given the opportunity to express their most pressing needs in their own language without preconception, judgement or need to straitjacket communications into prior paradigms.
- Assessors are themselves affected by traumatic situations. Caution must be exercised to not have assessments distorted, for instance by overidentification with victims, defenses such as dissociation or denial, or evocation of previous blind spots.
- Concurrent education should be given to affected people on different social levels about the nature and purpose of assessments.
- Assessments must be coordinated to ensure there is no unnecessary repetition.
- Where feasible, review assessments should be undertaken by the same person.
- Assessments should always be informed by the complexity of the process, and readiness to assuage any distress inadvertently evoked by the assessment.

5.3 General Modes of assessment

Given the complexity and variety of psychological responses to disasters there can be no simplistic proforma model for assessment. One's whole person as well as specialist skills must be available to communications from affected people.
The following modes are available for assessments. Within each mode are assessed both **verbal and nonverbal means** of communication. Nonverbal means include facial expressions, postures, body language and artistic expressions.

1. **Telling the disaster story.** People are facilitated to tell their stories fully and in their own words. Stories are filled in from other social systems, such as communities reporting about individuals and vice versa. Assessments are non-judgemental, yet take into account defensive distortions. For instance parents and teachers often underestimate children's distress, while people may project their own distress on others. In such cases they may say that their neighbours are worse off than themselves.

2. **Professional histories.** They include personal and family histories of disasters and means of handling them, assessment of past illnesses, personalities, strengths and vulnerabilities. Again others may shed light on such histories.

3. **Reenactments (Transference).** Trauma stories may be "transferred" from the traumatic situation to the assessment situation and reenacted or dramatised in

the latter. For instance, anger in the assessment situation may reflect anger from the disaster event.

4. **One's own responses (Countertransference).** One's own responses may be empathic identifications or reactions to other people's feelings, even if the latter are unexpressed. For instance, one's own despair or denial may reflect the way interviewees feel, while one's impulse to protect and provide may stem from others' attachment needs.

5.4 *Specifics of Three Dimensional Assessment; Use of the Triaxial Framework*

When "the pebble hits the pond", effects from survival responses ripple across various dimensions and their components (section 3.3, Appendix A and B).

Note that assessments include both

- A sweep of the ripples in all dimensions to see what effects the disaster caused and
- Diagnosis of salient points on the ripples by orienting the points and tracing their manifestations back to their original contexts.
- Assessments include adaptive and maladaptive, biological, psychological and social aspects of each ripple point which shows disturbance
- It is useful to do a checklist to see whether all the components of the three axes have been assessed.

What follows is assessment of the various components of the three dimensions of the "pond" (i.e. population) affected in disasters. In section 5.5 assessments of the three dimensions will be applied in different disaster phases and social systems. The principles above are applied in a pragmatic framework.

5.4.1 Parameter axis

Components of the parameter axis describe what happened when to whom. The following are assessed -

- *The details of the particular stressor* (flood, shooting), and the extent and nature of devastation.
- *Details of when it happened*, over what period.
- *The details of the affected community* - demographics, social system groupings and networks, special groups who may be of help or are vulnerable.
- *Ages* of those affected - children, adults, elderly.

5.4.2 The Process axis

The process axis assesses the nature of the ripple effects, including the what how and why of disaster consequences. Each of the components which follows has biological, psychological and social (functionally biopsychosocial) aspects.

- *Stressors.*

Assessment of the noxiousness of stressors includes the number dead and injured, degree of mutilation, presence of human motivation in the causation of the disaster, youth of victims closeness to the epicentre of the event, extensive destruction, suddenness of the event and unpreparedness.

The more these factors are present the more stressors are likely to lead to trauma, and be *traumatic stressors* (3.2). Lesser stressors which may be resolved and even lead to better adjustments are called *crises*. Lesser stressors again may be *"daily hassles"*. Disaster stressors usually have a cascade of a mixture of stressors.

- *Stress responses*

Assessment and making sense of stress responses relies on assessing which survival strategies (fight, flight, rescue, attachment, goal achievement, goal surrender, competition, cooperation) were evoked to deal with stressors. (See 3.3.2 and Appendix B.)

Stress responses may be adaptive, in which case they provide satisfaction. If insufficient or maladaptive, they may lead to stress and trauma (see below)..

The wide range of fluctuating and often opposite (e.g., altruistic and selfish) manifestations is due to the multiplicity of survival strategies used in disasters, and their adaptive and maladaptive, biological, psychological and social aspects. (For classification of these responses see table in Appendix B.)

The presence of even intense stress responses in the initial stages may not indicate bad prognosis, as they may lead to adaptive dealing with stressors.

- *Stresses and Traumas*

It is important to assess and distinguish *adaptive, maladaptive/stress,* and *trauma* responses. While adaptive responses lead to satisfaction, *unsuccessful/maladaptive* ones are associated with a sense of *strain stress or distress* which are nevertheless still reversible. On the other hand, *trauma responses* are associated with a sense of overwhelming threat of death and irretrievable disruption. Severe stress and trauma responses (often called *traumatic stress* or *critical incident stress responses*) need to be assessed and monitored for their potential long term entrenchment and evolution of symptoms and illnesses.

Stress and trauma responses are *biological, psychological and social. Psychological stress responses* include a variety of intense emotions, and cognitive difficulties experienced as difficulties in concentration, poor memory, sense of mental overload and fatigue with decreased mental

functioning. *Psychological trauma responses* include intense helplessness, powerlessness, aloneness, abandonment, engulfment, constant danger, disintegration. Cognitive responses include shock, dissociation, inability to sequence and have insight and perspective.

(For classification and specific diagnosis of biological, psychological and social adaptive, stress, and trauma responses see table in Appendix B.)

- *Strengths and Vulnerabilities*

Strengths are assessed in terms of training and successful past disaster experience, relevant coping skills, supportive networks and ability to use them, personal and financial resources, and resilience. Vulnerabilities to be assessed include past traumatic events and illnesses, past fragility and lack of resilience, current noxious stressors losses of people and resources (see *Stressors* above), lack of coping skills and supportive networks, and having young or elderly dependents.

- *Defenses*

Defenses mitigate stresses and traumas by diminishing awareness of them. Assessment involves identifying particular defenses and the benefits and costs of the tense coping equilibrium of which they are part.

Dissociation may manifest as a sense of unreality, out of body experiences or numbing. Fragmentation of responses may emphasise only one of biological, psychological or social responses. Disconnections (such as suppression or repression of awareness and memories), distortions of memories (such as projection, displacement), avoidance of anxieties (such as denial, withdrawal, overwork and substance abuse) all have benefits and costs in particular circumstances.

- *Symptoms and Illnesses*

Though both affected people and helpers naturally reject illness models while they are trying to reconstitute normality and in fact to prevent pathology from occurring, it must be recognized that traumas and defenses do lead to a wide variety of biological, psychological (including PTSD), and social symptoms and illnesses, which account for well known increases in morbidity and mortality after disasters. Assessments include diagnosis of these dysfunctions, and assessments of past and present vulnerabilities and strengths which compound with current stress and trauma consequences.

5.4.3. The Depth axis

Assessment of the depth axis (see also Appendix 1) is often forgotten as it does not deal with immediate survival issues. However, depth axis components include what makes life meaningful and worth surviving for. Thus disturbances to these components may actually cause more suffering than struggles for survival. Checking for these components, and diagnosing them when they present themselves, is therefore very important.

- *Judgements*

Positive judgements include pride, worth, goodness and lovableness for actions in different disaster phases. Negative judgements include anger, guilt, shame, and a sense of injustice at one's own and others' actions. Assessment includes understanding the specific sources of both positive and negative judgements.

- *Beliefs*

Beliefs include basic assumptions about oneself and the world. They include values, ideals, principles, rights, and codes of conduct. Assessment includes identifying both upheld values and ideals, and beliefs which were shattered. Assessment also includes noting the source of false beliefs and basic assumptions which arose in the disaster.

- *Identity, self*

Assessment includes enhanced and compromised aspects of identity. Enhanced self-respect may stem from having acted altruistically or effectively according to expectations, or even beyond one's prior self-estimation. Loss of self-esteem may arise from a sense of failed roles, and having acted outside one's ideals. Dignity may be maintained in adversity through maintenance of self-respect. It may be lost through loss of self-respect and its symbols, and denigrating treatment by others.

- *Spirituality, sacredness, beauty*

Disasters may shatter assumptions about God, consequences of good and bad actions, and connections with an ordered purposeful universe. Disasters may also be seen as having destroyed beauty and harmony. On the other hand, survival and its accompaniments may come to be seen as sacred and meaningful. As well, inventiveness may spring from necessity, and creative impulses may flourish with regeneration.

- *Existential meaning, purpose*

It is important to assess the balance of existential hope and despair, and the meanings, fulfillment and purpose which have been derailed. The latter can be central motifs of distress. Hope of positive meanings and purpose provide energy for recovery. Disasters may reshape past meanings of life in the context of increased wisdom and maturity.

5.5 ASSESSMENTS AT DIFFERENT DISASTER PHASES OF DIFFERENT SOCIAL SYSTEM LEVELS

The following section provides guidelines on assessment procedures at different disaster phases of specific social groups.

Note that

- The underlying intention is to assess needs at any given time at any given level so as to specifically match them with appropriate interventions.
- This can only be an approximation as both phases and social systems overlap and impact on each other in a dynamic system. For instance, events in one phase influence those in subsequent ones, and social systems impact on each other.

For the purpose of this manual the following definitions of disaster phases and social system levels will be used. (They are consistent with those in the AEM Disaster Recovery Manual.)

5.5.1 Definition of Disaster Phases

The phases considered are broadly preimpact, impact, post impact, and recovery and reconstruction.

Preimpact Phase

Preimpact phase is the time before the disaster strikes. It is the time for putting into effect lessons from past disasters, and for training and preparation. As the disaster approaches, it is the time for warnings, and possible evacuation.

Impact Phase

Sometimes called the heroic phase, it is the time during and immediately after the disaster strikes when people use strategies of survival to save themselves and others, and to preserve possessions.

Postimpact Phase (First days to weeks)

When the immediate threats of the disaster wane, the first part of the postimpact phase is characterised by joy of survival, strong egalitarian and generous bonds among survivors, strong sympathy and help from outside, and a sense of optimism about quickly returning to predisaster circumstances. This period is also called the honeymoon phase.
The phase of disillusionment follows as the difficulties of coming to terms with losses and rebuilding become apparent. Much frustration with scarce resources and bureaucratic and diminishing help may be accompanied by community tensions. As people try to assimilate their disaster experiences they may have a sense of still being immersed, reverberating or being assailed by images, responses, judgements and meanings from the disaster.

Recovery and Reconstruction (First month to years)

Physical and environmental reconstruction and replacement is accompanied by passage of identity from victim to survivor where individuals and communities resume responsibility for themselves and their disaster story. Disaster responses, their judgments

and meanings are worked through into overarching wisdom. Yet unresolved griefs, entrenched stress responses, maladaptive defenses, may evolve in this stage into symptoms and illnesses, or may emerge in a delayed form in previously apparently well functioning people.

5.5.2 Definition of Social System Levels

The groups to be assessed are communities, families, adults and children. Helpers are a special group which needs assessment and help (see Section 7). Other secondary victims, such as family members outside the disaster area, nearby communities, media reporters, body handlers, hospitals to which the injured are transferred, should be remembered and assessed.

Social system levels merge and overlap, and assessments within particular social groups use information from other social groups. For instance, individuals and families give information about communities and vice versa, and adults give information about children, and vice versa.

Although this manual refers only to the Australian context, the same principles of preparedness and response apply when helping in disasters internationally.

Communities

Communities are generally defined by all those affected directly by a disaster. Yet communities include a variety of intersecting groups which may be defined by geographic location, cultural, ethnic, socioeconomic, functional, institutional, or accidental visitor criteria. Disasters may also create new groups such as evacuees, and bereaved groups. Community groups cohere through social networks, hierarchies, established codes and institutions, and channels of communication.
Assessment therefore includes strengths and vulnerabilities of the community as a whole, its groups, networks, leadership, communication, and capacities of its institutions especially of its emergency services, local government, and health and welfare systems. Assessments are made of vulnerable parts of communities, such as hospitals, retirement villages, and ethnically and personally isolated groups.
Special sources of information for community assessments include prior sociodemographic profiles and other community assessments, and current disaster command post and community leaders.

The following points should be noted in community assessments

- It is important to develop an assessment style that is relevant to the particular community (such as civilian / military; urban / rural), its current tone, mood and morale, and culture (such as psychological mindedness and capacity to deliver services in a psychological framework.
- Assessments may be undertaken through visiting places and people formally and informally, attending briefings and by convening meetings.

- Assessments are made by different people at different hierarchical levels. They need to be integrated by person/s who do not have operational responsibilities and have requisite experience and knowledge to make overall “meta assessments”.
- Assessments should be mapped over time and carefully integrated in the overall management process.
- Assessments should be monitored for potential adverse consequences.

Families

Families include parents, children and grandparents. Other members in the same household including relatives and friends, extended households, and close family members who were not in the disaster area at the time may form parts of assessments. Pets and toys should also be included whenever practicable.

The following points should be noted in family assessments -

- It is critical to ensure that all members of the family and other residents in the household are included assessments, from infants to the older generations.
- Families may ‘protect’ vulnerable members from scrutiny, or use them as projections of their own distress.
- Wider family networks who suffer secondary stress should be assessed in their own right.
- The same ethics, such as of privacy and confidentiality (Appendix C), apply to family assessments as for those of individuals.

Adults

While adults are assessed as parts of communities and families, they should be assessed individually as well. Even though execution of roles and responsibilities weigh heavily on adults in their assessments and self-assessments, they may have many personal responses as well. These will be influenced by age, family status, and specific capacities and vulnerabilities.

During assessment the following points should be noted

- Affected individuals do not always recognise or report their difficulties and may need encouragement to do so. For instance being given information about common stress reactions may lead to people realizing that they are experiencing them too.
- Individuals may fluctuate in their functioning at different times in different roles, and in different circumstances.
- Assessment must be undertaken in a manner and space/setting congenial to the person. Privacy, confidentiality, dignity and rights of the person should be respected at all times (Appendix C).

Children

While assessment of children often utilises information from adults (parents, child carers, teachers, guidance officers), each child should also be assessed individually. Adults often underestimate and even suppress knowledge of children's distresses. Assessment of children requires knowledge of normal developmental phases, ability to communicate appropriately to the child's age, and use of play and drawing techniques with younger children.

During assessment the following points should be noted

- Children express their distress relatively more in physical symptoms and in actions. They are relatively more likely to associate events with atavistic and personalised meanings such as that they caused the disaster or it was a punishment for their misdeeds (see 5.9.4).
- Children may express their own vulnerabilities and distress, or they may act as symbolic vehicles to express family distress.
- Children's assessments should take similar care for dignity, confidentiality, rights and monitoring of assessments as adult assessments.

5.6 Assessments in the preimpact phase

5.6.1 Community

Assess the culture, groupings, information networks, strength and disaster preparedness of institutions and leaders. What are community demographics and past history with disasters?
Are current information and warnings dispersed in a credible manner, and are consequent preparations congruent with the likely danger? Alternately, are people acting on denial, rumours and myths?
Assess capacities and needs for support, especially of vulnerable institutions such as retirement villages, hospitals and schools, and vulnerable groups such as the ill, frail, old, marginalised and non-English speaking.

5.6.2 Families

Assess family structure and culture. Is the family prepared, does it have contingency plans? Is the family prepared especially for its vulnerable members? Does the family need education, training, slotting into community and communication networks? Are there imminent needs for evacuation, of whom, and what will be the cost in potential separation stresses?

5.6.3 Adults

Assess personal strengths (such as training, previous experience), vulnerabilities (such as physical and psychological illnesses, social isolation), and insight into the needs of the incipient situation. Do denial or inappropriate beliefs prevent appropriate action?

5.6.4 Children

Assess the child's maturity and capacities to understand safety precautions. Assess suitability of protective networks (including at school) prepared for the child. Should the child be evacuated (see 5.6.2)?

5.7 Assessments in the impact phase

5.7.1 Community

Assess the probable extent of loss, destruction and disruption in the community, its groups, leaders, hierarchies, networks and communications and institutions. Is correct information available to and from the community?
Are existing emergency services effective? Are new organizations and leaders emerging, and how effective are they? Are vulnerable groups safe and catered for?
Is spontaneous outside help appropriate, effective? Or are there unhelpful convergence phenomena?
Assess the extent to which the community is coping or needing professional help.

5.7.2 Families

If psychological services are present in the impact phase of disasters, their assessments revolve on how to survive and preserve themselves, and those around them. Assessments involve urgent issues of which strategies of survival to use, such as how to help retrieve and unite family members and save them.
Assessments include those in need of psychological first aid - the injured, shocked, stunned, confused, those behaving inappropriately in terms of survival, the isolated and those who feel abandoned.
Usually assessments of impact phase are retrospective. What family losses occurred? What threats to life and destruction were experienced and witnessed? How did the family survive? To what extent did family members become separated? How were separations handled?
What life saving, competent, altruistic acts occurred with what gratitude, within families and between families (e.g., neighbours)? On the other, what strains in rescue and protection occurred with what anguish or resentment?

5.7.3 Adults

Assess survival needs and which survival strategies are/were attempted from moment to moment. Were they successful or not? To what extent did the individual believe they/loved ones would die? What strains are/were present regarding the "survival calculus" that is calculations balancing personal and others' survival needs? What were

the eventual losses? How much shock and dissociation (disbelief, denial, derealization, depersonalization) are/were experienced?
Which physical, cognitive, emotional social or spiritual experiences stand/stood out from others? How were they interpreted?

5.7.4 Children

Did the child think it, parents or others would die? Attachment is the major survival strategy available to otherwise helpless children. How secure is/was it? How much separation is/was there physically and emotionally from protective figures? What other survival strategies did the child attempt? For instance, did the child try to rescue parents, pets, toys? Did the child help, and how effectively? What are/were the ultimate losses, including pets, dolls and toys? How much did the child absorb what was happening, or to what extent was it defended, for instance dissociated?
What are/were the salient events the child witnessed and how were they interpreted (e.g., monsters were causing the havoc, parents abandoned the child, the child had caused the traumatic event, or it was a punishment for its misdeeds).

5.8 Assessments in the postimpact phase

5.8.1 Communities

Many impact phase assessments are extended into the postimpact phase. What is the extent of destruction and loss, functioning of leaders, institutions and communication channels, caretaking for vulnerable groups, effectiveness of local groups, outside helpers, and further need for help?
In addition, assessment includes how post-disaster euphoria (honeymoon period) and subsequent disillusionment are handled. Is the phase of generosity and mutuality facilitated adaptively, and state of subsequent disillusionment anticipated and mitigated? How is the community accessing, rejecting, dealing with helper bureaucracies? Dealing with new stresses?
Assessment includes the extent and nature of cohesion and disruption within and between old and new hierarchies, community groups and outside services. Are information networks efficient, or are rumours, and misinformation rife? What assistance can be given to facilitate communication of correct and credible information?
Is there high community morale with mutual goals and cooperation, or low morale with tensions, envy and greed? Are old tensions and conflicts reactivated and even deepened? What can facilitate the establishment of helpful cooperative networks?
How is the community assessing its losses, including of community symbols and icons? Is there a need to facilitate public mourning ceremonies?
How is the community apportioning blame and guilt, esteem and shame? Are individuals or groups being scapegoated? What community values, symbols and identity have been enhanced or disrupted, and what meanings are made of the events?
What information is available to provide understanding in terms of survival needs in the disaster context, of the multitude of biological, psychological, and social responses, and of judgements and meanings reverberating from the disaster?

Is there circulation of advice about the balance between containing emotions for survival needs and expressing them for the sake of coming to terms? Are there warnings about accidents, physical problems, anxieties and depressions, alcohol and drug abuse, marital and problems in children, as a result of strain and imbalance?
Is priority help reaching the vulnerable, and the worst affected (see also 5.8.3)?
On the other hand, is the community adaptively accessing help and evolving new goals?

5.8.2 Families

To what extent has the family reconstituted with resumption of adaptive roles, or is disrupted and dysfunctional? Is the family availing itself of available information, social networks and available help?
Is the family mutually loving, supportive, open to each others' physical emotional and social needs, grieving together and setting new mutual goals? Or is the family splintered and competing for emotional needs? Is it tense, with suppressed emotions enacted such as in irritabilities, withdrawal, and absent or overactive sexual needs?
What positive judgements and meanings have evolved from disaster experiences, and what angers, guilts, shames, sense of injustice and negative meanings are smouldering?
Are vulnerable family members such as children and the elderly and frail properly cared for? To what extent have family strengths and vulnerabilities come to the fore? How can the former be encouraged and the latter be supported?

5.8.3 Adults

Following the euphoria of survival, how are people coping with the realization of what happened and how hard it will be to rebuild? How are they coping with their various roles, and how are they able to access social networks and help?
Which adaptive and maladaptive biological, psychological and social responses of which strategies of survival are still fluctuating and reverberating with the disaster? How are they being expressed (e.g., relived, suppressed, transferred to new situations, projected on others, and so on)?
What current stressors are present and what are the responses to them? Are they adaptive or maladaptive? Are insufficient or maladaptive means of dealing with new stressors due to faults in provision of help, still active disaster responses, and/or past vulnerabilities?
How have predisaster, disaster, and postdisaster events, strengths and vulnerabilities compounded? For instance, have past fitness, resourcefulness, and sociability paid off, or have prior say, heart conditions, depressions, and social isolation worsened?
What judgements and meanings were evolving? (E.g., " I didn't know I could be so effective." "I am a bad mother." People come good in disasters." "People let you down when the crunch comes.")
In the latter part of this phase (starting 7-10 days post-disaster), are people starting to come to realistic terms with events? Or are they still (re)living traumatic events very vividly and consistently, are still stunned oblivious and dissociated, or still overoptimistic, overimmersed, or have lost too intensely their life path and purpose? If so they may well need continued assessment and help.

5.8.4 Children

How is the child managing changes and how much care, attention and understanding is it receiving? Because children respond to adult expectations such as to not complain, and have greater cognitive difficulties to sequence make sense and express events, distress of children may go unnoticed. Therefore, extra patience is required to give individual attention to listen to children and assess their needs. Assessment takes into account adult reports, though it must be remembered that these may be overoptimistic or skewed. Children tend to express their survival response reverberations and relivings relatively more than adults through actions, emotions and physical manifestations. As well as relivings and anxieties of the actual disaster, children are likely to reflect attachment and protective anxieties, and angers and guilts involved around parents. Assessments in children require reading their behaviors and body language, their communications according to their developmental ages and their expressions in play and drawing. Personalised meanings which children are more likely to make of events, such as that they caused them, deserved punishment, and were unlovable, are assessed.
Persistence of the following may require monitoring and possible intervention - physical symptoms, sleep problems and nightmares, clinging, demanding, regression to earlier behavior, decreased function, overactivity or withdrawal, and anxious or aggressive play or acting out in the environment.

5.9 Assessments in the recovery and reconstruction phase

5.9.1 Communities

To what extent is the community progressing or is it stuck in its recovery and reconstruction of its environment, groups and networks?
Is the community well informed, able to access help? Are insurances and compensations distributed quickly and fairly? Has the community adequate advocacy?
To what extent and how appropriately, is the community self-reliant and assuming responsibilities for itself, and to what extent is it dependent on others? Is the community exploited for instance by real estate agents and tradesmen?
Are new balances harmonious with high morale, or with low morale, smouldering with conflict, blame, and sense of injustice? If so, what are the factors causing this?
Are significant memorials held, causes of the disaster resolved, justice achieved? Are heroes and helpers, but all survivors in individual ways, recognized?
Are creative integrations of the event into community history and meaning being achieved, values identity and existential meanings reestablished? Or is there lasting disillusionment, discontent, splintering, and people leaving the community?
Are those identified as vulnerable earlier progressing well, or are their earlier responses becoming entrenched into symptoms and illnesses? Are delayed biological, psychological or social symptoms and illnesses coming to the fore, and are they helped by service providers? Have contacts with referral services been made and maintained? Are communities, schools, helper agencies, informed to look out for disaster consequences for even up to years?

5.9.2 Families

To what extent has the family directed its efforts constructively and regenerated new lives, or are struggling or even given up e.g., become dependent on welfare? Are family relationships harmonious, or have earlier tensions worsened, or new ones developed? Has the family created a family narrative of the disaster, in which they all feel esteem, or are they bearing secret wounds in a 'conspiracy of silence'? Are their energies creative, or diverted to maintaining a facade and absorbed in maladaptive preoccupations?

Is any member of the family vulnerable or suffering symptoms and illnesses? To what extent are they symbolic of family stresses and strains?

5.9.3 Adults

Is the individual readjusting to new circumstances reconstructing a new life and fulfilling roles in family and community? Or is the individual still under the influence of the disaster, past vulnerabilities and subsequent stressors?
Are defenses still active and are they adaptive or have they turned compulsions (e.g., overwork, substance abuse, sexual cravings), and to gaps in memory, and of parts of self? Have maladaptive and traumatic responses solidified into biological, psychological and social symptoms and illnesses? If so, which ones? Can they be made sense of by tracing them to particular survival strategies in particular contexts?
Finally, have new and fulfilling self narratives of the disaster experience evolved, with deepening wisdom of one's own human capacities and frailties, or is the person consumed with anger, guilt, sense of injustice, and shattered beliefs? Is there creativity and spurt to new life, or is the person disconnected externally and internally, wasting and decaying?

5.9.4 Children

Have children recovered their expected developmental phases and their sense of security, belonging and future? Have they grieved their losses, and readjusted to new relationships, homes, friends, schools and routines? Have they done so on a deep level, or only superficially to please adults? Have their earlier symptoms resolved, are they more chronic, or have new ones developed? What sense can be made of the symptoms, relating to which manner of survival in what context?
Ultimately, have the children absorbed the story and meaning of the disaster into their lives in a way which is no longer threatening? Or has it radiated fear into their lives?

Having made assessments of disaster affected populations one can plan and execute interventions. This is the subject of the next section.

6. Interventions

6.1 General

The purpose of psychological service interventions in disaster affected populations is to enable affected people to maintain and retrieve their biopsychosocial integrity and to continue or resume existentially meaningful lives.
Dealing as one does in disasters with fresh wounds, gives opportunities to preempt serious pathology and excessive scarring. Further, even if pathology develops, its recent onset and relatively clear causation may lend themselves to efficacious healing. Types of interventions thus range from psychological first aid to long term clinical treatment. The means of delivery of such interventions is designed to be through a seamless, holistic service which as much as possible supports affected people's capacities in their own recovery.
The following sections will consider some general principles of intervention and modes of the healing process. This will be followed by specific interventions at different disaster phases for different sections of the population, in accordance with the schema used for assessments in section 5.

6.2 Some General Principles

The following principles include and extend those in Guide 2 of Community and Personal Support Services, endorsed for recovery managers in 1979 by the Standing Committee of Community Services and Income Security Administrators (then the Standing Committee of Social Welfare Administrators). (For contrasts between delivery of disaster and orthodox psychological services see 4.2.2).

- FIRST DO NO HARM. Interventions can have negative as well as positive effects, and therefore they should be continually monitored.
- Interventions should favour self management and autonomy. They should empower those they help in the management of their own coping, recovery and wellness.
- Interventions should maintain the dignity of affected people and should be delivered in a tactful, flexible, paradigm free, fair, equitable and ethical manner (see also Appendix C).
- Because recovery from disaster is a complex, dynamic and protracted process, interventions must be provided in a coordinated, timely, and culturally-appropriate manner, tailored to the prevalent needs of affected people in different phases, throughout the entire recovery process.
- Services should be available in all disaster phases at all social system levels, take into account biological, psychological and social aspects, and all human levels form instinctive to spiritual.

- Psychological services should integrate with affected populations information, understanding of issues, policies, goals, decisions, arrangements, and management.
- Personnel should be selected for their specialist expertise, group skills, and ability to integrate with disaster management and other service providers (see also sections 4 and 7).
- Psychological services must be properly integrated into disaster management arrangements. (See also section *3.4(ii)*.) Psychological service managers should be involved consistently at all service hierarchy levels from initial briefings through all disaster phases.
- Interventions should be coordinated to avoid multiple approaches, and follow ups should be carried out preferentially by the same people.
- Interventions should be documented professionally and confidentiality of the documentation be maintained. Plans for availability of documentation should take into account translocations of affected people. Such translocations should be documented too.
- Pathways of referrals should be established and maintained through all disaster phases.
- Providers should receive concurrent help and supervision (section 7).
- Knowledge and experience gained should be utilized in future preemption. Preparedness should be increased through exercises, training and research.

6.3 General Modes of Stress and Trauma Mitigation and Healing

When adaptive responses are insufficient and stress and trauma (3.3) occur, the goal of interventions is their mitigation and promotion of healing. Mitigation includes the preservation of as much biopsychosocial integration and meaningful life as possible, while healing involves finding after disruptions new integrated, meaningful, self-conscious life paths.
The following ingredients apply in all interventions ranging from psychological first aid through various crisis interventions, debriefings, trauma counselling, to clinical therapy. Different techniques use different weightings of the following ingredients.

1. **Recognition** of who or what group is affected in what way, how and why. Inappropriate current responses and beliefs may make sense when traced back to their biological, psychological and social survival response origins in the disaster context. Recognition includes assessments made in section 5.
2. **Psychological support; counter-trauma environment.** Its characteristics include a safe space with boundaries within which one can absorb, think, feel, express fully, communicate, and put one's experience in context. ***Therapeutic relationship*** is very important. It includes sensitive empathic listening and tuning into affected people for the purpose of being able to offer

skilled help. The relationship is reliable, punctual, objective, and non-judgemental. It provides a template for hope, trust, bonding, and faith that the world can provide kindness, comfort and reliability.

3. **Relief of specific distress; symptomatic treatment.** Intervention may mitigate specific distress and symptoms. This includes creature distress, such as facilitating provision of warmth or toiletries. People may be taught skills in asking for such items by understanding helping networks, and know how to ask for what, where and how. Empowerment may also be facilitated by learning physical skills to improve one's environment, while ventilation of feelings and skills to manage tension, anxiety, anger and other intense emotions facilitates taking control over one's internal environment. Drugs may also be helpful to control anxiety and depression, and to relieve other symptoms. ***Education,*** provision of information and clarification are key components which relieve distress. It can provide great relief to have clarified that what people are experiencing is typical of *normal people who experienced an abnormal event*. Thus the responses are *not pathological* and people are *not crazy*.
4. **Assimilating the trauma;** requires full understanding of the nature of the traumatic events, biopsychosocial survival responses to them, judgements, meanings and beliefs which arose from them, and ripples emanating from them to current times. Each response and its ramifications are made sense of in terms of the original context and its ripples, and is contrasted with current less turbulent and hopeful contexts, and appropriate responses to them. Correct understandings of both the disaster circumstances and of the present are merged cognitively and emotionally in a chronological story with new meanings which incorporate both. This facilitates adaptive responses to the present and the future, which include wisdom of past experience.

It must be seen that

- disaster intervention is a sophisticated process of many sensitive components, which can help greatly, but if improperly applied, can do harm.
- This may be most evident in simplistic applications of packaged interventions to affected populations, especially when they are still in traumatised, distressed or disorganised states.

6.4 *INTERVENTIONS AT DIFFERENT DISASTER PHASES AT DIFFERENT SOCIAL SYSTEM LEVELS*

The following section provides guidelines for interventions at different social levels at different times, using the principles in 6.2 and 6.3. For definitions of disasters, disaster phases and social system levels see section 5.5.

Because as was noted assessments and interventions overlap, many principles applicable to assessments at different social levels (5.5.2) also apply to interventions. For instance, interventions in communities need to be applied taking into account the nature of the

community, its mood, morale and culture, and interventions are organized and applied at different hierarchical levels. Similarly, interventions are applied as necessary to all family members, even if one member is chosen to symbolise family distress, and techniques with children may use play and drawing.
Like assessments, interventions are informed by the triaxial framework (5.4). Thus interventions in all groups which follow are tailored to adaptive and maladaptive biological, psychological and social responses and include dimensions ranging from the survival strategy responses to spiritual issues.

6.5 Interventions in the preimpact phase

6.5.1 Community

Between disasters it is important that links with communities and other services are maintained. Denial that disasters will happen is countered by pointing out the denial process and its reasons, and providing information and education about preventive measures, and training and exercises. Mandatory preventive measures such as compulsory fire alarms and exercises may be introduced.
These measures are intensified as a disaster looms. Education and information become more specific, and measures are taken for them to be effective. For instance, help may be given to provide information and warnings in simple language(s), making sure messages are not overwhelming and give people means to take action. Trusted communication networks, both formal and informal are identified and utilised. Rumours, and myths (such as it can’t happen twice) are countered with facts.
Advice may be given about evacuation, its benefits and psychosocial consequences of separation from community and families. If evacuation is required, advice may be given as to what to take, such as family photos and videos, pets, favourite toys and family heirlooms.
Vulnerable institutions, groups and individuals (5.6.1) should be identified and extra provisions made for them.
Psychological services may aid crystallization of clear leadership, hierarchy of command, and a network of rescue services with clearly identified roles, territories, and channels of communication. Psychological services may help maintain high morale and preparedness.

6.5.2 Families

All members of the family should have clear information and education about potential disasters, and complacency be countered by emphasising simple preventive means. Protective measures of home and property are helped to be put in place. Emergency drills, contingency plans and role assignments are encouraged.
All these measures are intensified when a disaster looms. Vulnerable members are identified and plans made for them. Pros and cons of evacuation and family separation may be discussed.

6.5.3 Adults

Help may given to clearly identify individual adults' different roles and places in helping and communication networks. Any potential conflicts between roles (e.g., firefighter and family protector) should be clarified and prioritization of roles rehearsed.
Individual denial should be countered by information and education about prevention, and training and exercises be provided for eventualities.
This is intensified in impending disasters. Absorption of information and warnings about the impending changes in people's worlds is facilitated. Help is give to make difficult choices and prioritise what may be abandoned or sacrificed, and what preserved at all costs.
Information is given about expected emotions such as fear and their effects are anticipated, e.g., tendency to abandon rehearsed procedures.

6.5.4 Children

Children's developmental phases and parental filters greatly influence their understanding and response to safety precautions and preparation for disasters. Roughly, children under 3 years old are totally dependent on adults. Children aged 4-7 can obey by rote, while children over 7 act ever more like adults with increasing age.
Psychological services can help to educate parents and schools about how to provide information, education, preparation and exercises to children of different ages.
If separation from parents is required, it should be as prepared, measured, and explained as possible. Separation anxieties may also be mitigated by contact with trusted adults, and retaining pets, toys, photos and transitional objects.
Adults are encouraged to explain to children that the coming events and separations are not their fault or responsibility.

6.6 Interventions in the impact phase

In this phase psychological service personnel are participant observers. That is, as well as being concerned to survive and preserve themselves, they help others do the same. In the process they may use their professional skills for psychological first aid, such as help to reunite missing family members. Premature interventions, such as, "It is normal to feel anxious about your missing child." may be felt as quite unhelpful. On the other hand, helpful interventions which enhance (not reflect on) adaptive strategies of survival, may lead to trust and acceptance in future interventions.
Psychological service providers can provide a "mind" where action is predominant. This can help clarify and resolve some impulsive and inappropriate actions and conflicts.

6.6.1 Community

Psychological services can be useful at different hierarchical levels. They may hold in mind prior protocols, communication networks, and help to maintain or reestablish them. Emergent helping networks are also encouraged as is their coordination with standing rescue teams. Both are encouraged to not stand on pride and territory, but help each other, and make clear requests for appropriate help from outside.

Leaders who may be wavering are encouraged and empowered to fulfill their roles, communicate orders and information, dispense rumours, and help morale. Leaders who know the bigger picture are encouraged to take responsibility for prioritization. This can relieve rank and file workers of much potential guilt, and obsessive needs to provide "perfect" treatment, albeit to only a small section of the population.
Central registers and information may be facilitated on various rescue efforts, people's whereabouts and their states of being.
Helpers may check that vulnerable groups are being attended.
Psychological understanding of "irrational" people, whose inappropriate actions for the circumstances may be directed by desires to search or care for relatives, may dispel "difficult" behavior and preempt frustrated helpers from using force.
Helpers may themselves be helped such as by bringing to notice exhaustion, need for rest, and instituting rosters. (See section 7 for helping helpers.)

6.6.2 Families

Physical help to survive and preserve, and look after vulnerable members may be offered. Helpers may help to appraise realistically priorities and survival strategy options, and encourage them. This may help relieve paralytic inaction.
Reuniting family members who were torn apart, and information about missing family members and likely rescue efforts on their behalf, may allow other family members to get on with their current necessities. Helpers may help activate and access helping networks, and help maintain reliable channels of information.

6.6.3 Adults

With correct information, most people do naturally what is most adaptive under the circumstances. Correct information and aiding adaptive survival strategies where they are most effective is facilitated. Needs for prioritizing may be confirmed or redirected by correct information.
Psychological first aid may be provided or facilitated, especially for those who are injured, alone, who are frozen with fear, are stunned or are paralysed. Such states include psychic shock and dissociation. They may be reversed or mitigated by physical and verbal contact with relatives and friends (even if only by mobile phone), reassurance about safety, holding the hand, and being prepared to allow people to express their recently frozen horrors and traumas, and providing shelter, warmth and normality, often symbolised by a warm cup of tea. may be reversed by. At times shock may be relieved by giving people control, such as by finding them useful tasks, including looking after others.

6.6.4 Children

Children are given as much information, reassurance and instructions about what is happening in the disaster as possible. Their adaptive strategies of survival, especially attachment, are also supported. Their pets and toys are safeguarded. Unnecessary separations are avoided, but if inevitable, their morale may be maintained by singing, playing, activities and hopeful adult spirits. Useful tasks can ameliorate their fears.

Shock and terror in children is also mitigated by personal contact and warmth, reassuring words (which need to be truthful however), allowing children to express their feelings, and relieving their guilt and responsibility.

6.7 Interventions in the postimpact phase

Postimpact is when organized psychological services have traditionally started their work. In such cases work may be hampered by initial lack of trust and credibility. More efficaciously, in this phase prior networks are activated and integrated in a seamless effective service with community and emergency services.

6.7.1 Communities

It is sought that all service interventions be psychologically informed. Expert advice and consultancy are provided at all hierarchical levels, ranging from government and emergency and recovery managers, to affected communities.

Information is dispersed about usual community responses such as the post-disaster euphoria, tendency to find scapegoats, and convergence phenomena. Myths about the frequency of panic, looting, unbounded heroism and capacity to recover, as well as pessimistic assessments of permanent damage are countered with proper information. Special care is taken that media reporters are properly informed, and that they themselves are not overoptimistic or overwhelmed.

Information about the ubiquity, normality and sense of many biological, psychological and social responses, negative judgements and meanings is widely distributed. All means of communication are utilised, including radio, television, newspapers, Internet, telephone hotlines, newsletters, pamphlets (such as the Red Cross pamphlets distributed at Australian disasters), posters, community meetings, and interpersonal communication.

In this phase realistic stocktaking of losses and public mourning for them, as well as establishing realistic causes of the disaster and avoiding scapegoating, can facilitate progress of assimilation of the disaster.

In this phase many aid agencies and individuals stream into the area. Help is much appreciated if well tailored, but may have adverse effects if part of convergence on and competition for victims. These phenomena are countered by bringing them to the attention of mangers, and helping them to be discerning about aid offered. Psychological services may help to coordinate quality aid, and to halt inappropriate help and voyeurs. Communities and helpers need to have a mutual understanding of losses, needs, available resources, and knowledge of the system by which to access and distribute them. Aid workers are facilitated to give resources according to need, expeditiously and efficiently, yet with grace in a spirit of generosity and compassion, maintaining dignity and respect for the helped. Consultation will ensure that priorities are met, aid is tailored, and a sense of fairness and justice are maintained. This may preempt community tensions, envy and greed.

Vulnerable groups such as orphans, bereaved, homeless, isolated, non-English speaking, and so on are identified and specialist early treatment (e.g., early bereavement counselling

given). Secondarily affected groups (such as relatives) are identified and catered for, as are those who left the district.
Aid workers and communities are also educated about the natural ambivalence to aid, and for bureaucracies to be rules bound and unfeeling. Truly unsympathetic and unjust bureaucracies may be stressful and even traumatogenic. Their effects may compound with earlier states and elicit states of helplessness and rage. Psychological services may diagnose and ameliorate these interactions, through bridge building, education, advocacy and conflict resolution.
Channels of communication are used to increasingly empower communities to seek their own help, and eventually to help themselves. This decreases a sense of dependency.
Aid workers are themselves educated about secondary stress effects and their prevention, and help is given them as required (section 7).

6.7.2 Families

Psychological services to families are most efficiently provided on an outreach basis. All families are visited in their homes, and other shelters.
Two workers may visit families in order to make sure that all members are catered for their biological, psychological and social needs, and the family dynamics are fully absorbed.
Family needs must be attended both on the level of the family as a whole, and on the basis of all their individual members.
Stress responses may be due to ongoing stressors which are ameliorated. This may involve arranging for creature comforts such as food, shelter, warmth, and medicine.
Reuniting families is very important. Families are also united with social and helping networks.
If it has been assessed that the family is tense and dysfunctional since the disaster, support and crisis counselling (Disaster Recovery Manual 5.1) are instituted in a family setting. These are subsumed in principles of stress and trauma mitigation (6.3).
Thus, in a safe environment facilitated by the therapeutic relationship, detailed cognitive and emotional recognition of what the family went through is achieved. Which survival strategies worked when in what interaction, and which did not, why, and with what consequences, is ascertained and fed back to family members. The sense and normality of their responses in the disaster context is pointed out.
Family members may express to each other how they saw the disaster from their personal perspectives, and express feelings to each other from such perspectives. Understanding of each other may resolve guilts and angers, and strengthen mutual esteem and bonds. Dignity and identity are preserved, or even enhanced. Adaptive meanings of the experiences may emerge.
Vulnerable family members are given special attention. Nevertheless, family distress behind the individual’s symptoms is discerned and addressed.

6.7.3 Adults

The same principles apply to individual adults as for families, and may occur contiguously with family healing. Thus reuniting with families and with social networks is beneficial to individuals as well as to whole families.

However, intimate one to one counselling relationships allow more personal issues to be addressed in more depth.
While ripples from disasters experienced by individuals may be able to be placed in logical context to the past, personal counselling often deals with situations where the connections to such contexts may be disrupted or hidden. Then people may appear to suffer irrational biological, psychological and social manifestations. Reasons for the disconnections may be protection against reliving traumatic events (e.g., sense of imminent death, deaths of others, helpless abandonments), accompanying negative judgements (guilt, shame, rage, outrage), and unacceptable meanings of oneself and the world. The connection may be retrieved through offering skilled and deep recognition of the symptoms (6.3), deep understanding and empathy for the traumatic events and their consequences, and hope and understanding that the traumatic event and its accompaniments are more than matched by hopeful current alternatives. Retrieval of connections to the traumatic event then allows once again understanding the symptoms in terms of rational biological, psychological and social survival responses in abnormal situations. With reconciliation of past and present, individuals may develop new realistically positive meanings and views of self and the world.
Such acute trauma therapy may prevent long term fragmentations of the mind and development of various entrenched symptoms. Therapeutic skills need to match the complexity of how the mind deals with trauma. They need to be able to additionally include dealing with past vulnerabilities and meanings, defenses and personality styles, all of which compound with the way affected people present.
Note that it may not be enough to simply reassure that symptoms are normal. Such reassurance may only be meaningful when all connections are in full awareness, and in the context of all other healing principles (6.3).

6.7.4 Children

Reuniting with parents and family, and creature comforts are even more urgent for children than for adults. Once this is achieved, it is important to reestablish children's routine, and education, contacts with peers, and opportunities for play and drawing to express their experiences.
As for adults, it is important to give children opportunities to express themselves in one to one situations. Their physical and social reenactments may then be connected to particular child versions of traumatic events, judgements and their meanings. For instance, children may feel that the disasters, deaths, and subsequent parental strains and irritability are due to their badness. They may also combine their concerns with atavistic meanings of predatory worlds, and monsters and witches.
Again acute therapy, this time tailored to children, may prevent such symptoms and meanings becoming entrenched. Interventions need to be at the level of children using their special modes and means of communication such as play and drawing (5.5.2).

6.8. Interventions in the recovery and reconstruction phase

This phase is prolonged, lasting even years. Many delayed symptoms and illnesses become manifest in this phase, so it is essential to maintain some level of psychological services for a long time.

6.8.1 Communities

Consultation and education at all hierarchical levels of the community and of recovery agencies is maintained. Consultation is provided on the process of handing over management to the local community. While self-reliance is encouraged, premature withdrawal of aid, and services is discouraged.

Information is provided to the communities, strained relatives ("Time to pull your socks up!") and bureaucracies about the real hardships, challenges and costs of this phase, and occurrence of solidified and delayed responses. Local doctors, marriage counsellors, welfare agencies are all alerted to likely increased workload stemming more or less obviously from the disaster experience.

Previously identified vulnerable groups are followed up. Those who were especially shocked (dissociated) during the disaster, and who were overimmersed in reliving the disaster are also followed up.

While capacities for self-recovery and independence are acknowledged and facilitated, appreciation must also exist for continued strain fluctuating tendencies to be disillusioned, dependent irritable, blaming, competitive, and divided (along old and new lines). Bridging communication and advocacy may facilitate more sensitive solving of needs, speedy and equitable insurance and compensation payments. Conflict resolution may resolve enmity between competing groups for the benefit of the whole community.

Community vulnerability from exploitative tradesmen and real estate buyers wanting to buy cheap is countered by issuing warnings and encouraging protective laws.

Absorption of the disaster into community culture is facilitated through mourning and memorial rituals, commemorations of the dead and the heroes, and celebration of the community's achievements. Regeneration ceremonies, creative and aesthetic remembering (plays, books, paintings, sculptures, and so on), and consolidation of communal wisdom are encouraged.

6.8.2 Families

Most families may forge new self-respectful identities which include their disaster experiences and reconstructed lives.

However, for others earlier difficulties may become entrenched or new ones become evident. Interventions may include expediting various needs and referrals to various community agencies and networks.

Advice may be given about frequent marital and sexual tensions on the basis of extra personal needs which partners cannot fulfill, or the meanings of symptoms in children in terms of their extra needs. Influence on family of maladaptive coping including overwork, alcohol and coffee intake and substance abuse may be addressed and altered. Similarly education about the sense and origin of delayed stress responses may give much relief.

More entrenched and deeper problems may require trauma therapy as described in the postimpact phase (see 6.7.2 and 6.3). In this phase relatively more attention may need to be paid to prior vulnerabilities (e.g., marital problems), beliefs and entrenched defenses, conspiracies of silence, avoidance of emotions, and more overt symptoms and illnesses. Special attention may be paid to identified “sick” members, but the whole family is also seen in its entire system.

Much skill and sensitivity are required in choosing and dosing the various prongs of treatment. For instance, one must assess the family’s strengths and vulnerabilities, and balance the costs of leaving defenses intact, with the potential pain in different family members of exposure of stresses and traumas.

Once the disaster is in full awareness, painful silences are replaced with family voices of understanding of various members’ experiences and of the family itself. A self-respecting mutually affectionate story is integrated in the family’s history.

6.8.3 Adults

Interventions with individual adults may have taken place within family contexts. Individuals’ adaptive roles in families and community networks are facilitated. Referrals are effected to various helping agencies according to need.

While clarification of the sense of long term or new symptoms or symptomatic treatment may offer sufficient relief, one to one trauma counselling or therapy may be required to heal longer term effects of stress and trauma (see also 6.7.3 and 6.3).

Biological, psychological and social symptoms and illnesses, as well as distresses associated with negative judgements, meanings, shattered beliefs and ideals of self and the universe, are traced back and made sense of in their original contexts of stressed survival attempts and lost fulfillments. As in the postimpact phase, this may require working through defenses and past vulnerabilities. Trauma ripples are then reworked in terms of past and current realities, and adaptive meanings and views of self and the world. New meanings evolve which include wisdom of the frailties, yet also capacities for resilience and fulfillments of human nature.

6.8.4 Children

While many children will have assimilated the disaster as a learning experience into their developing lives, and even gained confidence in their capacities to overcome adversity, others may lack confidence and a sense of security.

Children may need extra attention and explanations, and help to readjust to new relationships, schools, friends, and routines. They may need help to grieve and express their fears and emotions.

Trauma therapy may be required, using special methods for children. Parental and school collaboration are enlisted. Ultimately the child makes realistic sense of its disaster experiences according to its developmental phase, and is able to creatively use them within its life’s trajectory.

7. Helpers

Because helpers are themselves affected in disasters, similar assessments and interventions need to be applied to them as to other affected groups. Three broad helper groups are considered.

- Community self-help groups
- Emergency and recovery service personnel
- Psychological services personnel

The groups overlap with each other and with community groups already considered. Therefore what follows should be read in conjunction with community assessments and interventions in different phases described above. However, the following assessments and interventions highlight special helper cultures and needs.

7.1 Community help groups

Community help groups may be established prior to disasters, or may emerge during disasters.
As one of the principles of helping disaster communities is to help them to help themselves, it is an important priority that community self-help groups are identified, assessed for their capacities to function, and helped to function if their capacities are compromised.

7.1.1 Preimpact

Assessment. Formal and informal leaders and groups are identified, communication channels opened with them, and their capacities to deal with disasters are assessed.

Interventions include education, training and exercises which help to prepare for disasters. The groups may be used as two way conduits of information, and for warning and preparation to the community. Internal and external networks with other helping groups and apportioning of prospective roles may be facilitated.

7.1.2 Impact

Helpers are helped in whatever way possible to survive and preserve life and property. Prearranged lines of communication may facilitate outside agencies to assess the nature and extent of community destruction and needs. Preparations for postimpact intervention are instituted at all hierarchical levels.

7.1.3 Postimpact

Assessment includes identification of available community helpers, their cohesion, intact leadership, morale and networks. Helpers are assessed for burnout and secondary stress.

Intervention. Functioning helpers are assisted and encouraged in their reclamation of their networks, and in their work with affected people. Those who have been compromised themselves by the disaster may be given priority assistance so that they can

then assist the rest of the community. The nature of the assistance is as described above for other affected people. Helpers are cautioned for burnout and secondary stress, and treated for them if they occur (7.2.3).
Seamless cooperation between community and other helper groups is facilitated at all hierarchical levels, while potential tension between them may be mitigated through activation of prior plans, and two way sharing of current information, and goals.

7.1.4 Recovery and reconstruction

Assessment. Functioning of established, emergent and reforged helper groups, their cohesion, leadership and morale, as well as functioning of their members is assessed. Occurrence of delayed stress responses, burnout and secondary stress disorders are monitored.
Interventions. If necessary, self-empowered efficient local networks are supported as necessary. At the same time, as established long term groups take over from emergent ones, the groups and their leaders are acknowledged in their previous roles. Some may be redirected to new tasks and groups.
Leaders and their groups are helped for delayed stress reactions, burnout and secondary stress phenomena.

7.2 Emergency and recovery service personnel

Emergency and recovery service personnel, as well as staff members of hospitals, nursing homes, community and human service agencies, and the media, may be secondary victims in disasters.

7.2.1. Preimpact

Assessment. Preferably emergency and recovery services already include psychological components at different hierarchical levels and in teams. As trusted members, they can more easily assess and monitor that lessons from previous disasters of how personnel can be psychosocially affected are used to prepare for subsequent ones.

Interventions include countering denial and facilitating preparation and exercises. Encouragement to add psychosocial and “human” dimensions to physical concepts is enhanced by education and training in biopsychosocial and personal responses in disasters.
In current disasters, psychological services are part of the briefing process. Needs for clear roles, territories, cooperation with other services, lines of communication and responsibility (such as for prioritization of rescue efforts) are highlighted and facilitated. Morale is facilitated by support for leaders, encouraging humour, and confidence, but within realistic confines of what will be able to be achieved.

7.2.2 Impact

Psychological services may be part of emergency teams, such as mental health workers in medical teams. They may provide “psychological first aid” to rescue teams as well as to affected populations.

Assessment. Assessment includes the efficacy and quality of helper-victim interactions, and of emergency personnel functioning.

Interventions aid survival and preservation activities. Division of labour may include psychological first aid such holding victims' hands, explaining procedures, reinterpreting negative appraisals, while rescue personnel proceed with their physical tasks. Victim "uncooperativeness" may be quickly clarified and resolved, by dealing with fear for relatives or special life meanings (see also 6.6.3).
Concurrently staff is supported in their stresses, such as needs to prioritise according to the "survival calculus", and thus leave some victims without ideal help. Workers may be reminded of the need for breaks in which salient problems may be quickly discussed (decompression). Rosters are facilitated. At the end of rosters or of rescue work, food and drink, short sharing of experiences and feelings are facilitated. Workers are reminded about possible later responses and are warned about potential for accidents (demobilization, defusion).

7.2.3 Postimpact

This is a time of taking stock, appraising achievements and losses, and repairing dints in morale. Personnel need to feel continued support by their managers, personal needs arising from the work to be sensitively managed, and to have ready access to consultation and counselling.

Assessment. Group and individual achievements and failed objectives, gains and losses, are assessed objectively and subjectively. Team debriefs have operational and psychosocial components. Operational components make objective assessments of services provided, and where improvements may be made in the future. Psychosocial components contrast objective assessments with subjective sense of achievements and failures. Knowing the culture of the group, the members and their strengths and vulnerabilities is very helpful.

Intervention. The principles of provision of psychological services such as tailoring them to the culture and needs of recipients at particular times (6.2) and of stress and trauma mitigation such as provision of safe space and boundaries (6.3) must be applied to service personnel too.
As noted, correct application of these principles requires sophisticated psychological service skills and training which cannot be compressed into simple packages or didactic lessons such as, "Your responses are normal for abnormal circumstances."
Psychological services in this phase include **supervision** where client problems are ironed out, including by making service providers aware of personal blocks; **mentoring** includes discussing personal problems with a designated person; **counselling** may extend the above into dealing with secondary stress, and triggers to earlier vulnerabilities; psychosocial **debriefing** involves assimilating disaster experiences and responses into professional and personal histories.

Debriefing

Debriefing for service personnel is the equivalent of outreach to affected populations. It is intended that in the process the group achieves homogenous understanding of the disaster and personal roles in it, and that personal biological, psychological and social stress responses, and maladaptive judgements and meanings can be resolved and incorporated into adaptive alternatives.
Tailoring of psychological services to service personnel debriefs may involve the following.

- All service personnel should be included and be able to communicate safely across hierarchical lines.
- Especially difficult disaster stressors (critical incident stresses), should be recognized. They may include multiple deaths, mutilations, death of family and friends, role conflicts, priority conflicts, failed equipment, etc.
- The client is both the group as a whole, and all its individual members. Intragroup tensions which may be due to role blame or guilt may need to be ironed out for morale to be reestablished. At times certain members highlight group dysfunction, at other times group dynamics reflect individuals' characteristics, especially of leaders.
- Service personnel are especially concerned about whether they saved as many lives and as much damage as possible, and whether they did a good professional job. It is therefore important to go over the disaster in detail and make sense of what was done and what could not be done. In the process especially maladaptive rescue and goal achievement survival strategy stress responses (appendix B), and associated guilts, shames, angers, sense of injustice and negative meanings, are identified, made sense of, and alleviated by placing them in their realistic contexts.
- Adaptive meanings and purpose are facilitated by coming to terms that all considered, personnel did rescue as many people as possible, and did as good and worthwhile job as possible under the circumstances. Personal and group pride, and a sense of meaning and purpose emerge. Grief over losses is mitigated by the lessons learned which will make future disaster interventions still more efficient.
- Additional debrief sessions may be arranged as necessary, and individuals who are still stunned or otherwise suffering may receive individual attention.

7.2.4 Recovery and reconstruction

Personnel need to be followed up long term especially if traumatized in the disaster. Remember that delayed responses may arise.

Assessment. Includes checking for stress responses which are not settling after some time, or maladaptive defenses such as withdrawal, cutting off feelings, alcoholism, and substance abuse. Any of these symptoms may also arise after variable delays.

Professional assessments are made as for other affected populations (section 5). In particular, presence of secondary PTSD, compassion fatigue are assessed, as are other symptoms and illnesses. Biological, psychological and social stress responses, symptoms which may arise after variable delay, means of coping or defenses are assessed. Vulnerabilities and maladaptive meanings which may compound and be taken into subsequent disasters are assessed.

Interventions include counselling, and stress and trauma therapy (6.2, 6.3), tailored to the particular needs of the affected worker.

7.3 Psychological Services

Psychological service providers are perhaps more prone to secondary traumatic stress effects than other personnel, because of their openness to others' wounds (3.4(iii)). Therefore much of what has been said for emergency and recovery service personnel applies even more so for the psychological service component.

7.3.1 Preimpact

Assessment. Psychological services are assessed organizationally and individually for their training and preparedness for disaster work. This is done according to the criteria in sections 3.3-3.5. Personnel are offered or offer themselves accordingly.

Intervention. If denial is present about the importance of training and preparedness for disaster work, it is addressed organizationally and individually by offering specialist education and training. Preparations are made organizationally for release of appropriate groups and individuals, their rostering, and provisions are made for others to do extra duties in their place.
Preparing for a current disaster, rehearsed procedures and communication networks are activated. As much briefing as possible ensures most appropriate matching of resources with needs.
Potential stresses and stress responses in one's team and oneself are anticipated.

7.3.2 Impact

Psychological service personnel who are impacted like the rest of the affected population, need help in similar ways to other members of the population.
Those who are serving with other rescue personnel may themselves need support with breaks, rostering, decompression, demobilization and defusion (see section 7.2.2).

7.3.3 Postimpact

Psychological service groups will include those who have been involved in the preimpact and impact phases, and those who have mobilized only in the post impact phase.

Assessment. Those who have mobilised in the preimpact phase monitor their preparations and assess how they will match postimpact needs. Those who partook in the

impact phase assess successes and failures, costs on themselves, and resources to match further needs.
Psychological service groups and individuals who present their services in this phase are assessed as others were in the preimpact phase for specialist organizational and individual skills. Criteria for assessment are those described in sections 3.3-3.5. Personnel are deployed or rejected according to their skills and matching needs.
Once deployed, assessment of secondary stress and trauma effects following work in this phase is carried out as for other personnel (7.2.3).

Interventions. The same principles and methods of delivery are provided for psychological services as they provided for other services (6.2.2, 6.2.3, 7.2.2 and 7.2.3). Such interventions include breaks, rosters, and defusion during work, and supervision, mentoring counselling and debriefing. This is organized by higher levels of psychological services and management, but is also built into psychological service self-monitoring. Higher levels ensure maintenance of group and personal morale through support, and recognition and reward for effort.
As for other workers, debriefing (7.2.3) includes operational review as well as personal and group review of subjective responses to one's caretaking efforts and professional roles. Biological, psychological, social, and spiritual responses are reviewed and placed into realistic contexts.
Individual workers are also monitored and catered for according to their needs, for instance by one to one counselling.

7.3.4 Recovery and reconstruction

Assessment. Psychological services personnel needs similar follow up to other service personnel for entrenched or delayed maladaptive responses (7.2.4). Burnout, PTSD, secondary traumatic stress disorder, vicarious traumatization, and other biological, psychological and social symptoms and illnesses are assessed in relation to the disaster and other traumatic events, earlier vulnerabilities, and subsequent stressors.

Interventions. Personnel may need more supervision, debriefs, support, morale enhancing measures, and personal counselling and therapy (6.2, 6.3).
The experiences of helping others and of being helped oneself may enable psychological service personnel to creatively meld their disaster experiences with their everyday professional work, both individually and institutionally.

8. Research

Research must recognise the needs of affected people and must never compromise their healing or disaster management.

General professional and specific disaster codes of ethics (see Appendix C) must be adhered to in research. Ethical principles include not doing harm e.g., through

retraumatization; research goals should be informed from a base of established knowledge; subjects of research must give informed consent; their confidentiality must be maintained.

Research should occur through established ethical research channels such as AEMI, universities, or at least be supervised by them.

Disaster managers should be appraised of the advantages of the research and their cooperation be enlisted.

Results of research should be freely available, including to the subjects themselves, other researchers and agencies, and to bodies building up data profiles in Australia.

Research should be subject to quality assurance, best practice standards, and scrutiny as to whether they help to improve assessments and effectiveness of interventions.

Glossary

Refer Emergency Management Glossary

9.

Appendices

Appendix A

Three Dimensional (Triaxial) Biopsychosocial Framework

The three dimensional view of traumatic stress includes three axes.
The three axes are depicted in Figure 1

Figure 1

The components of the three axes or of the triaxial framework are depicted in Table 1

Table 1: Components of the Triaxial Framework

Process axis	*Parameters axis*	*Depth axis*
1. Stressors	1. Factors in traumatic situations	1. Basic instincts, drives
2. Appraisals	2. Phases of traumatic situations	2. Survival strategies
3. Stress Responses	3. Social system levels including helpers	3. Judgments and Morality
4. Strengths and vulnerabilities	4. Developmental phases	4. Basic meanings.
5. Trauma		5. Ideals, values and principles
6. Defenses		6. Codes, dignity, rights
7. Memories		7. Spirituality, religion, ideology; beliefs
8. Illnesses		8. Identity
9. Secondary spirals		9. Symbols
		10. Creativity, esthetics
		11. Sacredness
		12. Wisdom, knowledge, truth

The process axis components are depicted in more detail in Figure 2.

Figure 2

Appendix B

Survival strategies

The variety of survival strategies, appraisals which evoke them, and their adaptive and maladaptive manifestations are depicted in Table 2. Judgement columns indicate the potential of classifying adaptive and maladaptive ramifications of survival strategies along human function levels on the depth axis (Table 1).

Table 2

Appendix C

Australasian Society for Traumatic Stress Studies Code of Ethics

Definition

Trauma therapy is help administered by professionals to traumatized people in order to help them with the prevention, amelioration, healing and reduction of the consequences of trauma.

Traumatized people have experienced threat of any or all of physical, mental or social annihilation. Trauma sequelae result in an indefinite loss of a previous equilibrium for a less life enhancing one. They results in biological, psychological and social symptoms and illnesses.

Professionals are people trained to help traumatized victims. Their prime motive and obligation is to apply their expertise for the welfare of their clients or patients. They put

the latters' interests before their own or the interests of any other third party(ies). The rewards for their efforts are fees, or payments in some other culturally agreed to currency. Professional here will mean professional trauma therapists.

Specific Ethical Principles

In Relation to Clients, Patients

1. **First do no harm.**
2. **Primacy of clients' or patients' welfare.** Whatever is best for clients should take primacy. In particular the vulnerability of their traumatized state should not be exploited for financial, academic, organizational or personal rewards. The impulse to help should be balanced by likely benefits and disadvantages to victims.
3. **Collaboration with clients or patients.** To the degree possible trauma therapy should be collaborative and reciprocal, clients being able to control the occurrence of the therapy and having equal power in it. When clients are approached as part of an outreach process, its rationale should be explained very early and permission to continue be asked for. If clients are unable to give informed consent to therapy, a prime goal should be to help them to be able to do so. The rights as well as special needs of children, the elderly, the ill and ethnically unassimilated should be respected.
4. **Confidentiality.** Whatever knowledge or information a professional derives during therapy remains confidential unless it involves threats to the lives of others or is subject to criminal law. Any divulgence of information must be with the written consent of the client or guardian.
5. **Length of therapy.** This should be determined by clients' welfare and mutual negotiation. To the extent possible, it should not be curtailed or extended for the benefit of therapists or third parties.
6. **Rewards.** Payments should be through mutual negotiation.
7. **Third parties.** It should be clear that the welfare of clients and patients is paramount, even if third parties pay. If therapists' motivation or obligation is toward an organization this, as well as any potential conflicts of interest with the individual client must be declared. If therapy is not agreed to by clients under such circumstances or if their benefit from therapy is curtailed, therapy should not occur.

In Relation to Peers

1. **Collegial respect.** Due respect and deference should be given to colleagues' skills. These should not be denigrated to other clients or in public.
2. **Respect for Service Networks.** Practitioners need to know local government and non-government helper networks and rules and cooperate with them as much as possible.
3. **Advertising and competition.** Practitioners have the right to let potential clients know of their skills, but these should not be exaggerated or plied in a commercial manner. Similarly, others' skills should not be denigrated and territoriality should be avoided. Benefit to clients is again primary. Skills, training and references should be shared and supplied on request.
4. **Limitations on unprofessional conduct.** If it comes to the notice of practitioners that others are acting in unethical and dangerous manner, education, personal approach and as a last resort legal avenues should be taken to protect clients and patients.

In Relation to the Community

1. **Trauma prevention.** The community should be educated about what makes it vulnerable to trauma, how to prevent it, and how to prepare for it.
2. **Education.** The community should be educated about trauma, trauma therapy, its skills and ethics. Advice may be given about tailoring needs and available skills. Training of trauma therapists should be set in train.
3. **Ethics education.** Interchange with the community about dilemmas in trauma therapy should take place. Ethics committees should be set up by professional trauma associations whose members practise trauma therapy in order to learn teach and update knowledge on ethical issues.

In Relation to Self

1. **Recognition of skills of trauma therapy.** The professional recognises that trauma therapy requires special knowledge and skills which are not fulfilled simply by having a mental health professional qualification. Practitioners ensure that they acquire such knowledge and skills to whatever degree possible.
2. **Tailor skills and type of trauma therapy.** It should be recognized that there are many types of traumatic situations and types of therapy. Skills may not generalise across all situations. Practitioner are obliged to make sure that best available skills are applied to specific situations, and assess whether they are the best people to fill them.
3. **Limitations of skills and referrals.** When professionals are the best placed persons under the circumstances to help, they are obliged to do so, but also to declare to the degree appropriate their limitations. Otherwise they should alert clients to other options, and be willing to refer clients to them, ask them to help, or ask them for second opinions.
4. **Declaration of skills through professional network.** Professional should declare their skills through a professional trauma network, so that they may be asked to help in appropriate situations.
5. **Maintaining professional skills and fitness.** It is incumbent on professionals to keep up with their knowledge, make sure their standards are maintained and their mental health remains adequate. To this effect professionals should take part in peer group education, supervision, debriefing, and have a good understanding of their own traumas.

In Relation to Research

1. **First do no harm.** Because traumatized people are in a highly vulnerable state, they are open to exploitation of others' interests. Welfare of victims must always precede the interests of professionals. Research should in no way prejudice healing.
2. **Research goals.** The goal of research must be the obtaining and free dispersion of knowledge which will help future generations of victims. The goal should not be partisan to a particular form of therapy, drug, method, person or group. Lack of benefits, side effects and negative effects should be reported as much as positive ones. Potential biases such as funding bodies, and institutional and relevant group attachment should be declared.
3. **Consent.** Client or guardian consent should always be obtained. The nature of the research, its goals, benefits and risks, should be explained.
4. **Informed research.** Because research always siphons some energy from patient welfare, its value over and above knowledge already available should be assessed. Repeating previous research on the one hand, and on the other not paying attention to established principles should be avoided.
5. **Confidentiality.** People's identities must be preserved from recognition. This is particularly important in high profile disasters involving high profile identities.

1. ANY OTHER SUGGESTIONS?

TABLE OF PHASES AND STRATEGIES FOR INTERVENTION

	Social System Levels		
Disaster Phase			
Preimpact	Community	Families	Adults
Impact			
Postimpact			
Recovery			