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Disaster mental health response

Roberta J. Hinman
University of Northern Iowa

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Abstract

Following a natural disaster, most survivors rarely disintegrate and become incapable of coping; however, many are affected and may need significant community assistance (Fischer, 1993). After a natural disaster, many people will be repairing, rebuilding and attempting to resume their lives. Often relief agencies originally brought in to help will have left the effected community. When disaster strikes or threatens destruction, individuals may need mental health services to relieve stress, especially if survivors seem to experiencing a shattered sense of the world as a safe and meaningful place (Janoff-Bulman, 1992). Then what happens to individuals who did not get enough assistance or the proper assistance to recover financially and emotionally? Will local mental health agencies or interreligious response groups be there to assist or have the skills to assist individuals?

DISASTER MENTAL HEALTH RESPONSE

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Roberta J. Hinman

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Ann Vernon
Adviser/Director of Research Paper

4-23-96
Date Approved

Terry Kottman
Second Reader of Research Paper

4.23.96
Date Received

Michael D. Waggoner
Head, Department of Educational Administration and Counseling

Following a natural disaster, most survivors rarely disintegrate and become incapable of coping; however, many are affected and may need significant community assistance (Fischer, 1993). After a natural disaster, many people will be repairing, rebuilding and attempting to resume their lives. Often relief agencies originally brought in to help will have left the effected community. When disaster strikes or threatens destruction, individuals may need mental health services to relieve stress, especially if survivors seem to experiencing a shattered sense of the world as a safe and meaningful place (Janoff-Bulman, 1992). Then what happens to individuals who did not get enough assistance or the proper assistance to recover financially and emotionally? Will local mental health agencies or interreligious response groups be there to assist or have the skills to assist individuals?

Experience has shown that, while many of the direct effects of the disaster may be adequately handled by the individual, early provision of crisis intervention services can prevent or significantly reduce

the severity of a later emotional disturbance (Flynn, 1994). These persons will need professional mental health assistance to develop adequate coping skills, while others may need the presence of someone to support them emotionally (Hardin & Johnson, 1990). Research showed that persons who do receive mental health services immediately after the diaster showed clear behavioral signs of improvement even after one session (Shelby and Tredinnick, 1995).

Purpose and Rationale of Disaster Mental Health Services

The purpose of this paper is to help the reader understand disaster mental health services and how they differ from mental health programs and services in non-disaster times. Because the knowledge and skills required of mental health workers in disaster differs from those skills typically used in counseling situations, special attention should be given to the following concepts when training disaster mental health workers or crisis workers (Flynn, 1987). Much of the confusion and stress at the time of the disaster impact can be eliminated when a

mental health agency has a core of staff predesignated and trained as a disaster response team (Bolin & Bolton, 1986; Flynn, 1994,).

Key Concepts of Disaster Mental Health

In any given disaster, loss and trauma will directly affect many people. There are several key factors to consider when addressing loss and trauma in disaster. Therefore, mental health education about the effects of disastr, self-help intervention, and where to call for additional help must be rovided to the affected community at large.

First Key Concept

The first concept is that everyone who sees a disaster is touched by it in some way (Flynn, 1994). Even individuals who experience a disaster second hand through exposure to extensive media coverage can be influenced much the same as those who are part of the affected community (Hartsouth & Myers, 1985).

A disaster is a devastating event; witnessing massive destruction and terrible sights can evoke deep feelings. According to the American

Red Cross (1982), residents of disaster stricken communities report disturbing feelings of grief, sadness, anxiety and anger, even when they are not themselves victims. These strong reactions confuse them when, after all, they were spared any personal loss. Shelby and Tredinnick, (1995) stated that those individuals find comfort and reassurance when told that their reactions are normal in every way and that most everyone who sees a disaster is, in some sense, a victim.

Second Key Concept

The second key concept, according to Erikson (1976), described two types of trauma that occur jointly and continuously in most disasters, individual and collective trauma. Disaster mental services must take both types of trauma into consideration to address all of the needs of the community. Individual truma is defined "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" (Flynn, 1994, p. 1). Individual trauma manifests itself in the stress and grief reactions which

individual survivors experience. People will find it difficult, if not impossibe, to heal from the effects of individual trauma while the community around them remains in shreds and a supportive community setting does not exist (Flynn, 1994). Thus, mental health interventions such as outreach, support groups, and community organization, which seek to reestablish linkages between individuals and groups, are essential.

According to Flynn (1994) and Erickson (1976), collective trauma is "a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality" (p.4). Bolin and Bolton (1986) emphasize that collective trauma can sever the social ties of survivors with each other and with the locale. These may be ties that could provide important psychological support in times of stress (Bolin & Bolton, 1986; Flynn, 1994). Collective trauma is often less visible to mental health professional trained to work with individuals. However, it is essential

to identify and address collective trauma in disaster mental helath programs (Bolin & Bolton, 1986).

Third Key Concept

The third concept is that most people pull together and function during and after a disaster, but their effectiveness is diminished due to the multitude of stressors affecting them (Flynn, 1994). In the early heroic and honeymoon stages, there is a good deal of energy, optimism, and generosity. However, thought there is a heigh level of activity, there is often a low level of efficiency (Hartsough & Myers, 1985). As the implications and meaning of losses become more real, grief reactions intensify and fatigue sets in. As frustrations and disillusionment accumulate, more stress symptoms may appear (Flynn, 1994). Diminished cognitive functioning such as short-term memory loss, confusion, difficulty setting priorities and making decisions may occur because of stress and fatigue. This can impair survivors' ability

to make sound decisions and take necessary steps toward recovery (Green, Wilson, & Lindy, 1985; Mitchell, 1993).

Fourth Key Concept

The fourth concept is that most disaster survivors are normal people who function reasonably well under the responsibilities and stresses of everyday life. However, with the added stress of disaster, many individuals will show some signs of emotional and psychological strain including post-traumatic stress and grief responses (Zunin & Zunin, 1991). According to Flynn (1994), these reactions are normal reactions to an extraordinary and abnormal situation and are to be expected under the circumstances.

Fifth Key Concept

The fifth concept is that because disaster disrupts so many aspects of daily life, individuals may find it difficult to make sound decisons while they are trying to cope with daily necessities such as finding temporiary shelter or getting food for themselves and their family.

Problems for disaster survivors are immediate and practical in nature (DeWolfe, 1992). People may need help locating missing loved ones; finding temporary housing, clothing, and food; obtaining transportation; applying for financial assistance; getting medical care or replacing medication; or obtaining help with cleanup (Myers, 1991).

Sixth Key Concept

The sixth concept has to do with disaster relief procedures. Families are forced to deal with organizations that seem, or perhaps are, impersonal, inefficient, and inept (Bolin, 1980). Because of this, many individuals are unable to obtain the benefits they are eligible for in a timely manner. Individuals who felt competent and effective before the disaster may suddenly experience a serious erosion of self-esteem and confidence (Myers, 1990). Feelings of helplessness and anger are common. In response to this, mental health staff can assist individuals by reassuring them that most pople have difficulty wending their way through the bureaucracy after a disaster (Bolin, 1982).

Seventh Key Concept

Concept seven is that most people do not see themselves as needing mental health services following a disaster, nor do they seek out such services. In victim's eyes, to offer mental health assistance to a disaster survivor may add insult to injury (DeWolfe, 1992). In addition, most disaster survivors are overwhelmed with the time-consuming activities of putting the concrete aspects of their lives back together. Therefore, effective mental health assistance can be provided while the worker is helping survivors with those concrete tasks. For example, a mental health worker can use skilled but unobtrusive interviewing techniques to help a survivor in sorting out demands and setting priorities while they are sifting through rebble together (Flynn, 1994). Another example is spending time with vicitims in the waiting-in-line periods offering emotional support. This way workers can have discussions about coping and parenting as clients waited to be seen (Shelby & Tredinnick, 1995). In these sessions, workers included

suggestions that individuals could use in their recovery and in response to others (Cohen, 1987). Shelby and Tredinnick (1995) believed that this knowledge would mitigate against fear and anxiety, offer people concrete coping options, and increase the likelihood that the people would seek further contact with the mental health worker if needed.

Eighth Key Concept

The eighth concept is that disaster mental health services must be uniquely tailored to the communities they serve. Urban, suburban, and rural areas have different needs, resources, traditions, and respond differently to giving and receiving help (Flynn, 1994). It is essential that programs consider the ethnic and cultural groups in the community, and provide services that are culturally relevant and in the language of the victims. Disaster recovery services are best accepted and utilized if they are integrated into existing, trusted community agencies and resources (American Red Cross, 1982).

Ninth Key Concept

A final key concept is that mental health staff need to set aside traditional methods of counseling in working with disaster victims. It is necessary to avoid the use of mental health labels and to use an active outreach approach to intervene successfully in disaster. Mental health therapists seems less threatening when they refer to their services as "assistance," "support," or "talking" rather than labeling themselves as "mental health counselors" (DeWolfe, 1992, p.14).

Stages of Disaster

Ideally, professionals selected for disaster response and recovery work should be familiar with the stages of disaster and the feelings and behaviors associated with each of these stages. According to Perdue (1994) and Fischer (1993), there are four stages of disaster response during a natural disaster.

Emergency Stage

The purpose of this stage, sometimes referred to the heroic stage, is

to insure the safety of all involved. When a disaster strikes, it is very common for people to perform heroic actions to save their lives, their property, and the lives of others. People find themselves being called upon and responding to demands for heroic action. The "heros" may be community citizens or members of a community rescue team (Flynn, 1994).

Physical needs are dominant in this stage. Providing food, clothing, and shelter for victims is the most therapeutic initial intervention. Basic survival needs, such as care of the injured, followed by search and resue missions, are the highest priorities. Since professionals may be in short supply, a considerable amount of work may be delegated to uninjured victims and concerned outsiders (Janosik, 1986). Such assignments do a lot to eradicate feelings of powerlessness. The rationale for advocating crisis intervention in the postdisaster period is that during this time of acute distress, many individuals simultaneouly experience the same feelings and reactions. According to Janosik

(1986), the current belief is that psychological effects are temporary during a disaster and that cirisis intervention is all that may be required during this intital stage.

Relief Stage

The second phase is the relief stage. The primary purpose of this stage is to keep victims alive and stabilized. Shelter, food, drink, clothing and medical care are usually needed. Pastoral counselors, along with mental health and social service agency personnel who are skilled in crisis intervention, are desperately needed in this stage (Fischer, 1993). During this stage, many individuals are suffering from physical injury and delayed grief reaction. If help is not provided for or accepted in this stage, later emotional or mental disturbance may occur (Fischer, 1993; Flynn, 1994; Janosik, 1986).

Most people pull together and function during the heroic and relief stages, but their effectiveness is diminished when facing extensive clean-up and structural repair of their homes. Preexisting community

groups and emergent community groups which develop from the specific needs caused by the disaster are especially important community resources during this period (Fischer, 1994).

Disillusionment Stage

The third stage is the disillusionment stage. In this stage, it is important for the mental health worker to address the strong feelings of disappointment, anger, resentment, and bitterness if promises of aid are not delivered. Outside agencies may pull out, and some of the indigenous community groups may weaken or become maladaptive (Scanlon-Schlipp & Levesque, 1981). Financial hardship and social instability are present in this stage, and those who were already facing financial hardship before the natural disaster will find it extremely difficult to recovery without assistance (Fischer, 1993). In addition, contributing to this stage may be the gradual loss of the feeling of "shared community" as the victims concentrate on rebuilding their own lives and solving their individual problems (Flynn, 1994).

Recovery Stage

The recovery stage usually lasts from several months to several years after a disaster (Perdue, 1994). This stage is the most difficult to stabilize. The challenge of this stage is to help people get back to where they were before the disaster. Psychological support concerning after-effects of the event itself will be needed from the trained disaster professionals and paraprofessionals (Flynn, 1994).

In the recovery stage, many individuals continue on a downward slope for months (Hoff, 1989). The victims have come to the realization that they will need to solve the problems of rebuilding their own homes, businesses, farms, and lives largely by themselves. Furthermore, for those individuals who had problems prior to the disaster, such as illness or job loss, the emotional overload caused by the disaster can become completely devastating. Those who are overwhelmed financially and emotionally may get "tunnel vision" and

close out family and friends, thus blocking their opportunity for recovery (Flynn, 1994, p. 5).

It is important that disaster mental health professionals recognize the different phases of disaster and the varying psychological and emotional reactions of each phase (Bolin, 1980; Johnson, 1989). For example, it would be counterproductive to probe for feelings when shock and denial are shielding survivors from intense emotions. Once individuals have mobilized internal and external coping resources, they are better able to deal with feelings about the situation (Jolly, 1993). It is not usually effective to ask victims if they can find something "good" that has happened to them through their experience. However, talking about ordinary events and laughing at humorous points is sometimes healing (Flynn, 1994). Although most people are willing and even eager to talk about their experiences in a disaster, it is important to respect the times when an individual may not want to talk about how things are going (Flynn, 1994). Talking with a person who has

experienced the disaster does not always mean talking about the disaster (Zunin & Zunin, 1991). People usually "titrate their dosage" when dealing with pain and sorrow, and periods of normalcy and respite are also important (Flynn, 1994, p. 4).

Disaster Mental Health Methods

It is important for mental health personnel to take a proactive rather than reactive role when working with individuals in disaster (Phifer & Norris, 1989). Instead of waiting for clients to make their way into a center for mental health assistance, professionals might, for example, spend time with disaster victims who wait in lines for disaster relief. This approach gives the professional the opportunity to make initial contact and provide basic emotional support and teaching, without using terms that may have negative connotations, such as therapy or mental health patient (American Red Cross, 1991; Shelby & Tredinnick, 1995).

Flynn (1994) stated that it is important that mental health personnel

should also be well-acquainted with the functions and dynamics of the community's human service organizations and agencies. Excellent communication, problem-solving, conflict resolution, and group process skills are needed, in addition to an ability to establish rapport quickly with people from diverse backgrounds.

Shelby and Tredinnick (1995) stated that touching a disaster victim seems to be more effective than ordinarily would be expected in a clinical setting. Holding hands, offering a hug, cuddling small children, all seem to help restore a sense of self-worth and model appropriate actions to others. However, according to Corey, Corey and Callanan (1988), some therapists feel that engaging in any physical contact with clients is unethical and even "taboo" (p.218). Nevertheless, they reported that some therapists do feel that nonerotic contact is often appropriate and can have significant therapeutic value. In some cases, though, touching can be misinterpreted as exploitative; therapists may be afraid of the impulses or feelings toward clients; they may be afraid

of intimacy; or they may believe that to physically express closeness is unprofessional (Corey, Corey & Callanan, 1988).

Mental health professionals also need to help others to learn new coping behaviors and problems-solving skills during a disaster state and timing seems to be a critical key (Hoff, 1989). Skills learned during a disaster state often tend to last, and coping behaviors adopted during a crisis tend to be repeated during stressful situations in the future (Hoff, 1989). This gives victims an opportunity to create adaptive patterns of coping for the future, patterns that may not have been there before. As Flynn (1994) stated, "A little help, rationally directed and purposefully focused at a strategic time, is more effective than more extensive help given at a period of less emotional accessibility" (p.30).

Finally Flynn (1994) also noted that religion tends to be very important to individuals after a disaster. Many individuals will work closely or talk extensively with their pastor or priest following a

disaster. For this reason, it is extremely important for mental health professionals to work closely with the religious community during the recovery phase of a disaster.

Emotional Reactions and Interventions During the Stages of Disaster

It is critical to assess the emotional response experienced by people who progress through a disaster. Listed below are the most common emotional reactions to the stages of disaster along with interventions to deal with those emotional reactions. Though not all disaster follows the same sequences or stages, those listed are the most commonly found in a natural disaster (Mitchell, 1986).

Because involvement with disaster mental health work requires a perceptual shift from traditional mental health interventions, the acquisition of new skills and information is essential (Flynn, 1994). Effective interventions for mental health personnel will provide participants with certain knowledge, skills, and attitudes that will enhance their effectiveness in the disaster setting.

Heroic Stage

Emotions. During the "heroic" stage, people who have not lost loved ones may be feeling euphoric, altruistic, and optimistic rather than bereaved. Shock may surface as well as anxiety to the news. Some symptoms of this phase include inactivity, staring into space, low blood pressure, sweating, cold clammy skin, and agitation or hyperactivity (Bolin, 1980). Anguish and grief are also common emotions expressed in this first stage of the healing process.

Interventions. With anguish and grief, if someone has lost belongings or a loved one during a disaster, it will be important for him/her to mourn and work through the grief stages in order to move ahead emotionally (Mitchell, 1986). Help for loss can and should be brief and gentle (Shelby & Tredinnick, 1995). Some direct assistance in the form of making some arrangements, especially regarding safely issues, may be appropriate. It is important to start where the person is

and explore significant meanings of the events surrounding the disaster. Helping the individual maintain mastery and control is also essential. This is best done without medication unless absolutely necessary.

Another important intervention is reassuring the victims that disaster personnel are there to help and listen. Sometimes is it emotionally benificial for mental health personnel to remove the victim from the disaster scene to a less threatening, more secure environment (Mitchell, 1986).

Another important intervention during this stage is to keep families together if possible. It has been shown that stress is tolerated more easily if significant persons are present (Janosik, 1986).

Relief Stage

Emotions. During the relief stage, people are seeking facts, discussing the nature of the disaster, and trying to piece reality together to understand what has happened. They may be more invested in

discussing their thoughts than talking about feelings (Zunin & Zunin, 1991). However, feelings are very prevalent. Depression can be one of the emotions that frequently is masked by, or expressed in, agitated activity that is aimless or nonproductive. Unless the depression is recognized and addressed, it may readily progress to more serious mental and physical problems (Fischer, 1993).

In the relief stage, denial and rejection are also emotions expressed by family members who were directly or indirectly involved in the disaster. Withdrawing from family decisions and daily routines may be an indication of more serious mental problems (Bolin, 1980).

Interventions. A relief stage intervention may come from a mental health worker who gives a depressed person reassurance, encouragement, or factual information of where and how to get help. Offering a meal or a hot beverage while conversing or physical assistance in salvaging belongings may also be appropriate (Flynn, 1994). Helping depressed persons establish a routine of exercise,

involvement in activities or volunteer work will also be beneficial (Hoff, 1989). If victim is not functioning in appropriate ways, a referral to longer term care programs may be necessary.

In the relief stage, denial and rejection are expressed by many of the family members who were directly or indirectly involved in the natural disaster. Helping individuals deal with denial, it is best to allow them to deny, but not to agree with the denial. Gently and carefully tell the individuals the facts over and over if necessary, but do not promise things that may never happen (Flynn, 1994). It is important to be compassionate and understanding when dealing with rejection as well as denial (Fischer, 1994). Remember that victims of a disaster are normal people experiencing abnormal amounts of stress.

Disillusionment Stage

Emotions. In the "disillusionment" stage, people generally feel frustrated and angry. According to Flynn (1994), anger is one of the

natural and expected reactions to adversity. The degree of anger felt and the way in which it is expressed are often related to many causes. Some of this anger is in the form of external rage like yelling and some is internal and may present physical symptoms like high blood pressure (Hoff, 1989). Other emotions reflect the individual's feelings of helplessness and frustration with the disaster itself (Jolly, 1993).

Interventions. In dealing with anger, the mental health staff must be aware of the value of "ventilation" as a means of reducing excess emotion. Angry victims should be permitted to verbalize anger, but it generally is not advisable for them to take direct action while such strong feelings are being expressed (Mitchell, 1986). On the other hand, an understanding listener should not exhibit anxiety while listening to an angry outburst. Trying to talk the person out of being angry, expressing disapproval, or exhibiting other guilt-inducing reactions may be harmful (Flynn, 1994). Although, many helpers may find it uncomfortable and difficult to listen to angry expressions, it does

have significant therapeutic value for clients (Flynn, 1987; Scanlon-Schlipp & Levesque, 1981).

Mental health personnel may also need to help individuals find constructive channels for their anger and frustrations. This may involve helping them not to misdirect their anger toward family members, nor to sabotage their own efforts by getting angry at the agencies who try to assist them (Project COPE, 1983). It is important for mental health staff to provide individuals with information on how specific agencies work and to tell families that it is a common phenomenon in disaster response to have difficulty wending their way through the bureaucracy to get the needed assistance (Bolin, 1982).

Recovery Stage

Emotions. Guilt will appear, especially in the later phases of recovery, and may be recognized by clients' statements of remorse (Fischer, 1994). Also, during this lengthy recovery peroid, discouragement and apathy may surface if favorable results are slow to

appear. At other times, cooperation during the recovery stage may cause people to draw closer to one another and perhaps modify their values (Fischer, 1993).

Interventions. When mental health professifonals interview clients during this stage, it will be very important to listen carefully and give constant reassurance (Aguilera, 1978). Each individual will need the opportunity to express himself or herself on how he or she is dealing with and healing after this natural disaster. Judgmental statements should be avoided (Hoff, 1989).

Peculiar Behavior and Suicide Ideations after a Disaster

Sometimes the effects of a disaster can prove to be so overwhelming for a victim that the individual may temporarily seems to "go crazy" (Fischer, 1994, p. 21). The excessive stress can cause a breakdown of usual effective coping mechanisms and the individual may exhibit irrational and bizarre behavior. Frequently, individuals who suffer emotional breakdowns are those who have had previous

histories of breakdown and likely have had to be hospitalized for mental health treatment in the past (Fischer, 1994). It is important for the local mental health professionals to be aware of those who are more likely than most to suffer serious mental disturbance as a consequences of the disaster. Immediate assistance is required when victims show behavior which could be harmful to themselves or others (Jolly, 1993).

As with mental breakdowns, suicide ideations are common occurrences among disaster victims. The seriousness of this tragic aftermath is such that mental health professionals need to be alert to those individuals who might be likely to react to excessive stress in this way (Jolly, 1993). It has been found that those who do commit suicide usually have some previous history of attempts or communicate to others about their intent to do away with themselves (Fischer, 1994). Awareness of who in the community is susceptible to this sort of self-destruction is one of the vital roles the mental health professional can

play in alleviating the emotional suffering which accompanies all disasters (Jolly, 1993).

Return to Pre-Crisis Level of Functioning.

According to Flynn (1994), the most important support group for individuals is their family. Professionals should attempt to keep the family together in temporary housing or shelters after a disaster and family members should be involved as much as possible in each other's recovery (Flynn, 1987).

Myers (1991) stated that disaster relocation and the intense activity involved in disaster recovery can disrupt people's interaction with their support systems. Encouraging people to make time for family and friends is important. Emphasizing the importance of rebuilding relationships in addition to rebuilding structures can be a helpful analogy (Myers, 1991).

For people with limited support systems, disaster support groups can be especially helpful. Fischer (1993) pointed out that support

groups help to counter isolation. People who have been through the same kind of situation feel they can truly understand one another. Groups help to counter the myths of uniqueness, pathology and people can find reassurance that they are not alone or "weird" or "abnormal" in their reactions (Myers, 1991, p. 15). The groups not only provide emotional support, but survivors can share concrete information, recovery tips, and can benefit from the guidance of other experienced survivors. Besides the catharsis of sharing the experience, they can identify with others who are recovering and can begin to feel hope for their own situations. Mental health staff may involve themselves in setting up self-help support groups for survivors or facilitate support groups (Scanlon-Schlipp & Levesque, 1981).

Conclusion

The issues desribed in this paper illustrate some main differences between disaster mental health services and mental health programs in nondisaster times. Because the knowledge and skills required of

mental health workers in disaster differ from those needed in nondisaster times, special attention should be given to these concepts when training disaster mental health workers. Working with individuals in a disaster will allevate stress and provide victims the opportunity to talk about their experiences. The passage of time is also needed, and it will often lead to the reestablishment of equilibrium. Public information about normal reaction, education about ways to handle them, and early attention to symptoms that are problematic can speed recovery and prevent long-term problems from reoccuring after a natural disaster.

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