

DISASTER RELATED PSYCHOLOGICAL FACTORS

This guide, meant to be a resource for the classroom teacher in helping children to recover from the effects of a disaster, was prepared using information developed to assist teachers to help children recover from the Loma Prieta Earthquake of 1989. The ideas presented will help in coping with other general disasters, as well as with the mini-disasters that occur in the lives of individual children.

A Crisis Intervention Team, made of trained professional staff members, will play an important role in the recovery from any type of psychological crisis. Teachers can access a Crisis Intervention Team through their Principal or site administrator.

It is not the intent of the disaster preparedness plan to “train” the staff members to be mental health professionals, nor to expect them to function as such. The intent is to make available all information that pertains to preparing and coping with the effects of disasters, minor or catastrophic. Therefore, the psychological factors involved in disaster situations need to be understood by all staff members.

For purposes of maintaining preparedness in disasters, especially disasters that could involve mass injuries, it is necessary to consider both psychological and social needs, those emotional and community-related factors that affect the victim or family and significant others or that influence the staff in the performance of their duties. The emotional component is characterized by:

- (1) the individual’s reaction to a casualty situation, whether or not a personal injury has been incurred
- (2) the reaction of the family and significant others to the situation and to the victim’s injury or possibly death
- (3) the reaction of the staff to the situation, both as participants personally affected by the situation and as school district employees providing a disaster service
- (4) the reactions and behavior of the community.

The social component can be seen as the response of community agencies and services in providing necessary resources and in meeting responsibilities to those injured or affected, as well as the material resources of the victim and family.

VICTIMS

Victims undergo what might be called a disaster syndrome, which consists of four phases of emotional and mood reactions. Individuals differ in the time spent in each phase and in the intensity of reaction, but the general sequence is as follows:

1. **Shock Phase:** Immediate, lasting a few minutes to a few hours; behavior is dazed, stunned, apathetic, disorganized, does not respond to direction.
2. **Suggestibility Phase:** May last several days; shows unselfish regard for the welfare of others, willing to follow instructions, grateful, guilt due to survival, suggestible.

3. **Euphoric Phase**: May last several weeks; behavior includes identifying with others in the same situation, feeling of brotherhood, enthusiastic participation in group activities.
4. **Depressive Phase**: (personal frustration) – Hopefully fades as life returns to regular pattern; behavior is critical, complaint oriented, awareness of and annoyance with losses.

These phases are all normal behavioral responses. Experiencing a disaster is a crisis and as such is made more severe by the added factors of death, injury, family problems, job difficulties, illness, loss of personal belonging and the disturbance of regular routine. After the initial numbness and absence of panic wears off (usually one to two hours), the following behaviors set in:

- Fearful, crying, horror at sights of destruction/devastation/sounds; talks about it to everyone who will listen; watches all TV coverage; reads everything on the events – lasting several days.
- Returns to work and usual routine when possible; less apt to want to discuss disaster; avoids media; feels anxious, irritable, insomnia, depressed, guilt of surviving, angry (both direct and displaced) usually lasts several weeks.

In some instances, dysfunctional behavior responses may be manifested. They include continuing morbidity, anxiety, suicide, depression, poor concentration, phobias, headaches, gastrointestinal problems, drug/alcohol abuse, absenteeism from school/work, deterioration of personal relationships; recurrent recollection of event/recurrent dreams/nightmares.

RESCUE WORKERS

Rescue workers will experience many of the same feelings as victims. As participants, and possibly victims, the behavioral patterns of staff members may include excessive irritability, fault finding, holding grudges, being suspicious, resenting authority, and concern about safety for selves and family.

Stress in the working environment is created by:

- understaffed/overworked
- philosophic/emotional conflicts
- sudden death
- inexperience or anxiety about one's competence
- shock-impact of sights/smells
- family responsibilities vs. work demands
- political/bureaucratic problems

“Burn-out” is a problem that needs to be addressed, because it lowers group morale, increases absenteeism, lowers mutual support, increases scapegoating, and adversely affects home life. The symptoms are emotional, physical, and behavioral and might be acted out by detachment or over involvement. They are manifested in the following ways:

- deterioration of one’s sense of well-being
- chronic exhaustion/depression
- hostility/negativity
- loss tolerance for more difficult victims/problems
- dreading new encounters
- guilt for feeling negative
- helplessness/isolation

RECOVERY PROCESS

These factors stand out as essential in dealing with crisis recovery:

- Being able to talk about the experience and express the feelings accompanying the experiences
- Being fully aware of the reality of what has happened
- Resuming concrete activity and being able to reconstruct the pre-disaster life routine
- Accessible/available help
- Leadership clearly making decisions/giving directions
- Open avenues of communication for victims to locate family/friends
- Prevention of rumors by careful control of words used, information given – (Don’t use words such as PANIC, MORGUE, HATE)
- Planning ahead – being prepared

The main contribution to be made on the non-professional level is to provide Psychological First Aid – the initial aid received by a person in trouble. The goal should be either to return moderately disabled persons to reasonably good function in a short time, or to make more seriously disabled persons as comfortable as possible until they can be given more complete care. At the most basic level, it begins with keeping calm and expressing reassurance to the students during and after the occurrence.

The general principles of Psychological First Aid include:

- Accept every person’s right to his/her own feelings.
- Attempt to calm the victim, relieve the anxiety and stress.
- Communicate confidence in yourself.
- Contact members of victim’s family or support system.
- Size up disturbed person’s abilities as accurately and quickly as possible.
- Encourage the person to speak freely about whatever is on his/her mind, allowing him/her to “ventilate” feelings.

- When the person begins talking, interrupt as little as possible. After you have heard the full story, you can ask for details. Practice “active listening.”
- Do not argue with the person if he/she disagrees with you.
- In helping a child, deal with issues indirectly and provide food and comforting.
- Do not impose your methods of problem-solving upon the disaster victim; his/her solutions will be the most successful for him/her.
- Accept your own limitations in a relief role; do not attempt to be all things to all people.

Particularly in a disaster, children look to adults for help. How you react to a disaster give them clues on how they should react. If you react with alarm, their fear will increase. As the situation ceases, explain to the children what has happened and that help is coming.