13

Clinical Social Work With Survivors of Disaster and Terrorism

A Social Ecological Approach[1]

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The word *disaster* is derived from the Italian *disastro* or "unfavorable star" and implies a random act of wanton destruction by nature or by human intervention. Yet, in reality, disasters are a regular part of human experience. They occur in every part of the world, taking different forms and touching many lives. Planning to mitigate their effects and acting effectively to help communities to recover is not only possible but necessary (Kasi, Bhadra, & Dryer, 2007). As social workers, we appreciate that disasters disproportionately affect physically, socially, economically, and politically vulnerable populations (Mathbor, 2007; UN General Assembly, 2007). As clinicians, we appreciate the ways in which experiencing a disaster, as well as every aspect of relief and recovery, can affect the emotional well-being of vulnerable survivors (Inter-Agency Standing Committee [IASC], 2007). We understand that compromised well-being increases vulnerability, so the role that we play is crucial in supporting a population's ability to survive, thrive, and struggle as active participants in building the future.

This chapter discusses clinical social work intervention following natural disasters and terrorism (see Appendix A).[2] The purpose of the chapter is to compile, clarify, and discuss what has been

[1]*Editor's Note:* Although this chapter shares certain themes with those on trauma survivorship ("The Challenge of Clinical Work With Survivors of Trauma," Chapter 12, this volume) and grief and loss (Mourning and Loss: A Life Cycle Perspective," Chapter 16, this volume), it also addresses unique forms of these phenomena.

[2]This chapter will not discuss clinical social work in situations of sustained armed conflict, including war, state and community violence, or genocide. While some of the principles discussed in this chapter may be useful, elucidating the response of clinical social workers to these events would require a separate chapter.

learned in various countries and situations in order to integrate and build upon that knowledge to create opportunities for effective clinical response. Clinical social work theories inform interventions that preserve well-being, support psychosocial development, and facilitate reconstruction as well as address mourning, loss, and care of the mentally ill. They do so using the biopsychosocial model that forms an essential unit of clinical social work analysis, using an ecological framework to examine individual, biological, and intrapsychic life as it is situated in the sociocultural sphere. The chapter refers specifically to social ecological theories of resilience, psychodynamic theories that support resilience, as well as the new study of community resilience and the neurobiological principles that underpin it.

Commonly Used Terms in Disaster Relief and Recovery

The field of disaster relief and recovery has been closely linked to the humanitarian community. Over the years, the field has developed its own commonly used terms. Clinical social workers likely will find these concepts quite familiar, although they may find that they have used slightly different language.

Disaster

A *disaster* is "a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources" (United Nations International Strategy for Disaster Reduction [UNISDR], 2009. p. 9).

Disasters are often described as a result of the combination of (a) exposure to a hazard, (b) the conditions of vulnerability that are present, and (c) insufficient capacity or measures to reduce or cope with the potential negative consequences (UNISDR, 2009 p. 9).

According to this definition, disasters can be either natural or created by human beings. This chapter is limited to coverage of single-incident disasters, including natural disasters and terrorism.[3]

Terrorism

Terrorism can be defined as the "instrumental use or threatened use of violence by an organization or individual against innocent civilian targets in furtherance of a political, religious, or ideological objective" (Halpern & Tramontin, 2007, p. 34). We do not include terrorist violence that is part of an ongoing, active armed conflict or political occupation, as these are considered "complex emergencies" requiring additional strategies of care that are beyond the scope of this chapter.

What Do We Mean by *Psychosocial?*

The term *psychosocial* was coined by the international relief and development community to define approaches informed by the ecological or biopsychosocial perspective. It is the name given by the relief and development community to the biopsychosocial approach central to clinical social work theory.

The prefix *psycho* refers to the psychological dimension of the individual, and it has to do with the inner world of thoughts, feelings, desires, beliefs, values, cognition, and the ways in which people perceive themselves and others.

The suffix *social* refers to the relationships and environment of the individual. It includes the

[3]A complex emergency is a humanitarian crisis in which there is total breakdown of authority resulting from internal or external conflict, which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country program. These emergencies are characterized by extensive loss of life; widespread damage to society and the economy; the need for large-scale multifaceted humanitarian assistance; hindrance of such assistance by armed groups or factions; and danger to those providing such assistance (OCHA, 2004).

material world as well as the social and cultural context in which people live, ranging from the network of their relationships to cultural manifestations, to the community, and to the state. It is also used to refer to the socioeconomic resources and material conditions of life.

The term *psychosocial* is used to explain the way these aspects of the person are inseparable, with each continuously influencing the other, so that it is impossible to tease them apart (Duncan & Arnston, 2004).

Psychosocial well-being is a state in which one is able to master life tasks of love and work, family and community, and ascribe meaning to daily life so that one can raise the next generation in an atmosphere of hope. Every culture has its own, more specific definition of psychosocial well-being and how it should be represented, maintained, and acquired (Wurzer & Bragin, 2009).

Psychosocial interventions support people who are affected by disaster to create solutions that promote, rather than destroy, their well-being. They do so by increasing protective factors and reducing risks in the biological, social, and psychological realms.

The Psychosocial Sequelae of Disaster and Terrorism

One of the most important characteristics of natural disasters and terrorism is that they occur in the public sphere. No matter how highly individualized a society, disasters and terror happen to all its members together. Therefore, it is important that clinical interventions address whole communities and work within the commonality of the experience. The very fact of acknowledging the shared nature of the experience can help break down fear and isolation, in order to begin to support a sense of capacity, connection, and hope for the future (Erikson, 1976).

The term *natural disaster* is in a sense a misleading one, for natural disasters are never exclusively natural. They affect communities differently, depending on the quality of the infrastructure, the quality and proximity of emergency services, and the ways in which authorities respond to community needs and organizational representatives. Poor and marginalized communities are more likely to suffer more severely than wealthy communities or those whose citizens are well connected (Halpern & Tramontin, 2007; Pyles, 2007).

Disaster and terrorism have two distinct categories of psychosocial outcome that we discuss here. In disaster, there are massive, almost unimaginable levels of loss; in terrorism, there is exposure to extreme violence; and in some instances there are both.

The Psychosocial Consequences of Disaster and Terrorism: Massive Loss

Disaster disrupts almost every aspect of life, so losses are not only of the loved ones actually killed but also the loss of home, possessions, community and social fabric, historic continuity, and plans for the future. Therefore, each social and economic loss has psychological aspects, and each psychological loss has broader social consequences, as society's fabric is profoundly altered.

Losing Family, Friends, and Familiar Faces

In the first instance, there is the loss of people: family members, friends, and members of the community, from teachers to storekeepers. This is complicated by the fact that it takes some time to determine who has died and who is missing, a slow process in which, for many, hopefulness gives way to fear and then to the realization of death.

In disaster and terrorism, deaths are sudden and unexpected. When people die of illness, old age, or even war, the death is expected, though tragic. When people die in a disaster or terror attack, friends, family, and colleagues do not expect the person to die; they expect to see them again very soon. The death is a shock, leaving unfinished interpersonal business. When death is

unexpected, regrets may come unbidden: One may have had an argument with the person, forgotten to say good-bye, failed to remember an important occasion, or neglected to pay a well-deserved compliment. Now there is no chance to complete this unfinished business. Survivors are often left with a particular sorrow related to the circumstances of the last encounter (Halpern & Tramontin, 2007).

Furthermore, deaths are confirmed slowly, so there is a process that begins with a search for lost relatives, leading to the discovery of the person or to the identification of the body and burial. People move through a series of emotions from fear and anxiety to loss, grief, and bereavement (Jones, 2008; Wurzer & Bragin, 2009).

Complicated Grief and Ambiguous Loss

Sometimes, the body is not intact, so more time goes by until the remains are identified scientifically and the results are given to the family. In still other instances, the remains are never found. This leads to a situation of ambiguous loss, in which the survivors never really know for sure whether the person is actually gone. While grief and sadness are present, the bereavement process is truncated as it is hard to give up hoping when there is no evidence to contradict the fantasy that one day, the loved one will return (Coates, Schechter, & First, 2003; Robins, 2010).

Loss of Material Things

Simultaneously, the losses are practical. People lose their homes, their clothing, their documents, their medicines and prescriptions, plus all the possessions that they may have accumulated in life or inherited. To the extent that there are remnants of their homes and possessions, there is the overwhelming task of salvaging what one can, a process made even more difficult when accompanied by grief and the loss of the practical assistance of a husband, wife, parent, or even child (Halpern & Tramontin, 2007).

I found a mother in Sri Lanka sitting in a half-ruined house and crying over a mud-soaked pile of silks. She lamented, "My mother had saved these for me, and I for my daughter, for her marriage trousseau. . . they cannot be made with this detail any more, they cannot be replaced. . . ." A vital link between past and future was gone (Bragin, 2011).

Loss of Hopes and Dreams

The losses may include the hopes and dreams of survivors, who are forced by necessity to replace everything that they have owned from basic supplies to any luxury items. This can have serious consequences on life savings, businesses, and educational possibilities, or a future beyond survival (Coates et al., 2003; Erikson, 1976; Halpern & Tramontin, 2007).

Change in Relationships: Loss of Familiar Experience

When people and possessions are lost, human relations suffer. Family interactions are disrupted as the stresses of coping with postdisaster adjustments affect the way people behave toward one another. Children find that parents and teachers are preoccupied, short-tempered, and distracted (Bragin, 2005; Jones, 2008).

Loss of Certainty

While some disasters, such as floods and hurricanes, are yearly occurrences and disaster is a constant worldwide, certain disasters, as well as terror attacks, are surprises that shatter the assumptions of daily life. Major earthquakes, tsunamis, and terror attacks are new to the families who first experience them, even though history shows that they are in some sense regular occurrences (IASC, 2007; UNIDSR, 2007). All of these occurrences, when they have devastated a particular family or community, compromise the assumptions upon which daily life is based (Halpern & Tramontin, 2007). "I send my children to school, I go to the

sea to fish, I take the elevator to my office, and the day will end and the next one will begin." Suddenly, such reflexive assumptions of daily life are replaced with uncertainty.

Exposure to Extreme Violence

Extremely violent events, whether terror attacks, earthquakes, or tsunamis, have specific psychological consequences.

When people are exposed to extremely violent events, frequently their minds cannot accept the information. The experiences that they are undergoing seem fantastic, although in fact they are only too real. The mind retains the information presented by the experience but only in an unintegrated, unsymbolized form. Laub and Auerhahn (1993) described this phenomenon as "knowing and not knowing" simultaneously.

Recent developments in cognitive neuroscience explain how this happens. Very violent events do not enter the memory in the same way as other experiences do, through the meaning-making apparatus of the brain's prefrontal cortex. Instead, they are retained in an unsymbolized form and remembered differently (Siegel, 1999).

People exposed to extremely violent events find their minds haunted by the experience. They normally try to block out the experience, only to find that it returns in the form of nightmares and flashbacks. Those who are more successful in blocking out violent experiences completely often find that they have difficulty being able to think clearly about anything at all (van der Kolk, McFarlane, & Weisaeth, 1996).

When many are exposed to the same events, yet no one can properly process the information, the whole of society is affected. Meaning making in such circumstances cannot occur, thus making normal adaptations impossible. In effect, personal responses in situations involving disaster or terrorism have distinctly social implications (Bragin, 2011, Ungar, 2012).

The theories discussed below inform clinical social work practice and help address (a) massive and multiple losses, as well as exposure to extreme violence, characteristic of the psychological responses to disaster and terrorism, and (b) the social context in which such phenomena occur.

Clinical Social Work Theories That Support Best Practices in Disaster and Mass Violence

Clinical social work is especially qualified to address these consequences because of the profession's fundamental understanding of the integrated nature of the material, the social, the cultural, and the intrapsychic. The theoretical foundations of clinical social work in an ecological systems model make clinical social workers especially qualified to work in a community context while keeping the needs of the individual human psyche in mind. Since disasters happen to whole communities, this perspective is crucial.

In addition, aspects of psychodynamic theory help us understand, and therefore act on, those elements of psychological functioning that support resilience.

Ecological Systems Theory

Duncan and Arnston (2004) use Figure 13.1 to describe the context in which people experience life and, with it, disaster.

This perspective allows us to look at emergency situations of disaster or terrorism in a biopsychosocial context. It also enables us to imagine our interventions holistically, as events that affect and are affected by multiple layers of experience. This leads us to address the situation on all levels or choose a particular level as appropriate. This differentiates clinical social work interventions from some more place-specific interventions, such as critical stress debriefing, which have been found to be unhelpful at best and even harmful in some instances when applied to diverse environments (Jones, 2008; van Ommeren & Wessells, 2007). At the same time, it keeps us mindful of the role of individual development and helps us seek solutions that are developmentally appropriate and contextualized relative to family, community, and culture (Ungar, 2012).

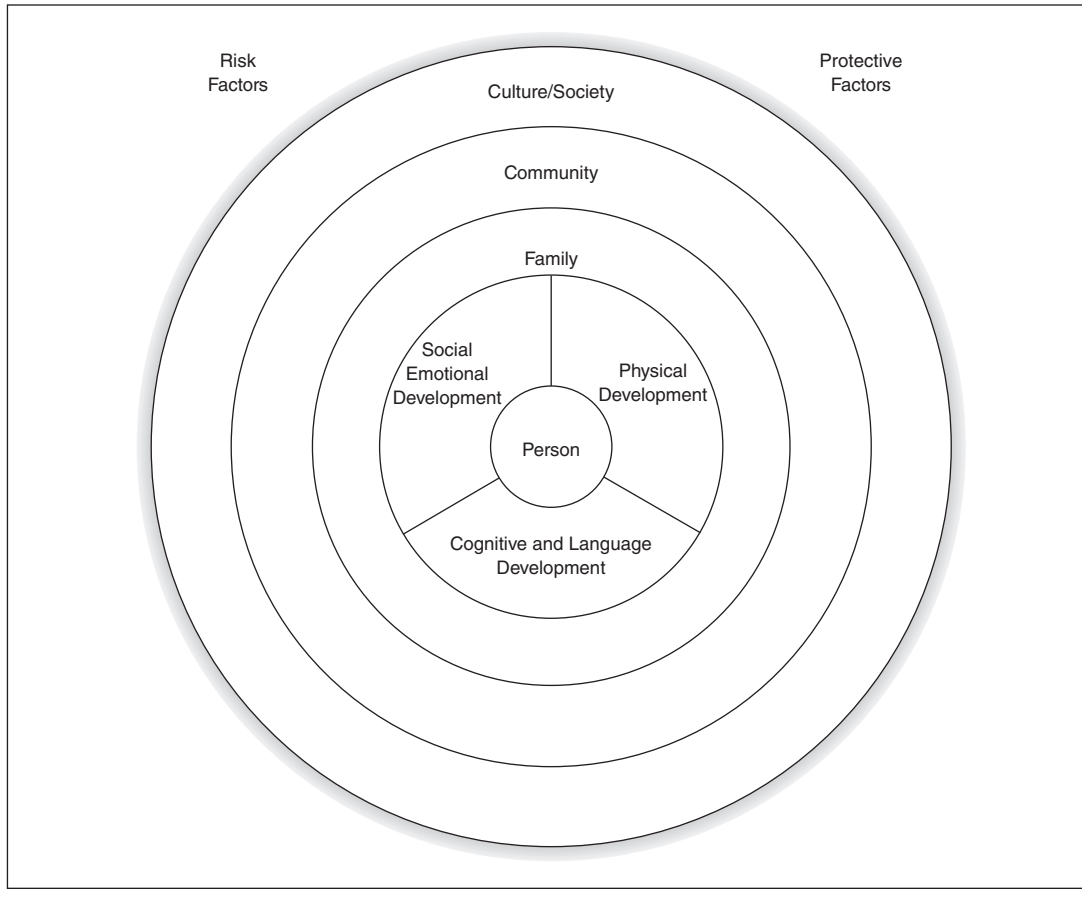

Figure 13.1 The Social Ecology of the Person

Source: Adapted from Duncan and Arnston (2004).

Dr. Timothy Sim (2009, 2011) is a systemic family therapist teaching at Hong Kong Polytechnic University. Following the 2008 earthquake in Sichuan China, Dr. Sim led faculty student teams to help establish social work support in the affected area. Using his skills in systemic family therapy, Dr. Sim used mapping exercises to determine needs, resources, strengths, and points of intervention with the diverse affected communities. Having mapped the communities' vulnerabilities and assets, both individually and as a group, his team was able to target their interventions effectively.

Community Resilience to Disasters: An Emerging Paradigm in the Social Ecological Framework

In keeping with global consensus on the need for comprehensive, culturally and locally determined care for people affected by disasters; the knowledge that such disasters are recurring and should be the subject ongoing of study and plan; and the fact that disasters affect communities as a whole, a new paradigm, community resilience, has developed around disaster health and mental health. Adopted by the U.S. Department of Health

and Human Services and the United Nations Office for Disaster Risk Reduction (UNISDR), it addresses the need to work with community partners to strengthen their hardiness before, during, and following disasters (Chandra et al., 2011).

Community resilience theory falls under the social ecological perspective on understanding recovery from disaster and terrorism. Community resilience is defined as "the sustained ability of a community to withstand and recover from adversity" (Chandra et al., 2011; p. 1). An additional factor is the capacity of a community to develop and grow in the face of adversity (Hall & Zautra, 2010). The underlying assumption is that the creation of resilient communities will facilitate community members' ability to care for the most vulnerable members and to help all community members to recover more quickly.

Community resilience has been seen as a function of resource robustness and adaptive capacity (Longstaff, Armstrong, Perrin, Parker, & Hidek, 2010). Social work literature has already identified underresourced and marginalized communities as those most negatively affected by disaster (Mathbor, 2007). Connectedness, institutional memory, and innovative learning comprise adaptive capacity in this model (Longstaff et al., 2010, p. 6). These are the factors that can be most readily strengthened to build the capital needed for robust community resilience. However, community resilience is ideally built before the next disaster occurs.

To build community resilience in resource poor communities, clinical social workers should advocate for:

- Engagement of community organizations and structures, including religious, cultural, civic, and medical
- Partnership and reciprocity between these structures and formal governmental institutions providing health and mental health care
- Development of an understanding of the specific elements that support community resilience among specific populations
- Empowerment of community institutions to provide ongoing subclinical care (Chandra et al., 2011)

Protective Factor Research: Supporting Resilience of Individuals and Families

Figure 13.1 illustrates how some factors in the environment create risk, such as living in a region prone to fires, floods, or hurricanes or being exposed to a terrorist attack. Yet other factors mitigate risk. They are referred to in the literature as *protective factors.* The capacity to survive and even to thrive psychologically in the presence of risk is known as *resilience* and can best be understood in an ecological context (Ungar, 2005, 2012).

Resilience is not magic. Resilience occurs when protective measures are sufficient to counter risks. Psychosocial interventions create programs designed to increase protective factors and attempt to reduce risk whenever possible. This is an essential part of the ecosystem in which people grow (Wurzer & Bragin, 2009). Ungar (2012) expresses this in an equation by which resilient behaviors result from interaction of the person in the environment divided by adaptive outcomes in the presence of adversity.

Protective-factor research studies resilient people to learn what they have in common and which biopsychosocial factors promote the capacity to thrive, despite the effects of severe stress. It also studies people exposed to serious risks over time, to learn which characteristics those who survived well had in common. These are known as *protective factors.* Protective-factor research shows that the presence of these in combination is what helps people survive extreme risk (Ungar, 2005, 2012).

Key Risk Factors That Exacerbate the Effects of Disaster

- Poverty
- Membership in a socially excluded group
- Preexisting mental or physical illness or disability
- Residence in group facilities: prisons, nursing homes, hospitals
- Lack of family or community connections
- Previous exposure to danger, violence, or abuse
- An attachment style that makes creating connections difficult or unlikely

- Inflexible intellectual style, emotional difficulty tolerating uncertainty
- Despair (Ungar, 2005, 2012)

Key Protective Factors

- Close interpersonal connections and an attachment style that makes it possible to create more
- A sense of self-worth (as a person or as a group member)
- A sense of self-efficacy (a sense that one is able to be effective in the world, that one's actions matter, either as an individual or as part of the group)
- Connection to the community and culture, whether in a community of origin or the chosen one
- Ability to think flexibly and creatively
- Ability to access available resources
- Transcendent spiritual belief (religious, political, or other)
- Altruism
- Hopefulness (Ungar 2005, 2012)

Contemporary neuroscience has begun to shed light on the ways that some protective factors work to promote resilience, specifically, secure attachment style, purpose or meaning in life, the ability to think creatively, and transcendent spiritual belief. These appear to give rise to other protective factors, including hopefulness or altruism, which in turn support the ability (or strength) to access available resources (Rutten et al., 2013).

The Role of Psychodynamic Theory in Supporting Resilience

In addition to the ecological systems perspective, clinical social work is also informed by a psychodynamic perspective, which helps clinicians understand the emotions underlying people's behavior. Additionally, it helps us understand the meaning of grief and loss and the effects of overwhelming experience on mind and body. It can help us understand aggression and the effects of violence on our capacity to think. Moreover, recent developments in attachment theory can help us understand the importance of human connection and the role it can play in developing and strengthening resilience, creating a useful clinical correlate to what we are learning from neurobiology.

One such protective factor is the ability to think and reflect in the midst of crisis. It has now been well established that stressful experiences affect the thought processes (Perry, 2002; Siegel, 1999), none more so than exposure to extreme violence. It is difficult for people to process the information they receive and make proper use of knowledge and information while being exposed to violence. As a result, panic can feed on itself and exacerbate the situation.

Attachment-based research suggests that thinking about thinking is a neuropsychological capacity that is cocreated with caregivers, allowing for the capacity, over time, to reflect on the minds and ideas of others (Fonagy & Target, 1996, 1997; Fonagy & Allison, 2012). People with "reflective function" "mentalize," that is, think about what they are thinking and what others might be thinking (Fonagy & Target, 1996; Siegel, 1999). This capacity may be lost in the midst of disaster, leading to public harm (Fonagy & Bateman, 2012).

By understanding the origins of mentalization and reflective function in human connectedness, and the harm that comes from losing this capacity, and by supporting the creation of community connections and using those connections to build mentalizing capacity, even under the most difficult of circumstances (Fonagy & Allison, 2012; Bragin, 2012), clinical social workers are better equipped to assist clients who have been exposed to extreme violence.

Psychodynamic theory also helps clinical social workers to address people's specific reactions to the violence of terrorism and the despair of disaster-born loss. Specifically, object relations theory addresses human emotions and behaviors that are disturbing for people to think about—such as aggression and violence. One object relations theorist, D. W. Winnicott, wrote about the role of aggression in human life. Winnicott

(1939/1984a, 1964/1984b, 1960/1984c) suggests that we are all born with aggression, and that it is as essential to our "going on being" as are love and care. Exposure to excessive violence, loss, or terror leaves people feeling helpless and often very, very angry. It is hard for them to understand and tolerate how angry they feel. Aggression turned inward can lead to despair, increasing the effects of stressful experiences on thought processes. Psychodynamic theory suggests that the ability to do good things "repairs" the effects of violence and helps people manage aggression provoked by experiencing violence and loss (Winnicott, 1939/1984a, 1964/1984b, 1960/1984c). We can use this information to help build programmatic responses in community as well as individual settings (Bragin, 2012).

Trauma Theory and the PTSD Controversy

The diagnosis of posttraumatic stress disorder (referred to as PTSD) formally entered the nomenclature in 1980. Prior to the development of this diagnosis, survivors of extremely violent events, from rape victims or war veterans to those who survived disasters, were considered by some psychiatrists in the global north[4] to have a character defect if they reacted with symptomatic behavior to the events that they had experienced (Herman, 1992). The new diagnostic category emphasized that strong responses after experiencing extreme situations were *normal* reactions to events that were beyond the capacity of the mind to endure them (Herman, 1992; van der Kolk et al., 1996).

Researchers soon discovered that symptoms suffered by survivors vary, not so much by the nature of the survivor's history but rather by the severity of the trauma they have suffered and the duration of the suffering (Hovens, Falger, Op den Veld, & Shouten, 1992). This revelation is important in understanding reactions to disasters and terrorism. The experiences of many of these survivors may differ from those of people who have lived through torture, war, repression, and community violence over a long period.

An additional and equally important discovery made by trauma researchers was the fact that many people who appeared not to have an adverse reaction immediately after the experience, did so later, sometimes after many years (Herman, 1992; van der Kolk et al., 1996).

Once professionals understood that the symptoms were in fact normal responses, they were able to develop programs to help survivors integrate their reactions and begin a return to normal life. Thus, trauma therapists in the global north were able to obtain treatment for their patients without fear of stigmatizing them (Bragin, 2007).

In addition, trauma-focused research facilitated the study of the effects of extreme experiences on the survivors. It also pointed the way for studying those who appeared more resilient than others, so that the protective factors that made their resilience possible could be replicated for others (Bragin, 2005, Wurzer & Bragin, 2009).

International Criticism of the Concept of PTSD

This diagnostic category, and the understandings that followed from its development, led to a proliferation of programs around the world that used some version of the Western model to address trauma symptoms. This application of PTSD theory to people in countries and cultures in the midst of, or immediately following, single violent incidents or natural disasters was greeted with dismay by many local experts. This view came from a number of different geographical locations and a number of differing viewpoints (IASC, 2007; Jones, 2008).

A most common concern was that any diagnosis, even one designed to do the opposite, could be used to pathologize entire populations as traumatized. Furthermore, it appeared to individualize

[4]This designation refers to the socioeconomic and political division that exists between the wealthy developed countries, known collectively as "the global north" and the poorer developing countries, or "the global south."

problems that were essentially social and communal in nature, fragmenting people and the resources available to help them (Bracken & Petty, 1998). Inasmuch as the expression and meaning of psychological distress is culturally constructed, it may be harmful to impose ideas about internal experience from external sources while ignoring indigenous ones (Wessells, 1999). Alcinda Honwana (2006), a Mozambican medical anthropologist, pointed out that PTSD was, in itself, a culturally constructed diagnosis, developed to explain the symptoms of American soldiers fighting a war in a foreign country who came home unable to adjust to "normal life," and then applied to disparate populations in which stress and distress were signaled in different ways and whose reactions to disasters in their home countries must be understood through their own lens.

In the 1980s, when PTSD theorists made many of their contributions, some of the current information from neurobiology was unavailable. We now know that the creation of a coherent narrative is a vital part of helping the brain and body to heal (Schore & Schore, 2008; Siegel, 1999). The original PTSD theorists wanted to emphasize that survivors of extreme events were likely to show symptoms of distress unrelated to any character pathology from the past. However, this led to a format for treatment that addressed the events themselves without regard to their historical context. This unwittingly created a climate for fragmentation and decontextualization rather than for the connection that promotes healing.

Furthermore, Jones (2008) found that the majority of the more severe psychological effects experienced by survivors of disasters and terrorism were related to the massive losses that they had experienced. Survivors both wanted and needed to talk about what their lives and communities were like before they were destroyed. Clinicians therefore felt that, instead of pathologizing survivors, talking about the past was critical to connecting them to the possibilities of the future. Allowing survivors to talk about their memories and their hopes, while assuming that their reactions to the stress of change are normal, may be helpful to most survivors in restoring a coherent narrative that helps them to include the disaster or incident of mass violence in their life stories as they move forward (Wurzer & Bragin, 2009).

In addition, it is important to note that those 6% to 7% of survivors with debilitating symptoms following disaster or terrorism, along with people already under treatment for psychological distress and serious and persistent mental illness, require a full range of appropriate treatments. PTSD treatment alone was seen as too narrow (Jones, 2008). For some survivors, that will mean treatment for trauma-related symptoms. For others, clinically sound and culturally competent care for complicated grief and depression will be required. The clinical social work theories presented earlier in this section may prove particularly useful for many of these patients. For still others, appropriate care may involve continuing the treatment they were receiving prior to the disaster for preexisting mental disorders (IASC, 2007; Jones, 2008).

Emerging Consensus on Best Practices to Support Well-Being in Disaster and Mass Violence

The 21st century began with a series of high-profile and large-scale disasters and terrorist attacks, including the September 11, 2001, attacks in New York City; the Asian tsunami; hurricanes Katrina and Rita; and devastating earthquakes in India, Pakistan, Iran, and China. In some of these situations, the care for affected families and communities was quite good. In others, the care itself, and the relief arrangements thereafter, caused more psychosocial suffering than it prevented (IASC, 2007). Kasi et al. (2007), writing from India, pointed out that the social work community needed to prepare for the inevitability of events such as these taking place every year. They cited the Indian example following the tsunami in which clinical social workers had positioned themselves to work with government at every level to plan and implement psychosocial and mental health responses. For this to work well there had to be some sort of consensus on best practices.

Originally, there was tension between clinicians, who focused on psychological distress, and humanitarian workers, who focused on the social aspects. However, through practice, research, and discussion, a consensus has emerged within the humanitarian community (IASC, 2007).

How did this consensus emerge? Because of the very nature of emergency situations, it is extremely difficult to conduct clinical trials to determine the best intervention. Originally, this led to the implementation of practices that imposed a Western medical model of care, one that marginalized both indigenous and holistic, psychosocial models. Frequently, psychologists and psychiatrists took the lead, with focused approaches on individual mental health that ignored the broader social and cultural domain. Later, follow-up research indicated that some of the practices popularized by these disciplines, such as critical incident debriefing, were ineffective at best and harmful at worst (Hobfoll et al., 2007) in preventing adverse psychological reactions and promoting long-term readjustment.

Responding to these criticisms, and to begin the process of compiling information on best practices, Stevan Hobfoll and his colleagues at the Summa-Kent State University Center for the Treatment and Study of Traumatic Stress brought together experts with experience in disaster and mass violence from Israel, Europe, and the United States to extrapolate from their own research. The result was a consensus document laying out five empirically supported intervention principles in the immediate and early to midterm stages of disaster. They mandate promoting (1) a sense of safety, (2) calming, (3) a sense of self and community efficacy, (4) connectedness, and (5) hope (Hobfoll et al., 2007, p. 284). Not surprisingly, these principles promote the same factors that mitigate psychosocial risk and support resilience.

At the same time, the Office for the Coordination of Humanitarian Affairs (OCHA) saw a need to develop guidelines that could be used worldwide to support psychosocial well-being and address issues of mental health in emergency situations. This too was a response to the problem of popular psychological practices being ineffective, harmful practices being imported, and local best practices from affected communities being marginalized.

International humanitarian coordination efforts are directed by the IASC. The IASC, which issued the guidelines, was established in response to General Assembly Resolution 46/182 (Office for the Coordination of Humanitarian Affairs [OCHA], 1999; UN General Assembly 2007; UNISDR, 2007), with the mandate to coordinate humanitarian action around the world and establish and advocate for best practice in humanitarian assistance. It is headed by the Director of the UNOCHA and is made up of the heads of United Nations agencies, the Federation of Red Cross/Red Crescent Societies, the International Committee of the Red Cross, and the consortia of international nongovernmental organizations (NGOs).

In 2005, the IASC established a working group to develop guidelines on mental health and psychosocial support in emergencies.[5] The purpose of the guidelines was to outline a set of responses to be employed during and immediately after emergencies, support psychosocial well-being, increase resilience, minimize risk, and provide care for mentally ill persons and those who are severely affected by the disaster. The guidelines highlight the importance of mobilizing disaster-affected persons to organize their own supports and participate fully in every aspect of the relief and recovery effort (van Ommeren & Wessells, 2007). The guidelines were launched for implementation in 2007. Their effectiveness is monitored and evaluated by an ongoing body called a *reference group*.

The majority of people affected by disaster or mass violence, while changed in many ways, appear to be able to endure their experiences and even to find a measure of meaning and happiness in life following their ordeal, while others, about 5% to 6%, suffer from severe stress reactions (Jones, 2008). Therefore, a simultaneous,

[5]The author served on this working group representing CARE International.

multilayered approach to the way services are provided is called for, one that targets every aspect of biopsychosocial well-being and not simply the prevention and response to psychological trauma (Bragin, 2011).

The guidelines outline the layers of care that should be provided, ensure the maintenance of psychosocial well-being, and include all members of the affected population. The pyramid in Figure 13.2 outlines the layers.

The rest of this chapter highlights the role of clinical social work and clinical social workers in providing care at each layer of the pyramid, ensuring that our skills inform every aspect of the effort to safeguard and restore well-being, even as professionally sound and culturally competent clinical care is provided to those who need it.

The Roles of Clinical Social Work During and After Disaster and Terrorism: A Multilayered Approach

A natural disaster has struck. You don't know where your family members are, where you can go to be safe, where you can find a bathroom (and your 5-year-old needs one badly), let alone where you will sleep tonight, and how long it

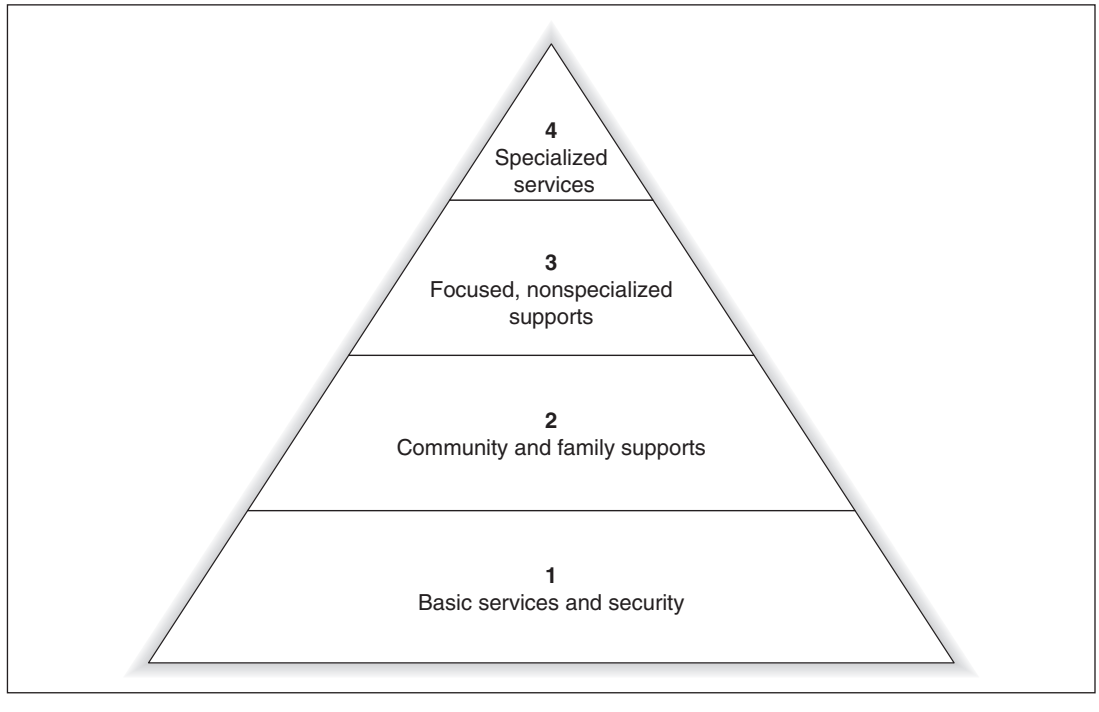

Figure 13.2 Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies

Source: IASC (2007).

Note: (1) *Basic services and security:* These are the supports needed by the entire population and must be provided to all survivors immediately. (2) *Community and family supports:* These supports are group oriented and subclinical. They involve many members of the community. Often, they are designed by community members, and supports are brought to bear as requested. (3) *Focused, nonspecialized supports:* The third layer represents the supports necessary for the still smaller number of people who additionally require focused individual, family, or group interventions by trained and supervised workers. This layer also includes psychological first aid. (4) *Specialized services:* The top layer of the pyramid is for those members of the community who are mentally ill and need access to medication and continued care and those who are having a severe reaction to the events and require professional treatment.

will be until you are safe. You certainly don't know what will happen next.

You hear that there is transport to safety and that food and water are being distributed, but you, your infant, and the 5-year-old are literally running from place to place trying to find them. Rumors are flying, and you don't know what to believe. Some of the scariest may be true.

At one point, denied safe passage at every turn, and with flood waters rising around you, you simply put your baby in the arms of strangers on a bus to safety. You try to do the same with the 5-year-old, but she shrieks and clings to you, so you hang on for dear life and hope for the best. No one takes the trouble to record the information for you and tell you how to find your baby again when you are safe.

You find your spouse at the crowded, chaotic shelter, where they say the bathrooms are unsafe, and the little one is crying. Your spouse can't forgive you for putting the baby on the bus, you are mad with worry, and meanwhile you have lost everything that you ever owned. As you struggle to locate your baby, support your child, and search for grandma among the unmarked dead, you must face the recrimination of family members as well as try to find a home and a means to make a living. You begin to despair and think that you can't go on.

The provision of basic information and basic services is a clinical issue!

Tier I: Basic Services and Security[6]

Develop Coordinating Structures From the Local to the Larger-Community Level

By getting information from all those who can help and ensuring that no one is working alone, coordinated efforts ensure maximum inclusion. Such coordination will make the next steps possible. This is hard work, and all our clinical skills will be needed to coordinate the multiple systems and personalities.

Participate in the immediate development of a central coordinating body and, within it, a psychosocial working group that can help ensure that everyone knows who is doing what and where.

Get Clear, Accurate, and Coordinated Information to the Population

People in the midst of disaster need the following information:

- What is known and not known about the nature of the disaster
- Where they can go to be safe
- Where they *cannot* go to be safe
- Where services are being provided
- Who can get the services
- How to register to locate missing family members

Ensure that information on these issues is disseminated clearly, consistently, regularly, and in all locally spoken languages.

Build the Capacity of Existing Health, Education, and Social Welfare Systems: Support Local Practitioners in Doing Their Jobs Well

One of the most important roles a clinician can play is to keep local health, welfare, and education systems in the lead and to provide health professionals, social workers, and teachers with the material and psychosocial support that they need to continue their work. Even though they are suffering the effects of the disaster themselves, it is important to recognize that they have valuable knowledge, skills, and experience. They are the ones who know exactly

[6]These correspond to Hobfoll et al.'s (2007) *safety, calm,* and *connections.*

what materials and information they already have and what is needed. They are the ones who know what will be useless or superfluous.

But, by definition, disasters overwhelm the available capacity of local systems. Therefore, outside help is needed. However, the most effective use of outside resources is to support the existing systems regardless of how overwhelmed they seem. To bolster their sense of empowerment and capacity, they must be assured that they retain their positions of authority and that necessary resources identified by these systems will be brought in, from equipment to personnel. At the same time, it is equally important to furnish the providers with psychosocial supports, so that they are able to carry on. (This is discussed in greater detail in the section Tier IV: Specialized Care.)

Support Skilled Workers, Merchants, and All Others in Being Useful at Their Work

When people have lost everything, it is important for them to remember that they have not lost their skills and capacities. They should assess the damage and take the lead in obtaining contracts for repair. Existing merchants should be consulted and given contracts to provide supplies to emergency workers whenever possible. When they have a role to play, they will cope better. This is best accomplished by daily meetings of the coordinating committee whose members will work with the concerned logistics managers.

Involve Community Members in Defining Their Own Well-Being and That of Their Children

The best information comes from the source, and poor information or external definitions of well-being may increase feelings of stress and inadequacy. Mental health and psychosocial support assessments in emergencies provide (a) an understanding of the emergency situation, (b) an analysis of threats to and capacities for mental health and psychosocial well-being, and (c) an analysis of relevant resources to determine, in consultation with participants, whether a response is required and, if so, what the nature of the response should be.

An assessment should include documenting people's experiences of the emergency, how they react to it, and how this affects their mental health and psychosocial well-being. The assessment should include how individuals, communities, and organizations respond to the emergency. It must measure resources, as well as needs and problems. Resources include individual coping/life skills, social support mechanisms, community action, and capacities of government and nongovernment organizations. Understanding how to support affected populations to more constructively address Mental Health and Psychosocial Support (MHPSS) needs is essential. An assessment must also be part of an ongoing process of collecting and analyzing data in collaboration with the affected community and all those providers and support persons who understand their community well.

This assessment can guide the work that clinicians perform after the emergency and the types of specialized supports they may provide. In some instances, the assessment itself helps affected persons feel safe, secure, and calm.

A coordinated participatory assessment process should begin immediately.

Community members should be encouraged to identify their own coping mechanisms:

- What is in place? What is missing? What more/new is needed?
- Which traditional practices or ways of doing things make people invisible?
- Who needs to be involved in creating change where change is needed?

Community-based monitoring and evaluation of clinical interventions can begin early as well, forming part of the assessment.

The Haitian Community Resilience Project: Engaging the Strengths of a Diaspora Community

The Haitian Community Resilience Project did not take place in Haiti, but in the diaspora communities of Brooklyn and Queens in New York City. These communities were known for their strengths; the excellent school performance of the children, the high community representation in the health care workforce, and the unfailing financial contributions to family members on the island. Further, Haiti itself seemed to many the embodiment of resilience. Born out of a slave rebellion, the newly born republic paid every penny of the price needed to purchase its freedom, despite economic boycott from Europe and the United States and isolation imposed by the Vatican. Through the spirit of community solidarity known as *Kombit*, and a deep spirituality, Haiti somehow survived all of this adversity, as well as a history of hurricanes, earthquakes, and environmental degradation (Nicolas, Schwartz, & Pierre, 2009).

The earthquake that struck Haiti on January 12, 2010, at 7.3 on the Richter scale, was the most powerful to occur in that country for 200 years; 1.5 million people were directly affected, including 220,000 who lost their lives, 330,000 injured, and 1.3 million forced to live in temporary shelter. The unprecedented size and damaging sequelae of this earthquake placed an unprecedented burden on members of the Haitian-American diaspora, including the estimated 86,687 Haitian-American residents of Brooklyn and Queens. Of these it was estimated that 60% had lost immediate family members, with the entire community supporting survivors either in their homes temporarily or on the island.

New York City's Department of Health and Mental Hygiene (DOHMH) launched a massive outreach effort in churches and community centers to learn from the existing community institutions what factors supported their resilience and where resources should best be placed to support existing structures or to reach people who those structures were not reaching. Beginning with a participatory assessment, DOHMH professionals engaged all levels of the community, from leaders to earthquake refugees, to indicate what was needed to support resilience, what was in place, what needed strengthening, and what more was needed.

The community members were able to recommend capacity building initiatives that would allow for ongoing community supports—psychological, social, and economic —provided at churches, schools, and community centers. The interventions supported both the Kombit and spiritual traditions of the community. Participatory evaluation revealed high use of these supports and a sense that they had succeeded in restoring and building capacity, connectedness, and the ability to adapt. Now New York's DOHMH intends to use this as an opportunity to jump-start community resilience-building measures (Bragin & Prince, 2012).

Community members can also be asked to target specific vulnerable groups; success is measured in part by the capacity of the community members to include such groups and get that information to those distributing relief. (This entire section is from IASC, 2007, Action Sheets 2.1 and 2.2.[7])

[7]More on participatory monitoring and evaluation and the entire assessment sequence can be found in the following key Web sites: www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf (IASC, 2007) and www.interventionjournal.com/downloads/31pdf/03_24%20Bragin%20.pdf (Bragin, 2005).

Ensuring the Protection of Vulnerable Groups

Very often in an emergency, those who are normally disenfranchised in a society remain invisible until their problems reach acute proportions. For example, after the events of September 11, 2001, in the United States, the families of the undocumented workers of color who were killed during the disaster were not supported to the same level as were others, until advocates sought them out and worked on their behalf. Problems such as this can occur in any society.

Learning about structures of power and historic discrimination are critical parts of any assessment so that even when cultural traditions are being honored and maintained, those that support discrimination and injury are not.

Supporting providers should include community standards of well-being in the design of all basic services, so that bathrooms are usable and safe, shelters are the same, and food and water cannot be exchanged for sex or money. (See IASC, 2007, Action Sheets 9–11 for details on this section.)

Identifying the Dead Before They Are Buried and Informing Families as Soon as Possible

One of the greatest sources of psychosocial distress is uncertainty about whether a loved one is dead or alive. It makes grief and mourning difficult and renders getting on with life almost impossible. Therefore, identification of the dead and notification of the living are essential for the restoration of well-being.

Fortunately, when healthy people die in a disaster or a terrorist attack, their bodies can be preserved for a day or two prior to burial, so that identification and registration can be made and, if possible, family members can be located and notified. There is no health-related need for immediate mass burial, unlike situations in which people die of disease (Wisner & Adams, 2002).

Clinicians can coordinate with health workers to ensure that bodies are identified before they are buried or cremated. Whenever possible, surviving relatives should be able to dispose of the identified bodies in accordance with their cultural traditions. Coordination meetings can help ensure this.

Tier II: Community and Family Supports and Tier III: Focused Nonspecialized Supports

These supports also provide some of the basic building blocks of well-being after disaster and terrorism (described by Hobfoll et al., 2007); that is, they build connections, promote self-efficacy and capacity, and begin to support the creation of hope.

Tier III supports, that is, those targeted to people who have suffered from specific types of devastation (e.g., loss of parents or children), are often nestled into family and community supports and will thus be presented here together with Tier II supports.

Support for Mourning Rituals and Ceremonies

It is normal to feel great sadness and anger in the wake of terrible calamities. These feelings do not require treatment unless they affect functioning over time. It is important to remember that losing a loved one in an untimely way changes the mourner forever. It will take at least 12 to 18 months to learn to live with the loss. This is not the same as moving on and getting over it.

Wherever possible, clinicians should support participation in traditional mourning rituals. In the case of death and mourning, even the nontraditional have traditions. Families should be permitted to define what they want to do, provided help to do it, and helped to create new traditions if old ones don't work.

Sam's Feast: A Ritual for Atheists

Everyone loved Sam, mostly because of the way that he loved life. Sam was an irreverent, foul-mouthed, smoking, and drinking 78-year-old who commented to everyone who would listen that he would womanize a bit more if only he could. He had no use for religion and had ceased to be an orthodox Marxist. Sam was a U.S. veteran of many conflicts for social justice, from the Spanish Civil War and World War II, to the civil rights movement in the South, to the struggles of immigrant workers in New York. That struggle brought him to the World Trade Center on September 11, 2001, where he was organizing undocumented workers at Windows of the World.

Sam would have hated all of the official ceremonies having to do with September 11. His partner in life, Esther, stated she wanted no part of any of this—not even the mention of his name—once it was clear that he was among those killed. (Conspiracy theorists still say that since his body was never found, he actually escaped and somehow made it to Cuba, where he remains in hiding, still organizing to this day.)

Esther, who was not his legal widow because she and Sam did not believe in marriage, had nothing to hold on to. At 60, Esther felt that she was living in a world in which nothing felt real at all. She couldn't own the ceremonies, and she was not acknowledged by official organizations because they didn't consider her a widow. Her sadness was complicated by this intensifying feeling of dissociation.

Members of the immigrant community that Sam had been organizing contacted their outreach worker to ask that someone visit Esther. Together with the outreach worker, they planned a huge memorial party, celebrating a small victory in gaining benefits for the workers.

There was a lot of Spanish wine, dancing, music, and an enormous feast. The songs of the Spanish Civil War were sung, Esther wore a dress from the Spanish war days, and an honor guard sang the anthem of the international brigades, standing at attention, left arms clenched. Young people Sam and Esther had mentored led the dancing and pledged to continue Sam's work. They collect Esther every year to march together with them in immigrants' rights marches and carry a banner in Sam's name.

Esther embraced this ritual as a way of beginning to think about Sam's death as a reality and how to rebuild her life.

Dancing Our Way From the Past to the Future: A Chinese Community Copes With Loss

The fact that every single child was in school that day was a source of pride to this small ethnic minority community in western China. Not so long ago, the rural schools were of poor quality and did not continue past grade four. Consequently, few students went beyond an elementary education. The perceived complication of an ethnic minority language spoken at home posed further educational challenges.

But by 2007, there were three schools in the nearby large town: elementary, middle, and high school. No one kept children at home. There were several regional universities and technical schools from which to choose. The school buildings were tall and well equipped, unlike the one-story prefabricated structures common in rural communities in other countries. This hardworking ethnic minority felt that they had really "made it." Many families sent the children to school happily the morning of the earthquake, but some had to argue and insist. All the schools in that town collapsed, killing all the students and teachers inside.

Families lost their only child. Everyone had to wait for two days until the army came with helicopters, rescuing the living and exhuming and helping to cremate the dead.

The community was devastated. Words were totally inadequate comfort. Parents who thought that they were helping their children by insisting that they go to school had instead sent them to their deaths.

The community had a custom: traditional dancing. Each generation taught the dances to the next, and they practiced them together with their children week after week. Slowly, they began to revive their dance troupe. With the support of the Hong Kong Polytechnic University Department of Social Work, the local social work teams were helped to understand that the weekly dancing was a way for the community to connect to their past as they slowly began to rebuild their future. At the first anniversary of their children's deaths, and the destruction of their community, the troupe danced for an international audience.

They wept, they remembered, but then they danced, with the surviving children (those too old or young to have been at school) dancing along.

The loss of a child is forever, and the grief may be lifelong. However, through this unusual transgenerational creative process, those with unbearable guilt, pain, and grief drew strength from one another and began the slow process of healing.

Source: Adapted from Sim (2009).

Support for First Responders

There is nothing that feels as good as being able to help someone in need, whether it is pulling them out of the rubble of an earthquake or carrying them from a burning building. Doing such lifesaving work in the company of others is a high unlike any other—a memory people recall until their dying days. First responders differ from soldiers because their mission is to heal, rather than harm, and their tasks are universally praised.

The high rates of posttraumatic stress in first responders, although lower than that of the affected population, are still noteworthy (Halpern & Tramontin, 2007). As previously noted, short-term debriefing was found to be ineffective (Hobfoll et al., 2007).

At first, rescuers may be incapable of rendering what they have experienced into a symbolic form. However, when the suffering stops, they may find that those parts of the experience that have not been symbolized return to haunt them.

Typical symptoms are substance abuse or risk-taking behavior that attempts to replicate the high of the lifesaving experience.

Psycho-educational interventions, which are designed to explain how the brain processes extreme experience, can be helpful. These are best done as part of a training program in which

responders (a) are given the information so that they can help others, (b) are asked to develop a plan to discuss the experiences together, and (c) are invited to lead the community in training new members of the team, so that they don't fall prey to substance abuse or to behaviors that put others at risk.

Support for Children and Adolescents

Disasters and terror attacks create situations that affect every aspect of social and emotional life. As described above, they create great distress among all affected members of society. Children are engaged in a dynamic process of development that won't hold still and wait for better times and more positive influences to shape outcomes. Therefore, communities must be assisted to create the most favorable conditions possible for the development of all children to move forward. This is separate from and precedes any treatment program designed for those who suffer from specific levels of distress.

The following steps review simple, community-based actions to support children's continuing growth and development when all the usual services are disrupted, where massive loss has occurred, and when families are distraught.

Support for Parents and Teachers

For children to develop normally, they need parents and teachers who are supported well enough to do a good job with the children in their care. This is a subclinical level of care requiring culturally competent intervention within the affected communities.

Supporting Parents

Some of the supports below designed for children will also support their parents. Though specialized supports for parents, independent of their children, may be helpful, structured groups, which require that appointments be regularly kept, are not as effective when people are under stress. Therefore, a service center that provides essential information can also have a drop-in corner where parents can come and talk, blow off steam, and receive psycho-educational materials. Peer-to-peer support can also be offered at schools.

Support for Teachers

At this level, we want to emphasize more specific supports for teachers that include providing group encouragement, places to talk and get coffee, and solid recognition. Teachers need to talk and freely exchange stories and experiences with one another in an environment of mutual support. Their needs must be recognized.

One of the most effective ways to accomplish this goal, apart from providing coffee breaks and downtime, is through experiential education sessions. Such sessions allow teachers and others directly involved in child care to find ways of discussing their own experiences so that they can help children to talk about theirs.

Helping Babies and Very Young Children

Keeping Families Together/Preventing Separations. Small children can be quite resilient in disaster because their family members are their safety and security mechanism. We know that losing family connection is a developmental disaster for children. The loss causes stress on the parents and the entire family system as well. Sometimes, misguided individuals may want to provide food and safety for children alone, not aware that this may lead to the destruction of family ties. Therefore, assistance must be offered to the entire family, including the children. (See Appendix B for a detailed guide to preventing separations in the midst of emergencies.)

If a child has been separated from his or her parents, ensuring continuity of care by surviving family members is critical until the parents are located and the family has been reunited.

Assist Parents in Caring for Small Children

If at all possible, a tent or other safe space for mothers and grandmothers of small children should be provided, thus assuring safety and

emotional support, as well as nutritious food, diapers, and beverages. In the international community, these are sometimes called *child-friendly spaces* and are easily run by volunteers, since parents are there with the children. Psychosocial support in the form of active listening can also be offered. Often, it's possible to have toddlers and younger children playing there, as well. That helps people to regain their balance.

There is no need to keep track of attendance. Parents can simply walk in and spend time as needed, no questions asked. A volunteer can find out if anyone needs additional emergency services and refer them.

Kids' Corner at Pier 94: World Trade Center 2001

One of the most difficult tasks following the World Trade Center attack of September 11, 2001, involved recovering and turning over the remains of the deceased to the surviving family, a task further complicated by the arduous process of documentation and disbursement of benefits. These tasks were performed at Pier 94 in Manhattan. Many surviving parents arrived with young children in tow. They were distraught, and the place still smelled of burning debris and decomposing bodies.

A dedicated child psychoanalyst, Desmond Heath, set up the Kids' Corner. It was a small space in a corner of the pier, staffed by volunteers, many of whom were clinical social workers. Children could draw or play with dolls and trucks while their parents went inside and waited in line for service. A sand tray with miniature dolls was also provided for those who wished to use that medium to make up stories.

Before and after receiving the information that they needed, and an urn containing the deceased's remains, parents were offered an opportunity to meet with volunteer clinicians, while their children continued to play, supervised by other volunteers.

Though the intervention was very brief, it helped these parents in distress to gather themselves and receive support at a critical time. It was also helpful to know that their children were able to play in a safe, supervised setting.

It proved beneficial for these children to express themselves through play with someone able to make sense of their feelings, if only for a few moments, before returning to the fray.

Source: Coates, Schechter, and First (2003).

Support for School-Age Children

Children from ages 6 to 12 like to learn the rules of the community and follow them. Disruptions from normal activities are particularly upsetting to them and so is exposure to violence or other rule breaking by adults. Therefore, interventions to maintain the flow of development involve as many normalizing activities as possible, coupled with specialized support to teachers, parents, and youth workers. The list below gives some essential suggestions.

Participation in Mourning Rituals. Children must be told who has survived and who has died and be allowed to participate with others in mourning rituals, so that they can see that there is an order to the things that have happened.

Emergency School. It is important to resume school as quickly as possible. Teachers can be

supplied with books of games and helpful activities, including guides for talking and playing with children following a disaster. Some programs focus on identifying traumatized children. This is not useful. Rather, children should come to school and find as much routine as possible. They should be able to talk about the disaster during a special talk time, but the rest of the day should be devoted to regular learning activities. The Web address of the International Network on Education in Emergencies is included at the end of this chapter. The website lists suggested activities for school-age children and available training for teachers.

Creating Space for Organized Sports and Games. Children need to know that it's okay to play, inasmuch as play helps them work out problems and feel better again. School-age children like to play games with rules, from sports to board games, because they are learning about the rules that govern the world in which they live and how to take their place within it. Both disasters and terrorism violate those rules, whether they are the rules of nature (a big wave should not come onto land and destroy everything in its wake), the social compact (the levees are kept strong by the engineers so that the river will not flood our city), or human behavior (people don't kill thousands of people just because they don't like what their government does). When games and sports are organized for children after a disaster or terror attack, it can help restore their sense of security. Learning the rules of the game and playing by them can help school-age children know that the world has not gone completely mad.

Participation in Age-Appropriate Helping Activities. School-age children can be helped to find age-appropriate ways of helping others. This will aid them in feeling important and more hopeful. It is important that the tasks be easy enough, so that they can feel successful. They can be involved in activities such as playing games with and telling stories to younger children and helping identify lost little ones. They can also help by creating art and music projects that parents and others can enjoy.

What Teachers Can Do to Work Effectively With School-Age Children

Because school-age children are learning the rules of society, and these rules have been broken by the natural disaster or terror attack, they will not feel safe unless they are sure that there are rules that everyone in the classroom agrees on, that will not suddenly be changed without warning. When they have difficulty with their own emotions, and fear an outbreak of inner feelings, they need reassurance that they are normal and that with help, normal life will return for them and their classroom:

- Make sure that the rules for behavior at school are clear and that everyone knows them.
- Make sure that children have access to good, clear factual information about the events and that this information is repeated as often as required.
- Provide opportunities to discuss feelings and fears, and offer reassurance that they are cared for and protected.
- Explain that it is normal to have trouble concentrating during difficult times, and help them do schoolwork as a team and homework working one-on-one with a volunteer.
- Explain that their reactions (poor concentration, worry, psychosomatic symptoms) are related to the disaster, and that they will feel better with time.
- Don't reward psychosomatic complaints by paying too much attention to them, or the child will develop a habit of seeking love and support this way. Instead, provide reassurance and help children with psychosomatic problems put their worries into words.
- Teach children the principles of conflict resolution to help them feel empowered to control their behavior and solve problems among themselves.

Talking About Difficult Issues With School-Age Children

- Recognize that school-age children want and need as much factual information as possible.
- Allow children to discuss their own theories and ideas about what happened, so that they can begin to master the events.

- Tell children how and where they can obtain information and assistance.
- Initiate group discussions about distressing events that they may (or may not) have experienced, since it may be assumed that even those who are not directly affected would have heard about them. This will help affected children feel less alone in their suffering.
- If a child brings you a rumor or false alarm, take time to find out what the facts are and inform the child, reminding him or her of accurate sources of information.
- Tell the children that it is okay to feel afraid, confused, angry, and guilty. These are all normal responses to an extraordinary situation.
- Use realistic terms with children, and avoid euphemisms.[8]

The Program for Underserved Schools: Principals, Kids, and Teachers Get Support

Carol Sedgwick (not her real name) was principal of a school very near the World Trade Center. Her school catered to poor immigrant kids. After the towers collapsed, a temporary shelter was set up in her school, and at first she was glad to be of help. Her students and teachers who lived in the neighborhood had to go through police barricades and have their IDs checked before they got to school. Attention was lavished on those schools directly affected. However, to these students and teachers, who lived near the site⁄ but were powerless and invisible, it seemed that no services were being offered and more and more was asked of them.

When the Program for Underserved Schools' workers came to talk to Ms. Sedgwick, she was angry and bitter. She wanted to talk about the burdens that she faced but claimed to have no time to do so. She certainly had no spare rooms for any outsiders.

One worker then responded by joining her for an early breakfast and a cup of coffee. After some time, Ms. Sedgwick began to feel she could trust her and felt able to discuss what was troubling her about the larger response. She agreed to meet with some of the other principals to talk about their difficulties. She also articulated ways in which she needed help with the school.

The teachers proved even more angry and hard to reach. Many were immigrants themselves and felt badly treated. Rap groups were started in the teachers' lounge with no rules as to what the teachers could talk about. They began with their anger about the school and their treatment by the larger society. Soon, they were talking about how hard it was to help students under extraordinary circumstances.

That gave the social workers an opening to advise them about ways to work with children affected by a terrorist attack or disaster in the classroom and how to talk with them about difficult issues.

As the teachers felt better equipped, they were able to reach out to their students. Attendance and morale started to improve, especially when the principal announced that they would not provide further services unless they received services themselves.

(Continued)

[8]These last two sections are adapted from the IRC (International Rescue Committee) *Training Manual for Teachers* (2003) and the Christian Children's Fund (2005) *Emergency Manual Part 3* (2005).

(Continued)

The teachers asked the psychosocial team to agree to take the most difficult children into the group. They wanted those children to be accepted regardless of their relation to the disaster. They just wanted help with difficult kids. The most unruly children turned out to be those whose families were the most distressed by the collapse of the towers, either because they had lost family members or because it reminded them of previous disasters that they had fled to come to the United States. As undocumented workers, they were unable to access help and were too afraid to ask questions.

Program staff spent 18 months holding rap groups for teachers and art groups for children and helping this principal (and others at similarly affected schools) to articulate and advocate for her school's needs.

For Adolescents

Adolescence involves a new burst of growth in both brain and body, not seen since early childhood. Psychodynamic theory tells us that adolescents, like all others affected by disaster and terrorism, are not really able to think about the events and so may be prone to act out in destructive ways, either against other people or property or against themselves. This is not only because such events have been stored differently in their developing brains but also because they may be very angry and very sad and unable to manage such feelings.

Involving adolescents in every aspect of rebuilding and program development is important for several reasons. First, it reinforces their sense of hope as well as the feeling that they can be of use. Furthermore, such involvement supports reparation, the psychic mechanism by which doing good things helps mitigate the guilt and rage that sometimes follow survival.

All the following activities, employed in combination, will help most adolescents begin to process and heal from their experience.

Participation in Mourning Ceremonies. Like their younger siblings, adolescents need to participate in mourning ceremonies. Many will want to question the values that they have been taught, the meaning of life and death, and whether or not there is a purpose in life. Expressing these thoughts should not simply be allowed but actively supported. Special opportunities for adolescents to grieve for their friends and classmates can be provided through activities at school and at local religious or community centers.

Starting School as Quickly as Possible. Like younger children, adolescents need the routine of school to help reassure them that life will go on. Those who are scheduled to graduate or take qualifying exams should be reassured that those events will still occur and that they need not lose out.

Providing Opportunities to Participate in Community Service. Nothing feels better after a disaster or terrorism than being able to do something about it. This is particularly true for adolescents, who may feel helpless and betrayed at a vulnerable age. These young people can and should serve as community volunteers and be praised for their activities as they help build shelters, find lost children, and promote hygienic practices. They can be the "legs" that ease coordination and information sharing. Classes at school can be asked to create and execute specific projects in which all class members have a role.

Providing Opportunities for Artistic and Cultural Expression. These activities could take the form

of entertaining sick children or the elderly or something to do to have fun. Adolescents can paint murals and decorate temporary shelters. Opportunities to portray the past should be linked with their own visions of the future.

Supporting the Process of Thinking and Understanding. Adolescents are at a stage of development where formal cognition is developing. Encouraging them to express their opinions, identify problems and needs, and create their own solutions aids in the development of this new capacity. Increasing their awareness that they possess a mind and a brain and helping them form their ideas, without censorship, is critically important.

Supporting Participation in Prosocial Cultural Activities That Allow Them to Learn About and Develop Cultural Identity. When these strivings are pushed underground, they can appear in dangerous ways, such as joining hate groups or being recruited into gangs. However, when such strivings are respected and young people are free to participate in their own cultures and identify with them, they learn tolerance, even in the face of crisis.

Giving Importance to Sports and Games. Making sure that adolescents have some time for organized games, sports, dances, and other fun activities lets them know that it is still okay to enjoy living.

Post-Tsunami Sri Lanka: Youth Clubs Make a Difference

Fifteen-year-old Nilusha felt alone and abandoned. Her father was lost at sea, her mother seemed lost at home in the wake of the tsunami, and little remained of their home. Her school was full of mud and disgusting smells. She'd never take her exams, and she'd never graduate. Life seemed about over. Her friends were all overwhelmed, with parents locking them away for fear of danger. Would the sea betray them again?

However, not an hour's bicycle journey away, life was completely normal. It was all so weird. Kids who were just as poor as Nilusha had been completely unaffected by the devastating wave. Was it her fate to be unlucky, she wondered, as she tried half-heartedly to help her mother?

Radha was a member of a local youth club for poor kids run by an INGO (international nongovernmental organization). Teens could gather together and study, have parties and dances, and volunteer for social projects. The club was primarily made up of kids who had been beneficiaries of social and economic support when they were small. They usually had a clubhouse. It was a place where you could hang out and not be hassled.

When the tsunami came, these young people were already organized! Radha convinced the others not to just sit back but to do something. The INGO offered them assistance if they desired it. These teenagers got on their bicycles and rode to the disaster area.

There Radha met Nilusha, whom she had asked for directions amid all the detritus. The girls talked and agreed that Nilusha and others in the community could join the youth club on Saturday, when they returned to the neighborhood. The groups worked together, with local young people identifying problems that the whole group could focus on with the others subsequently joining in.

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They made maps of the camps for displaced people, showing where the problem areas were and where there were safe places to go. They got little kids to help in the drawing of the maps. They brought problems to the authorities and asked them to work on them.

They divided up as teams according to interests and went to the local authorities to volunteer. Their organization also helped them find places to be useful.

Some wanted to work with young children, others to work in construction. Some wanted to organize sports matches. Others wanted to use singing and acting talents to entertain old people who were in despair. Radha and Nilusha were both on the team to entertain old people.

Nilusha and her friends, who were affected by the tsunami directly, felt supported by the others. They felt that they were not alone. They also had an ongoing way to work toward improving their situation. The artistic activities they participated in helped them begin to think about the disaster and symbolize it in their minds. The sense of group solidarity helped members feel connected to one another.

At the end of 1 year, Nilusha and the other affected young people were back in school and feeling hopeful. They still identified many problems in the community and in their lives, but they felt that they could be effective in making a change. They felt greater levels of efficacy and had high hopes for the future.

Psychological First Aid: Listening in the Face of Disaster

Anger, sorrow, and even helplessness are not clinical problems requiring treatment. On the other hand, it is important to train volunteers, such as Nilusha and Radha, or those who sit with parents and teachers, to be able to listen to people on the spot, when they need to talk, supporting and directing them to the proper care.

Very similar to medical first aid, psychological first aid involves providing care immediately after a critical incident has occurred. This care is intended first to address immediate issues of safety and comfort and then to facilitate planning for additional care. Psychological first aid is typically provided by the first to arrive or those who become aware of the critical incident quickly. It is an attempt to bring comfort and reassurance to victims and to ensure that they get adequate follow-up care. It is not to be confused with psychological assessments or treatment, both of which can only be provided by trained professionals.

Guidelines for psychological first aid are contained in Appendix C.

Tier IV: Specialized Care

Specialized care refers to clinical care and mental health treatment. This tier has two subcategories of clients: (1) those with ongoing, serious, and persistent mental illness and (2) those with acute reactions to the grief, loss, and exposure to violence they have experienced.

Support for the Serious and Persistently Mentally Ill

In all disasters, people suffering from serious and persistent mental illness are among those affected. It is important to ensure that these persons are protected from harm and

receive clinically sound and culturally competent care by trained professionals with as little interruption as possible. This group will get only a brief mention here, since the basic intervention is to locate these people, ensure that they are safe, and restore them to the care that they need, including appropriate medications.

They fall into two groups: (1) those in institutions and (2) those residing in the community. It must be determined that those who are in institutional care are brought to safety away from the disaster and are not abandoned or endangered in any way.

Those who are ambulatory will often come to the attention of the police or others when they create disruptions in shelters or other public accommodations. The loss of stability caused by the disaster and the loss of all the structures of daily life may be profoundly distressing to this population. If they have been unable to take their medications, they will be reacting to that as well. Mentally ill persons will need to be seen in whatever medical facilities are available to determine their diagnosis, how long they have been ill, and what medications and other care they were receiving.

When Risk Overwhelms Resilience: People Who Require a Clinical Level of Intervention Following a Disaster or Terror Attack

Among the most vulnerable in times of disaster or terrorist attacks are those who have suffered complicated grief, those who are vulnerable due to factors originating in family or personal history, or a combination of the two.

Jiang, a member of the Sichuan dance troupe, had two daughters. The oldest, a teacher, named Ha, was pregnant with her first child. Her younger daughter had completed high school and gone to work in a business enterprise. On the morning of the earthquake, Jiang's older daughter phoned, saying that she did not want to go to work as she was having a bit of morning sickness and wanted to come to her mother's house to chat. Jiang scolded her daughter and reminded her of the old days when teachers in their district seldom came to school, and the students had a low level of education. She urged her daughter to eat a cracker and go along to school. She wouldn't stay home from work for such a little thing, and neither should her daughter. She was angry with her for being so "spoiled." Later, it was discovered that Ha was killed instantly when her school building collapsed.

Jiang joined the dance troupe and tried to put her hopes in her second daughter, but her grief became more intense with the passage of time. She found herself blaming her younger daughter for surviving when her oldest had died. She blamed herself every day. Nothing relieved her depression.

Jiang's grief, like many people's, was complicated by her belief that she herself had sent her daughter to her death. She felt unworthy to have another child who had survived, when so many of her friends had lost their only one. She felt that she did not deserve to feel better in any way, at any time. Her cultural club, which had proved sufficient for the rest of the members, was not enough for Jiang. Soon she began to feel ill and went to the doctor for her headaches and backaches. The doctor thought that these illnesses were due to a lack of balance in her emotional life and recommended psychotherapy.

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Therapy for Jiang could not focus on removing her symptoms, for others would come in their place. Instead, she needed to face and accept the fact that she had not been able to control what happened to her daughter and that on a day when she was impatient, she had unwittingly sent her daughter to her death. This is a difficult process in therapy, as the therapist often wants to "make it better" or to "absolve" the patient of his or her feelings of self-loathing. But the reality is that no one can take the pain away.

The dance group provided a protective holding environment for Jiang while she dealt with her grief and guilt in treatment. Two issues merged here: (1) a malignant feeling of guilt over both her actions and the feelings underlying them, which had proved unbearable, and (2) the difficulty of contemplating those feelings and making mental use of them, inasmuch as they had been locked away inside.

Her therapist recommended family therapy, as a way for the entire family to speak of and then memorialize the dead together but away from the eyes and ears of the community.

Jiang and the therapist met with family members and asked their forgiveness. Other family members told Jiang that they would all have done the same, told their children to go to work and not be a baby, and that they did not blame her. They urged her to look at her remaining daughter and see her light and her love.

To tolerate her guilt, Jiang began to volunteer for the local women's committee, raising funds to help elderly people who had lost their only child. In this way, she began to feel that she was compensating for what she had done. She gradually became able to look fondly at her second daughter.

When I met Jiang and her therapist, she had completed her weekly family therapy and remained in the dance troupe. However, follow-up sessions were scheduled in 3 months. The expectation was not that she would forget her daughter but that she would be able to bear the pain and rejoin life again.

For some patients, the real issue is not guilt or loss or something that happened to them or something that they did; instead, it comes from their family history and the ways that history has made them vulnerable.

My colleague called for a consultation with a disturbing case. The client in question—I will call him Paul—was a precociously bright African American adolescent, barely 14, enrolled as a freshman at a competitive public high school. Paul had been referred because of his "defiant attitude." His mother was particularly concerned that Paul, in whose high school African Americans were a tiny minority, was placing himself at risk.

Trauma in his family had come down through the generations, with his own mother having witnessed the attempted lynching of her father by an angry mob. Her untreated psychological difficulties, and real-life economic stress, left her struggling to be empathic to her son but often with an unconsciously communicated need to be avenged by him.

According to the therapist, Paul was responding rather well to treatment until the events of September 11, 2001. Then, he began to decompensate in a variety of ways, spending all his time on the Internet, writing about his very specific and perfect view of the appropriate response to the events ("How dare you say tragedy—this was evil, this was war"), and raging at anyone, including his mother, who responded in any way that he considered incorrect. He no longer ate or slept well and was awake all night, pacing and writing and refusing medication. What was particularly interesting is that he had not seen the events, since his high school was located in a different borough.

When he returned home one day, Paul told his mother that the smell was of burning bodies and the ash was of the dead and, indeed, that they were breathing in the bodies of their neighbors. He was overwhelmed by the sense of the evil that had been done, worse than Hiroshima and Nagasaki, because it was not committed during an act of war. He began to develop a complex scheme of who was guilty, who was more guilty, and what was appropriate as an expression of grief. His mother, a devout Christian, was cursed for her lack of respect for the dead when she spoke of her compassion for the mothers of the boys who died while committing the act (though such compassion was important for her own psychic survival).

Every waking moment of Paul's life revolved around the careful construction of behavior and ideas that repudiated all possible connection to the terrorists.

There is a great deal more to say, in a long and complicated story. However, we will focus here on the uncanny. This young man had gotten stuck in his own fantasies of violent retribution—in this instance, enacted by bright young men who were older and wealthier but perhaps not so different from him (Osama bin Laden visited Disneyland as a child). They were smart, educated, and aggrieved. They acted on their worst fantasies of retribution. He felt in this enormous crime a frightening breakthrough of his most violent fantasies. He needed to remind himself and everyone else that he was no terrorist.

Paul's history had already taught him that violence can be enacted. The acts of terror in the present time made it clear that the world had not become safe.

His therapy was aimed at helping him reduce the abject dread he experienced in relation to his anger and in gaining facility in expressing these complex feelings in words. The goal was to help him channel his aggression into academic success, which could help him feel good about himself and about the world.

He had a talent for poetry and began to write, attending poetry slams, where he expressed his anger at those he felt were responsible for the terrorist attacks and also those responsible for the violence against his grandfather. In this way, he was able to make the links between his family's past and his own future. As he was able to write about his anger and talk about it, he was better able to tolerate it and use it to benefit himself and others.

Most of those who develop symptoms during or following a disaster or terrorist attack are close to the situation or have suffered a complicated loss, such as Jiang. Some have been directly involved as survivors. But people with a family history of violence and terror, such as the attempted lynching of Paul's grandfather, may find that a repeat incident opens these wounds. Others who struggle with emotional issues related to either anger or loss find that the events trigger great distress that needs to be addressed clinically. For these populations, a focus on

symptom reduction will not help enough, and one must help them to tolerate the experience of living in a world where great loss or extreme violence are possible, through clinical interventions such as those described here.

Conclusion

> *The sea represents more to fish than merely the means for biological life. It is their whole world, and embodies what it means to be a fish. Imagine a disaster that tears them from the sea, and with survivors coming to rest in a goldfish bowl filled with tap water. In this environment they can subsist, for this is how they experience it, but it is no world. How can they be helped to get back to the sea, or to begin to turn tap water into something more resembling the sea, and on their terms? For the overwhelming majority of survivors the task seems comparable to this.*
>
> —Derek Summerfield (2001, p. 1)

The 21st century began with a series of disasters and terrorist attacks engulfing every part of the globe. With them came loss on a massive scale to whole populations, as well as exposure to death and destruction on a scale greater than the mind can conceive. International standards have now been developed to address the psychosocial consequences of these events.

Addressing the clinical aftermath of disaster and terror requires a multilayered and holistic response. In such circumstances, it is necessary to attend not only to individuals within the context of their lives, and to whom suffering and loss have come not individually, but also to communities as a whole.

Clinical social work is uniquely qualified to address these issues through its fundamental understanding of the integrated nature of the material, social, cultural, and intrapsychic worlds. This chapter attempts to facilitate the work of clinicians who wish to make the link between the theory and practice of their profession and the contemporary international standards for supporting resilience, mitigating risk, and supporting the well-being of survivors of disaster and terrorism.

Appendix A

Do's and Don'ts in Community Emergencies

Experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided. These are identified below as "Do's" and "Don'ts" (IASC, 2007).

Do's	Don'ts
Establish one overall coordination group on mental health and psychosocial support.	Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with one another.
Support a coordinated response, participating in coordination meetings and adding value by complementing the work of others.	Do not work in isolation or without thinking how one's own work fits with that of others.
Collect and analyze information to determine whether a response is needed and, if so, what kind of response.	Do not conduct duplicate assessments or accept preliminary data in an uncritical manner.

Do's	**Don'ts**
Tailor assessment tools to the local context.	Do not use assessment tools not validated in the local, emergency-affected context.
Recognize that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialized supports.	Do not assume that everyone in an emergency is traumatized or that people who appear resilient need no support.
Ask questions in the local language(s) and in a safe, supportive manner that respects confidentiality.	Do not duplicate assessments or ask very distressing questions without providing follow-up support.
Pay attention to gender differences.	Do not assume that emergencies affect men and women (or boys and girls) in exactly the same way or that programs designed for men will be of equal help or accessibility for women.
Check references in recruiting staff and volunteers and build the capacity of new personnel from the local and/or affected community.	Do not use recruiting practices that severely weaken existing local structures.
After trainings on mental health and psychosocial support, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly.	Do not use one-time, stand-alone trainings or very short trainings without follow-up if preparing people to perform complex psychological interventions.
Facilitate the development of community-owned, managed, and run programs.	Do not use a charity model that treats people in the community mainly as recipients of services.
Build local capacities, supporting self-help and strengthening the resources already present in affected groups.	Do not organize supports that undermine or ignore local responsibilities and capacities.
Learn about, and where appropriate, use local cultural practices to support the local people.	Do not assume that all local cultural practices are helpful or that all local people are supportive of particular practices.
Use methods from outside the culture where it is appropriate to do so.	Do not assume that methods from abroad are necessarily better or impose them on the local people in ways that marginalize local supportive practices and beliefs.
Build government capacities and integrate mental health care for emergency survivors in general health services and, if available, in community mental health services.	Do not create parallel mental health services for specific subpopulations.
Organize access to a range of supports, including psychological first aid, to people in acute distress after exposure to an extreme stressor.	Do not provide one-off, single-session psychological debriefing for people in the general population as an early intervention after exposure to conflict or natural disaster.

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Do's	Don'ts
Train and supervise primary/general health care workers in good prescription practices and in basic psychological support.	Do not provide psychotropic medication or psychological support without training and supervision.
Use generic medications that are on the essential drug list of the country.	Do not introduce new, branded medications in contexts where such medications are not widely used.
Establish effective systems for referring and supporting severely affected people.	Do not establish screening for people with mental disorders without having in place appropriate and accessible services to care for identified persons.
Develop locally appropriate care solutions for people at risk of being institutionalized.	Do not institutionalize people (unless an institution is temporarily an indisputable last resort for basic care and protection).
Use agency communication officers to promote two-way communication with the affected population as well as with the outside world.	Do not use agency communication officers to communicate only with the outside world.
Use channels such as the media to provide accurate information that reduces stress and enables people to access humanitarian services.	Do not create or show media images that sensationalize people's suffering or put people at risk.
Seek to integrate psychosocial considerations as relevant into all sectors.	Do not focus solely on clinical activities in the absence of a multisectoral response.

Source: IASC (2007).

APPENDIX B

Preventing Separations in Acute Emergencies: A Guide for First Responders

Losing family care, after losing life and limb, is among the most serious consequences of surviving an emergency for children, especially those 5 years of age or younger. There are three situations in which separations are likely to take place:

1. Separations due to mass movement
2. Separations due to the necessity for sudden departure
3. Separations due to the family's incapacity to continue to care for the child

Preventing Separations During Mass Movement

- Keep parents and children together.
- Make child registration available with the International Committee of the Red Cross (ICRC) as the movement occurs.
- Provide all children and parents with identification tags (provide string, tags, writing implements, and people who can assist with writing).
- Have volunteers ensure that all children under 5 years old are tagged.
- Provide adults with flyers, and post notices in public places, showing in words and pictures whom to notify if a child is lost.
- Bring separated children to the front of any convoy or to a place where all adults can see them, so that they can be identified by family and community members en route.

If the movement is with vehicles, then do the following:

- Provide vehicle drivers with rosters of children and parents on the day of the move.
- Provide staff (or seek a literate volunteer) to assist with the tagging and listing of each child in each vehicle.
- If children under 5 are to be placed in a vehicle and it is impossible to take the entire family, make sure that they are accompanied by a parent or that parent's designee.
- If it is not possible to have the child accompanied, make sure his or her name and the names of parents or family members are recorded before the vehicle departs and the parent is given identifying information regarding the vehicle and its destination. This must be in writing even if the parent cannot read.

Preventing Separations Due to Sudden Departure

Sometimes we know that a population is under threat of displacement, either through attack or natural disaster, before the events actually happen. Families should be informed about what they can do to keep from losing children along the way.

Families can do the following:

- Use songs and rhymes to teach their children their own names and the names of their village.
- Attach an identifying name tag to babies' clothes or jewelry or even paste such information on the child's head with a Band-Aid.
- If the parent becomes sick, weak, or tired and fears that she will let go of the child's hand or drop the child, stop and label the child or, if that is not possible, attach an identifying bit of clothing or jewelry before handing the child to someone else.

Preventing Separations Due to the Incapacity to Continue Care

Some families leave babies and young children behind because they do not have the resources to care for them anymore. These separations can be avoided by identifying vulnerable families and providing assistance. Assistance should never be provided to institutions for group care, as families who are poor or ill may feel forced to abandon their children in order to provide a better quality of care for them. Identify vulnerable families and provide assistance directly on the spot.

Especially vulnerable families may be found

- where the parents lack food and shelter,
- where the caregiver is either disabled or caring for one or more disabled children,
- where one or both parents are sick or dying,
- where one or more family members have already died, and
- where the caregiver appears exhausted for any reason and is unable to go on.

In these instances, parents should be given all possible support and be asked for a designated caregiver. Where extended family members are present, those members should be supported to see to the child or children's welfare within the community. Where strong community organizations are present, support them to support their community members to support families to support children.

Appendix C

Psychological First Aid

The following outline provides a general guideline for giving basic psychological first aid. As such, it gives only rudimentary information about how to talk to someone in distress. Use of this outline should be combined with good judgment, cultural sensitivity, and appropriate caution and respect. Consultation with a trained professional at the earliest opportunity following a critical incident is advised.

Although anyone may need assistance, psychological first aid should first be offered to those most likely to need it. Those needing prompt attention will include those requesting help, those visibly upset (crying, yelling, mute), those with a known history of tragic loss, those with a history of mental illness, and those apparently most significantly affected by what has occurred.

Preparing to deliver psychological first aid	1. Maintain a calm presence. 2. Be sensitive to culture and diversity.
Initiating contact	1. Ask about immediate needs. 2. Ask for permission to provide assistance.
Providing safety and comfort	1. Ensure immediate physical safety. 2. Attend to physical comfort. 3. Encourage interaction with others. 4. Attend to children first, if present. 5. Protect from additional traumatic experiences (media inquiries, lack of privacy, etc.). 6. Comfort those with a family member or close friend who has died. 7. Discuss relevant grief and spiritual issues. 8. Support those who receive a death notification by remaining with them. 9. Support those involved in body identification by accompanying them to the location of the body.
Being a calming presence	1. Sit and talk with those who are visibly upset. 2. Answer any questions about what has happened. 3. Provide someone to remain with those in distress during their time of greatest anguish. 4. Monitor or accompany those likely to harm themselves or others (based on your knowledge of their comments, behavior, or history).
Gathering information: Current needs and concerns	Through respectful conversation, gather information about the following: 1. Nature and severity of experiences during the traumatic event 2. Death of a loved one 3. Concerns about immediate post event circumstances and ongoing threat 4. Separations from or concern about the safety of loved ones 5. Physical illness, mental health conditions, and need for medications 6. Losses (home, school, neighborhood, business, personal property, and pets) 7. Extreme feelings of guilt or shame 8. Thoughts about causing harm to self or others 9. Availability of social support 10. Prior alcohol or drug use 11. Prior exposure to trauma and death of loved ones 12. Specific youth, adult, and family concerns
Providing practical assistance	Based on the information gathered, provide the following: 1. Identify the most immediate needs. 2. Clarify these needs. 3. Discuss an action plan for each need. 4. Act to address each need, including making a referral to a competent mental health professional for follow-up.
Connecting with social supports	1. Encourage contact with primary support persons (family and significant others). 2. Encourage use of immediately available support persons (colleagues and respected people in community) 3. Discuss support seeking and giving. 4. Model social support through your conversation.

Sharing information on coping	1. Provide basic information about stress reactions. 2. Review common psychological reactions to traumatic experiences and losses. 3. Provide basic information on ways of coping.
Linking with support services	1. Provide a direct link to additional needed services. 2. Promote ongoing use and coordination of helping relationships.

Source: Adapted from the National Child Traumatic Stress Network and National Center for PTSD (2006).

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