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CURRENT THINKING ABOUT CRISIS OR PSYCHOLOGICAL INTERVENTION IN UNITED STATES DISASTERS

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This article discusses current thinking about psychological or crisis intervention in post-disaster situations in American society. It is less a report of research findings than a setting forth of general assumptions being made and response procedures being advocated. Furthermore, the article reflects what the author personally perceives as the stance being taken by federal agencies and mental health practitioners in the United States with respect to the mentioned intervention. Thus, the views expressed do not necessarily represent the official policies or formal position of the National Institute of Mental Health or the United States Department of Health, Education and Welfare, the two government agencies most heavily involved in present day crisis intervention.

Mental health crises have existed since time immemorial and continue to express themselves the world over. On occasion, the news media will highlight various mental health crises because of the dramatic qualities which attend some of these situations. Principally, these are catastrophic and natural disasters, wars, and suicidal behavior. While such crises are not new to mental health, it has been largely within the last few decades that a useful body of knowledge has been assembled for teaching purposes in professional and graduate schools.

The term "crisis" may be differentiated from "emergency" in the mental health field, as in the realm of physical health, as the author has noted (1976). Any situation which affects the emotional or mental equilibrium of the individual to the extent that intervention should be supplied in order to preclude possible damaging physical or psychological sequelae, constitutes a *crisis*. It may differ over time and vary from minutes to months. The crisis may enlarge or diminish and may develop into an emergency, which necessitates immediate attention. *Crisis* refers to a time interval in a sequence of events; whereas, *emergency* suggests a need for present action. In the extreme, one dimension of crisis is marked by self-destructive behavior, with a fulminating quality which requires acting with dispatch.

An emergency in mental health suggests an urgent, sudden and pressing need, somewhat analogous to an emergency in physical medicine. The etymological base of the word points to a raising-up or heightening of a condition or situation. A quick change is implied, wherein the symptoms are intensified. Any emotional or mental disturbance requiring prompt attention in order to prevent loss of life or injurious physical and psychological effects constitutes a mental health emergency. As to duration, an emergency is arbitrarily often defined as constituting a few hours or less than a working day at most.

With regard to treatment in the mental health realm, any therapeutic procedure which utilizes relevant techniques in order to ameliorate the mental and emotional stresses related to crisis may be considered *crisis*

counseling or *intervention*. By definition, a short-term and time-limited method is utilized. Any long-term procedure does not characterize crisis counseling, although it may be a suitable follow-up procedure in its own right.

EXEMPLARY INSTANCES OF DISASTER REACTIONS

The personal loss and special stress associated with disasters have been neglected as factors contributing to self-destructive behavior, until recently. Reports from both North America and Latin America have pointed to direct and indirect phenomena surrounding disasters which invoke an increase in suicidal behavior. It should be noted that statistics can be inflated markedly in short order as a result of such events. For example, following Hurricane Fifi, in Honduras, where roughly - five thousand people were killed and thousands more left homeless, it was reported that some twenty persons committed suicide almost overnight upon hearing that they must leave their homes never to return due to resettlement elsewhere. The deep-rooted ties to home were undoubtedly bound to the ego structures of these victims. The problem of mobility is also likely to affect persons differentially at different age levels. Children of army personnel are frequently called upon to move, but usually suffer less psychic trauma than our unfortunate friends in Honduras, due to family unity and learned expectancies. The stress of destruction, followed by relocation and rehabilitation, may take a severe toll and require much more careful evaluation. Would persons in Beverly Hills, California; Battle Creek, Michigan; or Dallas, Texas; have responded in a manner similar to the victims in Honduras? The plain fact is that we simply do not know. Personally, this author doubts it. Nevertheless, the phenomenon needs to be studied in order to train and treat the inhabitants of communities throughout the world. Depressive reactions and suicidal behavior have been reported in association with a number of disasters but the reasons for the occurrence of each are not yet clear.

When a dam broke in Buffalo Creek, West Virginia, in 1972, killing one hundred and twenty-five persons and rendering thousands homeless, bodies were strewn for miles up and down the valley as a consequence. The sequelae resulted in unanticipated emotional and mental health problems, according to Titchener and Kapp (1976). They report the persistence of insomnia and phobias in apprehension of further destruction, particularly on rainy nights. Many community members displayed continued apathy, loss of interest in work and interpersonal relationships, a diminution of sexual relations, and a marked decline in general day-to-day efficiency, in contrast to their former level of functioning. Moreover, anger, resentment, and hostility was widespread more than two years after the disaster.

EXPECTED PHENOMENA

As noted by White and Haas (1975), much of the research on disasters has been sporadic, limited to the interest of a particular investigator focusing upon local problems and based upon narrow theory. They emphasize that no broad body of knowledge has emanated from such research and earlier findings have not been updated in terms of the social and economic changes occurring in the United States. The psychological effects of disaster on victims in a stricken community illustrates this point clearly. On the basis of a very small number of research reports, it was thought for years that any mental or emotional effects were minimal, at most. Recent disasters have shown that not to be the case. This misperception has been due largely to inadequate research, which has been much too parochial, in addition to the fact that skilled mental health clinicians have not been involved in disaster studies until recently. It was only after such disasters as the San Fernando earthquake

in 1971, Buffalo Creek, Rapid City, and Agnes floods in 1972, the Mississippi Valley floods of 1973, the storms and floods in Nome, Alaska in the winter of 1974–75, and the recent Grand Teton Dam flood in Idaho in spring of 1976, that the real necessity for crisis intervention and mental health counseling became obvious.

It has become increasingly apparent that at least three aspects of disaster behavior, heretofore thought to be predictable with good reliability, do not obtain in fact. First, when operating under the stress of a disaster, it was believed that people would over react in the ways one might expect in such a situation. In essence, they would probably become panicky and even go berserk under the pressure. People seldom get so panic stricken that they run amuk during a disaster, unless they are pinned into an enclosed area which is on fire. Although a number of behavioral disturbances are associated with disasters, including some which are dramatic, going berserk in not one of them. Secondly, shortly after the disaster impact, it was felt that solace could be taken in the fact that in time of disaster, our fellow-men would always behave in constructive ways. For example, cohesiveness and a mutually cooperative spirit would inevitably provide the bottom line upon which group behavior could be established. While there are instances where some persons behave, at least temporarily, by giving of themselves unstintingly to assist their fellow humans in distress, it is far from being foreordained. It is not uncommon for persons under such conditions to become hostile towards friends and family, resentful of neighbors who have been spared personal heartache, and angry and suspicious of helping personnel. This phenomenon of open resentment usually shows itself later, after initial shock and helping responses have occurred. Neither heroism, nor hostility, are destined reactions, however. (Titchener and Kapp, 1975; Drabek and Stephenson, 1971; Dynes and Quarantelli, 1974). Thirdly, professionals must realize that years of experience taken from psychotherapy may not provide them with very helpful methods to employ in order to assist persons with the mental health problems associated with disaster. Classical psychotherapy procedures not only may be ineffective, but they are often inappropriate and even deleterious to crisis intervention efforts. Reflective techniques, and lack of direction and guidance, can add to frustration and promote further mental stress. (Hart, 1974; Robinson and Campbell, 1976).

CRISIS INTERVENTION FOR CRISIS WORKERS

Personal contact by the author with officials and crisis workers in such recent disasters as the Grand Teton Dam flood, in Idaho, and the Big Thompson Canyon flood, in Colorado, have highlighted the need for support of the mental health crisis workers themselves. Under such pressure, physical exhaustion inevitably takes its toll, along with the added ingredients of emotional stress and trauma. It often becomes necessary for workers to wear many hats, so to speak, by engaging in numerous activities which transcend the specific areas of expertise and training for which they have been oriented. The sources of stress may vary from assisting with the removal and identification of dead bodies, to the effective handling of persons with depression and paranoid symptoms stemming from loss of personal belongings, property, loved ones, or friends. Doubts begin to emerge about whether or not situations have been handled in the most effective manner.

Not only do mental health crisis workers, including the professionals, need support and case consultation on an ongoing basis, but they also frequently require some respite or retreat from their duties for a given period of time before returning to work. Scheduling a break from crisis activities with suitable back up forces, should be part of the planned program. These periods away from the activities involved need not be lengthy, since a few hours, or a single day, will often suffice. However, prior ar-

rangements should allow for continuing sensitivity to the worker's needs so that longer periods, or more specific intervention to assist the worker, can be supplied when necessary. It is no favor, either to victims or crisis workers, to foster therapeutic encounters when suitable services cannot be provided. To the extent possible, it is helpful to screen workers ahead of time, so that those who may not be as adaptable as others to any given situation may be eliminated or assigned to other duties.

It is useful to provide the worker with a clear understanding of what may be expected, so that personal recognition of one's own limitations and shortcomings can be placed in proper perspective. It should be emphasized that every human being has his, or her, limit and it is appropriate and healthy to recognize this fact when the time comes. Heroic actions must be realistic. The mental health crisis worker would be ill-advised to expect himself, or herself, to act in superhuman ways in expenditure of energy of any dimension; physically, emotionally, or mentally. Recognition of these facts is an absolute necessity to prevent becoming a self imposed victim of the so-called "burn out" phenomenon. These components should be openly discussed, together with all other facets of the crisis intervention program.

DIFFERENCES BETWEEN CRISES IN WAR AND NATURAL DISASTERS

At least one reason why many persons believe that cohesiveness occurs following disasters, stems from past efforts displayed during time of war. Wars which are regarded as justified by a majority of the population bring coalescence. In contradistinction to war, people affected by non-military disasters do not always mobilize community resources into a unified whole, working in concert toward a common cause. Some of the differences which serve to contrast war efforts with mental health problems often seen in disasters are these:

(1) War is an ongoing process, operating continuously. Specific activities and jobs are targeted toward a war effort, all emphasizing long-term, meaningful production.

(2) A nation's spirit has been insulted or challenged by war; a fact which does not obtain in disasters. There is little national interest to motivate persons affected by disasters. Only a temporary call for cooperation obtains. Since the victims of a disaster realize that the event has already occurred, emphasis is placed mainly upon mopping-up operations. Rebuilding focuses around individual motivation, rather than group responsibility. In war, some great injustice or misdeed has taken place which must be undone. By contrast, disasters are fateful events over which man has little or no control. It may appear as if the community and its inhabitants are victims of fate, which man has little or no control. It may appear as if the community and its inhabitants are victims of fate, which merely adds to the feeling of frustration and utter despair.

(3) The tooling-up period present in war seldom accompanies disaster efforts. The nation's resources in all sectors, private and government alike, assist in a period of war mobilization and preparation. Equipment and supplies are also made available to other countries assisting in the war program. Being of shorter time span, disasters permit no such preparation. Unlike war, there is little or no entertainment or glamour to appeal to persons who are disaster victims.

(4) War does not occur precipitously, as a rule, while disasters do. There is no time to fight back in disaster. Disasters occur like the hit-and-run driver of an automobile. There are feelings of frustration and powerlessness. When one is given time to muster courage to fight back, a rehabilitation effort will follow. However, when there is nothing present to fight, there is little for the ego to use in the process of reorganization and reconstruction.

(5) Although various mental disturbances develop from the stresses of both wars and disasters, suicides decrease during the former,

but are not unusual during and after the latter. People feel there is something to live for in wartime, but this motivation is more likely to be absent when associated with disasters.

A particularly important variable in the psychological response to disaster appears to be the time factor, although this requires further documentation and research. Disasters occurring over a period of several days or weeks, such as floods and hurricanes, seem to take a greater toll psychologically than those which happen rapidly, because recovery measures can begin much more quickly in the latter instance.

POST-DISASTER ACTIVITIES

Once a disaster occurs, the immediate, acute problems need to be managed and plans for handling them must be put into action. Both Federal and local administrators should know when and how to expedite their forces. Thus, a focused disaster activity can be integrated at the Federal, State and local levels. Various professional disciplines ought to be mobilized to carry out their assignments in the most effective manner possible. Non-professional workers who are trained and supervised, can be brought into action from the beginning. It is important to take account of where people are likely to congregate, so that most of the activities can be concentrated in that area. A continuing follow-up activity is necessary, even after the acute phase has passed.

PRE-DISASTER TRAINING

Some health unit or clinic in every community should have a mental health team geared to respond to the crisis occurring with disasters. It is necessary to plan ahead and train a cadre of workers to be available to handle problems stemming from natural disasters prior to their occurrence. To give a homely analogy, the most efficacious way to train a surgeon would scarcely be to wait for a ruptured appendix to appear before having the neophyte surgeon begin his practicum work. Hence, both pre- and post-disaster training are of the utmost importance. There is a need to develop various kinds of preparedness programs in the realm of mental health activities. Educational projects for children and adults should be part of this activity. Fire drills have long been a standard part of preparedness activities, but there is no reason why psychological first aid and crisis intervention services cannot be an integral part of the total preparedness training effort. Some of these require the assignment of specific tasks in the home by all family members, in keeping with their capabilities. Instilling a sense of responsibility is the nucleus of good mental health for persons of all ages. It is the essential ingredient in the prevention of mental problems, including suicidal acts and depression.

SPECIFIC PROBLEMS AFFECTING CHILDREN

Although a variety of emotional and mental health disturbances in children have been reported following disasters, the most prominent seem to be phobias concerning the natural elements and future disasters, sleep disturbances, and a lack of personal responsibility. These disorders have been in contrast to behavior shown before the disaster, and have been reported in various types of natural disasters. For example, the tornado in Xenia, Ohio, and the earthquake in San Fernando, California, as well as the Buffalo Creek flood disaster, all produced sleep disturbances, fears, loss of interest in school, and less responsibility among children. The persistence of these problems was unexpected, particularly prolonged sleep disturbances. It had been thought previously that such disturbances would abate following the disaster, but instead, they have remained for one to two years, or more. In addition, these problems have been reported in a large segment of the youngsters in the stricken communities, rather than in a small number of children. At least three-quarters of the youngsters in the affected areas have been subject to these disturbances.

SPECIFIC PROBLEMS AFFECTING ADULTS

Frequent symptoms appearing among adults include initial anxiety, often followed by anger, hostility, and resentment. Subsequently, depression and loss of ambition are not unusual. As noted previously, the commonly expected reactions of panic, followed by cohesiveness, understanding, and mutual assistance, do not always manifest themselves in the manner one might hope for. Marital discord tends to increase. This includes difficulties in the management of money, caring for children, and responsibility for housework, as a point of contention for change after a disaster. From a variety of disasters, we know that not only do problems of mental depression and sleep disturbances, including nightmares, increase following disasters, but disorders of a psycho-physiological nature affecting physical health may become apparent as well. There is a frequent increase in alcohol consumption and the use of tranquilizing agents for traumatic neuroses and anxiety, as well as in medications required for the management of such problems as stomach ulcers, headaches, and hypertension. Many of these disturbances resemble psychological equivalents of self-destructive behavior, when they persist over time. This is especially true if the individuals involved continue to neglect caring for themselves to heighten the difficulties which they have acquired.

THE DISASTROUSNESS OF DISASTERS

It is apparent from a statistical point of view, as well as a clinical one, that relatively small increases in aberrant behavior can sometimes inflate actuarial information to a marked degree. The pervasive aspects of publicizing negative behavior should be carefully considered. To dramatically illustrate the point, in a community of fifty thousand persons, if there were three more suicides than in standard year, that would constitute a starling increase in rate. The national average in the United States has hovered around one per ten-thousand population, for several decades. In the last few years, there has been an increase of about thirty percent in the United States, from ten to thirteen per one-hundred-thousand population yearly. In a city of fifty-thousand, this same rise of three, from five to eight per annum, would be an increase of sixty percent. It is not yet known to what extent part of the increase observed in recent times has been a function of natural disasters. Undoubtedly, some of it has been related to the economic depression, to which disasters simply add insult to injury, so to speak. The point is that when a community is affected by any phenomenon which produces physical and health problems, the insidious nature of the situation appears truly disastrous. Thus, a quick and dramatic increase in suicide rates for both attempted and completed acts can result because of the small number of cases which contribute to the computations. This does not minimize the problem, but it can alert those involved to the complexities of health issues.

THE FEDERAL ROLE IN THE MENTAL HEALTH ASPECTS OF DISASTER ASSISTANCE

Recognizing that disasters may be of catastrophic proportions, the United States Congress has taken the position that the problems ensuing therefrom are often greater than the ordinary citizen should normally be expected to bear alone. With this thought in mind, Public Law 93-288, the Disaster Relief Act of 1974, was created. Section 413 of this Act authorizes the National Institute of Mental Health to provide crisis counseling and training, including financial assistance, to State or local agencies, or private mental health organizations, for the victims of major disasters, in order to relieve mental health problems caused or aggravated by such disasters or their aftermath. This program has been developed in cooperation with the Federal Disaster Assistance Administration, which provides funds for its support.

For the purposes of this Act, a major disaster is defined as any hurricane, tornado, storm, flood, high-water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, snow storm, drought, fire, explosion, or other catastrophe in any part of the continental United States, or its territories, which causes damage of sufficient severity and magnitude to warrant major disaster assistance. After the official declaration by the President, this program may provide supplemental support for 180 days, with further authorization available when justified on an individual basis beyond that period. When existing facilities in the State are not capable of meeting communities needs, a proposal for support may be submitted through the State Coordinating Officer to the National Institute of Mental Health and the Federal Disaster Assistance Administration. The following baseline information is necessary to evaluate the proposal: (1) a description of the geographic area to be served; (b) an estimate of the number of victims requiring counseling; (c) the kinds of emotional and mental health problems likely to be encountered; (d) the local/State mental health resources available for use; (e) an estimate of the length of time for which mental health services will be required; and (f) a budgetary estimate of the itemized expenses necessary to render the service. A Government team coordinated through the Mental Health Disaster Assistance Section at the National Institute of Mental Health evaluates the proposal and makes the decision with regard to funding. If warranted, money may be made available very quickly to meet the immediate mental health needs of the citizens in the disaster area.

RECOMMENDATIONS FOR ALLEVIATION

Out of the numerous disasters which have been studied, both from a clinical and rudimentary experimental point of view in the last few years, it has become apparent that at least five points can be made. They are:

(1) Crisis intervention is usually helpful and is clearly superior to no intervention in time of disaster;

(2) The type of intervention must depart from standard psychotherapy procedures. The techniques utilized must be innovative and be suitable to the needs of the community, at the moment;

(3) An outreach program, rather than one which functions in a particular location, is likely to be particularly beneficial in time of disaster. One-stop centers, which can serve as a referral and way-station, can be an integral part of such an effort;

(4) Wide usage of traditional mental health terms should be avoided. Casting a crisis intervention effort in that mold will not be effective and can even be harmful in delaying the delivery of services to needy persons. People in disasters, who are in need of crisis intervention, do not see themselves as mentally ill and, in point of fact, usually are not. The use of such a nosology is rarely helpful; and

(5) To the extent possible, careful records should be kept, information documented, and research carried out, in conjunction with helping services, so that one can profit from the experience. All too frequently, even professional persons will rue, in retrospect, the fact that they did not make arrangements to collect certain kinds of data which could have been obtained easily, and which could stand in a good stead for projections for future training and service delivery to needed populations.

Being aware of many of the problems which accompany disasters, as well as the proper utilization of crisis intervention techniques, can augur well for developing programs to meet society's needs in the future in very practical ways. Such efforts would be in contradistinction to some of the less effective, post-hoc methods which have been applied in the past.

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