Crisis Intervention
After Major Disasters

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IMAGE OF DISASTERS

Major disasters are large-scale devastating events that destroy homes and infrastructure, kill people, and leave many others physically injured and psychologically traumatized. Such disasters are infrequent but devastating enough for us to make advanced preparation a high priority. This paper begins with a brief description of acute and post traumatic stress disorders and then describes some early intervention strategies for counseling traumatized adults and children immediately following a major disaster of natural or man-made origin.

VENEZUELAN FLOOD

This paper was written in response to the December 1999 floods that devastated much of Venezuela, killed 10,000 to 30,000 people and left 500,000 people homeless and psychologically traumatized. It was written for professionals, who volunteered to work in the shelters, set up around the country, for survivors of the

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flood. Theoretical concerns were minimized so that it would be technically useful to professionals with different theoretical orientations and to non-professionals working in the shelters as well. While it was first used to aid survivors of the flood it has subsequently been found useful following other disasters such as hurricanes, earthquakes and massive fires. The techniques described can also be applied to survivors of man-made disasters such as war, terrorist attacks, and violent social unrest.

SIGMUND FREUD

Sigmund Freud's psychoanalytic theory and technique developed around the ever-present traumas of early childhood experience and the neurotic symptoms that resulted from these and became established in the adult personality structure. This was a powerful insight but only available, in the early days, to practicing psychoanalysts and their patients. But in 1914 the First World War began and students of Freud, who entered the military, found themselves faced with psychologically traumatized soldiers on both sides of the war. They independently modified Freud's technique to attend to the needs of these soldiers whom they described as suffering from 'War Neuroses'. The symptoms these soldiers demonstrated included: trembling, screaming, apathy, agitation, terror, irritability, angry outbursts, helplessness, and so on. When the world learned of the benefits these soldiers with war neuroses obtained, with modified forms of psychoanalytic therapy, psychoanalysis received a new wave of international attention.

WAR NEUROSES

By the Second World War psychoanalytic influence had already entered United States military psychiatry. The successes of psychoanalytically informed therapy for soldiers with 'war neuroses' during and after the Second World War helped launch the post-war Golden Age of Psychoanalysis in the United States. During the US war involvement in Vietnam, traumatized soldiers appeared once again and in efforts at self-healing the veterans formed groups to discuss their symptoms and struggles to get readjusted to the post-war situation. During the course of these meetings they developed a deeper understanding of what then came to be described as 'Post Traumatic Stress Disorder'. Soon thereafter people began recognizing that the same symptoms of soldiers traumatized by war were present in people who suffered other sorts of psychological crises associated with horrific car accidents and assaults.

WHAT IS A PSYCHOLOGICAL CRISIS? - WOMAN WITH RED PILLOW

What is a Psychological Crisis?

In a psychological crisis a traumatic event overloads a person's capacity to cope in his or her usual fashion, and what cannot be coped with, or well processed psychologically, is converted into symptomatic behavior. Psychological crises cannot reliably be predicted by the events that precede them. An event that precipitates a psychological crisis for one person will not necessarily precipitate a crisis for another person. Nonetheless, some events of disastrous character commonly precipitate psychological crisis reactions. These include physical assaults, torture, rape, automobile accidents, intense personal losses, natural catastrophes such as earthquakes, fires, and floods and man-made disasters such as war, terrorist attacks, and violent social unrest. Events like these will often induce a psychiatric disorder that we now call an 'Acute Stress Disorder'.

ACUTE STRESS DISORDER - WOMAN SITTING ON RUBBLE

The Acute Stress Disorder is characterized by intense fear, helplessness and horror. There may be an emotional numbing, a lack of emotional responsiveness, a feeling of detachment, reduced awareness of surroundings, a sense of unreality, or amnesia. People suffering an Acute Stress Disorder may feel anxious, excitable, agitated, distressed, despair, irritability, or hopelessness. They may re-experience the event in recurring dreams, flashbacks, or persistent intrusive memories of the trauma. They may avoid people, places and objects that re-awaken memories of the traumatic event. They may have difficulty concentrating and difficulty functioning in their usual way at home and at work. They may also suffer survivor guilt, guilt for not providing enough help to others, or self-critique about what they did or did not do in the crisis situation. They may isolate themselves or behave erratically. Some people may become aggressive or self-destructive, disregard self-care, become confused or behave in a bizarre fashion.

PHYSICAL AND PSYCHOLOGICAL TRAUMA – TRAPPED CHILD

When therapeutic intervention comes quickly, the symptoms of Acute Stress Disorder will typically diminish or disappear entirely within 30 days. Sometimes the symptoms will disappear even when untreated. But in many cases, particularly when untreated, the Acute Stress Disorder may persist. If its duration is from one to three-months we call it an ‘Acute Post Traumatic Stress Disorder’. When the symptoms last more than three months, we call it a ‘Chronic Post Traumatic Stress Disorder’. (The preceding diagnostic information is derived from the Diagnostic Statistical Manual - V, 2013)

It is common for Chronic Post Traumatic Stress Disorder symptoms to persist for many years, become serious constraints on a person's life, and pose serious challenges for family members in dealing with the patient's irritability, belligerence, unwarranted fears, nightmares, etc.

FIRES

In horrific fires, floods and earthquakes people often lose prized possessions, homes, and loved ones.

FLOODS

EARTHQUAKES

In response to these losses people commonly experience depressive reactions, grief, anxiety, confusion, derealization, sleep and eating difficulties, psychosomatic complaints, agitation, emotional deregulation, screaming, crying, physical attacks on one's own body, arguing, fighting, and so on. In these cases, the first step is to find safety and help the person to calm down enough to begin a proper crisis counseling intervention.

CRISIS COUNSELING IN THE FIELD – HOLDING HAND OF A TRAPPED PERSON

Working with Patients with Acute Stress Disorders

Crisis counselors working with patients with Acute Stress Disorders may initially assist them in the management of various practical tasks and then find a safe place to talk about the disaster, the survivor's symptoms, or whatever else is foremost on the patient's mind. Though it is sometimes initially painful to talk about the traumatic event, people often report a sense of relief and a reduction of symptoms after they have been able to discuss it.

While adults may talk with a therapist, a child suffering an acute stress reaction is likely to talk about it in the child's non-verbal language of play as well as in the verbally spoken metaphors of the stories they tell from their imagination. So, with children, we are more likely to conduct a play therapy session. We will go into this further in the section on children. When the behavior change of the traumatized person affects the whole family, it is often helpful to conduct a family therapy session to address difficult issues and improve communication between family members.

A TRAUMATIC EVENT IS ONE IN WHICH A PERSON'S COPING MECHANISMS ARE OVERWHELMED BY THE INTENSITY AND MAGNITUDE OF THE TRAUMATIC SITUATION. - WOMAN IN YELLOW SHIRT

A traumatic event is one in which a person's coping mechanisms are overwhelmed by the intensity and magnitude of the traumatic situation. Being overwhelmed in this way, primitive defenses are mobilized resulting in symptomatic behaviors. Beneath these symptoms are unmetabolized aspects of the traumatic experience and also the remnants of traumatic experiences from early childhood. In treating the Acute Stress Disorder and Post Traumatic Stress Disorder we want to recover

the traumatic experience, break it down into smaller pieces, understand it, make it more intelligible, and liberate the emotions previously frozen in the trauma-based symptoms.

There are some circumstances in which the person is uninterested or unable to speak of the traumatic event. In these circumstances the person is encouraged to speak about whatever is uppermost in his or her mind and the symptoms will sometimes diminish nonetheless. While we encourage the patient to speak about those things that are difficult to speak about, we always respect the patient's defenses. And if the patient is not ready to speak, we don't push them.

The crisis counselor working directly in the disaster site must always be mindful of any on-going threats to health and safety. Get out of danger first.

Make a distinction between panic and fear. Fear is a rational and healthy response to a dangerous situation. Fear helps us manage or flee a dangerous situation. Panic is an irrational anxiety response to a situation that could be dangerous but isn't right now. The panic reaction is often more dangerous than any remote possibility of danger, as the panic reaction often leads to carelessness, impulsiveness, and sometimes to tragic accidents.

EMERGENCY WORKERS

The crisis counselor needs to evaluate the situation for present danger and resources available, and needs to establish priorities of who to counsel first and how to coordinate care with the resources available. The crisis counselor is kind, calm, empathic, understanding, warm, organized, efficient, and emotionally

present. The crisis counselor must communicate clearly, facilitate connections between people, foster collaboration with other professionals and non-professionals, and take control of the situation to limit any additional trauma.

SLIDE

1) Counselors Need to take Care of Themselves and Each Other

2) Counselors Need to Remember to Think Clearly

3) Counselors Need to Set Priorities

4) Counselors Need to Work Collaboratively

5) Working with Patients in Crisis is not the same as Working with Patients in a Private Practice Setting

6) Counselors Working in a Crisis Need to be Flexible

In natural and man-made disasters everyone in the area is affected by the crisis, including the counselors themselves. As such, there are several useful things to keep in mind:

1) Counselors Need to take Care of Themselves and Each Other

It is easy for counselors to become overwhelmed and emotionally drained by this kind of work. Food, water, rest, and consultation are essential to the proper functioning of the crisis counselor. A traumatized and overwhelmed therapist is not able to be as helpful as one who is rested and calm. Experienced psychotherapists who have never worked in crisis before are often surprised to discover how thoroughly exhausting this work can be. Crisis counselors need to look after each other.

2) Counselors Need to Remember to Think Clearly

It is easy to lose perspective and become confused in a crisis. Counselors should slow down, make a checklist of priorities to address with each case, and discuss their clinical decisions with their colleagues.

3) Counselors Need to Set Priorities

In a crisis, people often lose their ability to differentiate between what is important and what is not. It is helpful for the counselor to have a checklist to offer guidance through the work. It might include information such as: name of patient, age, address, family members, physical illness or injury, medications, time of last meal, and time of last counseling session. Safety, medical concerns, sleep, food, and shelter must be either attended to or considered before any psychological treatment can begin.

Many people are delirious, anxious or depressed because of medical problems, which may include concussions, brain damage, metabolic conditions, or lack of medication for previously diagnosed problems. Others are agitated due to lack of sleep. If a person hasn't eaten for most of the day, he or she may appear depressed, agitated, or have difficulties thinking. It is dangerous to treat these kinds of problems as psychological problems when they are partially or fully the result medical or metabolic issues. Sometimes a patient needs a meal, a cup of water, a rest, a medical referral, some first aid or some medication more urgently than anything else.

4) Counselors Need to Work Collaboratively

Crisis intervention after major disasters is best performed under the conditions of intense interdisciplinary interaction. Such an environment gives counselors the opportunity for mutual supervision and consultation with medical doctors, nurses,

psychiatrists, psychologists, social workers, emergency personnel, and others involved. It is easy for crisis counselors to become overwhelmed by the intensity of the problems encountered and, as a result, find their thinking clouded. Frequent clinical consultation is essential for conscientious crisis intervention.

5) Working with Patients in Crisis is not the same as Working with Patients in a Private Practice Setting

Counselors need to leave the private practice model behind. Your crisis intervention 'office' may be a large room or shelter with many other people in it doing all sorts of different things, or it may not be in a building at all. Confidentiality may be a lowered priority or seriously compromised by the nature of the emergency and the need for support from others. We try to maintain some level of privacy but beyond that we need to be flexible with the crisis intervention 'frame'. The counselor meets with people whenever they are in need, and sessions are limited only by the resources available.

6) Counselors Working in a Crisis Need to be Flexible

Crisis counselors need to look at the crisis situation clearly and be as flexible, creative, and innovative as possible. They need to improvise with space, time, materials and resources. They need to collaborate closely with others. They need to assess their task and choose goals appropriate to the circumstances and the situation. They need to be forgiving of others and themselves when they lose their composure. And, if at all possible, they need to maintain both their sense of calm and their sense of humor.

SLIDE

The three goals of crisis intervention are:

1) To help the patient to COPE with the trauma.
2) Help the patient ADJUST to the new situation.
3) Return the patient to the PREVIOUS LEVEL OF FUNCTIONING.

Crisis Intervention

Just as the crisis intervention setting is different from a private practice setting, so too are the problems the crisis counselor needs to treat. The problems include the kinds of symptoms described above in the section on the Acute Stress Disorder. During the crisis, the goal of treatment is not characterological change, interpretation of transference, or insight into the childhood origin of the patient's problems.

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1) To help the patient to COPE with the trauma.
2) Help the patient ADJUST to the new situation.
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These goals are met by inviting the patient to talk about his or her experiences, get some perspective on the event, sort out the associated thoughts and feelings, and problem solve about how to deal with his or her new situation.

First Contact

In the first contact it will be useful to get some basic information like the person's name, age, medical condition, and social support system, but the crisis patient should not be subjected to a lengthy intake evaluation. The counselor should try to set the patient at ease, clarify the task, and invite the patient to talk. A good crisis counselor is a good listener but is also more active than a psychotherapist seeing

patients in a private practice. The crisis counselor clarifies, reassures, educates, offers advice about practical matters that the patient needs to deal with, and refers patients to appropriate agencies and programs. The counselor needs to be very mindful of the patient's medical condition and seek medical consultations if disorientation, confusion, anxiety, depression, agitation or sleeplessness are at levels that severely impair functioning, indicate a physical injury, or make the crisis intervention impossible.

SLIDE

Short-Term Goals include:

Calm down

Try to come to terms with intense fear

Talk about what has just happened

Get shelter for the night

Have something to eat, etc.

Long-Term Goals include:

Find permanent housing

Enroll in school

Get into a longer-term therapy

Look for a job

Make plans to move to another town, etc.

Long-Term and Short-Term Goals

In the midst of a crisis, people lose perspective. They are flooded with thoughts and feelings. They have difficulty setting priorities and as a result, they tend to get very concerned about unimportant things or things they can't deal with, and at the

same time avoid or ignore the more immediate concerns of the moment that they can manage. For this reason, it is often useful to help the patient to organize their thoughts into two sets of goals - a set of short-term goals and a set of long-term goals.

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Look for a job

Make plans to move to another town, etc.

The crisis counselor needs to be active and directive in helping the patient sort out these two types of goals and then in helping the patient to achieve the short-term goals. One survivor of the Venezuelan flood was primarily distressed about how she was going to return a lost book she had borrowed from the library. It was probably dynamically important but in the midst of the crisis it was the least of her concerns after her entire house had been destroyed.

Making a Plan

People in crisis have trouble concentrating, thinking straight, using good judgment, and setting priorities. It is often helpful for the therapist to take notes while talking to the patient, keep track of all the information that emerges, and have a list of topics to address during the interview – topics like short-term and long-term goals. During the interview it is useful to make a plan with the patient's collaboration, write the plan in legible penmanship, number each of the points and format it so that it is easy to read. It may say things like:

1) If I get upset, I will talk to a counselor.
2) I will make sure to have dinner tonight.
3) I will find a place to stay for tonight.
4) I will call my uncle to see if he can help me out during the next two weeks.
5) I will talk to my doctor about replacing my medication for my asthma.

You can refer to this plan in your subsequent session or pass it on in a file for the next therapist that may pick up the case, as this is often the arrangement in a shelter setting where multiple counselors may be helping the same patient over the course of several days. If there is no documentation of what you have done and what needs to be done with the patient, there will be no continuity of care and the patient will be subjected to a chaotic uncoordinated treatment regimen. Furthermore, if the plan is illegible it functionally does not exist.

FLOOD – TELLING THE STORY

Telling the Story

People develop the symptoms of an Acute Stress Disorder because they have been exposed to a traumatic situation that overwhelmed their ability to cope with the situation in their usual way. Consequently, their symptoms, like other psychological symptoms, serve to cover or hide the overwhelming and unmetabolized experiences. Psychoanalysis is called the "talking cure" and while crisis intervention is different from psychoanalysis, it is based on the same principle of helping the patient to talk about what is difficult to talk about, so as to transform psychological symptoms into stories that help the patient make sense of what has happened.

FIRE – TELLING THE STORY

It is important to remember that there is no generic response to a crisis. If ten people are traumatized by a combat situation, they will each be traumatized in a unique way that pertains to each of their own personal histories. If ten people are traumatized by an earthquake, they will each have a different experience of it. One will feel guilty for what he didn't do. One will feel abandoned. One will feel weak. One will feel betrayed. One will feel ashamed of something he did. One will go silent. One will get focused on a seemingly obscure and insignificant event. One will become sad realizing the emptiness of a marital relation in the face of this tragedy. One will have a crisis of faith. One will feel forgotten. And so on. The disaster is an assault on psychic integrity and as such, reveals not only the recent trauma but the conflicts and traumas of the past, which gave rise to the long-standing personality structure.

EARTHQUAKE – TELLING THE STORY

Houses with different kinds of construction will, of course, be affected in different ways in an earthquake and psyches with different kinds of personality structures will be affected in different ways in a major disaster.

Crisis intervention is intended to help the patient tell his or her story, hang words on the traumatic experience, get some distance from the event to help understand what had happened, and return the patient to his or her previous level of functioning. As the patient tells the story of the traumatic experience he or she may laugh, cry, yell, whisper, fall silent for a while, recall another seemingly unrelated loss, or become preoccupied with some feature of the story that may seem to us to be insignificant. The therapist should listen patiently and keep the patient returning to his or her story. The process of telling one's story and being heard produces a favorable change in the way the crisis is dealt with psychologically. The chaotic flood of emotions and images becomes more manageable when communicated in a verbal, narrative form. Some call this "mentalizing".

SLIDE

Common Themes in the Stories of Trauma

1) Some people are overwhelmed by emotion and because of this have difficulty speaking.

2) Some patients who are emotionally numb while telling a story of horror

3) Some people feeling guilty for surviving a tragedy when others died.

4) Some patients feel that they have, in some way, caused the disaster or feel they could have done something to save their family or friends.

Common Themes in the Stories of Trauma

In the process of hanging words on the experiences of trauma we find several recurring clinical presentations. This list by no means describes all the different stories but offers a glimpse of some familiar scenarios:

1) Some people are overwhelmed by emotion and because of this have difficulty speaking. Counselors should help them calm down by taking them to a quiet place, offering a cup of water, allowing them to express their emotion, and then helping them speak about what they are experiencing. Sitting with the patient in silence or letting him or her cry for a while is very helpful but eventually it will be important to help the person to speak, little by little, about the disaster.

2) Some patients who are emotionally numb while telling a story of horror. In these situations, the counselor can point out the usual feelings that most people have in such circumstances and wonder, with the patient, what feelings might be hidden from view. But it is also important to remember that if a person is emotionally numb, it is to ward off overwhelming affect. It is important that the counselor respect the patient's defenses and gives the patient time to let the feelings about the experience come to the surface. Some survivors of trauma may appear to be doing well in the first days following the disaster and then completely fall apart a week or two later, when they are in the safety of another context and the danger of the traumatic situation is far behind them.

3) Though it is irrational, it is also very common to encounter people feeling guilty for surviving a tragedy when others died. The crisis counselor can help these patients to mourn their losses by inviting them to talk about the people and things they have lost. It is sometimes useful to ask the person if his or her deceased loved

one would have wanted the patient to go on suffering or, alternatively, carry on, in remembrance of the deceased, living life to the fullest. This tends to shift the focus from endless survival guilt to mourning one's losses and finding a place in one's heart for those that have died.

4) Some patients feel that they have, in some way, caused the disaster or feel they could have done something to save their family or friends. In these circumstances it is important to help them recognize the power of the opponent they were up against, acknowledge the fear and confusion of the moment, and help them to mourn their losses. Another related problem is the search for someone else that must be guilty. Blaming oneself or finding blame in others only postpones the inevitable task of mourning the terrible losses.

After the person has told his or her story, it is often useful for them to tell the story again and again and again. Patients won't need to be told to do this, it will come naturally but we can show understanding and let them know they are not boring us. Each time the story is told it is likely to be further elaborated and the withheld emotions further liberated. It is useful for a patient of any age to make drawings of the traumatic experience, and dictate or write a narrative, which is kept by the patient with a copy in the case notes.

FLOODED HOUSES

Termination

Crisis counseling is, by its nature, very brief. Many interventions take place entirely in one session. It is important to conduct the session as a single session treatment. If the counselor sees the patient again, that is fine. Some crisis

counseling may take place over several sessions, but it is helpful to regard each session as an intervention unto itself. The crisis intervention should end with a concrete plan for the patient to follow. The plan should be written and given to the patient. If the patient is a child, the plan should be given to the adult in charge or placed in a chart for the child's on-going care. The counselor should make any and all referrals that might be necessary and, then, the patient and therapist need to say their good-byes. The therapist needn't worry about being too neutral. It is helpful in crisis counseling for the counselor to express feelings about the tragedy and empathy toward the patient, offer advice, and wish the patient good luck. Though physical contact is avoided in psychotherapy, hugs are not uncommon in the midst of catastrophic events. A reassuring touch or a hug can sometimes make all the difference in the treatment. While counselors need not be excessively nervous about touching a patient, it is important to remember that the crisis patient is often feeling like an exposed nerve and any unwanted or excessive physical affection can feel intrusive or confusing. Any physical affection should always be in the interest of the patient, not the crisis counselor.

CHILD SURVIVORS OF THE VENEZUELAN FLOOD OF 1999

Children

Most of what was said above applies to children, as well. The big difference is that when children tell their story they speak in the language of play and the metaphors of their imagination. As such it will be helpful to meet children who have suffered the traumatic experience of a major disaster with a pocket full of crayons and a pad of paper and/or a bag of toys and puppets.

MONICA

With paper and crayons children can draw a picture and tell a story that will reflect their concerns in metaphor. The invitation is for them to draw whatever they want and tell a story about it. To help the counselor understand the metaphor, it is useful to invite the child to talk about the picture. The counselor should not ask, "What is it?" but rather "What can you tell me about this?" "What happened before this scene that we see here in this picture?" "What is going to happen next?" “How do the people or animals in the picture feel?” It’s often useful to write the story down as the child dictates it to the counselor.

DRAWING OF FLOOD COMING DOWN BETWEEN TWO HOUSES

Afterward the counselor can read the story back to the child and the story can be elaborated. In this way, the counselor and the child have the opportunity of entering into a dialogue about the monster or the war or the big animal or whatever other metaphor might be used to speak of their concerns about the child’s traumatic experience.

MARJORIE

Drawing a picture and telling a story is also a useful technique when children experience flashbacks of the trauma or are awakened by nightmares of the trauma. When they can draw their dream and tell a story about it, they can often get some distance on it and manage it a little better. When children wake up at night frightened by a nightmare, it does no good to deny the existence of the monster that they just saw. Instead, ask them to show you what they saw by describing it, drawing a picture of it or telling a story about it.

DRAWING OF PEOPLE GETTING CARRIED BY FLOOD

Often no interpretation of the material is necessary. The counselor should just let the children express themselves and elaborate their stories while the counselor remains curious about what is happening and empathizes with the affect. If children have some difficulty getting started, the counselor can invite the child to draw a picture of the traumatic event for example, draw the house before and after the flood, the trees before and after the fire, the building during the earthquake, etc.

SABRINA

Toys and puppets provide the same opportunity to express the child's deepest concerns in the metaphors of play. Children should be spoken to honestly, but in small doses that acknowledge the reality of the disaster and its consequences, and thereby help them to come to terms with what has happened. Perhaps the child claims to not be afraid but might tell us that puppet or baby doll is afraid.

DRAWING WATERS FLOOD THROUGH A HOUSE

To reduce helplessness, children benefit from being given active roles in caring for themselves and others in developmentally appropriate ways. The inclusion of family members or caregiving persons in child interviews helps the child's social network understand the child and support the therapeutic benefits after the counseling ends. One crisis counselor, who was working in the shelter for the Venezuelan flood survivors, saw some adolescents looking restless in the way her own teenagers do just before getting into mischief. She called them over and put

them to work helping in the shelter and they happily took on their new jobs with a sense of real purpose.

MAN WITH WEDDING PHOTO

Connections, Disconnections, and Re-connections

We all know ourselves and find pleasure in our world through the connections we have to the people, places and things in our lives. When those connections are cut due to fire, flood or earthquake, children and adults become frightened not only by the event they just suffered but also by the disconnection from everything that once was their world. In such circumstances it is important to try to reconstruct the world by hanging on to whatever has survived – including objects and memories. When working with children, it is often useful to gather together their drawings and stories so they can be stapled together into a 'book', which may, for the rest of their lives, be the only thing remaining of all that they lost. In addition, names and contact data can be included in this personal story book, which may accompany the child in unknown ways for years to come.

VENEZUELAN CHILD SURVIVORS OF THE FLOOD, TWO YEARS LATER

Children need to feel at home in their temporary shelter. If possible, define their sleeping space, put their possessions in a bag, and offer some sort of consistency. Reassure them of your efforts to do your best to help them but don't offer promises you can't keep. Be honest. They will often enjoy having something like a toy that they can hang onto and use to maintain some sense of security during an otherwise chaotic time. It can be useful to invite the children to sit together and have stories read to them in the shelter. Children might also find some comfort in taking turns

talking about their experiences of the trauma in a group context – but this should be carefully monitored, as some children might be overwhelmed further in such an activity.

MOTHER AND SMALL CHILD

When working with children, crisis counselors should expect regressions, including dependent clinging, loss of urinary and bowel continence, and emotional upsets emerging seemingly for no reason at all. When children begin to feel safe, many will allow their memories and feelings to come to the surface and suddenly just start crying. Other times a word, a song, an activity, or a person's name will serve as a trigger and suddenly the memories and feelings will come rushing in. Children may have symptoms of insomnia, eating problems, aggressive behavior, withdrawal, and so on. It is best to initially look at these symptoms as expressions of the traumatic experience but, in fact, some of it might be pre-existing behavior simply re-appearing within the context of the emergency shelter.

INJURED MAN AND A GIRL ON A STRETCHER

In this regard, it is also important to remember that adults and children, affected by crises include people with the full range of diagnoses – depressives, obsessive compulsives, psychotics, addicts, mentally retarded people, borderline patients, delinquents, etc. And in a crisis, counselors will see all of them. People will often fall apart in a crisis and look much worse than they usually do, but after a suitable crisis intervention they will be able to cope with the situation, adjust to the new reality, and return to their previous level of functioning.

Finally – and this is worth repeating – crisis counselors need to pace themselves in their work to avoid becoming overwhelmed. If they do get overwhelmed, they will require a crisis intervention themselves. Though there is no shame in a crisis counselor needing a crisis intervention, whenever possible, we should try to avoid the possibility of the counselor becoming overwhelmed. The crisis counselor needs to pace him or herself, eat properly, rest properly, consult with colleagues on cases, and speak with a colleague or supervisor about particularly stressful or upsetting cases.

WUHAN FLOOD OF 1931

As psychologists we have an important role to play in crisis intervention after major disasters. We always hope there won't be another major disaster, but we also know that they are inevitable, in one form or another. For this reason, it is best for us to always be prepared.

LET'S GET PREPARED