Crisis Counseling Continuing Education Course
(6 Hours/Units)

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CE Course Objectives: This course is designed to help you:

1. Define and become familiar with crisis counseling fundamentals
2. Identify and implement various types of crisis counseling
3. Evaluate and identify common crisis reactions and symptomology
4. Access and utilize applicable resources
5. Identify risk factors

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1. Definitions

Crisis counseling is designed to be brief and generally persists no longer than a few weeks. The emphasis is on a single or recurrent crisis that may produce traumatic symptoms. If a trauma or crisis is not resolved in a timely and/or effective therapeutic manner, the experience can lead to more lasting psychological, social and medical problems. The term “crisis” refers to the manner in which an individual responds to a traumatic or difficult situation. Various events may trigger the crisis response such as developmental hurdles (such as going through puberty), natural disasters, and the death of a loved one.

2. Crisis Counseling Methods

Crisis counseling may involve providing education, guidance, outreach, and support. Crisis Counseling is not a substitute for individuals who require more intensive psychiatric treatment but can help the client cope with the crisis by offering assistance and support. Crisis counseling is not psychotherapy. Crisis intervention is focused on minimizing the stress of the event, providing emotional support and improving the individual’s coping strategies in the here and now. Similar to psychotherapy, crisis counseling involves assessment, planning and treatment, but the scope of is generally much more specific. While psychotherapy focuses on a wide range of information and history, crisis assessment and treatment focuses on the client’s immediate situation including factors such as safety and immediate needs (Wiger, D.E. & Harowski, K.J., 2003. Essentials of Crisis Counseling and Intervention. Hoboken, New Jersey: John Wiley & Sons).

The following includes commonly used methods and approaches to crisis counseling:

**Education:** Most people possess the ability to adjust and recover from a crisis when they have the support, guidance and resources necessary. The foundation of crisis intervention is to assist the client in facing the impact of the crisis. A crisis involves normal reactions to an abnormal situation. Effective crisis counseling provides information, activities and support that
will enable the individual to recover from the crisis. Imparting information and discussion may be an important part of crisis intervention.

**Insight:** A crisis in one’s life may result from low self-awareness or not recognizing the impact of the behavior on others and oneself. Increasing insight and awareness may lead to choices that promote recovery and wellness.

**Identifying and implementing potential:** Every crisis represents an opportunity for personal growth and to discover one’s potential. While support is important, this does not mean that the person in crisis should not be allowed, encouraged and sometimes required to make decisions and take action to resolve the crisis and improve the quality of their life.

**Understanding problems:** During a crisis, it may be helpful to identify one’s intentions. While the intentions of others are often to make life better, behavior can nevertheless be misguided, misunderstood and less effective. Self-understanding is an important key to recovery.

**Creating necessary structure:** Another important element of crisis intervention and counseling is to provide an emotional "container" for one’s experience. This will better allow the client to express, explore, examine and become active in ways that help ensure the crisis is not prolonged. There are necessary activities and routines in life during times of distress that provide comfort and support.

**Challenging irrational beliefs and unrealistic expectations:** Few people, during times of crisis, have the necessary skills to fully examine what they are thinking, what they assume and what they expect from their self and from others. Our thoughts, especially the ones we don’t look at, contribute a great deal to how we feel and what we do next in response to our feelings.

**Interrupting vicious cycles and addictive behavior:** Crisis can be the result of vicious cycles or addictions. For example, drug and alcohol use can not only destroy our life, but it will confuse how we actually feel about our self, others and the world around us. It is difficult to experience and identify what they truly want if their feelings are modified by chemicals, medications, alcohol and other drugs. A challenging crisis may cause a person to escape how they feel which may involve the use of medication, drugs, alcohol, sex, thrill seeking, parties or working excessively. Assuming the perpetual the role of a "victim" may cause others to rescue the person in crisis. Vicious
cycles begin with behaviors that are intended to avoid emotional pain, but ultimately these avoidance and escape strategies create additional problems. The behaviors found in a vicious cycle may prolong and/or intensify a crisis.

Support: During a crisis, it is often helpful to form brief relationships with others in order to gain support. Crisis counseling and intervention are very helpful and necessary. A healthy dependency is usually temporary and will always lead to increasing independency. Unhealthy dependencies are long term and create increasing dependency rather than independency.

Facing fear and emotional pain: A crisis may include a time period of fear and/or sadness. Facing emotional pain is the most healthy response to a crisis. This does not require that a client makes themselves miserable. At the same time, the client should not be encouraged to invest time and energy becoming involved in activities that help them avoid thoughts and feelings. People in emotional pain need to be empowered and supported.


The infancy of modern day crisis counseling dates back to World War I and World War II. Prior to this time, soldiers who exhibited significant psychological reactions to the experiences at war were frequently seen as weak. However, it soon became evident that soldiers who were immediately offered treatment functioned significantly better than their untreated counterparts.

There are several shared approaches among the many crisis counseling theories including:

1. Assessing the Situation
   The first element of crisis counseling involves assessing the client’s current situation. This involves listening to the client, asking questions and determining what the individual needs to effectively cope with the crisis. During this time, the crisis counseling provider needs to define the problem while at the same time acting as a source of empathy, acceptance and
support. It is also essential to ensure client safety, both physically and psychologically.

2. **Education**
   Those who are experiencing a crisis often need information about their current condition and the steps they can take to minimize the damage. During crisis counseling, mental health professionals often help the client understand that their reactions are both normal and temporary. While the situation may seem both dire and endless to the person experiencing the crisis, the goal is to help the client see that he or she will eventually return to normal functioning.

3. **Offering Support**
   An important part of crisis counseling involves offering support, stabilization and resources to the client. Active listening is critical, as well as offering unconditional acceptance and reassurance. Offering this type of support during a crisis can help reduce stress improve coping.

4. **Developing Coping Skills**
   In addition to providing support, crisis counselors also help clients develop coping skills to deal with the immediate crisis. This might involve helping the client explore different solutions to the problem, practicing stress reduction techniques and encouraging positive thinking. This process is not just about teaching these skills to the client, it is also about encouraging the client to make a commitment to continue utilizing these skills in the future.


The **American Counseling Association** recommends 5 ways to help with coping AFTER a crisis situation.
1. Recognize your own feelings about the situation and talk to others about your fears. Know that these feelings are a normal response to an abnormal situation.
2. Be willing to listen to family and friends who have been affected and encourage them to seek counseling if necessary.
3. Be patient with people; fuses are short when dealing with crises and others may be feeling as much stress as you.
4. Recognize normal crises reactions, such as sleep disturbances and nightmares, withdrawal, reverting to childhood behaviors and trouble focusing on work or school.
5. Take time with your children, spouse, life partner, friends and co-workers to do something you enjoy.

DISASTER COUNSELING SKILLS

Disaster counseling involves both listening and guiding. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem-solving and referral to resources. The following section provides "nuts-and-bolts" suggestions for workers.

ESTABLISHING RAPPORT

Survivors respond when workers offer caring eye contact, a calm presence, and are able to listen with their hearts. Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport.

ACTIVE LISTENING

Workers listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

Allow silence - Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.

Attend nonverbally - Eye contact, head nodding, caring facial expressions, and occasional "uh-huhs" let the survivor know that the worker is in tune with them.
**Paraphrase** - When the worker repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that . . . " or "I have heard you say that . . . "

**Reflect feelings** - The worker may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared etc., does that fit for you?" This helps the survivor identify and articulate his or her emotions.

**Allow expression of emotions** - Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem-solving. Workers should stay relaxed, breathe, and let the survivor know that it is OK to feel.

**SOME DO'S AND DON'T'S**

**Do say:**

- These are normal reactions to a disaster.
- It is understandable that you feel this way.
- You are not going crazy.
- It wasn't your fault, you did the best you could.
- Things may never be the same, but they will get better, and you will feel better.

**Don't say:**

- It could have been worse.
- You can always get another pet/car/house.
- It's best if you just stay busy.
- I know just how you feel.
- You need to get on with your life.

The human desire to try to fix the survivor's painful situation or make the survivor feel better often underlies the preceding "Don't say" list.
However, as a result of receiving comments such as these, the survivor may feel discounted, not understood, or more alone. It is best when workers allow survivors their own experiences, feelings, and perspectives.

**Critical Incident Stress Management**

Early intervention after a traumatic incident, known as Critical Incident Stress Management (CISM) is used to attempt to reduce traumatic effects of an incident, and potentially prevent a full-blown occurrence of PTSD. However, recent studies regarding CISM seem to indicate iatrogenic effects. Six studies have formally looked at the effect of CISM, four finding no benefit for preventing PTSD, and the other two studies indicating that CISM actually made things worse. Hence this is not a recommended treatment (*Hiley-Young, B., and Gerrity, E.T. 1994. “Critical incident stress debriefing Value and limitations in disaster response,” NCP Clinical Quarterly*).

**Stress Management**

Stress Inoculation Training (SIT), one of the most researched and comprehensive anxiety management programs for survivors of sexual assault and rape (*Meadows & Foa, 1998*). SIT is helpful in imparting coping skills thereby reducing anxiety, hypervigilance, hyperarousal, sleep disturbances, and difficulty in concentration (*Foa et al., 1999*). These coping skills include muscle relaxation training, controlled breathing exercises, role playing, covert modeling, positive thinking, self-talk, assertiveness training, guided self imagery and dialogue, and thought stopping (*Foa et al., 1999*).

**Crisis Hotlines**

A crisis hotline is a phone number people can call to get immediate over-the-phone emergency counseling, usually by trained volunteers. Such hotlines have existed in most major cities of the United States at least since the mid-1970s. Initially set up to help those contemplating suicide, many have expanded their mandate to deal more generally with emotional crises. Similar hotlines operate to help people in other circumstances, including rape victims, runaway children, and people who identify as gay, lesbian, bisexual, transgender, or intersex (*Wiger, D.E. & Harowski, K.J., 2003*).
Such services began in 1953, when Chad Varah, an English vicar, founded The Samaritans service, which soon established branches throughout the United Kingdom. The first Samaritans branch in the United States was established in Boston in 1974. In addition to Boston, there are currently Samaritan branches in Falmouth (serving the Cape Cod and Islands area), the Merrimack Valley, the Fall River/New Bedford area. Outside of Massachusetts, there are branches in New York City, Providence, Hartford, Albany, and Keene, NH (Wiger, D.E. & Harowski, K.J., 2003. Essentials of Crisis Counseling and Intervention. Hoboken, New Jersey: John Wiley & Sons).

In the United States, San Francisco Suicide Prevention started a hotline "Call Bruce" in 1962. A similar service, Lifeline, was established in Australia in 1963. A totally volunteer-run crisis hotline, Lifelink Samaritans, was established in Tasmania in 1968 by concerned citizens of Launceston. This service provides emotional support 24 hours a day to callers from all over the state of Tasmania and does not have any religious affiliations. The organization is a member of Befrienders Worldwide and has a "twinning" relationship with Northampton Samaritans in the UK. Lifelink Samaritans is the oldest telephone befriending service in Tasmania and the fourth oldest in Australia (Wiger, D.E. & Harowski, K.J., 2003. Essentials of Crisis Counseling and Intervention. Hoboken, New Jersey: John Wiley & Sons).

A criticism of suicide hotlines in the past was that those who were determined to kill themselves were unlikely to call one. Also, those with social anxiety may not have the emotional resources to do so. Until recently, there was no evidence that the presence of suicide hotlines reduced the incidence of suicide. However, a 2007 study has suggested otherwise, as peoples' thoughts of suicide decreased during a call to a crisis line, and were lessened for several weeks after their call. Another issue is that crisis hotlines often contact local authorities. The fear of embarrassment from having the police involved can deter many people who would have otherwise called the hotline. Compounding this further, getting police involved can cause a troubled situation at home to become even worse, members of an already dysfunctional family become more irate with the distressed person. Also, being asked for an address can be seen as an

3. Practice Guidelines: Core Elements for Responding to Mental Health Crises

**Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.**

Crises have a profound Impact on people with serious mental health or emotional problems. Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization.

Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises. The statistics below paint a sobering picture of how crises affect the lives of people who have mental or emotional disabilities:

- From one third to one half of homeless people have a severe psychiatric disorder.

- Approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness.

- The likelihood of mental illness among people confined in state prisons and local jails is three to four times higher than in the general population and, compared with other inmates, it is at least twice as likely that these individuals will be injured during their incarceration.

- About 6 percent of all hospital emergency department visits reflect mental health emergencies.

- Due to a lack of available alternatives, 79 percent of hospital
emergency departments report having to “board” psychiatric patients who are in crisis and in need of inpatient care, sometimes for eight hours or longer.

- Almost one in 10 individuals discharged from a state psychiatric hospital will be readmitted within 30 days; more than one in five will be readmitted within 180 days.

- About 90 percent of adult inpatients in state psychiatric hospitals report histories of trauma.

- About three quarters of youth in the juvenile justice system report mental health problems and one in five has a serious mental disorder.

- Mothers with serious mental illnesses are more than four times as likely as other mothers to lose custody of their children.

- People with serious mental illnesses die, on average, 25 years earlier than the general population.

These statistics are incomplete; they reflect just a sampling of scenarios that, while commonplace, constitute significant life crises for individuals with serious mental illnesses.

Many such individuals experience a cascade of crisis events that place them in more than one of these statistical groups. For instance, readmission to a psychiatric institution—a high probability for adults who have been discharged from a state psychiatric hospital, based on these data—may feature a series of crisis events for the individual: the psychiatric emergency itself; forcible removal from one’s home; being taken into police custody, handcuffed and transported in the back of a police car; evaluation in the emergency department of a general hospital; transfer to a psychiatric hospital; a civil commitment hearing; and so on. And at multiple points in this series of interventions, there is a likelihood that physical restraints, seclusion, involuntary medication or other coercion may be used. Intense feelings of disempowerment are definitional of mental health crises, yet as the individual becomes the subject of a “disposition” at each juncture, that person may experience a diminishing sense of control.
In the wake of rare but highly publicized tragedies attributed to people with mental illnesses, there is often a temporary surge in political concern about mental healthcare and expanding crisis interventions. Sadly, the more commonplace crises endured every day by many thousands of adults, older adults and children with serious mental or emotional problems tend to generate neither media attention nor political concern.

While no one with a mental or emotional disorder is immune from crises, people with what are termed serious mental illnesses—defined as schizophrenia, bipolar disorder and major depression—may be most reliant on public systems. They also may be at great risk of recurrent crises and interventions that exacerbate their clinical and social problems. These guidelines focus most specifically on individuals with serious mental or emotional problems who tend to encounter an assortment of governmental or publicly funded interveners when they are in crisis. Nevertheless, the values, principles and strategies embedded in the guidelines that follow are applicable to all individuals with mental healthcare needs, across populations and service settings.

Individuals whose diagnoses do not fit “serious mental illnesses” may be vulnerable to serious mental health crises that can have devastating outcomes. Interventions on their behalf are more likely to occur within the private healthcare sector, which mirrors public mental health systems’ problems in providing early and meaningful access to help. Within these parallel systems, crisis services are provided in a broad array of settings that ultimately will require translation of the guidelines presented here into specific protocols that break cycles of crises and advance the prospects of recovery for people with mental illnesses.

What it means to be in a mental health crisis

Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.
While behaviors that represent an imminent danger certainly indicate the need for some sort of an emergency response, these behaviors may well be the culmination of a crisis episode, rather than the episode in its entirety. Situations involving mental health crises may follow trajectories that include intense feelings of personal distress (e.g., anxiety, depression, anger, panic, hopelessness), obvious changes in functioning (e.g., neglect of personal hygiene, unusual behavior) or catastrophic life events (e.g., disruptions in personal relationships, support systems or living arrangements; loss of autonomy or parental rights; victimization or natural disasters).

Because only a portion of real-life crises may actually result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good.

**The Need for Crisis Standards**

Individuals experiencing mental health crises may encounter an array of professionals and non-professionals trying to intervene and help: family members, peers, healthcare personnel, police, advocates, clergy, educators and others. The specific crisis response offered is influenced by a number of variables, among them:

- where the intervention occurs,
- at what time of day it occurs,
- when it occurs within the course of the crisis episode,
- the familiarity of the intervener with the individual or with the type of problem experienced by the individual,
- interveners’ training relating to crisis services,
- resources of the mental health system and the ready availability of services and supports, and professional, organizational or legal norms that define the nature of the encounter and the assistance offered.
The guidelines presented here define appropriate responses to mental health crises across these variables. They were developed by a diverse expert panel that includes individuals with and without serious mental illnesses who are leaders within mental health professions and mental health advocacy.

These crisis guidelines promote two essential goals:

1. Ensuring that mental health crisis interventions are guided by standards consistent with recovery and resilience and

2. Replacing today’s largely reactive and cyclical approach to mental health crises with one that works toward reducing the likelihood of future emergencies and produces better outcomes.

**Responding to a Mental Health Crisis Ten Essential Values**

Ten essential values are inherent in an appropriate crisis response, regardless of the nature of the crisis, the situations where assistance is offered or the individuals providing assistance:

**1. Avoiding harm.** Sometimes mental health crises place the safety of the person, the crisis responders or others in jeopardy. An appropriate response establishes physical safety, but it also establishes the individual’s psychological safety. For instance, restraints are sometimes used in situations where there is an immediate risk of physical harm, yet this intervention has inherent physical and psychological risks that can cause injury and even death. Precipitous responses to individuals in mental health crises—often initiated with the intention of establishing physical safety—sometimes result in harm to the individual. An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of “watchful waiting.” In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimize the duration and negative impact of interventions used.

**2. Intervening in Person-centered ways.** Mental health crises may be
routine in some settings and, perhaps, have even come to be routine for some people with serious mental health or emotional problems. Nevertheless, appropriate crisis assistance avoids rote interventions based on diagnostic labels, presenting complaint or practices customary to a particular setting. Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual’s personal preferences and goals can be maximally incorporated in the crisis response.

“To promote patient-centered care, all parties involved in health care for mental or substance-use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental/substance use problems and illnesses” Institute of Medicine (2006) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Recommendation 3-1, p. 126

3. Shared responsibility. An acute sense of losing control over events or feelings is a hallmark of mental health crises. In fact, research has shown “feeling out of control” to be the most common reason consumers cite for being brought in for psychiatric emergency care. An intervention that is done to the individual—rather than with the individual—can reinforce these feelings of helplessness. One of the principal rationales for person-centered plans is that shared responsibility promotes engagement and better outcomes. While crisis situations may present challenges to implementing shared, person-centered plans, ultimately an intervention that considers and, to the extent possible, honors an individual’s role in crisis resolution may hold long-term benefits. An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.

4. Addressing trauma. Crises, themselves, are intrinsically traumatic and certain crisis interventions may have the effect of imposing further trauma—both physical and emotional. In addition, people with serious mental illness have a high probability of having been victims of abuse or neglect. It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual’s relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making
this crucial information available (for instance, by executing advance directives).

5. **Establishing feelings of personal safety.** An individual may experience a mental health crisis as a catastrophic event and, accordingly, may have an urgent need to feel safe. What is regarded as agitated behavior may reflect an individual’s attempts at self-protection, though perhaps to an unwarranted threat. Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual’s needs and latitude to address these needs creatively.

6. **Based on strengths.** Sharing responsibility for crisis resolution means understanding that an individual, even while in crisis, can marshall personal strengths and assist in the resolution of the emergency. Individuals often understand the factors that precipitated a crisis as well as factors that can help ameliorate their impact. An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.

7. **The whole person.** For individuals who have a mental illness, the psychiatric label itself may shape—even dominate—decisions about which crisis interventions are offered and how they are made available. An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount. That the individual may have multiple needs and an adequate understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. An individual’s emergency may reflect the interplay of psychiatric issues with other health factors. And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real-world concerns that significantly affect an individual’s response: the whereabouts of the person’s children, the welfare of pets, whether the house is locked, absence from work, and so on.
8. **The person as credible source.** Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed skeptically by others. Particularly within the charged context of mental health crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking. Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual’s assertions are not well grounded in reality and represent obviously delusional thoughts, the “telling of one’s story” may represent an important step toward crisis resolution. For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person’s strengths and needs.

9. **Recovery, resilience and natural supports.** Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment. Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual’s broader life course. An appropriate crisis response contributes to the individual’s larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.

10. **Prevention.** Too often, individuals with serious mental illnesses have only temporary respite between crises. An appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. Hence, an adequate crisis response requires measures that address the person’s unmet needs, both through individualized planning and by promoting systemic improvements.

The National Consensus Statement on Mental Health Recovery identifies recovery as an individual’s journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full
potential. It also cites 10 fundamental components for systems:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope


Principles for enacting the essential values

Several principles are key to ensuring that crisis intervention practices embody these essential values:

1. **Access to supports and services is timely.** Ready access to assistance is important not only because it holds the promise of reducing the intensity and duration of the individual’s distress, but also because as a crisis escalates, options for interventions may narrow. Timely access presupposes 24-hour/7-days-a-week availability and a capacity for outreach when an individual is unable or unwilling to come to a traditional service site.

2. **Services are provided in the least restrictive manner.** Least-restrictive emergency interventions not only avoid the use of coercion, but also preserve the individual’s connectedness with his or her world. Individuals should not be unnecessarily isolated from their routine networks of formal and natural supports and should be encouraged to make contact with outside professionals, family and friends who can provide assistance through the crisis event and beyond.

3. **Peer support is available.** Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a
supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis.

4. **Adequate time is spent with the individual in crisis.** In settings such as hospital emergency departments, there may be intense pressure to move patients through quickly. People who provide assistance must have an adequate understanding of the crisis situation, not only objectively, but also as it is being experienced by the individual who is in crisis. Unfortunately, individuals in acute crisis—particularly following involuntary transport to an evaluation setting—may not be in a position to discuss their presenting complaints clearly and concisely. Personnel in healthcare and similar settings must regard face-to-face time with the individual not as a distraction, but as a core element of quality crisis care. Settings that cannot accommodate the individual in this way may not be appropriate venues for psychiatric crisis intervention; as is discussed elsewhere in these guidelines, such a determination should be regarded as a problem in care and drive performance improvement at both the organizational and systemic levels.

Staff behaviors that consumers feel Are most important to individuals in a mental health crisis:

- Having the staff listen to me, my story and my version of events
- Being asked about what treatment I want
- Trying to help me calm down before resorting to forced treatment
- Being asked about what treatments were helpful and not helpful to me in the past


5. **Plans are strengths-based.** It may be fairly routine for professional staff to concentrate on clinical signs and other deficits to be addressed, particularly when an individual is in a crisis state and, therefore, “symptomatic.” Yet appropriate crisis intervention gives at least equal attention to the individual’s immediately available and potentially available assets. A strengths-based plan helps to affirm the individual’s role as an active partner in the resolution of the crisis by marshalling his or her capabilities. A strengths-based approach also furthers the goals of building resilience and a capability for self-managing future crises.

6. **Emergency interventions consider the context of the individual’s**
**overall plan of services.** Many individuals with serious mental illnesses go into mental health crises while receiving some sort of services and supports. Appropriate crisis services consider whether the crisis is, wholly or partly attributable to gaps or other problems in the individual’s current plan of care and provide crisis measures in ways that are consistent with services the individual receives (or should receive) in the community. In addition, appropriate crisis services place value on earlier efforts by the individual and his or her service providers to be prepared for emergencies, for instance, by having executed psychiatric advance directives or other crisis plans. Incorporating such measures in a crisis response requires that interveners be knowledgeable about these approaches, their immediate and longer-term value, and how to implement them. Appropriate crisis interventions also include post-event reviews that may produce information that is helpful to the individual and his or her customary service providers in refining ongoing services and crisis plans.

**7. Crisis services** are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene with the problems being presented. Crisis intervention may be considered a high-end service, that is high-risk and demanding a high level of skill. Within the course of a psychiatric emergency, various types of crisis interventions may occur—some by healthcare professionals, some by peers and some by personnel (such as police) who are outside of healthcare. Throughout, the individual experiencing a mental health crisis should be assured that all interveners have an appropriate level of training and competence. What that means may vary considerably between scenarios. For instance, a significant number of instances of police involvement with individuals in mental health crises result in injuries or even death. Accordingly, some police departments have taken special measures to train officers in identifying and de-escalating mental health crises. Many have also established links with mental health professionals who can provide timely on-site assistance. These efforts have required police and health care professionals to connect across traditional bureaucratic boundaries.

**8. Individuals in a self-defined crisis are not turned away.** People who seek crisis services but do not meet the service criteria of an organization should receive meaningful guidance and assistance in accessing alternative resources. This is particularly applicable in organizations or programs that carry out a screening or gate keeping function. For instance, it is not sufficient, upon determining that an individual fails to meet the criteria for
hospitalization, to tell the individual or family members to make contact again if the situation worsens. Such practices tacitly encourage the escalation of crises. Individuals and their families should be assisted in accessing services and supports that resolve issues early on, and an organization providing screening or gatekeeping services should be fluent with alternatives for when service thresholds are not met. When these alternatives are lacking, the organization should consider this a problem in care and take action accordingly. Likewise, an organization providing early intervention that routinely receives referrals from hospital gatekeepers might consider improving its outreach so that individuals seeking help are more likely to access their services directly, without placing demands on programs designed for late-stage emergencies.

An Alternative Approach “The Hospital Diversion Program at the ROSE HOUSE is currently available to residents of Orange and Ulster counties [New York State]. This peer-operated house is designed to assist fellow peers in diverting from psychiatric distress, which may lead to a hospitalization. The program is located in a three-bedroom home set up and furnished for comfort. The house is equipped with a variety of traditional self-help and proactive tools to maintain wellness. Trained peer companions are the key ingredients in helping others learn self-help tools. Peer companions are compassionate, understanding and empowering. We exist to fill a gap in the mental health system that can break the cycle of going from home to crisis to hospital. The ROSE HOUSE offers a stay of up to five days to take control of your crisis or potential crisis and develop new skills to maintain your wellness. Peer companions staff the house 24 hours a day to address the needs of guests as they arise. Participation in the program is completely voluntary and free of charge. You are free to come and go as you please. We also will maintain contact and support for you, at your request, after you finish your stay. We have found that occasional calls and visits reinforce recovery and self determination.” From the website of Projects to Empower and Organize the Psychiatrically Labeled (PEOPLE, Inc.) at: http://www.projectstoempower.org

9. Interveners have a comprehensive understanding of the crisis.
Meaningful crisis response requires a thorough understanding of the issues at play. Yet, for people with serious mental illnesses, interventions are commonly based on a superficial set of facts: behaviors are seen to present a safety issue, the individual has reportedly failed to take medications as prescribed, or an encounter with the police has occurred. An appropriate understanding of the emergency situation not only includes an appreciation
for what is happening at the moment, but also why it is happening and how an individual fares when he or she is not in crisis. Crises—particularly recurrent crises—likely signal a failure to address underlying issues appropriately. When crisis intervention occurs outside of the individual’s customary setting, such as in a hospital emergency department or a psychiatric inpatient unit, it may be challenging to gain a good picture of the individual’s circumstances.

10. Helping the individual to regain a sense of control is a priority. Regaining a sense of control over thoughts, feelings and events that seem to be spinning out of control may be paramount for an individual in mental health crisis. Staff interventions that occur without opportunities for the individual to understand what is happening and to make choices among options (including the choice to defer to staff) may reinforce feelings that control is being further wrested away. The individual’s resistance to this may be inaccurately regarded as additional evidence of his or her incapacity to understand the crisis situation. Incorporating personal choice in a crisis response requires not only appropriate training, but also a setting with the flexibility to allow the exercise of options. Informed decision-making in this context is not a matter of simply apprising the individual of the empirically derived risks and benefits associated with various interventions; it also includes an understanding among staff that an ostensibly sub-optimal intervention that is of the individual’s choosing may reinforce personal responsibility, capability and engagement and can ultimately produce better outcomes. The specific choices to be considered are not limited to the use of medications, but also include the individual’s preferences for what other approaches are to be used where crisis assistance takes place, involving whom and with what specific goals. While the urgency of a situation may limit the options available, such limitations may also highlight how earlier interventions failed to expand opportunities to exercise personal control. Post-crisis recovery plans or advance directives developed by the individual with assistance from crisis experts are important vehicles for operationalizing this principle.

11. Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served. Given the importance of understanding how an individual is experiencing a crisis and engaging that individual in the resolution process, being able to effectively connect with the individual is crucial. A host of variables reflecting the person’s identity and means of communicating can
impede meaningful engagement at a time when there may be some urgency. Establishing congruence requires more than linguistic proficiency or staff training in cultural sensitivity; it may require that to the extent feasible, an individual be afforded a choice among staff providing crisis services.

12. Rights are respected. An individual who is in crisis is also in a state of heightened vulnerability. It is imperative that those responding to the crisis be versed in the individual’s rights, among them: the right to confidentiality, the right to legal counsel, the right to be free from unwarranted seclusion or restraint, the right to leave, the right for a minor to receive services without parental notification, the right to have one’s advance directive considered, the right to speak with an ombudsman and the right to make informed decisions about medication. It is critical that appropriately trained advocates be available to provide needed assistance. Correctly or not, many individuals with serious mental illnesses have come to regard mental health crisis interventions as episodes where they have no voice and their rights are trampled or ignored. Meaningfully enacting values of shared responsibility and recovery requires that the individual have a clear understanding of his or her rights and access to the services of an advocate. It is also critical that crisis responders not convey the impression that an individual’s exercise of rights is a hostile or defiant act.

13. Services are trauma-informed. Adults, children and older adults with serious mental or emotional problems often have histories of victimization, abuse and neglect, or significant traumatic experiences. Their past trauma may be in some ways similar to the mental health crisis being addressed. It is essential that crisis responses evaluate an individual’s trauma history and the person’s status with respect to recovery from those experiences. Similarly, it is critical to understand how the individual’s response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on that history. Because of the nature of trauma, appropriately evaluating an individual requires far more sensitivity and expertise than simply asking a series of blunt, potentially embarrassing questions about abuse and checking off some boxes on a form. It requires establishing a safe atmosphere for the individual to discuss these issues and to explore their possible relationship to the crisis event.

“Confounding and complicating the prevalence of trauma in public mental health service recipients is the fact that mental health services themselves are often experienced as traumatic. The use of coercive interventions such as
seclusion and restraint, forced involuntary medication practices, and philosophies of care based on control and containment vs. empowerment and choice often cause unintentional re-traumatization in already vulnerable populations.” National Association of State Mental Health Program Directors (2005) NASMHPD Position Statement on Services and Supports to

4. Managing Stress in Crisis Response Professions

Introduction

Stress prevention and management should address both the worker and the organization. Adopting a preventive perspective allows both workers and organizations to anticipate stressors and shape responses, rather than simply reacting to a crisis when it occurs (Center for Mental Health Services [CMHS], 2005).

Crisis response workers and managers—which include first responders, public health workers, construction workers, transportation workers, utilities workers, and volunteers—are unique in that they are repeatedly exposed to extraordinarily stressful events. This places them at higher-than-normal risk for developing stress reactions (Pan American Health Organization [PAHO], 2001).

A Guide to Managing Stress in Crisis Response Professions provides a framework for stress management strategies for crisis response workers and managers. These strategies are sufficiently broad so that individuals and groups can select those that best fit their needs and circumstances. Education about stress and its prevention and mitigation through planning are essential.

A Guide to Managing Stress in Crisis Response Professions

4A. Understanding the Stress Cycle

Stress is an elevation in a person's state of arousal or readiness, caused by some stimulus or demand. As stress arousal increases, health and performance actually improve. Within manageable levels, stress can help sharpen our attention and mobilize our bodies to cope with threatening situations.
At some point, stress arousal reaches maximum effect. Once it does, all that was gained by stress arousal is then lost and deterioration of health and performance begins (Luxart Communications, 2004).

Whether a stressor is a slight change in posture or a life threatening assault, the brain determines when the body's inner equilibrium is disturbed; the brain initiates the actions that restore the balance. The brain decides what is threatening and what is not. When we face challenging situations, the brain does a quick search. Have we been here before? If so, how did we feel? What was the outcome? Can we cope with the situation now? If there's doubt as to any of these questions, the stress response goes into high gear (McEwen & Lasley, 2002).

The following provides workers and managers with a list of common stress reactions. Most people are resilient and experience mild or transient psychological disturbances from which they readily bounce back. The stress response becomes problematic when it does not or cannot turn off; that is, when symptoms last too long or interfere with daily life.

**Common Stress Reactions**

**Behavioral**

- Increase or decrease in activity level
- Substance use or abuse (alcohol or drugs)
- Difficulty communicating or listening
- Irritability, outbursts of anger, frequent arguments
- Inability to rest or relax
- Decline in job performance; absenteeism
- Frequent crying
- Hyper-vigilance or excessive worry
- Avoidance of activities or places that trigger memories
- Becoming accident prone

**Physical**

- Gastrointestinal problems
- Headaches, other aches and pains
- Visual disturbances
• Weight loss or gain
• Sweating or chills
• Tremors or muscle twitching
• Being easily startled
• Chronic fatigue or sleep disturbances
• Immune system disorders

**Psychological/Emotional**

• Feeling heroic, euphoric, or invulnerable
• Denial
• Anxiety or fear
• Depression
• Guilt
• Apathy
• Grief

**Thinking**

• Memory problems
• Disorientation and confusion
• Slow thought processes; lack of concentration
• Difficulty setting priorities or making decisions
• Loss of objectivity

**Social**

• Isolation
• Blaming
• Difficulty in giving or accepting support or help
• Inability to experience pleasure or have fun

(Adapted from CMHS, 2004)

First the brain sounds an alert to the adrenal glands. The adrenals answer by pouring out the first of the major stress hormones—adrenaline—for the classic fight-or flight response.
The fight-or-flight response evolved with the prime directive of ensuring our safety and survival. The pulse begins to race as the adrenaline steps up the heart rate, sending extra blood to the muscles and organs. Oxygen rushes in as the bronchial tubes in the lungs dilate; extra oxygen also reaches the brain, which helps keep us alert. During this stage of the fight-or-flight response, the brain releases natural painkillers called endorphins. This phase, in which adrenaline plays a leading role, is the immediate response to stress (McEwen & Lasley, 2002).

When the stress response is active for a long period of time, it can damage the cardiovascular, immune, and nervous systems. People develop patterns of response to stress that are as varied as the individuals (Selye). These responses simply suggest a need for corrective action to limit their impact (Mitchell & Bray, 1990; Selye).

4B. Extreme Stress Reactions

An optimum level of stress can act as a creative, motivational force that drives a person to achieve incredible feats. As noted earlier, most people do not suffer severe effects from manageable levels of stress. Chronic or traumatic stress, on the other hand, is potentially very destructive and can deprive people of physical and mental health (PAHO, 2001).

If stress is extreme and not managed, some individuals may experience posttraumatic stress disorder (PTSD). PTSD is a psychiatric disorder than can occur following the experience or witnessing of life-threatening events. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can be severe enough and last long enough to significantly impair the person's daily life (National Center for Post-Traumatic Stress Disorder [NCPTSD], 2005).

PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorce, family discord, and difficulties in parenting (NCPTSD, 2005).
Increased substance use or abuse is also a concern. While researchers appear to be divided on whether substance abuse disorders increase following a disaster, there is evidence to suggest that substance use increases. While substance use increases alone do not qualify as substance abuse disorders, they can create potential health and public safety problems.

5 Understanding the Stress Cycle have responsibility for public safety as part of their job duties (Center for Substance Abuse Treatment, 2003).

While the effects of PTSD are serious and difficult to deal with, it can be treated by a variety of forms of psychotherapy and medication.

For more information and resources on PTSD, go to NCPTSD's Web site: http://www.ncptsd.org.

4C. Managing Stress Before, During, and After an Event

Everyone who experiences a disaster is touched by it, including crisis response workers and managers. Good planning can limit health and psychological consequences, minimize disruptions to daily life, and contribute to the growth and empowerment of the individual experiencing the disaster.

The Nation's mental health, substance abuse, public health, medical, and emergency response systems face many challenges in meeting the behavioral health needs that result from disasters. Management of the behavioral health consequences of disasters requires a range of interventions at multiple levels in the pre-event, event, and post-event phases.

Pre-Event Planning

There are many preventive measures that you as a supervisor can put in place before an event occurs which can minimize stress. A thoughtfully planned communications strategy can lessen the impact of stress while accomplishing the goal of delivering accurate and timely information within the organization and to the public (Federal Emergency Management Agency [FEMA], 2005).

A clear understanding of roles and procedures is critical to helping individuals manage stress. Training and preparedness in incident management procedures are therefore key to stress management.
The National Incident Management System (NIMS), developed by the U.S. Department of Homeland Security (DHS), establishes standardized incident management processes, protocols, and procedures that all responders—will use to coordinate and conduct response actions (FEMA, 2005).

The NIMS Incident Command Structure (ICS) provides a consistent, flexible, and adjustable national framework within which government and private entities at all levels can work together to manage domestic incidents, regardless of their cause, size, location, or complexity. ICS helps all responders communicate and get what they need when they need it (FEMA, 2005).

NIMS ICS is composed of several components that work together as a system to prepare for, prevent, respond to, and recover from domestic incidents. These components include: command and management, preparedness, resource management, communications and information management, supporting technologies, and ongoing management and maintenance.

For more information on NIMS and NIMS ICS, go to: FEMA's Web site: http://www.fema.gov/nims/.

Following are some suggested action steps that may help you and your workers cope with stress in a more effective manner.

**Minimizing Stress Before the Crisis**

- Become familiar with the NIMS ICS and your organization's role in it; and train personnel in its use.
- Establish clear lines of authority and responsibility to minimize stress by eliminating confusion about who reports to whom (Call & Pfefferbaum, 1999; CMHS, 1994).
- Provide regular training on stress management techniques.
- Create a facility evacuation plan and practice drills regularly.
- Provide ongoing training to ensure that staff are thoroughly familiar with safety procedures and policies.
- Develop guidelines to help workers prepare for deployment.
- Maintain an updated list of family members' contact information for each employee.
- Have a pre-established plan for how employees will check on their families if disaster strikes during work hours (CMHS, 1994).

**During the Crisis—At the Scene**

At the disaster scene, you, as a manager, can provide certain supports for workers to mitigate stress and help them effectively perform the tasks at hand.

**Minimizing Stress During the Crisis—At the Scene**

- Clearly define individual roles and reevaluate if the situation changes.
- Institute briefings at each shift change that cover the current status of the work environment, safety procedures, and required safety equipment (CMHS, 1994).
- Partner inexperienced workers with experienced veterans. The buddy system is an effective method to provide support, monitor stress, and reinforce safety procedures. Require outreach personnel to enter the community in pairs (CMHS, 1994).
- Rotate workers from high-stress to lower stress functions (CMHS, 1994).
- Initiate, encourage, and monitor work breaks, especially when casualties are involved (McCarroll, Ursano, Wright, & Fullerton, 1993). During lengthy events, implement longer breaks and days off, and curtail weekend work as soon as possible.
- Establish respite areas that visually separate workers from the scene and the public. At longer operations, establish an area where responders can shower, eat, change clothes, and sleep (CMHS, 1994).
- Implement flexible schedules for workers who are directly impacted by an event (CMHS, 1994). This can help workers balance home and job responsibilities.
- Reduce noise as much as possible by providing earplugs, noise mufflers, or telephone headsets (CMHS, 1994).
- Mitigate the effects of extreme temperatures through the use of protective clothing, proper hydration, and frequent breaks.
- Ensure that lighting is sufficient, adjustable, and in good working order.
- Lessen the impact of odors and tastes, and protect workers' breathing by supplying facemasks and respirators (McCarroll et al., 1993).
- Provide security for staff at facilities or sites in dangerous areas, including escorts for workers going to and from their vehicles (CMHS, 1994).
- Provide mobile phones for workers in dangerous environments. Ensure that staff know who to call when problems arise (CMHS, 1994).

**After the Crisis**

The ending of the disaster assignment, whether it involved immediate response or long-term recovery work, can be a period of mixed emotions for workers. While there may be some relief that the disaster operation is ending, there is often a sense of loss and "letdown," with some difficulty making the transition back into family life and the regular job. Following are some action steps that can help ease the disengagement and transition process for workers (CMHS, 1994).

**Minimizing Stress for Workers After the Crisis**

- Allow time off for workers who have experienced personal trauma or loss. Transition these individuals back into the organization by initially assigning them to less demanding jobs (CMHS, 1994).
- Develop protocols to provide workers with stigma-free counseling so that workers can address the emotional aspects of their experience (CMHS, 1994).
- Institute exit interviews and/or seminars to help workers put their experiences in perspective (Bradford & John, 1991) and to validate what they have seen, done, thought, and felt.
- Provide educational in-services or workshops around stress management and self-care.
- Offer group self-care activities and acknowledgments.

**4D. Self-Care for Crisis Response Professionals**

Supervisors, managers, and workers must assume responsibility for their own self-care. Self-awareness involves recognizing and heeding early warning signs of stress reactions. There are many things that you can do to alleviate stress before, during, and after a crisis occurs (see chart on facing
This chapter outlines some ideas that can be put in place to help you and your family cope with whatever emergencies may occur. Peace of mind and concentration will be enhanced if you are prepared.

**Self Monitor for Signs of Stress**

Be familiar with the signs of too much stress. Common stress reactions are provided in Chapter I. Usually, the symptoms are normal in every way, and simply suggest a need for corrective action to limit the impact of a stressful situation (Mitchell & Bray, 1990; Selye, 1984). Information is also provided in Chapter I about when stress becomes abnormal and destructive (PTSD).

Whether you are a supervisor or worker, you may not be the best judge of your own stress as you become intensely involved in the disaster work. Therefore, a buddy system, where coworkers agree to keep an eye on each other's stress reactions, can be important.

**Before the Crisis**

Your entire family should be involved in developing and maintaining a family emergency preparedness plan. Excellent materials on home emergency preparedness are available from the U.S. DHS, FEMA, local chapters of the American Red Cross, and local Offices of Emergency Services.

For more information on personal preparedness, go to www.ready.gov.

**Minimizing Your Stress Before the Crisis**

- Post a weekly schedule at home so that family members can be located in an emergency.
- Develop a home safety and evacuation plan, and review and practice it regularly.
- Create child care and pet care plans.
- Design a plan for how family members will contact each other during a crisis.
- Familiarize yourself with the disaster plans in your children's schools and in each family member's workplace.
- Gather and store emergency supplies including food, water, first aid kits, battery-operated radio, flashlights, and extra batteries.
• Prepare an emergency bag in advance in case you are deployed.
• Take advantage of any pre-disaster training and orientation that your organization provides, including cultural sensitivity awareness.

During the Crisis

It’s normal to experience stress during a disaster operation, but remember that stress can be identified and managed (Aid Workers Network, 2003). You are the most important player in controlling your own stress. There are many steps you can take to help minimize stress during a crisis.

Minimizing Your Stress During the Crisis

• Adhere to established safety policies and procedures.
• Encourage and support coworkers.
• Recognize that "not having enough to do" or "waiting" are expected parts of disaster mental health response.
• Take regular breaks whenever you experience troubling incidents and after each work shift. Use time off to "decompress."
• Practice relaxation techniques such as deep breathing, meditation, and gentle stretching.
• Eat regular, nutritious meals and get enough sleep.
• Avoid alcohol, tobacco, drugs, and excessive caffeine.
• Stay in contact with your family and friends.
• Pace self between low and high-stress activities.

After the Crisis

You may finish a disaster response project in a state of physical and emotional fatigue, and you may feel some ambivalence about giving up your disaster role. Be aware that you may experience some “letdown” when the disaster operation is over (CMHS, 1994). It is important to give yourself time to stop and reflect on the experience and how it changed you. Following are some action steps that may be helpful to get closure in the weeks after the crisis.

Minimizing Your Stress After the Crisis

• Consider participating in organized debriefing or critique.
• Reconnect with your family.
• Have a physical checkup.
• Continue normal leisure activities. Stay involved with your hobbies and interests.
• Consider stress management techniques such as meditation, acupuncture, and massage therapy.
• Draw upon your spirituality and personal beliefs. Take advantage of faith-based counselors and workplace counseling units.
• Avoid using alcohol, tobacco, or drugs to cope with stress. Seek professional substance abuse treatment if necessary.
• Use Employee Assistance Programs if you need to.

In Summary
Stress management is key to emergency management. Successful stress management is built on prevention and planning, a solid understanding of roles and responsibilities, support for colleagues, good self-care, and seeking help when needed.

Crisis response professionals may be repeatedly exposed to unique stressors during the course of their work. Successful implementation of any stress management plan requires overcoming some obstacles and barriers, including priority setting, resource allocation, organizational culture, and stigma.

Taking action to prevent and reduce stress is a critical element of effective emergency management and supports those in crisis response professions in their collective healing and recovery.

4E. Individual Approaches for Stress Prevention and Management

Management of Workload

• Set task priority levels with realistic work plans.
• Recognize that "not having enough to do" or "waiting" is an expected part of disaster mental health response.
Balanced Lifestyle

- Eat nutritious food and staying hydrated, avoiding excessive caffeine, alcohol, and tobacco.
- Get adequate sleep and rest, especially on longer assignments.
- Get physical exercise.
- Maintain contact and connection with primary social supports.

Stress Reduction Strategies

- Reduce physical tension by using familiar personal strategies (e.g., take deep breaths, gentle stretching, meditation, wash face and hands, progressive relaxation)
- Pace self between low and high-stress activities.
- Use time off to "decompress" and "recharge batteries" (e.g., get a good meal, watch TV, exercise, read a novel, listen to music, take a bath, talk to family).
- Talk about emotions and reactions with coworkers during appropriate times.

Self-Awareness

- Recognize and heed early warning signs for stress reactions.
- Accept that one may not be able to self-assess problematic stress reactions.
- Recognize that over-identification with or feeling overwhelmed by victims' and families' grief and trauma may signal a need for support and consultation.
- Understand the differences between professional helping relationships and friendships to help maintain appropriate roles and boundaries.
- Examine personal prejudices and cultural stereotypes.
- Recognize when one's own experience with trauma or one's personal history interfere with effectiveness.
- Be aware of personal vulnerabilities and emotional reactions and the importance of team and supervisor support.
5. Disaster Crisis Counseling

5A. Disaster Phases and Responses

Despite the differences in disasters, communities, and individuals, survivors’ emotional responses to disaster tend to follow a pattern of seven “disaster phases” (National Institute of Mental Health, 1983; DHHS, 2000e):

- Warning or threat;
- Impact;
- Rescue or heroic;
- Remedy or honeymoon;
- Inventory;
- Disillusionment; and
- Reconstruction or recovery.

The characteristics of the disaster, as well as those of the community and its individual residents, affect the duration and nature of the seven phases. The phases do not necessarily move forward in linear fashion; instead, they often overlap and blend together. Furthermore, individuals may experience a given phase in different ways (DHHS, 1999), and different cultural groups may respond differently during these phases. Below are brief descriptions of each phase, including examples of responses of different cultural groups during each phase.

For further information about disaster characteristics and phases, refer to the Training Manual for Mental Health and Human Service Workers in Major Disasters (DHHS, 2000e).

REPORT

Disaster Resurfaces Emotional Reactions to Prior Stressors

Flooding occurred in Clovis, California, in 1995, when a canal and ponding basins overflowed. Many families, mostly Hmong, who lived near the canal were displaced. The Hmong population is a low-income community with immigrants from Southeast Asia who have a history of war and severe losses. Many were suffering from Post-Traumatic Stress Syndrome prior to the flood. The flood increased financial stress and anxiety, and exacerbated their existing symptoms.

California Final Report, 1995
Warning or Threat Phase

The warning or threat phase occurs with hurricanes, floods, and other disasters for which there is warning hours or days in advance. Lack of warning can make survivors feel vulnerable, unsafe, and fearful of future unpredicted tragedies. The perception that they had no control over protecting themselves or their loved ones can be deeply distressing.

Racial and ethnic groups sometimes differ in the ways in which they receive information about risks and in the credence they place on such information. For example, Hispanics are more likely than non-Hispanics to use social networks for disaster information (Blanchard-Boehm, 1997; Perry and Mushkatel, 1986) and to believe information obtained through these networks (Perry and Lindell, 1991) than are members of other groups. Furthermore, some marginalized communities do not have adequate or functioning warning systems. When disaster warning information is not provided in multiple languages or is not closed-captioned, people who do not understand English or who are deaf or hard of hearing may not receive adequate warning.

Impact Phase

The impact phase occurs when the disaster actually strikes. This phase can vary from the slow, low-threat buildup associated with some types of floods to the violent and destructive outcomes associated with tornadoes and explosions. Depending on the characteristics of the disaster, reactions range from confusion, disbelief, and anxiety (particularly if family members are separated) to shock or hysteria.

Rescue or Heroic Phase

In the rescue or heroic phase, individuals’ activity levels are typically high and oriented toward rescue operations, survival, and perhaps evacuation. People generally work together to save lives and property; pre-existing tensions between racial and ethnic or cultural groups are set aside. However, if family members are separated, anxiety may be heightened.

Remedy or Honeymoon Phase

During this phase, optimism may reign as the community pulls together and government and volunteer assistance become available. The interactions
between relief workers and survivors from different cultures can be very important and can influence people’s long-term perceptions of the disaster relief effort. Perceptions and beliefs about how healing occurs also may influence recovery. Frequently, however, disaster workers who have had no orientation to local cultures and lack sensitivity to them are brought in to help out during this phase. Such workers may exacerbate, rather than mitigate, cultural differences.

**Inventory Phase**

During the inventory phase, survivors recognize the limits of help and begin to assess their futures. They become exhausted because of multiple demands, financial pressures, and the stress of relocation or living in a damaged home. Initial optimism may give way to discouragement and fatigue. This also is a time characterized by high levels of grief and loss. Families who lose loved ones will grieve and cope in different ways.

**Disillusionment Phase**

The disillusionment phase occurs when survivors recognize the reality of loss and the limits of outside relief. This phase is characterized by a high level of stress that may be manifested in personally destructive behavior, family discord, and community fragmentation. Obtaining assistance from relief agencies can be extremely difficult, and survivors may feel helpless and angry. Hostility between neighbors and among groups is common, and tensions may erupt among different cultural, racial, and ethnic groups.

**Reconstruction or Recovery Phase**

The final phase, reconstruction or recovery, may last for years. This phase involves the structural rebuilding of the community as well as the integration of changes occasioned by the disaster into one’s community and one’s life. A common problem is a lack of housing, particularly if the disaster destroyed much of the low-income housing stock. In such situations, the private market typically hinders rebuilding of low- and moderate-income rental units (Fothergill et al., 1999). Therefore, housing shortages and rent increases disproportionately affect racial and ethnic minority groups (Bolin and Stanford, 1991; Peacock and Girard, 1997). It is not unusual for local political issues to create friction and fragmentation in the impacted community during the disparate reconstruction progress and buyouts between neighboring counties.
Civil Unrest Causes Emotional Problems for Refugees

The civil unrest and fires in Los Angeles that came in the wake of the Rodney King verdict affected a community inhabited by many refugees from Central America and Asia. For immigrants who came from war-torn countries, the Los Angeles disturbances reactivated fears and emotions associated with their homeland. Many experienced increased agitation, depression, confusion, and recollections of prior bereavements.

California Final Report, 1994

DISASTER PHASES AND RESPONSES

Survivors’ reactions to and recovery from a disaster are influenced by a number of factors, including:

- The disaster’s unique characteristics, such as its size and scope, and whether it was caused by human or natural factors (see Table 1-3);
- The affected community’s unique characteristics, including its demographic and cultural make-up and the presence of pre-existing structures for social support and resources for recovery; and
- The individual’s personal assets and vulnerabilities that either reduce or exacerbate stress (DHHS, 2000e).

TABLE 1 - 3

Characteristics of Disasters

Researchers have identified several common characteristics of disasters that are particularly important when discussing emotional distress and recovery (Bolin, 1985: DHHS, 2000a, p. 6.). These characteristics are as follows:

- **Intensity of the impact**: Disasters that wreak intense destruction within a short period of time are particularly likely to cause emotional distress among survivors than are disasters that work their effect more slowly.
- **Impact ratio (i.e., the proportion of the community sustaining personal losses)**: When a disaster affects a significant proportion of a community’s population, few individuals may be available to provide material and emotional to support survivors.
- **Potential for recurrence or other hazards**: The real or perceived threat of
recurrence of the disaster or of associated hazards can lead to anxiety and heightened stress among survivors.

- **Cultural and symbolic aspects:** Changes in survivors’ social and cultural lives and routine activities can be profoundly disturbing. Both natural and human-caused disasters can have symbolic implications.
- **Extent and types of loss sustained by survivors:** Property damage or loss, deaths of loved ones, injury, and job loss all affect emotional recovery.

### 5B. Culture and Disaster

**CULTURAL COMPETENCE AND DISASTER MENTAL HEALTH SERVICES**

Culture as a source of knowledge, information, and support provides continuity and a process for healing during times of tragedy (DeVries, 1996). Survivors react to and recover from disaster within the context of their individual racial and ethnic backgrounds, cultural viewpoints, life experiences, and values. Culture offers a protective system that is comfortable and reassuring. It defines appropriate behavior and furnishes social support, identity, and a shared vision for recovery. For example, stories, rituals, and legends that are part of a culture’s fabric help people adjust to catastrophic losses by highlighting the mastery of communal trauma and explaining the relationship of individuals to the spiritual. Despite the strengths that culture can provide, responses to disaster also fall on a continuum. Persons from disadvantaged racial and ethnic communities may be more vulnerable to problems associated with preparing for and recovering from disaster than persons of higher socioeconomic status (Fothergill et al., 1999).

Because of the strong role that culture plays in disaster response, disaster mental health services are most effective when survivors receive assistance that is in accord with their cultural beliefs and consistent with their needs (Hernandez and Isaacs, 1998). As disaster mental health service providers seek to become more culturally competent, they must recognize three important social and historical influences that can affect the success of their efforts. These three influences are the importance of community, racism and discrimination, and social and economic inequality.
The Importance of Community

Disasters affect both individuals and communities. Following a disaster, there may be individual trauma, characterized as “a blow to the psyche that breaks through one’s defenses so suddenly and with such brutal force that one cannot react to it effectively” (DHHS, Rev. ed. in press). There also may be collective trauma—“a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community” (DHHS, Rev. ed., in press). Cultural and socioeconomic factors contribute to both individual and community responses to the trauma caused by disaster.

The culture of the community provides the lens through which its members view and interpret the disaster, and the community’s degree of cohesion helps determine the level of social support available to survivors. In other words, a community that is disrupted and fragmented will be able to provide less support than a cohesive community.

A classic example is presented by sociologist Kai Erikson, who studied the impact of the devastating 1972 flood in Buffalo Creek, West Virginia (Erikson, 1976). The flood led to relocation of the entire community. Erikson describes a “loss of community,” in which people lost not only their sense of connection with the locale but also the support of people and institutions. Results of this community’s fragmentation included fear, anger, anxiety, and depression.

Other studies have emphasized positive effects that can result from disaster experiences in communities that perform a protective role and cushion the stress of the disaster (Dynes et al., 1994). Compared with nondisaster-related suffering, which is isolating and private, the suffering of disaster survivors can be collective and public (Dynes et al., 1994). However, devastating disasters can have positive outcomes. They can bring a community closer or reorient its members to new priorities or values (Ursano, Fullerton et al., 1994). Individuals may exhibit courage, selflessness, gratitude, and hope that they may not have shown or felt before the disaster.

Community often is extremely important for racial and ethnic minority groups, and it may dramatically affect their ability to recover from disaster. For example, a racial or ethnic minority community may provide especially strong social support functions for its members, particularly when it is
surrounded by a hostile society. However, its smaller size may render it more fragile and more subject to dispersion and destruction after a disaster. Members of some racial and ethnic minority groups, such as refugees, previously have experienced destruction of their social support systems, and the destruction of a second support system may be particularly difficult (Beiser, 1990; Van der Veer, 1995).

**REPORT**

**Disaster Projects Confront Distrust**

Several disaster crisis counseling projects supported by the Federal Government have had to address the distrust of ethnic minority groups and their reluctance to use available resources. For example, following the 1994 California earthquake, the disaster crisis counseling project found that many immigrants’ distrust of government posed a barrier to their use of disaster services. Likewise, some of the survivors of a hurricane in Alabama were immigrants from Asian Communist countries who did not trust any government and were not accustomed to receiving Government assistance.

*California Final Report, 1995 • Alabama Final Report, 1999*

**Racism and Discrimination**

Many racial and ethnic minority groups, including African Americans, American Indians, and Chinese and Japanese Americans, have experienced racism, discrimination, or persecution for many years. Both legally sanctioned and more subtle forms of discrimination and racism are an undeniable part of our Nation’s historical fabric. Despite improvements in recent decades, evidence exists that racial discrimination persists in housing rentals and sales, hiring practices, and medical care. Racism also takes the form of demeaning comments, hate crimes, and other violence by institutions or individuals, either intentionally or unintentionally (DHHS, 2001).

As a result of past or present experiences with racism and discrimination, racial and ethnic minority groups may distrust offers of outside assistance at any time, even following a disaster. They may not be accustomed to receiving support and assistance from persons outside of their own group in non-disaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.
Particularly during the “disillusionment phase” of the disaster, when intragroup tensions are typically high, racial and ethnic minority groups can face the brunt of anger and even blame from members of the larger culture. Such psychological assaults and experiences with racism and discrimination can result in increased stress for individuals and groups.

**REPORT**

**Damage from Mississippi Tornadoes Unequal**

In the late 1950s, several tornadoes struck rural Mississippi. The only persons killed were black. A subsequent study found that many people in the black community had great difficulty in coming to terms with this disaster. They did not understand how a just God could discriminate in such a fashion between white and black.

*Perry and Perry, 1959*

**Social and Economic Inequality**

Poverty disproportionately affects racial and ethnic minority groups. For example, in 1999, 8 percent of whites, 11 percent of Asian Americans and Pacific Islanders, 23 percent of Hispanic Americans, 24 percent of African Americans, and 26 percent of American Indians and Alaska Natives lived in poverty (DHHS, 2001). Significant socioeconomic differences also exist within racial and ethnic minority groups. For example, although some subgroups of Asian Americans have prospered, others remain at low socioeconomic levels (O’Hare and Felt, 1991).

Social and economic inequality also leads to reduced access to resources, including employment; financial credit; legal rights; and education, health, and mental health services (Blaikie et al., 1994). Poor neighborhoods also have high rates of homelessness, substance abuse, and crime (DHHS, 2001).

Poverty makes people more susceptible than others to harm from disaster and less able to access help (Bolin and Stanford, 1998). Low-income individuals and families typically lose a much larger part of their material assets and suffer more lasting negative effects from disaster than do those with higher incomes (Wisner, 1993). Often, disadvantaged persons live in the least desirable and most hazardous areas of a community, and their homes may be older and not as sound as those in higher income areas. For example, many low-income people live in apartment buildings that contain
unreinforced masonry, which is susceptible to damage in a disaster (Bolton et al., 1993).

Although disaster relief activities can help ameliorate some of the damage rendered by a disaster, some groups cannot readily access such services. Negative perceptions derived from pre-disaster experiences may serve as a barrier to seeking care. Lack of familiarity with sources of community support or lack of transportation are common barriers for many immigrants and unwillingness to disclose their immigration status is a major barrier.

Middle-class disaster survivors are more likely than lower-income people—including those from other cultures—to know how to complete forms, communicate adequately, talk to the “right” people, or otherwise maneuver within the system. Thus, they may be more likely to receive aid than survivors with fewer means or those from different cultures (Aptekar, 1990). On the other hand, affluent groups may find it difficult to accept assistance from mental health and social service agencies. They may fear a loss of control and find it humiliating to accept emergency assistance such as clothing, food, loans, and emotional support from disaster workers.

In some instances, people of lower socioeconomic status exhibit strong coping skills in disaster situations because they have seen difficult times before and have survived. In other instances, the loss of what little one had may leave an individual feeling completely hopeless.

<table>
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<td><strong>Tornadoes Destroy Homes in Sioux Nation</strong></td>
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In 1999, tornadoes ravaged the Oglala Sioux Nation in South Dakota. Housing units are scattered throughout this vast reservation; one home may be 10 to 20 miles from the nearest neighbor or community. Many roads on the reservation are unimproved. Only 10 percent to 15 percent of the homes have telephone service. Because of the lack of adequate housing, multiple family units reside in one dwelling. In some situations, 20 family members live in a two-bedroom home with no running water or sewage system. Outhouses are commonplace.

*South Dakota Application, 1999*
CULTURAL COMPETENCE AND DISASTER MENTAL HEALTH PLANNING

Providing culturally competent mental health services to survivors requires action before, during, and after a disaster. The disaster mental health plan, which should be part of a State or community emergency management plan, can help ensure an efficient, coordinated response to the mental health needs of the affected population (DHHS, Rev. ed., in press). These plans specify roles, responsibilities, and relationships among agencies and organizations in responding to a community’s mental health needs following a disaster (DHHS, Rev. ed., in press).

Well-designed disaster mental health plans enhance coordination and minimize chaos, thereby helping to ensure that survivors receive assistance in a timely, helpful, and culturally sensitive manner should a disaster occur. Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems. In the absence of such planning, disaster relief is disorganized, especially in the immediate aftermath. Confusion and inefficiency can prevail when survivors attempt to gain access to services.

REPORT

Disaster Strikes a Highly Diverse Community

On January 17, 1994, a major earthquake struck Los Angeles and Ventura Counties. The Northridge earthquake was the largest and most violent to hit an urban area in the United States since the 1906 San Francisco quake. The post-disaster recovery effort provided mental health services to 1.9 million persons, representing myriad ethnic groups, special populations, and lifestyles.

The size and scope of the two affected counties, as well as the ethnic diversity of their residents, constituted a challenge to disaster mental health providers. For example, Ventura County is home to many undocumented migrant farm workers, the majority of whom do not speak English and are mistrustful of government at any level. Language and cultural barriers had to be overcome for persons from several Asian cultures as well. The diverse population in the affected areas also included other special populations, such as physically challenged persons and runaway youth, two groups that required special outreach strategies.

The disaster mental health program staff recognized from the beginning of the project the need to develop and provide culturally relevant and linguistically appropriate services,
Successful program planners recognize that creating culturally competent environments requires more than recruiting bilingual and bicultural mental health workers, sponsoring a single diversity management class, sending a few employees to a cultural competence workshop, or hiring a “token” racial or ethnic minority group representative. Rather, cultural competence must be a part of the program values; included in the program’s mission statement; and encouraged in attitudes, policies, and practices at every level.

To develop a culturally competent disaster mental health plan, planners must:

- Assess and understand the community’s composition;
- Identify culture-related needs of the community;
- Be knowledgeable about formal and informal community institutions that can help meet diverse mental health needs;
- Gather information from and establish working relationships with trusted organizations, service providers, and cultural group leaders and gatekeepers; and
- Anticipate and identify solutions to cultural problems that may arise in the event of a disaster.

Table 1-4 presents questions that should be addressed in the mental health plan. For further information about disaster mental health planning, refer to Disaster Response and Recovery: A Strategic Guide (DHHS, Rev. ed., in press).

| TABLE 1 - 4 |
| Questions to Address in the Disaster Mental Health Plan |

**Community demographic characteristics**

- Who are the most vulnerable persons in the community? Where do they live?
- What is the range of family composition (i.e., single-parent households)?
- How could individuals be identified and reached in a disaster?
- Are policies and procedures in place to collect, maintain, and review current and
emergent demographic data for any area that might be affected by a disaster?

**Cultural groups**

- What cultural groups (ethnic, racial, and religious) live in the community?
- Where do they live, and what are their special needs?
- What are their values, beliefs, and primary languages?
- Who are the cultural brokers in the community?

**Socioeconomic factors**

- Does the community have any special economic considerations that might affect people’s vulnerability to disaster?
- Are there recognizable socioeconomic groups with special needs?
- How many live in rental property? How many own their own homes?

**Mental health resources**

- What mental health service providers serve the community?
- What skills and services does each provider offer?
- What gaps, including lack of cultural competence, might affect disaster services?
- How could the community’s mental health resources be used in the event of different types of disasters?

**Government roles and responsibilities in disaster**

- What are the Federal, State, and local roles in disaster response?
- How do Federal, State, and local agencies relate to one another?
- Who would lead the response during different phases of a disaster?
- How can mental health services be integrated into the government agencies’ disaster response?
- What mutual aid agreements exist?
- Do any subgroups in the community harbor any historical or political concerns that affect their trust of government?

**Nongovernmental organizations’ roles in disaster**

- What are the roles of the American Red Cross, interfaith organizations, and other disaster relief organizations?
- What resources do nongovernment agencies offer, and how can local mental health services be integrated into their efforts?
- What mutual aid agreements exist?
- How can mental health providers collaborate with private disaster relief efforts?
Community partnerships

- What resources and supports would community and cultural/ethnic groups provide during or following a disaster?
- Do the groups hold pre-existing mutual aid agreements with any State or county agencies?
- Who are the key informants/gatekeepers of the impacted community?
- Has a directory of cultural resource groups, natural helpers, and community informants who have knowledge about diverse groups been developed?
- Are the community partners involved in all phases of disaster preparedness, response, and recovery operations?

Guiding Principles and Recommendations

Developing cultural competence requires a concerted effort by disaster mental health planners and front-line workers. Successful programs share common practices that are defined by nine guiding principles. These principles, listed here, have been identified by CMHS.

This section discusses each of the nine guiding principles and suggests ways to integrate them into disaster mental health planning and crisis counseling programs. The guiding principles, in many ways, overlay the Key Concepts of Disaster Mental Health (DHHS, 2000e), presented in Table 2-1. The Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F, summarizes key content in a convenient form for use in program planning.

TABLE 2 - 1

Key Concepts of Disaster Mental Health

The following concepts should be adopted by all disaster mental health providers, including those serving culturally diverse survivors. The concepts can also help administrators and service providers set program priorities. The concepts deviate in some ways from those on which mental health work has traditionally been based. However, their validity has been confirmed again and again in disasters of various types that have affected a broad range of populations (DHHS, 2000a).

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma—individual and community.
- Most people pull together and function adequately during and after a disaster, but
their effectiveness is diminished by the effects of the event.

- Stress and grief in disasters are normal reactions to abnormal situations.
- Many emotional reactions of disaster survivors stem from problems of daily living brought about by the disaster.
- Disaster relief assistance may be confusing to some survivors. They may experience frustration, anger, and feelings of helplessness related to Federal, State, and private-sector disaster assistance programs.
- Most people do not see themselves as needing mental health services following a disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be tailored to the culture of communities where they are provided.
- Mental health workers should set aside traditional methods, avoid mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of disaster.
- Social support systems are crucial to recovery.

PRINCIPLE 1: RECOGNIZE THE IMPORTANCE OF CULTURE AND RESPECT DIVERSITY

Culture is one medium through which people develop the resilience that is needed to overcome adversity. Following a disaster, culture provides validation and influences rehabilitation. However, when daily rituals, physical and social environments, and relationships are disrupted, life becomes unpredictable for survivors. Disaster mental health workers can help reestablish customs, rituals, and social relationships and thereby help survivors cope with the impact of a disaster. When doing so, these workers need to recognize that diversity exists within as well as across cultures (Cross et al., 1989). In disasters, individuals within a given cultural group may respond in very different ways; some will be receptive to disaster relief efforts, while others will not. Older adults and young people within a particular culture may react to losses or seek help in different ways, depending on their degree of acculturation. Disaster mental health workers also must be aware of and sensitive to issues stemming from biculturalism; these issues include conflict and ambivalence related to identity and the need to function in cross-cultural environments (Hernandez and Isaacs, 1998).
REPORT

Concerns About Child Care Heightened by Bombing

Following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, local mental health agencies mobilized to provide services to the survivors. One Latino child perished in the Murrah Building and several Latino children were wounded at the YMCA day care center. Mental health workers realized that they would have to address the concerns and guilt of Latino parents regarding child care because in this culture individuals generally resist using babysitters or placing their children in day care.

Oklahoma Application, 1995

REPORT

Indigenous Outreach Workers Provide Community-Appropriate Services in Guam

In the aftermath of the 1997 super-typhoon, Paka, the Territory of Guam partnered with the University of Guam College of Life Sciences to provide culturally appropriate crisis counseling services. Strategies such as paying special attention to racial tensions, matching workers to the population served, and providing training on culturally respectful interactions helped the outreach workers gain entry to the island’s diverse population.

The demographics of the staff mirrored that of the community, and the mental health providers were an integral part of the community. Culture-specific training provided a forum for interacting with representatives of helping agencies on the island and from neighboring Saipan. Outreach tools and strategies included a monkey hand puppet used to engage children, a program for hotel workers, and a program for seniors that used symbolism and activities to encourage recovery. Broadcast and print media, as well as personal conversations, were used to educate the public about the project and the emotional effects of disaster.

Guam Site Visit Report, 1998

Recognizing the importance of culture and respecting diversity require an institution-wide commitment. To meet this commitment, disaster mental health workers must understand their own cultures and world views; examine their own attitudes, values, and beliefs about culture; acknowledge cultural differences; and work to understand how cultural differences affect the values, attitudes, and beliefs of others. Table 2-2 examines important
considerations mental health workers should keep in mind when dealing with people from other cultures.

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**Important Considerations When Interacting with People of Other Cultures**

Giger and Davidhizar’s “transcultural assessment and intervention model” was developed to assist in the provision of transcultural nursing care. It is currently used by several other health and human services professions. The model identifies five issues that can affect the interactions of providers and service recipients. These issues, adapted below to apply to disaster crisis counseling, illustrate the importance of acknowledging culture and of respecting diversity. A complete description of the model can be found in *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar, 1999).

**Communication:** Both verbal and nonverbal communication can be barriers to providing effective disaster crisis counseling when survivors and workers are from different cultures. Culture influences how people express their feelings as well as what feelings are appropriate to express in a given situation. The inability to communicate can make both parties feel alienated and helpless.

**Personal Space:** “Personal space” is the area that immediately surrounds a person, including the objects within that space. Although spatial requirements may vary from person to person, they tend to be similar among people in a given cultural group (Watson, 1980). A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive. Disaster crisis counselors must look for clues to a survivor’s need for space. Such clues may include, for example, moving the chair back or stepping closer.

**Social Organization:** Beliefs, values, and attitudes are learned and reinforced through social organizations, such as family, kinships, tribes, and political, economic, and religious groups. Understanding these influences will enable the disaster crisis counselor to more accurately assess a survivor’s reaction to disaster. A survivor’s answers to seemingly trivial questions about hobbies and social activities can lead to insight into his or her life before the disaster.

**Time:** An understanding of how people from different cultures view time can help avoid misunderstandings and miscommunication. In addition to having different interpretations of the overall concept of time, members of different cultures view “clock time”—that is, intervals and specific durations—differently. Social time may be measured in terms of “dinner time,” “worship time,” and “harvest time.” Time perceptions may be altered during a disaster. Crisis counselors acting with a sense of urgency may be tempted to set timeframes that are not meaningful or realistic to a survivor. The result may be frustration.
for both parties.

**Environmental Control:** A belief that events occur because of some external factor—luck, chance, fate, will of God, or the control of others—may affect the way in which a survivor responds to disaster and the types of assistance needed. Survivors who feel that events and recovery are out of their control may be pessimistic regarding counseling efforts. In contrast, individuals who perceive that their own behavior can affect events may be more willing to act (Rotter, 1966). Disaster crisis counselors need to understand beliefs related to environmental control because such beliefs will affect survivors’ behavior.

**PRINCIPLE 2: MAINTAIN A CURRENT PROFILE OF THE CULTURAL COMPOSITION OF THE COMMUNITY**

No one knows when or where disaster will strike. For this reason, a pre-disaster assessment of a community’s composition and familiarity with cultural traditions and customs during times of loss, trauma, and grief can provide invaluable knowledge in the event of a disaster. The range of cultural diversity—ethnic, religious, racial, and language differences among subgroups—should be assessed and described in a comprehensive profile of the community. A comprehensive community profile describes the community’s composition in terms of:

- Race and ethnicity;
- Age;
- Gender;
- Religion;
- Refugee and immigrant status;
- Housing status (i.e., number of single-parent households, type of housing, rental versus ownership, number of persons per household);
- Income and poverty levels;
- Percentage of residents living in rural versus urban areas;
- Unemployment rate;
- Languages and dialects spoken;
- Literacy level;
- Number of schools; and
- Number and types of businesses.

Information about the values, beliefs, social and family norms, traditions, practices, and politics of local cultural groups, as well as the history of racial relations or ethnic issues in the community, should be included in the
community profile, because these cultural characteristics may take on additional significance in times of stress (DeVries, 1996). This information should be gathered with the assistance of and in consultation with community cultural leaders (“key informants”) who represent and understand local cultural groups.

Other sources of data incorporated in the community profile include the city hall or the county commissioner’s office, as well as the resources listed in Appendix C. Finally, information included in the community profile should be updated frequently, because such data can change rapidly.

REPORT

Migrant Farm Workers Employed as Outreach Workers

In 1998, El Niño caused a series of storms that devastated many California communities. The storms affected a large number of migrant farm workers, including many in Ventura County. The migrant workers were unwilling to seek help because of cultural proscriptions and language barriers. Some were illiterate.

To improve its ability to assist the migrant workers, Ventura County’s disaster crisis counseling project hired peer farm laborers. These workers, who had contacts and credibility within the migrant community, enabled the project to establish a unique communication model to reach farm laborers. The peer counselors went into labor camps and met with the victims of the rains and their indigenous leaders. Local residents noted that these were the first “government” workers in recent memory to be allowed in the farm workers’ camp.

California Final Report, 1998

PRINCIPLE 3: RECRUIT DISASTER WORKERS WHO ARE REPRESENTATIVE OF THE COMMUNITY OR SERVICE AREA

Disaster mental health programs are most effective when individuals from the community and its various cultural groups are involved in service delivery as well as in program planning, policy, and administration and management. Recruiting staff whose cultural, racial, and ethnic backgrounds are similar to those of the survivors helps ensure a better understanding of both the survivors and the community and increases the likelihood that survivors will be willing to accept assistance. For example, if American Indian or Alaska Native populations have experienced a disaster, tribal leaders, elders, medicine persons, or holy persons might be recruited to serve
as counselors or in some other capacity. The community profile can be reviewed when recruiting disaster crisis counseling workers to ensure that they are representative of the community or service area.

If indigenous workers are not immediately available, coordinators can attempt to recruit staff with the required racial or ethnic background and language skills from other community agencies or jurisdictions (DHHS, Rev. ed. in press).

Recruitment based solely on race, ethnicity, or language, however, may not be sufficient to ensure an effective response. People who are racially and ethnically representative of the community are not necessarily culturally or linguistically competent. The ability to speak a particular language is not necessarily associated with cultural competence. For example, a well-educated, Spanish-speaking Hispanic professional may not understand the problems and cultural nuances of an immigrant community whose members are living in poverty (DHHS, 2000d).

Table 2-3 highlights the attributes, knowledge, and skills essential to development of cultural competence that should be considered when recruiting disaster mental health staff.

| TABLE 2 - 3 |
| Staff Attributes, Knowledge, and Skills Essential to Development of Cultural Competence |
| Personal Attributes |
| • Genuineness, empathy, and a capacity to respond flexibly to a range of possible solutions |
| • Acceptance and awareness of cultural differences and cross-cultural dynamics |
| • Willingness to work with survivors of different cultures |
| • Ability to articulate one's own values, stereotypes, and biases and to identify how they may accommodate or conflict with the needs of culturally diverse disaster survivors |
| • Openness to learning about the cultures of diverse groups |
| Knowledge |
| • History, tradition, values, artistic expressions of culturally diverse disaster survivors |
Help-seeking behaviors, informal helping supports, and natural healing practices of survivors of various cultures
Role of language, speech patterns, and communication styles in culturally distinct communities
Psychosocial stressors relevant to diverse groups (e.g., migration, acculturation stress, legal and illegal discriminatory patterns, racism, and socioeconomic status)
Community resources (agencies, informal helping networks) and their availability for special populations

Skills

- Ability to discuss cultural issues and to respond to culturally-based cues
- Ability to assess the meaning of culture for the disaster survivor
- Ability to interview and assess survivors on the basis of their personal, psychological, social, cultural, political, or spiritual models

(Adapted from: Benedetto, 1998; DHHS, 1998)

PRINCIPLE 4: PROVIDE ONGOING CULTURAL COMPETENCE TRAINING TO DISASTER MENTAL HEALTH STAFF

Cultural competence is an essential component of disaster mental health training programs. Training should be provided to help mental health workers acquire the values, knowledge, skills, and attributes needed to communicate and work in a sensitive, nonjudgmental, and respectful way in cross-cultural situations. Such training should be provided to direct services staff, administrative and management staff, language and sign-language interpreters, and temporary staff.

Cultural competence training programs work particularly well when they are provided in collaboration with community-based groups that offer expertise or technical assistance in cultural competence or in the needs of a particular culture. Involving such groups not only enables program staff to gain firsthand knowledge of various cultures, but also opens the door for long-term partnerships (Hernandez and Isaacs, 1998).

Training should cover basic cultural competence principles, concepts, terminology, and frameworks. For example, training should include discussion of:

- Cultural values and traditions;
- Family values;
• Linguistics and literacy;
• Immigration experiences and status;
• Help-seeking behaviors;
• Cross-cultural outreach techniques and strategies; and
• Avoidance of stereotypes and labels (DHHS, 2000e).

Even if the initial training period is of limited duration, participants should have an opportunity to examine and assess values, attitudes, and beliefs about their own and other cultures. Self-assessment helps identify areas where skills need to be developed (DHHS, 1998). Training should stress that people of a given cultural group may react quite differently to disaster, depending on their level of acculturation.

Cultural competence training is a developmental process. Ongoing education—through in-service training and regularly scheduled meetings with project staff to discuss cultural competence issues—is essential (Hernandez and Isaacs, 1998).

REPORT

Innovative Program Developed for Seniors

Following civil unrest in Los Angeles in 1993, a crisis counseling program was developed to assist the community. One element of this program was peer counseling with senior adults, including a group of elderly Samoans. No mental health professionals from the Samoan population could be found to help address the needs of these monolingual older adults in South Bay. Project staff worked with the head of the Samoan Council of Chiefs to offer a first-of-its-kind peer counselor training delivered via simultaneous translation. It worked beautifully. Twenty Samoans became deeply committed to counseling seniors in their community.

California Final Report, 1994

PRINCIPLE 5: ENSURE THAT SERVICES ARE ACCESSIBLE, APPROPRIATE, AND EQUITABLE

Survivors are not always receptive to offers of support. For example, some members of cultural groups may be reluctant to take advantage of services because of negative past experiences. Undocumented immigrants may not seek services because they fear deportation. Such individuals may be reluctant or refuse to move to temporary shelters, to accept State or Federal
assistance, or to discuss information that they think could be used against them.

Inequitable treatment following disasters may reinforce mistrust of the public services and disaster assistance systems. Following the 1989 Loma Prieta earthquake in California, shelter services in the more affluent neighborhoods had more community volunteers than survivors. The mayor visited the disaster site in these areas. Less affluent neighborhoods had fewer volunteers, and some volunteers made remarks that the survivors felt were offensive. The mayor did not visit these areas (Dhesi, 1991). Moreover, food and meal preparation in shelters was not culturally appropriate following the earthquake, and many Latinos reported that they became sick from eating the food prepared by the Anglo relief workers (Phillips, 1993).

In studies of Hurricane Andrew’s aftermath, racial and ethnic minority group survivors were less likely to have insurance than were white survivors because of practices that exclude certain communities from insurance coverage at affordable rates. Survivors from minority groups were also more likely to receive insufficient settlement amounts (Peacock and Girard, 1997). Concerns related to gender also were investigated after Hurricane Andrew. Many non-English-speaking women of color, especially single women, were subjected to dishonest practices of construction contractors (Enarson and Morrow, 1997).

The delivery of appropriate services is a frequent problem. Racial and ethnic discrimination, language barriers, and stigma associated with counseling services have a negative effect on many individuals’ access to and utilization of health and mental health services (Denboba et al., 1998). Families who participated in focus groups reported problems with cultural and ethnic biases and stereotypes, offensive communication and interactions based on such biases and stereotypes, lack of cross-cultural knowledge, and lack of understanding of the values of various cultural groups (Malach et al., 1996).

Disaster mental health programs must take special care to exercise culturally competent practices. They should make efforts to ensure that staff members speak the language and understand the values of the community. Providing food that has cultural significance can be important. Involving cultural group representatives in disaster recovery committees and program decision making (for example, as members of planning boards or other policy-setting
bodies) can help ensure that disaster services are accessible, appropriate, and equitable.

**REPORT**

**Hurricane Response Designed to Be Culturally Competent**

Hurricane Hortense struck Puerto Rico in 1996 with devastating impact. The disaster crisis counseling program was designed to be particularly sensitive to the Puerto Rican culture. For example, recognizing that this culture encourages strong ties with friends and neighbors, the program provided group debriefing sessions.

The project also used cultural celebrations to advance its goals. For example, the festival of the Three Kings Day, which occurs in early January, was used as an opportunity for special outreach in which project staff went door to door “giving asaltos”—a tradition of singing Christmas carols and giving donated gifts—as a way to identify needs and provide information and social support. The project also used dramatization to inform persons in the community about disaster phases and disaster planning.

*Culturally sensitive outreach techniques also can help ensure that services are accessible and appropriate to all survivors. For example, outreach workers should:*

- Allow time for and devote energy to gaining acceptance, take advantage of associations with trusted organizations, and be wary of aligning their efforts with those of agencies and organizations that are mistrusted by cultural groups;
- Determine the most appropriate ways to introduce themselves;
- Recognize cultural variations in expression of emotion, manifestation and description of psychological symptoms, and views about counseling; and
- Assist in eliminating barriers by carefully interpreting facts, policies, and procedures.

Table 2-4 addresses special considerations that should be taken into account when counseling refugees.
Special Considerations When Working with Refugees

Refugees may differ from each other and from native populations on several dimensions, including:

**Language:** Refugees frequently do not speak English well, if at all. This presents communication challenges throughout all phases of a disaster.

**Culture:** Refugees have their own cultures. Because they are new to the United States, they usually are less well-versed in Western culture than are immigrants, who have had more time to understand it.

**Economic marginalization and differences:** When they arrive in the United States, many refugees can barely manage economically. Many are supporting relatives left at home. On the other hand, some refugees—especially those with education and highly sought skills—find well-paying jobs quickly. Thus, although poverty is common among refugees, not all refugees are poor.

**Fractured social relations:** The communities of origin of many refugees have failed to provide needed security. In addition, many refugees have experienced personal attacks by representatives of their community or the larger society. Some become so disillusioned by this experience that they are reluctant to form new community bonds. In addition, refugees often face within-group schisms. Preexisting ethnic, religious, and political divisions of the society of origin are frequently reinstituted in refugee communities formed in the new country.

Some refugees solve the problem by restricting new relationships to the safest ones, for example, by forming or joining small groups of people who emigrated from the same geographic area. When a disaster forces relocation, it can break up this small community and make recovery more problematic (Athey and Ahearn, 1991).

The negative experiences of many refugees also make them suspicious of government. They may be reluctant to seek out or accept assistance following disaster. Undocumented migrants may fear deportation, but even refugees who have achieved legal status may fear that accepting of assistance following a disaster will put them at risk of deportation. Thus, refugees often are the last group to obtain assistance following disaster.

**Experience of traumatic stressors and of loss:** Refugees often have experienced horrific events that cause symptoms of Post-Traumatic Stress Disorder. They may have lost family members, their homes, and their possessions, and some have been deprived of sufficient food or water, lacked medical care, or lived in inadequate housing for long periods of time. A disaster can lead to the emotional re-experiencing of these events (Vander Veer, 1995). On the other hand, some refugees may have gained strength and resilience from their previous experiences and bring that strength to the new disaster.
Family dynamics and role changes: Another challenge for many refugee families is that of new family dynamics upon resettlement. Children may have seen their parents fearful, helpless, and stressed during the flight and—upon resettlement—anxious, powerless, and exhausted. Children may come to believe that adults are not to be trusted because they have not seen adults playing a protective and nurturing role.

Intergenerational conflict resulting from differing rates of acculturation presents another family problem. Finally, parents may feel deprived of their role as family heads when they find they must depend on children as language translators or navigators within the new culture (de Monchy, 1991).

De Monchy (1991) identifies three principles for effective service delivery with refugees:

1. Trauma experiences need to be acknowledged.
2. Refugees need to be recognized as successful survivors, and their wisdom and strengths affirmed.
3. Empowerment and the recovery of control need to be encouraged, especially for refugees who are reestablishing parental roles with their children.

PRINCIPLE 6: RECOGNIZE THE ROLE OF HELP-SEEKING BEHAVIORS, CUSTOMS AND TRADITIONS, AND NATURAL SUPPORT NETWORKS

Culturally competent disaster mental health services proactively respond to the culturally defined needs of the community. Disruption of many aspects of life and the need to adapt to difficult circumstances cause stress and anxiety in many survivors. In some cases, these problems can be as difficult as the disaster itself. Effective response requires familiarity with help-seeking behaviors; customs and traditions related to healing, trauma, and loss; and use of natural support networks of various cultural groups.

Help-Seeking Behaviors

Different cultures exhibit different help-seeking behaviors. In many cultures, people turn to family members, friends, or cultural community leaders for help before reaching out to government and private-sector service systems. They may prefer to receive assistance from familiar cultural community leaders or groups rather than unfamiliar service systems. In most communities, churches and other places of worship play a role similar to that of an extended family, and survivors turn to them first for assistance.
Many survivors may be reluctant to seek help or may reject disaster assistance of all types. Some people feel shame in accepting assistance from others, including the government, and equate government assistance with “welfare.” Members of racial and ethnic minority groups, including refugees and immigrants, also may be reluctant or afraid to seek help and information from service systems because of historical mistrust of the health, mental health, and human services systems or because of fear of deportation (Aponte, Rivers, and Wohl, 1995). Other groups may prefer to suffer or even perish rather than seek help from people they mistrust. Therefore, building trusting relationships and rapport with disaster survivors is essential to effective crisis counseling.

Those who do seek help may find relief procedures confusing. Feelings of anger and helplessness and loss of self-esteem can result from survivors’ encounters with relief agencies. These feelings result from the survivors’ lack of understanding of the disaster relief system as well as government and private agencies’ often bureaucratic procedures.

**Customs and Traditions in Trauma and Loss**

Religious and cultural beliefs are important to survivors as they try to sort through their emotions in the aftermath of traumatic events. Beliefs may influence their perceptions of the causes of traumatic experiences. For example, in many cultures, people believe that traumatic events have spiritual causes. These beliefs can affect their receptivity to assistance and influence the type of assistance that they will find most effective. Different populations may elaborate on the cultural meaning of suffering in different ways, but suffering itself is a defining characteristic of the human condition in all societies. In most major religions, including Christianity, Judaism, Islam, Hinduism, and Buddhism, the experience of human misery—resulting from sickness, natural disasters, accidents, violent death, and atrocity—also is a defining feature of the human condition.

Different cultural groups also handle grief in different ways. Family customs, beliefs, and degree of acculturation affect expressions of grief. Disaster mental health workers must recognize that grief rituals, although diverse in nature, can help people return to a reasonable level of functioning. For example, Western tradition holds that grief should be “worked through.” This process includes acceptance of the loss; extinction of behaviors that are
no longer adaptive; acquisition of new ways of dealing with others; and resolution of guilt, anger, and other disruptive emotions.

**REPORT**

**Shamans Counter Bad Luck**

In 1995, northern California experienced a series of storms that led to flooding, landslides, and mud debris flow. The State implemented a FEMA-funded crisis counseling program for the victims of the storms. One group affected were Hmong immigrants, persons with a history of war and severe losses. In serving the Hmong population, the program utilized the color red in many printed materials and supplies because Hmong culture includes a belief that red symbolically wards off evil spirits. Another consideration involved the Hmong belief that floods are an omen of doom and that shaman cleansing rituals are needed to counter the bad luck that this omen portends. As a way of acknowledging and respecting this belief, the staff developed and provided a referral list of shamans in the local area.

*California Final Report, 1996*

If a community remains intact after a disaster, cultural norms, traditions, and values determine the strategies that the survivors use to deal with the effects. When the entire community is affected, however, cultural mechanisms may be overwhelmed and unable to fulfill their customary functions of regulating emotions and providing identity, support, and resources (DeVries, 1996). Disaster mental health workers can support the healing process by helping rebuild the community’s cultural support system. Workers will be most effective when they recognize and understand the importance of culture in the lives of disaster survivors and the beliefs, rituals, and level of acculturation of the community in which they work.

**Customs and Traditions for Healing**

Many cultural groups hold beliefs about illness and healing that differ sharply from those held by Western society. People in every culture share beliefs about the causes of illness and ideas about how suffering can be mitigated. For example, members of some cultures believe that physical and emotional problems result from spiritual wrongdoings in this life or a previous one. They believe that healing requires forgiveness from ancestors or higher spirits. Some people believe that suffering cannot be ameliorated
(DeVries, 1996). Others demonstrate stress and emotional conflict through complaints about their physical health.

Traditional healers, such as local herbalists, faith healers, and acupuncturists, play important roles in recovery of mental and physical health within some cultures. In general, the work of healers is based on the principle that the body cannot be isolated from the mind, and the mind cannot be removed from its social context. Disaster mental health workers who interact with cultures in which healers play a key role in health must understand the concepts of integration of body, mind, and spirit when they provide disaster crisis counseling services to diverse populations. They must be able to integrate traditional methods of healing into service delivery (de Monchy, 1991). Although the crisis counselor may not subscribe to certain cultural healing beliefs, he or she must acknowledge their existence and recognize their importance to some disaster survivors. At the same time, the worker must be alert for any use of dangerous healing practices, such as ingestion of harmful mixtures containing lead or other toxic substances, and take corrective measures. Reestablishing rituals in appropriate locations is another way to help survivors in the recovery process. Symbolic gathering places, such as churches, mosques, trees, and safe places for meeting after sundown are important in some cultures and are required for certain rituals. After a disaster, survivors may lose access to symbolic places, and this loss may limit their ability to mobilize healing resources. Identifying new locations for rituals can foster social support and facilitate coping mechanisms following disaster (DeVries, 1996).

Disaster mental health workers also may help organize culturally appropriate anniversary activities and commemorations as a way to help survivors mark a milestone in the healing process. Cultural and religious traditions, including special ways of both celebrating and mourning, can be incorporated into such events and may enrich their symbolic meaning and healing potential. Any attempts to facilitate activities involving customs and traditions must be undertaken carefully and only after consultation with members of the involved cultural groups.

REPORT

Alaska Villagers Helped by Tribal Elders

In 1994, severe rains in Alaska resulted in extensive flooding of the Koyukuk River.
Three native villages experienced tremendous damage and residents had to be temporarily evacuated. With FEMA funding, the State of Alaska developed a disaster crisis counseling project that included among its staff professionals and paraprofessionals, Alaska Native and non-native staff, and tribal elders. Among the counselors were individuals with cultural sensitivity and respect for the wisdom of the elders. The project organized sewing circles and birchbark basket-making circles in order to use the mechanisms of the culture’s social life to assist in its recovery.

*Alaska Final Report, 1995*

**REPORT**

**Importance of Culturally Competent Ethnic Workers**

Flooding in Florida displaced many residents in 1998. One area that was flooded included a community with a high percentage of African Americans, a majority of whom were living in rental property. Unfortunately, the landlords were less than prompt, thorough, or enthusiastic in making repairs.

The disaster crisis counseling program that was developed in response to the flood employed an African American team leader from the county where most of the affected people lived. She was especially important in accessing community leaders and gatekeepers, helping identify needs of the community, and providing services.

*Florida Final Report, 1999*

**Natural Support Networks**

In many cultures, the family or kin group is chiefly responsible for its members, and support from kin may be essential in helping individuals overcome grief and trauma. However, when disaster strikes, all members of the extended family may be affected, leaving many people without this customary support network.

Traditions concerning the role of the family, who is included in the family, and who makes decisions vary across cultures (DHHS, 2000e). Elders and extended family play a significant role in some cultures, whereas in other cultures, isolated nuclear families are the decision makers (DHHS, 2000e). Households in racial and ethnic communities are, on average, larger than white households (O’Hare, 1992); they also are more likely to be
multigenerational. Asians, for example, are more than twice as likely as whites to live in extended families (O’Hare and Felt, 1991).

Disaster mental health workers must recognize that family support may not be available when entire kin groups are affected. Helping families and friends reunite is one way to ensure mutual support. Likewise, formal support groups can help assure those with limited access to relatives and acquaintances that they are not alone. Individuals who do not relate to support groups because of cultural and linguistic differences may need more individualized services.

Disaster mental health workers also must recognize that in many cultures, the individual cannot be separated from the family and community (Reichenberg and Friedman, 1996). In such cultures, unlike those of Western society, the individual does not exist apart from the group; outreach efforts focused on individuals are, therefore, neither comprehensible nor effective. For example, among some Asian American and Pacific Islander populations, intervention strategies that diffuse the power of family relationships are especially inappropriate. Mental health workers can assess who is significant in a survivor’s family structure by asking the survivor to describe his or her home, family, and community (Managua, 1998).

**PRINCIPLE 7: INVOLVE AS “CULTURAL BROKERS” COMMUNITY LEADERS AND ORGANIZATIONS REPRESENTING DIVERSE CULTURAL GROUPS**

Involving “cultural brokers”—community leaders and groups that represent diverse groups—is vital to the success of disaster mental health efforts. Collaborating with organizations and leaders who are knowledgeable about the community is the most effective way of gaining information about the community. Collaboration can assist in assessing needs, creating community profiles, making contact with and gaining the trust of survivors, establishing program credibility, integrating cultural competence in training, and ensuring that strategies and services are culturally competent (DHHS, 1998).

**Did You Know …**
According to 1990 census data, nearly 14 percent of the Nation’s population—32 million people—speak a language other than English in their homes. More than 300 languages are spoken in the United States (Goode et al., 2001).
In most communities, and in diverse communities in particular, some of the most influential individuals are cultural group leaders who possess “insider” knowledge of the community and are willing and able to articulate that knowledge (Hernandez and Isaacs, 1998). These individuals, who may not be immediately visible, can include spiritual leaders, members of the clergy, teachers, civic leaders, local officials, or long-term residents who have the respect and confidence of their neighbors. They often can provide outsiders with the best insights into a local culture’s values, norms, customs, conventions, traditions, and expectations (Hernandez and Isaacs, 1998).

Organizations representing various cultural groups and other special interest groups in the community should be invited to participate in disaster mental health programs. These organizations can provide valuable insight during the planning process, serve as a point of entry to the survivor community, and enhance cultural relevance of service delivery. Including individuals from various cultures on planning task forces and committees will help ensure that they concur with the selected strategies.

Should a disaster occur, community-based organizations can provide an important communication link with the cultural groups they represent. For example, churches do much more than serve the spiritual needs of the African American community. They are also the center of political, social, educational, and cultural activities. Therefore, African American ministers may play an important part in mental health outreach and recovery efforts.

Informal, culture-specific groups such as sewing circles and youth sports teams can also be sources of support to disaster survivors. The crisis counseling program staff should identify the most effective ways to work with such groups. Community-based organizations that should be involved include:

- Civic associations;
- Social clubs;
- Neighborhood groups;
- Faith-based organizations;
- Interfaith groups;
- Mutual aid societies;
- Voluntary organizations;
- Health care and social service providers; and
- Nonprofit advocacy organizations (Hernandez and Isaacs, 1998).
To ensure effective use of resources, crisis counselors should coordinate their work with that of other public and private agencies responding to the disaster. The coordinating agency should recognize unique jurisdictional situations that may arise when working with various American Indian and Alaska Native cultures. American Indian and Alaska Native tribes are federally recognized sovereign nations. Disaster mental health agencies should acknowledge the need for a partnership that includes various agencies within tribes, different levels of government, and many tribes working together to improve access to disaster assistance. Although under the Stafford Act, a State government must request a Presidential disaster declaration on behalf of a tribe, agencies subsequently can work directly with the tribe and with existing authorities and resources to tailor disaster plans to the tribe’s unique needs and jurisdictional requirements.

**PRINCIPLE 8: ENSURE THAT SERVICES AND INFORMATION ARE CULTURALLY AND LINGUISTICALLY COMPETENT**

Language can be a major barrier to service delivery. Survivors who are monolingual, limited in their English, or deaf or hard of hearing may be at a particular disadvantage. Emergency response programs generally have few or no staff trained to work with bilingual populations (Phillips and Ephraim, 1992). For example, most of the information provided immediately after Hurricane Andrew in Florida was available only in English (Yelvington, 1997). As a result, many Latinos and Haitians did not receive needed food, medical supplies, and disaster mental health assistance information.

“Linguistic competence” ensures accurate communication of information in languages other than English. This capability enables an organization and its personnel to communicate effectively with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals who are deaf or hard of hearing (Goode et al., 2001). Elements of linguistic competence include the availability of trained bilingual and bicultural staff, translations of educational materials and documents, and sign-language and language interpretation services. Although linguistic competence and cultural competence involve distinct skills, they are intrinsically connected (DHHS, 1999).
Availability of Trained Bilingual and Bicultural Staff

Ideally, disaster mental health workers should be bilingual, bicultural, and from the affected community. However, in many circumstances, workers who are bilingual but not from the affected culture and community must be hired. In such situations, communication challenges may arise, even though the disaster worker or interpreter speaks the same language as the survivors. Examples or related issues follow.

- Disaster mental health workers may be responsible for assisting survivors who have a language pattern that is different from their own. Dialects, in addition to colloquialisms and accents, can be difficult to understand and communication barriers can result.
- Words may have different meanings even among people who share a language. Rogers (1992) noted difficulty in communicating disaster information between members of the United States Army and people in a native Polynesian culture because, although they both spoke English, the two groups did not assign a common meaning to certain words and phrases. The language differences led to frustration and a breakdown of credibility.
- Bilingual disaster survivors who primarily speak Spanish may be more withdrawn when interviewed in English rather than in Spanish. An individual’s speech pattern may be halting or disrupted and expression of affect may be reduced when the person is required to speak in a language other than his or her primary language. In such situations, the disaster worker’s assessment of the survivor’s issues and needs can be distorted. Ideally, the preferred or primary language of bilingual disaster survivors should be used in delivering outreach and other services (Aponte et al., 1995).

Program managers must be cautious in selecting bilingual staff members and interpreters. Those who are bilingual also must understand nonverbal and cultural patterns to communicate effectively. Bilingual staff members should demonstrate bilingual proficiency and undergo cultural competence training (DHHS, 2000a).

REPORT

Multiple Methods Employed to Communicate with Asian Groups
Hurricane George caused extensive damage in Alabama in 1998, leaving many people homeless and others with major losses to their homes and businesses. Included among the disaster survivors was an Asian population. The disaster crisis counseling program used several methods to reach and serve them. For example, it developed leaflets in the Cambodian, Laotian, and Vietnamese languages and distributed them to churches serving large numbers of Asian immigrants. The crisis counseling project also employed interpreters, a strategy that was viewed as highly effective in disseminating information to these groups. Finally, the project provided screening and information services to Asian adolescents in a church group.

**Alabama Final Report, 1999**

**Dissemination of Educational Information**

Written information should be translated\(^3\) into multiple languages, as appropriate for the community to be served. The literacy level of the target population must be considered when developing written materials. Any written materials should be supplemented with other forms of information (DHHS, 2000a). For example, messages may be conveyed by radio or through announcements at churches and other community centers. Most localities now have television stations that broadcast in the languages of various cultural groups. Although these communications media should be used, it is important to note that some people do not have access to television and may depend on radio broadcasts for information.

Crisis support programs should establish relationships with multicultural television stations, radio stations, and newspapers before a disaster occurs. In addition, program staff should invite television and radio station personnel to participate in the development of a disaster communications plan.

The information needs of people who are deaf or hard of hearing also must be considered. Closed-captioned television, for example, is a critical communication tool for this population. The Federal Communications Commission requires that all emergency information presented on television be accessible to persons who are deaf or hard of hearing.

\(^3\) Interpretation is the oral restating in one language of what has been said in another language. Translation typically refers to the conversion of written materials from one language to another (Goode et al., 2001).
Language and Sign-Language Interpretation

Language interpretation may be used when the language barrier is so great that communication between mental health workers and survivors is not possible or when no bilingual staff can be hired. Sign-language interpretation also must be considered when developing communication strategies.

Although language interpreters may be the only viable option in some situations, hiring bilingual staff members remains the preferred solution. Van der Veer (1995) notes that an interpreter’s behavior may evoke certain feelings in the disaster survivor. Factors such as the interpreter’s gender, age, or level of acculturation may affect the survivor’s willingness to speak openly. Disaster survivors may be ashamed of mental health problems that are considered a sign of madness or a cause for contempt in their cultures. They also may distrust interpreters who are from the same country and speak the same language, but who have different political or religious backgrounds (Van der Veer, 1995).

Interpreters should be trained to accurately convey the tone, level, and meaning of the information presented in the original language. Without adequate training, interpreters may interpret information inaccurately or incompletely. The most common problems include changing open-ended questions into leading questions, altering the content of questions, and adding comments. Problems in interpreting answers include leaving out part of the answer, adding something to the answer, and making mistakes because of limited understanding of English (Van der Veer, 1995).

When working with refugees, mental health workers should be aware that interpreters might have experienced traumatic events similar to those experienced by the refugees. In such situations, the interpreter may want to avoid reliving unhappy or traumatic memories. Thus, the interpreter may present information inaccurately, evade certain topics, change the subject, or tell the mental health worker that the interview is too stressful for the disaster survivor (Westermeyer, 1989). Table 2-5 provides useful guidelines for using interpreters.

TABLE 2 - 5
Guidelines for Using Interpreters

The following guidelines should be considered when using language interpreters (Bamford, 1991; Gaw, 1993; Paniagua, 1998; Westermeyer, 1989):

- Before hiring interpreters, attempt to identify mental health workers who speak the language spoken by survivors and who identify with the survivors’ culture.
- Hire certified, qualified interpreters who share the survivor’s racial and ethnic background.
- Determine the survivor’s dialect before asking for an interpreter.
- Compare the level of acculturation of the interpreter with that of the survivor. If it is not similar, effective communication may not be possible because Western values may be reflected in the interpreter’s comments.
- Introduce the interpreter to the disaster survivor, and allow time for them to build trust through informal conversation.
- Take time for translation. Use a sequential mode of interpretation—that is, the disaster survivor speaks, the interpreter interprets what has been said into English, the disaster mental health worker speaks, and the interpreter speaks again.
- Do not use survivors’ friends and relatives, including their children, as interpreters. The survivor may not feel comfortable expressing concerns of a personal nature to relatives and friends. Using children can reverse the hierarchical role of parents and place burdens on children. Moreover, such responsibility may require skills beyond the child’s current stage of development and be too stressful for the child (DHHS, 2000c).

PRINCIPLE 9: ASSESS AND EVALUATE THE PROGRAM’S LEVEL OF CULTURAL COMPETENCE

Self-assessment and process evaluation are keys to ensuring that disaster mental health services are as effective as possible and to making maximum use of resources. Self-assessment helps programs identify organizational problems that may impede the delivery of culturally competent services. The self-assessment tool presented in Table 2-6 may be used in conjunction with the Cultural Competence Checklist for Disaster Crisis Counseling Programs, presented in Appendix F. The Cultural Competence Continuum (Figure 1-1) is another useful tool for assessing a program’s level of cultural competence.

| TABLE 2 - 6 |
| A Cultural Competence Self-Assessment for Disaster Crisis Counseling Programs |
| Six elements are needed to ensure cultural competence of mental health agencies |
(Bernard, 1998). Programs can use these elements to assess their level of cultural competence as well.

**Leadership**

- Are the leaders of the program committed to cultural competence?
- Does the project manager hold staff accountable for knowledge of the provision of appropriate services to all disaster survivors?

**Understanding of cultural competence**

- Has the program staff developed a common understanding of cultural competence and do they clearly and frequently communicate that understanding to others?

**Organizational culture**

- Does the crisis counseling program promote and encourage cultural competence?
- Is the program administered by an organization with a strong commitment to and history of working toward cultural competence?
- Are policies, procedures, and systems in place for delivering interpretation, bilingual, or translation services?

**Training**

- Have all crisis counseling staff members been trained in cultural competence, and are they familiar with the diverse cultural and ethnic groups in the community?
- Are training programs ongoing?
- Are regular meetings convened and educational opportunities offered for staff members to discuss cultural competence issues and concerns, build cross-cultural skills, and develop strategies?

**Cultural competence plan**

- Has the program identified goals designed to address the mental health needs of the community in a culturally competent manner?
- Has the program explored various methods of working with disaster survivors in a way that respects and is sensitive to the needs of all groups in the community?
- Has the program established partnerships with community-based agencies that serve cultural and ethnic groups for input on needs assessment, program planning, and evaluation?
- Has the program developed a mechanism to acquire knowledge about the customs, values, and beliefs of special populations?

**Managing the plan**
Process evaluation helps ensure that the disaster mental health program stays on course. It also can identify problems or gaps in providing culturally competent services. Involving representatives from as many cultural groups as possible in process evaluation ensures that diverse cultural groups or group perspectives are heard and understood.

The program can use a variety of techniques for collecting information for process evaluations. For example, staff might create an evaluation task force or advisory group or a discussion or focus group that includes representatives of different cultural groups. A group that includes a disaster survivor perspective, as well as representatives of partner agencies, can provide qualitative information and innovative ideas that can help the crisis counseling program more effectively address the community’s cultural needs. Evaluation methods should be consistent with the cultural norms of the groups being served. Evaluators should be sensitive to the culture and familiar with the culture whenever possible and practical (DHHS, 2001).

Program staff should regularly communicate process evaluation findings to key informants and cultural groups engaged in the project and in the evaluation in order to ensure their ongoing support.

Developing a culturally competent disaster crisis counseling program requires commitment and diligence. The rewards of such dedication are at the heart of the program—effective and appropriate services to help disaster survivors recover and heal.

6. Additional Resources

The following are various national crisis hotlines:

**National Suicide Hotlines USA**
United States of America
Toll-Free / 24 hours a day / 7 days a week
Cancer Information Service: 800-422-6237

Look Good/Feel Better: 80033ABTEC a free public service program for women undergoing cancer experiencing appearance side effects

ChildHelp USA National Child Abuse Hotline: 800-4-A-CHILD (422.4453) or 800.2.A.CHILD (222.4453, TDD for hearing impaired)
Provides multilingual crisis intervention and professional counseling on child abuse. Gives referrals to local social service groups offering counseling on child abuse. Operates 24 hours, seven days a week.

Department of social services for public to access information:
- 800-345-KIDS: Provides information concerning children available for adoption and other children's programs
- 800-342-3009: Access to general information regarding Department programs and HEAP Hotline
- 800-732-5207: Day Care Complaint Line
- 800-342-3720: Child Abuse Hotline

National Child Abuse Hotline: 1-800-25-ABUSE

Boys Town Suicide and Crisis Line: 800-448-3000 or 800-448-1833 (TDD) Provides short-term crisis intervention and counseling and referrals to local community resources. Counsels on parent-child conflicts, marital and family issues, suicide, pregnancy, runaway youth, physical and sexual abuse, and other issues. Operates 24 hours, seven days a week.

Covenant House Hotline: 800-999-9999

Crisis line for youth, teens, and families. Gives callers locally based referrals throughout the United States. Provides help for youth and parents regarding drugs, abuse, homelessness, runaway children, and message relays. Operates 24 hours, seven days a week.
800-942-6908 Spanish Speaking 24-hour-a-day hotline, Provides crisis intervention and referrals to local services and shelters for victims of partner or spousal abuse. English and Spanish speaking advocates are available 24 hours a day, seven days a week. Staffed by trained volunteers who are ready to connect people with emergency help in their own communities, including emergency services and shelters. The staff can also provide information and referrals for a variety of non-emergency services, including counseling for adults and children, and assistance in reporting abuse. They have an extensive database of domestic violence treatment providers in all US states and territories. Many staff members speak languages besides English, and they have 24-hour access to translators for approximately 150 languages. For the hearing impaired, there is a TDD number. This is a great resource for anyone--man, woman or child--who is experiencing or has experienced domestic violence or abuse, or who suspects that someone they know is being abused.

Domestic Violence Hotline: 800-829-1122

National Association of Anorexia Nervosa & Associated Disorders (ANAD): 847-831-3438 (long distance)

National Mental Health Association: 800-969-6642 9AM-5PM Mon-Fri information on mental health topics and referrals, access to an info specialist

Elder Abuse Hotline: 800-252-8966

Alzheimer's Association Hotline: 800-621-0379 8:30AM-4:00PM, Mon-Fri information and referral services, free brochures

HIV/AIDS/sexually transmitted diseases
The CDC (Center for Disease Control) National Prevention Information Network 1-800-458-5231 9AM-6PM Mon-Fri includes info on new medicines, treatment trials, HIV & AIDS, with info specialists avail. to answer questions; also at www.CDCNAC.org (CDC National Aids Clearinghouse)
National AIDS Hotline: 800-342-AIDS (2437)
Information and referrals to local hotlines, testing centers, and counseling. Open 24 hours, seven days a week.

AIDS Hotline in Spanish: 800-344-SIDA (7432)
Open 8 a.m. to 2 a.m. Eastern Standard Time, seven days a week.

AIDS Hotline for the Hearing Impaired: 800-243-7889 (TDD)
Open 10 a.m. to 10 p.m. Eastern Standard Time, Monday through Friday

National Sexually Transmitted Disease Hotline: 800-227-8922
Information and referrals to free and low-cost public clinics. Operators can answer general questions on prevention, symptoms, transmission and treatment of sexually transmitted diseases. Open 8 a.m. to 11 p.m. Eastern Standard Time, Monday through Friday.

Sexually Transmitted Disease & AIDS/HIV Information Hotline: 800-332-2437, TTY - 800-332-3889 (Ohio)

1-800-840-6537: Parent Hotline is a website dedicated to helping families who are in a crisis situation. It lists behaviors for parents to be aware of such as drug use and a questionnaire on if a child is in need of intervention. Very resourceful site.

Poison Control Any Kind of Substance: 800-662-9886

Poison Control: 800-362-9922

Nationwide RAINN National Rape Crisis Hotline: 800-656-4673
runaway/exploited children

Missing Children Network: 800-235-3535
Thursday's Child's National Youth Advocacy Hotline at 1 (800) USA KIDS

National Hotline for Missing and Exploited Children: 800-843-5678
Operates a hotline for reporting missing children and sightings of missing children. Offers assistance to law enforcement agents. Hours of operation are 7:30 a.m.-11 p.m. Eastern Standard Time.
National Runaway Switchboard: 800-621-4000
Provides crisis intervention and travel assistance to runaways. Provides information and local referrals to adolescents and families. Gives referrals to shelters nationwide. Also relays messages to, or sets up conference calls with, parents at the request of the child. Operates 24 hours, seven days a week.

Child Find of America Hotline: 800-I-AM-LOST (426.5678)
Looks for missing and abducted children. Operators available 9 a.m. to 5 p.m. EST Monday-Friday. Voicemail on evenings and weekends with calls returned.

CONFIDENTIAL Runaway Hotline: 800-231-6946

Parent Abduction Hotline: 800-292-9688
Provides crisis mediation in parental abduction. Provides prevention information and referrals to local agencies. Operators available 9 a.m. to 5 p.m. EST Monday-Friday. Voicemail on evenings and weekends with calls returned.

Boys Town National Hotline 800-448-3000
National Drug Information Treatment and Referral Hotline: 800-662-HELP (4357) Information, support, treatment options and referrals to local rehab centers for any drug or alcohol problem. Operates 24 hours, seven days a week.

National Cocaine Hotline: 800-COCAINE (262-2463)
Information, crisis intervention, and referrals to local rehab centers for all types of drug dependency. Operates 24 hours, seven days a week.

Al-ateen: 800-352-9996

Alcohol Abuse and Crisis Intervention: 800-234-0246

Alcohol and Drug Abuse Helpline and Treatment: 800-234-0420

Alcohol Hotline Support & Information: 800-331-2900

National Youth Crisis Hotline: 800-442-HOPE (4673)
Provides counseling and referrals to local drug treatment centers, shelters, and counseling services. Responds to youth dealing with pregnancy, molestation, suicide, and child abuse. Operates 24 hours, seven days a week.

7. References


