Spiritual Care and Mental Health for Disaster Response and Recovery

NYDIS

NEW YORK DISASTER INTERFAITH SERVICES

Spiritual Care and Mental Health for Disaster Response and Recovery

THE REVEREND STEPHEN HARDING, BCC, STM, EDITOR

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Acknowledgements

This manual is the culmination of effort by many key leaders, past and present in the New York City religious and mental health communities. It represents decades of clinical and congregational experience that has been focused by the vulnerabilities found and the best practices results of our collective response to the relief and recovery efforts following the September 11, 2001 terrorist attack on the World Trade Center and subsequent disasters that have impacted this great city. To that end, we owe a debt of gratitude to the many thousands of volunteer disaster chaplains and the clergy and religious leaders who care for the people of this City who informed this work.

In particular, we would like to extend our thanks to the Rev. Susan Lockwood and to Rabbi Zahara Davidowitz-Farkas for their contributions and editorial leadership in gathering the authors and preparing the initial drafts of this manual. We would also like to thank the Rev. Julie Taylor for her work as the initial project manager for this manual, and we thank all three for their wisdom and their help with the genesis of this project.

Additionally, we thank all the authors who have generously given of their experience of disaster response and for their willingness to share their knowledge with others.

It is with our deepest gratitude and admiration that we thank the Rev. Stephen Harding for being the Editor of this manual. His insights and his ability to bring the contents together in a cohesive and comprehensive manner will make your using it more user-friendly and ultimately more helpful when you need it most.

We thank Carole Erger-Fass of BugDesign for her graphic artistry and the clarity of the layout. We also thank Heather Glick for the photos that are throughout this manual.

Finally, we also wish to acknowledge and thank you, the reader, and all those persons of faith who have and who will come forward to help others in times of great need. It is in this spirit of coming together to help others that this manual is presented to you.

Bless you for all that you do and for being ready to help,

The Rev. Dr. Martha Jacobs, BCC
President, Board of Directors
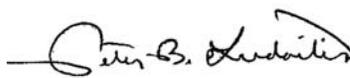
Peter B. Gudaitis, M.Div.
Executive Director & CEO

About NYDIS and Statement of Inclusivity

New York Disaster Interfaith Services (NYDIS) is a 501(c)(3) faith-based federation of disaster service organizations and philanthropies that work in partnership to provide disaster readiness, response, and recovery services for New York City. NYDIS' mission is to coordinate, develop, and support these disaster services to mitigate, prepare for, and respond to all hazards — both natural and human-caused. NYDIS and its members provide secular disaster human services to faith communities and individuals alike, regardless of membership or religious affiliation. NYDIS also trains, credentials and deploys disaster chaplains and spiritual care workers from its member agencies.

In times of crisis, NYDIS convenes its leadership with government agencies and local, state, and national disaster management organizations. These partnerships facilitate the delivery of services, resources, and information to religious communities, under-served victims, and impacted communities.

NYDIS regularly partners with the American Red Cross, FEMA, the Human Services Council, the NYC Department of Health & Mental Hygiene, the NYC Office of Emergency Management (OEM) as well as NYC and NY State VOADs to communicate with the NYDIS membership and all other interested religious communities on emergency management matters and to coordinate disaster advocacy, disaster chaplaincy, mitigation education, preparedness training of religious leaders, and relief and recovery programs. It is through this faith-based, cooperative initiative that our member and participating faith communities can prepare themselves and the public at a grass-roots level.

This manual for religious leaders is the result of a six year journey since September 11, 2001. Since that terrorist attack, New York City has experienced plane crashes, anthrax attacks, some of the aftermath of hurricanes Rita and Katrina, other storms, horrific fires, transit strikes, and various other events that have impacted our City. This manual is the culmination of experience from many people; each chapter reflects the lessons learned from things having gone badly as well as from success.

Each individual chapter is written from its author(s)' own point of view and own faith tradition(s). Every effort has been made to use inclusive language that is respectful to all traditions throughout this manual. However, we have also tried to be faithful to each author(s)' original work, and we have tried to maintain a balance between each of these needs. Please understand, where we fall short of this ideal, that *we intend this guide to be helpful for all and that members of all faiths, traditions, and beliefs are welcome and included as our readers.*

Contributors

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Introduction

BY THE REVEREND STEPHEN HARDING, BCC, STM

While certain houses of worship and religious leaders in New York City had done good work in the field of disaster response before the World Trade Center attacks, the landscape for communities of faith and houses of worship changed forever in New York City after September 11, 2001. Because of the enormous role that imams, pastors, priests, rabbis, anyone with a responsibility for a house of worship played in the recovery effort, the needs of our City called each religious leader to a new level of disaster response. Worshipping communities, too, faced a new challenge of responding and, as individual members of a house of worship, faced a new array of difficult decisions regarding individual safety. Going to help; caring for the families;

listening; and then preparedness and planning were the watchwords of the day once the recovery effort was concluded.

The challenges of those times are still with us, and the need to remain vigilant and prepare for the next disaster has not gone away. This manual was developed by New York Disaster Interfaith Services (NYDIS) to help you do several things as individual leaders of houses of worship:

• Prepare yourself and the members of your worshipping community by developing a disaster plan **in advance**;
• Help you identify the phases of disaster so that you know where you are as things are going on around you;
• Provide you with information about preparation and your role as religious leaders in all phases of disaster;
• Provide you with information and resources that you can call on and use if you need them; and
• Help you to start thinking about what you would do if a disaster happened to your own house of worship or in your community.

The contributors to this manual all have experience in responding to disasters. Some worked as part of the recovery effort for the World Trade Center and/or other disasters; others have extensive experience in working with relief organizations; still others are therapists; others teach; and all write from the experience of 'having been there.' These chapters are the things they have done and that have worked for them.

While no one can prepare for a specific disaster, this manual will help you to be ready for whatever comes. The language of the American Red Cross is that 'all disasters are local'. That is, all disasters happen in a specific location and they happen to people in that location; the level of response will vary depending on circumstance, and for that reason, **our definition of *disaster* refers to "any situation that overwhelms the community's ability to respond"** (Beinin, 1985)[1].

Houses of worship and religious leaders are integral parts of their communities, and as such, have an important role and function in responding to a disaster. September 11, 2001 is seared into our memories, and as a City, the attack on the World Trade Center may be the benchmark of disaster for which to prepare.

However, in looking at the events that have affected our City over the last one hundred years, the recurring events that affect neighborhood communities and houses of worship are:

- Fire
- Shootings
- Shootings in which children have been killed
- Mass Transportation Incidents: subway, train, and ferry crashes; strikes; etc.
- Power Outages and Blackouts
- Aviation disasters: Helicopter and airplane crashes
- Flooding and the threat of flooding due to storms
- September 11, 2001
- First bombing of the World Trade Center (1993)
- Influenza (1918)

Most of the items on this list are local; some affect everyone; and the large events are huge in terms of the nature of the event, the response from the City, and the recovery from them.

Therefore, after taking New York City's history into consideration, we present the following list of disasters that we are likely to face in our neighborhoods and for which we should plan:

Disasters that we are likely to face in our neighborhoods

Natural	Man-Made	Threats	Potential Events
Earthquake	Civil Unrest	Biological	Disruption in Water Supply
Fire	Mass Transportation Incidents	Chemical	Drought
Flooding	Power Outages	Explosive	Viral Epidemic
Hurricane	Shootings	Nuclear	(Avian Flu, SARS)
Storms		Radiological	Storm Surge
Tornado		Terrorist Attack	

Our intent with this manual is to provide an outline of preparation at the local house of worship level so that you, the religious leader, will have a sense of the overall likely response to an event; how you and the members of your worshipping community may be able to help; the demands that may be made of you and your members; chapters on spiritual care for yourself and for others; guidelines for mental health; and strategies to enable you, in your capacity as a religious leader, to continue to provide care for yourself, the members of your worshipping community, and your neighborhood community in the event of a disaster.

The internal structure of this manual's content follows the phases of a disaster: mitigation, preparedness, response, and recovery. That is, material relating to mitigation and preparedness is found toward the beginning, material on response is in the middle, and material relating to recovery is toward the end.

Most chapters in this manual are organized into four parts:

• A narrative description of the chapter topic;
• Guidelines and Interventions for religious leaders (action plan) intended for reference and concrete interventions in the various phases of a disaster as events unfold;
• A resource section that provides websites and articles related to the material in each chapter;
• An appendix that provides more detailed information or a specific document for that chapter.

We have provided a Reference Section that contains a Glossary of Emotional States; Age-Specific Reactions and Interventions; New York City Government Response; Primary National Volunteer Response Organizations; New York City Disaster Response Agencies and Organizations; Incident Command System; New York State Government Response to Disaster; and the Federal Response to Disaster.

Some final thoughts: We live in one of the most religiously and spiritually diverse cities in the world. *In responding to any disaster in New York City, we are most likely going to be working with persons whose beliefs are different from our own. It is essential that each person's belief is accepted, respected, and supported without judgment or question and without proselytisation.* This is especially true in working with the victims and their families. They can be extremely vulnerable, and they will need your support of their belief system at that time.

In responding to any disaster, one does not respond as an individual, but as part of a team. Religious leaders are rarely in charge at a disaster site or support facilities. Our role is to provide religious and spiritual support to the victims, victims' families, our community, and (sometimes) first responders, in the manner that is most helpful to them.

Perhaps the most important thing in all this is to know what you would do if the disaster happened in your house of worship. The second most important thing would be to have communicated your plan to the members of your worshipping community and have gotten them to be a part of it.

The manual can be read sequentially or for specific information as it is needed. Each chapter stands alone in its own right and can be read separately for its content. We hope that this guide will be helpful to you as you and your members plan what you would do in a disaster. We thank you for your courage in responding to the need to prepare for disaster and for your compassion in responding to those in need.

For further information about disaster response, please contact any of the disaster response agencies or contact NYDIS, 22 Cortlandt St., 20th Floor, New York, NY 10007, 212.669.6100, **info@nydis.org**.

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[1] Beinin, L. (1985). Medical Consequences of Natural Disasters. Springer- Verlag, Berlin, Heidelberg, New York, Tokyo, in Planning for the Emergency Medical Service Response to Chemical Disaster Jiri Pokorny, Vladimir Dolezal and Erik K. Noji, in Methods for Assessing and Reducing Injury from Chemical Accidents, Edited by Philippe Bourdeau and Gareth Green @ 1989 SCOPE. Published by John Wiley & Sons Ltd, taken from http://globalecology.stanford.edu/DGE/CIWDGE/ SCOPE%20Books%20Web%20Archive/SCOPE%2040/SCOPE_40_2.8_Pokorny_189-210.pdf.

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Preparation and Mitigation Phases
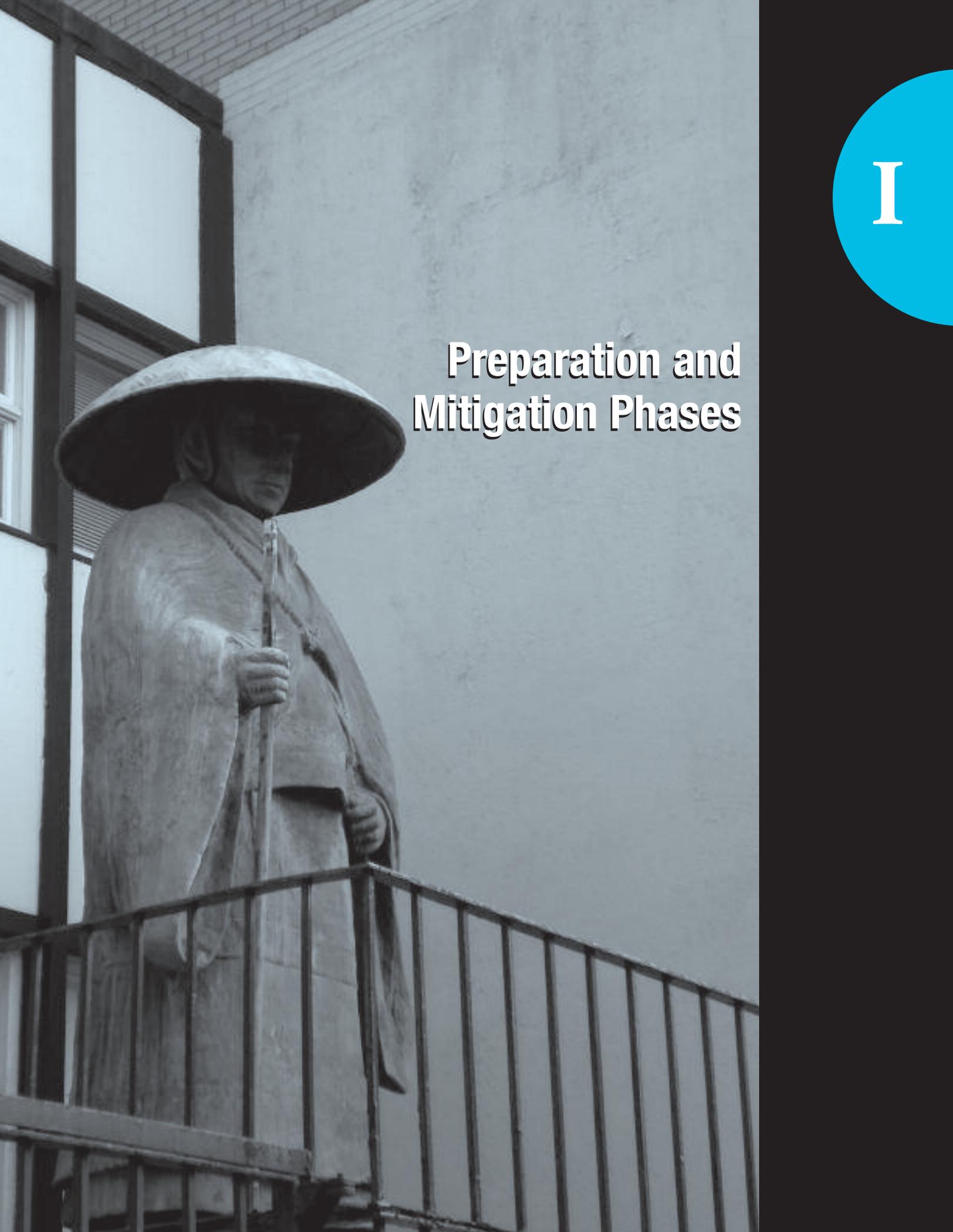
Disaster Response Planning & Preparedness:

PHASES OF DISASTER

BY JACK HERRMANN

1

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Editor's Note: This Chapter is the continuation of an adaptation of a state plan for disaster preparation and response. In total, the original chapter comprises Chapters 1, 14, 16-18.

Chapter Overview

Many of you are reading this manual as part of your efforts to prepare as a spiritual care professional who will be ready to respond during times of disaster. Your main role will be to provide emotional and spiritual support to those affected by disaster, but it is also critical for you to understand the context in which you will be providing this support—the bigger picture, so to speak.

Disaster relief operations are complex systems having more to them than just a response mechanism. They require a significant amount of pre-planning. Disaster experts have long known that waiting until a disaster strikes to test a community's response procedures can be disastrous. How communities respond to disaster can even induce more stress on individuals and place them at risk for developing a variety of adverse reactions and psychological consequences. This section takes the first step towards introducing you to the key elements of disaster management and response at multiple levels.

The focus of this chapter is on the framework of disaster planning, preparedness, and response. In the event of a disaster in your community, you may be asked and/or may want to help. It will help you to have an understanding of the structure of the overall response so that you know how your efforts will enhance the overall operation that makes disaster response possible.

Disaster Management Continuum[1]

All disaster response begins at the local level and as such, communities must be prepared for whatever happens, no matter how big or small. Health care systems play an integral role in a community's disaster response; therefore, these systems must also be prepared to meet the tremendous challenges that are brought forth by disasters and public health emergencies. Successful disaster response requires a community and its health care system to:

- Define and anticipate disaster risks and hazards;
- Prepare the material resources and skilled personnel to respond to these risks and hazards;
- Develop comprehensive plans to deploy these resources to assist the community and its recovery;
- Learn from disasters and translate the lessons learned into invaluable future preparedness.

Disaster experts have long known that waiting until a disaster strikes to test a community's response procedures can be disastrous.

Disaster management is the preparation for, response to, and recovery from disaster. While there are different understandings of Disaster Management, it is generally viewed as a cycle with the following five key phases:

• Planning and Preparedness Phase
• Mitigation Phase
• Response Phase
• Recovery Phase
• Evaluation Phase

Each phase presents opportunities for disaster mental health and spiritual care professionals to be involved. Each of the phases below, while written from a community perspective, can and should be translated into a perspective that includes the needs of a house of worship as well.

Planning and Preparedness Phase

The *Planning and Preparedness Phase* is designed to structure the disaster response prior to the occurrence of a disaster. It is a state of readiness to respond to a disaster or other emergency situation and involves evaluating the community's potential disaster risks, vulnerabilities, and the likelihood for a disaster to occur. This risk assessment process is sometimes referred to as an *All-Hazards Analysis*[2]. An All-Hazards Analysis can be completed at multiple levels, including:

• Federal, state, and county levels
• Hospital, business and agency levels
• Personal and family levels

Depending on the disaster, there are some incidents that may present more risk and challenge than others for hospitals. For example, a small house fire may present minimal risk for both a community and a hospital if they have the resources to adequately respond to the needs of the individuals involved. A large structural fire, such as a 23 floor office building with multiple people killed or suffering significant burn injuries, may present significant challenges for both the community and the health care system, no matter how large the city or how many resources they have at hand. Communities and houses of worships' systems must assess the risk of such scenarios above and plan accordingly.

The Planning and Preparedness phase also assesses the community's or house of worship's systems' infrastructure (i.e., availability of backup communications, transportation options, economic viability, etc.) and its capability to respond to the potential risks and vulnerabilities identified in the All-Hazards Analysis. Assessing available mental health and spiritual care personnel and training them in disaster response is an example of a Planning and Preparedness activity.

Disaster response is the organization of activities used to respond to the event and its aftermath.

It is important to note, however, that having the best plan or the most experienced team will not always guarantee a successful disaster response. There are some disasters whose magnitude and/or unique characteristics will stress even the most prepared system or team. In these cases, individual and system flexibility is imperative. Developing a plan and response team that is flexible and able to adapt to whatever occurs is extremely important. In many cases, peoples' lives will depend on it. Consider the scenario where an entire hospital is rendered inoperable as a result of a flood or decontaminated by a biological or chemical agent. A plan and response team that had only considered the provision of services from their usual site will quickly become overwhelmed with how to respond when their site suddenly does not exist.

Mitigation Phase

The *Mitigation Phase*, also known as the Prevention Phase, is characterized by the measures taken to reduce the harmful effects of a disaster in order to limit its impact on human health, community function, and economic infrastructure. During this phase, steps are taken to prepare a community or house of worship for disaster, especially high-risk locations (e.g. hospitals in areas that typically flood) and populations. There is supporting research that suggests individuals, communities, and hospitals are more resilient following disaster when they have anticipated and prepared for disaster outcomes. For example, having a personal or family disaster plan can be a step towards mitigating the effects of disaster when it strikes a particular family. Ensuring that all personnel understand their roles in disaster response and are educated on the appropriate evacuation plan for a particular individual, family, agency, department, or organization, and other response activities can achieve similar positive outcomes.

Response Phase

The *Response Phase* is the actual implementation of the disaster plan. Disaster response is the organization of activities used to respond to the event and its aftermath. The Response Phase focuses primarily on emergency relief: saving lives, providing first aid, minimizing and restoring damaged systems (communications and transportation), meeting the basic life requirements of those impacted by disaster (food, water, and shelter), and providing mental health and spiritual support and comfort care.

Recovery Phase

The *Recovery Phase* focuses on the stabilization and return of the community and health care system to its pre-impact status or what some describe as "getting back to normal." Activities of the Recovery Phase can range from rebuilding damaged buildings and repairing a community's infrastructure to relocating populations and instituting intermediate and long-term mental health interventions. The Recovery Phase can begin days, or in some cases, months after disaster strikes. In the aftermath of catastrophic disasters such as Hurricane Katrina, the concept of returning a community or healthcare system to its pre-impact status might seem unlikely or impossible. In these cases, the recovery efforts focus on helping communities and systems adapt to a new sense of 'normal.'

Phases of Disaster **13**

Evaluation Phase

The *Evaluation Phase* of the disaster management continuum often receives the least amount of attention. A timely and thoughtful evaluation process is essential in determining what worked versus what did not, so that future revisions and enhancements to the disaster plan and response system can be made. Communities or health care systems that fail to implement an evaluation phase in the context of their disaster management process find they are no better prepared the next time disaster strikes.

As you can see, each phase presents unique opportunities for communities, hospitals, and individuals to focus on how they will prepare for, respond to, and recover from disaster before the event actually happens.

Responding to Disaster: Who Gets Involved, How, When, and Why?

The Local Response

All disasters start at the local level [3]. No matter how large or small, local communities are expected to provide immediate disaster response. On a daily basis, our police officers, firefighters, and emergency medical technicians are our community's first responders. Their primary mission centers on the rescue and recovery of those in harm's way. Whether fire, flood, or act of terrorism, these individuals are usually the first on the scene.

There are others who also respond and provide assistance to those impacted in the immediate aftermath of disaster. Mental health professionals, spiritual care professionals, and the community's hospitals may also be activated in those early minutes and hours after disaster.

Triage and assessment becomes a significant factor in a community's first response. It is not only the assessment and medical triage of injured victims, but also the assessment of needed human and material resources to respond to the incident. Usually when disaster strikes, there are a number of responding agencies and the scene of a disaster can quickly become chaotic and confusing. In an effort to avoid some of this unnecessary confusion, there is always someone placed in charge of assessing the situation and evaluating the needs of the response system.

Section Summary

Prior to a disaster, coordination of the agencies and organizations described in this module should be of primary interest. Identifying specific roles and relief procedures for each agency and organization could prevent some of the unnecessary challenges communities and houses of worship have faced in times of disasters.

> Usually when disaster strikes, there are a number of responding agencies and the scene of a disaster can quickly become chaotic and confusing.

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[1] Veenema, T.G. (Ed.). (2003). *Disaster Nursing and Emergency Preparedness for Chemical, Biological, and Radiological Terrorism and Other Hazards.* New York: Springer Publishing Company.

[2] For more information about All-Hazards Analysis, refer to the Mental Health All-Hazards Disaster Planning Guidance document, which is available on your CD-Rom or can be downloaded from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services web site at **www.samhsa.gov**.

[3] *Editor's Note: All disasters are local in terms of their initial impact on the immediate community. The level of response will vary, depending on the nature of the disaster or event.*

The Faith Community as Intermediate and Long Term Caregiver:

STEPPING FORWARD IN A DISASTER

BY WILLIAM O. SAGE

2

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Introduction

At the time of a natural or human-caused disaster, we count on the response of emergency services including police, fire, and medical services. Increasingly, the faith community also has stepped forward to respond to the initial impact of disaster as well as the protracted recovery period that follows. Every disaster—September 11, 2001, the devastating hurricanes that swept across Florida in 2004, the Columbine High School shootings in 1999, the bombing of the Alfred P. Murrah building in 1995—has its unique context, circumstances and set of challenges. Complex, catastrophic disasters create great emotional and spiritual upheaval for survivors and victims, as well as for their families, neighborhoods, and communities.

Understanding these complexities and building an awareness of appropriate responses and interventions are important for faith leaders, who not only need to prepare for an immediate response to disaster but also need to know how to strengthen the possibilities for positive outcomes over the long-term recovery process for those who have been traumatized by disaster.

Trauma comes from the Greek root for "wounded." Psychologists and sociologists have put forward a variety of definitions. According to Bessel A. Van der Kolk, trauma occurs when "one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences. This results in a state of helplessness, a feeling that one's actions have no bearing on the outcome of one's life." Trauma also results when individuals experience an extraordinary event that actually threatens survival and shatters assumptions about safety, meaningfulness and a benevolent world (Schachter 2003).

The Faith Community as Immediate and Long-Term Caregiver

Special care professionals – particularly chaplains and leaders of religious traditions – including laypersons – are generally viewed as accessible caregivers who occupy positions of trust and offer safe space for pastoral and crisis intervention. Further, the faith community is:

Complex, catastrophic disasters create great emotional and spiritual upheaval for survivors and victims, as well as for their families, neighborhoods, and communities.

- viewed as being particularly capable of offering the language of faith, hope, and spiritual reinforcement when individual, family, or community face sudden tragedy or spiritual crisis;
- viewed as being able to mobilize material, social, and spiritual resources over the long term for those affected by disaster;
- viewed as being a voice for the voiceless when needs are still to be met for those recovering from the disaster; and,
- generally committed to caregiving responsibilities for long-term recovery without expiration dates, as opposed to timeline-driven governmental resources.

PREPAREDNESS PHASE

The Faith Community and the Importance of Preparedness

The faith community is usually prepared to assist individuals, families, and communities that have faced losses from local disasters like fire and flood. In general, it is less prepared to face the challenges of a catastrophic disaster in which there are mass casualties and significant loss of property or both. Preparing in advance can make both a quantitative and qualitative difference in both the immediate and long-term outcome for those individuals, families and communities affected by catastrophic events. Advanced preparation takes into account the following key points:

- Caregivers from the faith community will find that their caregiving responsibilities will last weeks, months, and even years.
- Caregivers, in general, are more prepared to provide short-term recovery efforts and are less well-equipped to address extended recovery periods or recovery following particularly complex disasters.
- Caregivers from the faith community will find that meeting the emotional and spiritual needs of disaster survivors is vital in any long-term recovery process. Helping to find new meaning and purpose are critical spiritual and emotional care objectives.
- Caregivers from the faith community increasingly face complex, catastrophic

disasters. As a result, they will require more extensive awareness about the appropriate interventions and desirable applications for restoring emotional stability and spiritual renewal. Caregivers can minimize the risk of compassion fatigue and burnout with greater awareness and intentional preparation.
- Caregivers benefit from information and knowledge about viable intervention applications based upon best practices and previously tried positive examples. Acquisition of skills and use of best practices to provide spiritual and emotional support are beneficial to affected individuals.
- Caregivers from the faith community maximize their performance, mobilization, and delivery of resources when they are aware of the laws and policies of governmental and regulatory agencies.

Faith Community Preparedness for the Life-cycle of a Disaster

There are discernable differences between the physical, material, and emotional and spiritual phases of recovery following a disaster. This is particularly true when there is extensive loss of life. For example, when a fire destroys a school dormitory and claims the lives of students, the material reconstruction of the physical edifice will be completed much sooner than the emotional and spiritual recovery of the victims' parents and relatives. Such recovery can take a lifetime as the grief process is particularly profound for parents who lose a son or daughter.

Emotional and spiritual recovery are deeply affected by the nature, scope, and complexity of the disaster.

The phases of material and physical recovery include:

- The **emergency phase** in which first responders—family, neighbors, and local emergency response personnel (firefighters, police, and emergency medical services)—get people to safety, administer emergency medical care, and restore order. Basic human needs such as provision of food, water, shelter, medical care, clothing, and transportation are met.
- The **short-term or stabilizing phase** incorporates, in addition to the provision of basic physical needs, the organization of volunteers and other established and specialized services (such as debris removal or specialized security). In major disasters, when local resources cannot meet these needs, state and federal governmental assistance often becomes a part of the response. Faith-based disaster response organizations may also play a significant role in this phase.
- The **long-term recovery phase**, which can take months or even years, not only entails a combination of local, state, and federal response programs, but also includes the full involvement of faith-based disaster response agencies that address unmet needs and provide long-term intervention designed to assist individuals, families, and communities to make a full recovery.

The **emotional and spiritual phases** of recovery are much less predictable. Emotional and spiritual recovery are deeply affected by the nature, scope, and complexity of the disaster. The outlook for long-term recovery is profoundly impacted by loss of life, significant loss of property, or both. Trauma resulting from a catastrophic incident causes immeasurable pain, suffering, and loss.

The cycle of emotional and spiritual recovery encompasses
- profound uncertainty about the loss of security and how to return to what was normal before the incident; and
- emotional reactions, including traumatic stress, that overwhelm basic coping mechanisms (common reactions to trauma may include feelings of being overwhelmed, withdrawal from usual activities, recurring intrusive memories and/or memory loss, and phases of anxiety, panic, fear, anger, hostility, and/or depression).

Spiritual reactions include:
- a crisis of faith in which there are feelings of being abandoned by God, finding it hard to pray, no spirit of thankfulness;
- despair, loss of hope, and a prolonged state of hopelessness;
- disengagement from religious practices and interaction with faith leaders and faith communities;
- the need to perpetually ask "why" a compassionate God would allow such suffering and pain to happen; and,
- a search for continuous reassurance that God will provide safety and security, and re-establish goodness in life.

Overall, many of us are more comfortable giving thanks in our prayers than crying out the pain and suffering we feel following a disaster or tragedy.

The process of recovery from a trauma will vary from one incident to another and will be significantly influenced by the nature and scope of the disaster...

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS

In the short term, the primary purpose for pastoral and crisis intervention with both individuals and families is to offer security and safety. Over the long term, the primary purpose is to assist and facilitate the restoration of faith and hope, and to help find meaning in life following a disaster, particularly when there has been a loss of life.

RESPONSE PHASE

At the time of crisis, the religious leader will want to:

- **Offer Security**. Above all, disaster victims need assurance about their safety. Offer hospitality ("Do you need anything? A drink of water, food, a blanket? Do you have shelter?"). Some houses of worship have opened their premises as shelter accommodations, feeding centers, distribution centers, and/or day care centers. They have also partnered with ecumenical or inter-religious groups to implement emergency preparedness plans that had been developed prior to the disaster.

- **Listen Carefully and Provide Support**. Assist the disaster victim to express him or herself and allow the victim or survivor to accept the reality and experience the pain of loss. Listening carefully usually accomplishes more than talking to the victim. Listening with an attentive ear but providing attentive language when appropriate, as well as supportive language and open-ended questions, will help reduce the shock and produce conversation during which interventions for support are possible. Presence with the bereaved and affected individuals and families is the most important reassurance that religious leaders can offer at any time of disaster.

- **Avoid "Fixing."** Religious leaders can only assist victims and survivors. They cannot do everything for the victim or survivor, nor can they fix what is not fixable. Religious leaders can not bring back those who died as a result of the disaster, but they can assure the family that the faith community will be there to help them through the pain and loss; they can also commit to helping victims find new hope and purpose in life. Religious leaders can commit to accompaniment over the long term.

- **Focus on the Needs of the Survivor**. Constant review is important in the context of ensuring that the needs of the victim or survivor are being met. Such review should take care that the focus of the religious leader remains fixed on meeting the needs of the victim and not those of the caregiver. "Whose needs am I trying to fulfill here?" is a key question that should be constantly re-assessed.

RECOVERY PHASE

It may take some time after a crisis for the initial shock to subside. The process of recovery from a trauma will vary from one incident to another and will be significantly influenced by the nature and scope of the disaster—for example, whether or not it was a natural event (such as a flood, tornado, hurricane, winter storm, heat wave, or earthquake) or a human-caused incident (such as a hazardous materials incident, nuclear power plant disaster, school shooting or terrorist act).

In general, trauma stress specialists agree that suggesting the use of ritual in trauma recovery can be helpful and meaningful for many victims and survivors. Ritual can assist in reestablishing hope. According to Lisa Schirch, Eastern Mennonite University (EMU) faculty, ritual is:

...Trauma stress specialists agree that suggesting the use of ritual in trauma recovery can be helpful and meaningful for many victims and survivors.

• **A unique social space, set aside from normal life**. For example, houses of worship made parlors available for the surviving spouses, partners, and loved ones of September 11th victims to gather regularly following the terrorist attacks. Bereavement groups were established, special summer programs for children and youth were organized by religious institutions, and recreation equipment in school grounds in memory of the deceased was created.

• **A way to communicate through symbolic actions using body language, senses, emotions, and symbols rather than words**. Examples are prayer groups, support groups using cultural practices such as established meals together, and the establishment of new religious traditions such as prayer circles, Wednesday night sacred texts study groups, or healing-music events. All such activities are aimed at bringing the members of houses of worship together during difficult times.

• **An experience that marks and assists in the process of personal and relational change or transformation**.

PREPAREDNESS PHASE

Why Prepare?
As disasters have become more complex and grown in scope, the need for preparedness has become more apparent. Disasters of varying scale have occurred in the New York City area for decades. These have ranged from house and apartment fires to large-scale disasters such as those of September 11th. Emergency services have increasingly become both more sophisticated and coordinated—particularly governmental services. The faith community continues to struggle to develop a similar level of sophistication and coordination but there remains a need to prepare further.

Such preparation is paramount if survivors, victims, and their families are to recover from devastating disasters. The ethnic, linguistic, cultural, religious, and heritage diversity of the New York City area adds to the challenge of developing appropriate responses to meet not only the immediate physical and material needs of those affected, but also the demanding emotional and spiritual needs of the long-term recovery process. The faith community can contribute significantly by learning more about the nature and scope of disasters from an emotional and spiritual perspective, as well as by building on the best practices already developed by those who have experienced previous disaster responses.

The resources listed in the resource section of this chapter will help build further awareness, understanding, and knowledge about appropriate responses. Take time to learn more about the phases of recovery and the emotional and spiritual dimensions of preparedness – and remember to include other services in the care your provide, as appropriate.

RESOURCES

FURTHER READING AND RESOURCES

Books and Articles

Church World Service, *Bringing God's Presence to Trauma Victims*. Order from **www.cwserp.org**

Church World Service, *Cooperative Faith–Based Disaster Recovery in Your Community*. Order from **www.cwserp.org**

Church World Service, *Guide to Disaster Ministry in Your Congregation*. Order from **www.cwserp.org**

Ehrenreich, John H., *Coping with Disasters: A Guidebook to Psychosocial Intervention*.
Download from **www.mhwwb.org/copingwithdisaster.pdf**

Harbough, Gary, *Act of God, Active God*. This pocket guide addresses spiritual understandings of faith questions arising from natural disasters. Order from **www.augsburgfortress.org**

Herman, Judith. *Trauma and Recovery: The aftermath of violence—from domestic abuse to political terror*. Basic Books, 1997. A classic that provides valuable information on trauma and the stages of recovery.

Joseph, Judith C., *A Chaplain's Companion*. This pocket-sized booklet describes the major faith traditions and rituals helpful to working in a hospital, nursing home, hospice, or long-term care facility. It also provides prayers appropriate to those faith traditions when operating in an inter-religious setting. It is particularly aimed for chaplaincy work.
Contact: **www.conexuspress.com**

Melander Rochelle, & Eppley, H., *The Spiritual Leader's Guide to Self-Care*, Bethesda, MD. The Alban Institute, 2002. This resource is a companion for religious leaders, lay leaders, and others who would like guidance about how to make changes in their personal life and ministry with regard to vision, work, relationships, and spiritual and intellectual needs.

Internet Resources

The Alban Institute provides a listing of resources available from the Alban Institute for laity and ordained. **www.alban.org**

The Centering Corporation provides resources for pastoral care to bereaved individuals as well as pastoral resources for responding to grief as a result of a death or other non-death related loss. **www.centering.org**

Church World Service provides an introduction to some of the stressors, defines stress and trauma, describes symptoms, discusses what to do after you experience a traumatic event, offers aids to the management of cumulative stress, and offers links and on-line resources to further resources. **www.churchworldservice.org/hr/self-care/stress-tauma/index.html**

The International Critical Incident Stress Foundation provides a bookstore listing of reading materials useful for crisis intervention. **www.icisf.org**

The Sidran Institute provides suggested essential readings in understanding trauma, treatment issues, trauma and memory, and provides links to training opportunities. **www.sidran.org/essential.html**

Preparedness and Training Information

The Association of Traumatic Stress Specialists provides a broad range of useful, published resources, including resources for training and study. **www.atss-hq.com**

Church World Service posts training opportunities for disaster preparedness as well as post-disaster training for ecumenical and inter-religious participants. **www.churchworldservice.org**

Eastern Mennonite University provides information about training opportunities in the New York area, as well as information on the trauma awareness and resilience training offered on the EMU campus through the STAR (Seminars on Trauma Awareness and Resilience) Program. **www.emu.edu/ctp/star_intro.htlm**

The Federal Emergency Management Agency provides current information about FEMA assistance programs, meetings, training events, and other useful up-to-date information on recovery assistance and disaster preparedness. **www.fema.gov** Of particular interest is the FEMA "Are You Ready" guide prepared for citizen preparedness, which can be downloaded from **www.fema.gov/areyouready/why_prepare**

The International Critical Incident Stress Foundation provides an abundant resource reading list on crisis intervention and stress management techniques. **http://www.icisf.org**

New York Disaster Interfaith Services provides information about training events in the Greater New York Area. **www.nydis.org**

Self-Care

3

BY AUSMA O. MURSCH, THE REVEREND CANON STORM SWAIN & THE REVEREND STEPHEN HARDING

Ausma Mursch is the former Executive Director of Lutheran Counseling Service. Following 9/11, her agency offered spiritual care and counseling for individuals and families impacted by the disaster, and then established a self care program for religious leaders that has received national recognition.

The Reverend Stephen Harding, Editor, is an Episcopal priest in the Diocese of New York. After 9/11, he served in the Family Assistance Centers, the Respite Centers, and the Temporary Morgue at Ground Zero. He currently is the Director of Pastoral Care at NYU Medical Center and the Protestant Chaplain for the Fire Department of the City of New York.

The Reverend Canon Storm Swain is the former Canon Pastor at the Cathedral of St. John the Divine and the Co-Chair of the Episcopal Diocese of New York's Disaster Response Team. She is part of the Leadership Team of Disaster Chaplaincy Services – NY and serves on the NYDIS Board of Directors.

Introduction

Cura Animarum is the Latin for *"the care of the soul".* Spiritual leaders have been and continue to be in the business of caring for souls, forgetting that their own personal souls also need attending. Unless you take time to care for your own needs, you may not be effective in supporting others. This involves being vigilant in tending to one's own care, one's wholeness. In medical terms we would refer to it as a prescription for health. Such a prescription involves choosing a treatment plan, implementing the plan, and finally safeguarding that plan so that it cannot be sabotaged. Sometimes it involves reaching out for support and encouragement.

"Faith is a bird that sings to the dawn, while it is still dark." Kabir, the Indian religious poet, wrote these powerful words many centuries ago. They still evoke meaning for us today, as we so often become victims of the darkness, forgetting the "light giving" resources of our faith and our faith communities.

This is especially true in a disaster. While the information below is intended to help one cope during a disaster, they are also part of a balanced lifestyle. In general, not paying attention to these things as part of one's leadership style is not good, and one's personal well-being is exacerbated during a disaster.
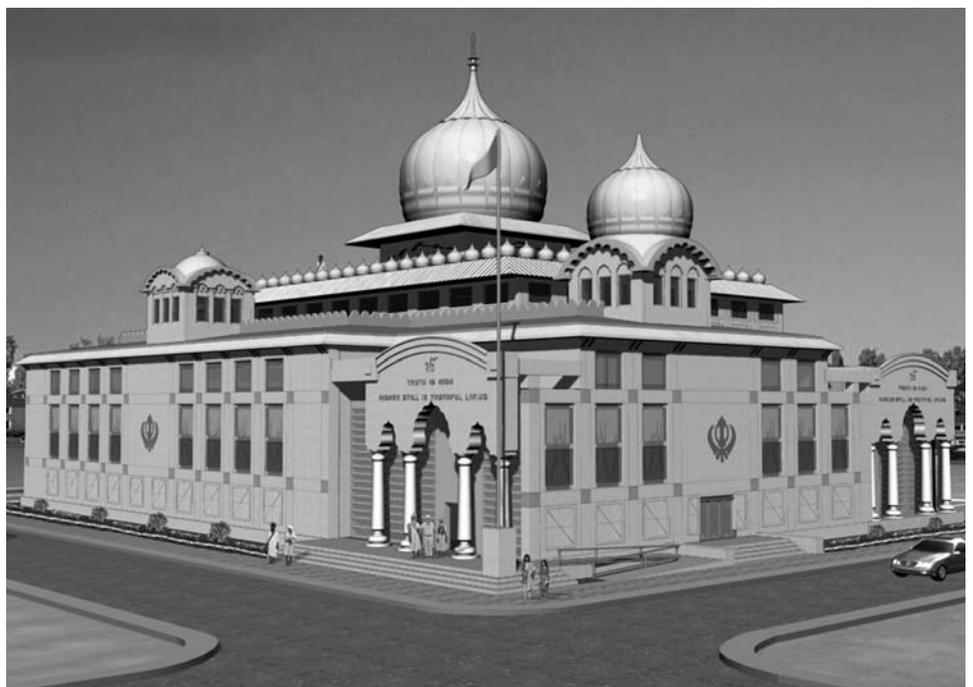
Unless you take time to care for your own needs, you may not be effective in supporting others.

As part of one's preparedness plan it is important to be aware of the normal signs and symptoms that occur during a disaster. Such knowledge would also be useful in helping others who may be in need of support – identify the following in advance:
• What nourishes you?
• Who can you talk to about your experience as (a) religious leader or chaplain?
• What is your support structure?
• Are you spending enough time with your family and your friends?
• Are you currently doing any of the following:
  – Exercising
  – Paying attention to your spiritual practices
  – Eating nutritious food
  – Finding the time you need for yourself
  – Doing things that give you pleasure

A number of self-care questionnaires are provided as the appendix to this chapter. It is suggested that you familiarize yourself with the content and complete them after a crisis situation has occurred.

It is important to be aware of the normal reaction and symptoms that occur during a disaster for one's own well-being and in support of others. There are many helpful resources, herein we have noted one specific resource from the US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA) website, **www.mentalhealth.samhsa.gov**.

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS

Individual Approaches for Stress Prevention and Management [1]

1. Manage workload:
   • Set priority levels for tasks with a realistic work plan.
   • Delegate existing workloads so workers are not attempting disaster response in addition to their usual jobs.

2. Balance lifestyle:
   • Get physical exercise and stretch muscles when possible.
   • Eat nutritiously and avoid excessive junk food, caffeine, alcohol, or tobacco.
   • Get adequate sleep and rest, especially on longer assignments.
   • Maintain contact and connection with primary social supports.

3. Apply stress reduction techniques:
   • Reduce physical tension by such activities as taking deep breaths, meditating, and walking mindfully.
   • Use time off for exercising, reading, listening to music, taking a bath, talking to family, or getting a special meal.
   • Talk about emotions and reactions with coworkers during appropriate times.

4. Practice self-awareness:
   • Learn to recognize and heed the early warning signs of stress reactions.
   • Accept that you may need help to assess problematic stress reactions.
   • Avoid overly identifying with survivors'/victims' grief and trauma, which may interfere with discussing painful material.
   • Understand differences between professional helping relationships and friendships.
   • Examine personal prejudices and cultural stereotypes.
   • Be mindful that vicarious traumatization or compassion fatigue may develop.
   • Recognize when a personal disaster experience or loss interferes with effectiveness.

Normal Reactions to a Disaster Event

• No one who responds to a mass casualty event is untouched by it.
• Profound sadness, grief, and anger are normal reactions to an abnormal event.
• You may not want to leave the scene until the work is finished.
• You will likely try to override stress and fatigue with dedication and commitment.
• You may deny the need for rest and recovery time.
• You may experience guilt or other emotions more fully or less fully than you usually do.

Self-Care **23**

Signs That You May Need Stress Management Assistance

- Disorientation or confusion and difficulty communicating thoughts.
- Difficulty remembering instructions.
- Difficulty maintaining balance.
- Becoming easily frustrated and being uncharacteristically argumentative.
- Inability to engage in problem-solving and difficulty making decisions.
- Unnecessary risk-taking.
- Tremors/headaches/nausea.
- Tunnel vision/muffled hearing.
- Colds or flu-like symptoms.

- Limited attention span and difficulty concentrating.
- Loss of objectivity.
- Inability to relax when off-duty.
- Refusal to follow orders or to leave the scene.
- Increased use of drugs/alcohol.
- Unusual clumsiness.
- Disruption of prayer life.
- Insomnia.
- Becoming angry.
- Feeling unseen and/or unheard.
- An increase in taking over the counter drug.

Ways to Help Manage Stress

- Limit on-duty work hours to what you can do and still be effective.
- Work until cognitive decision-making is affected.
- Rotate work from high stress to lower stress functions.
- Rotate work from the scene to routine assignments, as practicable.
- Use counseling assistance programs available through your agency.
- Drink plenty of water, and eat healthy snacks like fresh fruit, whole grain breads, and other energy foods.
- Take frequent, brief breaks from the scene as practical.
- Talk about your emotions to process what you have seen and done.
- Stay in touch with your family and friends.

- Participate in memorials, rituals, and use of symbols as a way to express feelings.
- Pair up with another responder so that you may monitor one another's stress.
- Remember to keep praying and to use the resources of your own faith tradition for yourself.

Care for Religious Leaders

1. It's important for religious leaders to know that people may have one, some or all of the following feelings and reactions after a trauma or disaster. These are common and normal reactions to a traumatic event.
- Anger at God
- Feeling distant from God
- Withdrawal from one's place of worship
- Uncharacteristic involvement in/with the house of worship
- Sudden turn toward God
- Familiar faith practices seem empty (prayers, scriptures, hymns)
- Religious rituals and sacraments seem empty
- Belief that God is powerless
- Loss of meaning and purpose
- Sense of isolation (from God, worshipping community, religious leader(s)
- Questioning of one's basic beliefs
- Anger at religious leader(s)
- Believing God is not in control
- Believing God doesn't care
- Belief that we have failed God[2]

In addititon, Pastor Tom Taylor (a Lutheran) offers personal reflections related to self-care that may be helpful. These can be found on the Lutheran Disaster Response of New York (LDRNY) website: **www.ldrny.org**

It is important to be aware of the normal reaction and symptoms that occur during a disaster for one's own well-being and in support of others.

If you suspect that you have compassion fatigue, please consult with either a mental health professional or a colleague who is knowledgeable about it.

Recommendations

1. Religious leaders should never defend God. As my CPE supervisor reminded me after one of my verbatim reports: "God doesn't need a defense attorney. God needs you to listen!"

2. When words are in doubt, silence is golden. Physical presence is more important than carefully constructed theological statements.

3. Language that is not helpful may include phrases such as:"I know how you feel" if you don't. It is better to say, "I don't know how you feel; can you share with me what it is like?"

4. Religious leaders should never use the following phrases: "This was God's will," "God took your loved one because he needed an angel in heaven," "Your husband is better off in heaven with God." Also, if someone makes these statements to a religious leader, the religious leader should never correct them, I know the temptation is there but don't do it!

5. On self-care: Religious leaders need to know that listening to another's trauma can lead to secondary trauma or what is sometime called compassion fatigue or vicarious traumatization (see below). Some handle it better than others.

6. Have a mentor/friend who will listen, not judge, but also will be honest in reflecting back what he/she sees how you are functioning.

7. A spiritual director can be as important as a therapist. Absolutely!

8. Have activities, hobbies or interests outside of the house of worship — a hobby, sport, reading….etc.

9. Keeping a journal of personal experiences, feelings and thoughts – they can be very helpful in processing the experience in a healthy way.

10. Let family members know if you are stressed out or zoned out because of dealing with a crisis experience. Spouses and children may think their behavior is at fault, if a religious leader is moody or spaced out. I know from personal experience!

11. Keep a sense of humor, where appropriate, of course! It is a lifesaver.[2]

Compassion Fatigue

One of the dangers in providing spiritual care and/or emotional support is the inherent risk of secondary trauma – of being traumatized simply by hearing the direct victims' own experience of what the disaster or trauma was like for them. This phenomenon is known as secondary stress disorder, vicarious traumatization, and/or compassion fatigue.

Because secondary trauma can have the same or similar symptoms as primary trauma, or later, Post Traumatic Stress Disorder (PTSD), we are listing them here so that you can recognize them in others or in yourself. If you suspect that you have compassion fatigue, please consult with either a mental health professional or a colleague who is knowledgeable about it.

N.B. Post-Traumatic Stress Disorder (PTSD) requires an 'incubation period' of thirty (30) days from the time of the trauma before it can be diagnosed as PTSD. If a diagnosis is made within the first thirty days after traumatization, the diagnosis may be Acute Stress Disorder. (For further information, please contact a mental health professional.)

Burnout is the state of physical, emotional, and mental exhaustion caused by a depletion of ability to cope with one's environment and the demands of one's daily life.

The three symptom clusters of PTSD[3] are:

Intrusion

1. Recurrent and intrusive distressing recollections of the event, including thoughts, images, and perceptions;

2. Recurrent distressing dreams of the event;

3. Acting or feeling as if the traumatic event was recurring (including a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes);

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;

5. Physiological reactivity or exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Avoidance

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma;

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma;

3. Inability to recall an important aspect of the trauma;

4. Markedly diminished interest or participation in significant activities;

5. Feeling of detachment or estrangement from others;

6. Restricted range of affect (e.g., unable to have loving feelings);

7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

Arousal

1. Difficulty falling or staying asleep;

2. Irritability or outbursts of anger;

3. Difficulty concentrating;

4. Hypervigilance;

5. Exaggerated startle response.

Like PTSD, burnout can affect anyone. *Burnout is the state of physical, emotional, and mental exhaustion caused by a depletion of ability to cope with one's environment and the demands of one's daily life.* Post-traumatic stress disorder is an anxiety disorder caused by exposure to an overwhelming traumatic event, in which the person later repeatedly re-experiences the event.

Compassion Fatigue, however, is a state that uniquely affects caregivers, e.g. religious leaders, emergency workers, and psychotherapists, due to working with traumatized populations. Immediately following 9/11, or any disaster, you may have spent days, months, and longer listening to personal testimonies of the grief and trauma experienced by members of your faith community. Constant exposure to this kind of secondary traumatic stress, coupled with your own experiences, puts you at risk for Compassion Fatigue. Figley (1996) defines Compassion Fatigue as "*a state of tension and preoccupation with the individual or cumulative trauma of clients.*"

Religious leaders and other caregivers can develop resiliency to the effects of crisis by maintaining a system for personal self-care. Key to this self-care system is the establishment of healthy habits and the development of skills that help you to maintain a balance in your life. By maintaining this balance through comprehensive self-care, one can can become more effective, energetic, creative, and enthusiastic – both personally and professionally. Also, as religious leaders, one can become models of wellness and faith for the people for whom you care.

If the religious leader does not practice good self-care, caring for others can be overwhelming.

Remember: By responding to the needs of others, spiritual caregivers are always at risk for compassion fatigue or secondary trauma. Self-care is essential to remain effective through all phases of a disaster!

If the religious leader does not practice good self-care, caring for others can be overwhelming. Compassion Fatigue may occur particularly in individuals who are in a position of helping and supporting others. Religious leaders are on the list of helping professions that may be susceptible to Compassion Fatigue. It is critical to assess one's compassion fatigue symptoms using a tool such as "The Compassion Fatigue Scale-Revised" (Figley, Baranowsky & Gentry; *please refer to Appendices D and E of this chapter*). This is especially important in times when the demand for support is high. Continual provision of spiritual care and emotional support above and beyond the already established high expectations for religious leaders makes those lacking established systems for self-care even more vulnerable. Pay attention to yourself!

Conclusion: Caring for one's self may initially appear selfish. However, in order to remain an effective caregiver to those affected by a disaster, awareness of and provision for one's own well-being and provision for same needs to be maintained throughout all phases of a disaster.

Editor's Note: The resources and websites listed here are provided by the authors as resources for issues raised in this chapter. For a list of all the resources provided in this manual, please refer to Chapter 10, just before the Reference Section.

RESOURCES

Academy of Traumatology: **http://www.traumatologyacademy.org**.

The Lutheran Counseling Center (LCC), with support from LDRNY, has put together a comprehensive, holistic health and wellness pilot program designed especially for pastors. LCC's pastoral health and wellness program offers pastors tools to create personal health and wellness, through professional support, small groups of colleagues working with you, educational forums, and interactive web site consultation: **www.lcc132.org**.

Lutheran Disaster Response New York (LDRNY): **www.ldrny.org**.

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration: **http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf**.

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This Chapter has the following Appendices:

Appendix A: Model Self-Care Programs

Appendix B: Standards of Self-Care (Traumatological Institute)

Appendix C: Clergy Burnout Inventory (CBI)

Appendix D: Compassion Satisfaction/Fatigue Self-Test

Appendix E: Compassion Satisfaction/Fatigue Interpretation Scale

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[1] From the US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration website: **http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf**.

[2] Items 1 (p.24) and 1-11 (p.25) are from Pastor Tom Taylor, in resources/spiritual care on the LDRNY website, **www.ldrny.org**

[3] From "Diagnostic Criteria for 309.81 Posttraumatic Stress Disorder," DSM-IV, American Psychiatric Association, Washington, DC, 1994, p. 428

[4] From the Academy of Traumatology Green Cross' website. These standards and more information can be found at **http://www.traumatologyacademy.org**.

MODEL SELF-CARE PROGRAMS

Comprehensive Health and Wellness Program:

"*Consultation Circles for Personal and Professional Growth and Renewal*"

Description of the Circles Program
   In 2003, in response to the need for a program that might provide care for the caregiver, most especially religious leaders in the aftermath of 9/11, the **Lutheran Counseling Center** launched a successful yearlong proactive health and wellness pilot project, tailored for religious leaders, to promote and sustain habits of wellness. The *Consultation Circles for Personal and Professional Growth and Renewal* initiative was designed to address the comprehensive health and wellness of religious leaders in a very personal way, yet in a group context for the purpose of providing a sense of support as well as mutual accountability. Due to the well-documented link between the health of spiritual leaders and the vitality of their faith communities, the *Consultation Circles Program* was grounded in the concept that by helping religious leaders care for themselves, the ultimate beneficiaries would be the faith communities they serve. The goal of the program was to assist religious leaders in adopting a self-care process for increased effectiveness and empowerment in their personal and professional lives.

   Through the utilization of resources from well-known and respected health and wellness experts, *Consultation Circles for Personal and Professional Growth and Renewal* offers a completely innovative, fresh approach to self-help. The program is carried out through Consultation Circles consisting of a maximum of eight members. Each Circle is part of a three-stage process. The program is a comprehensive program that involves a twelve-month commitment by the participants. A key and distinctive component of the program is the built-in system of accountability that helps to keep participants motivated and connected.

Through the program one also receives:

• Support for the development of a personal plan for health and wellness.
• Professional support personnel to help create and follow a personal prescription for wellness.
• A small group of colleagues and a group facilitator with whom to meet for collegial support, spiritual and professional discussions, and accountability.
• Educational forums that can address issues related to family dynamics, establishing and maintaining personal boundaries for good mental health and overall wellness, establishing and nurturing spiritual disciplines, personal finances and financial planning and identifying symptoms of Compassion Fatigue and the necessary self-care disciplines and resources to develop resiliency to Compassion Fatigue.
• Skills for addressing issues affecting personal and professional effectiveness.
• A process for personal renewal and health maintenance.
• A program for modeling wholeness and wellness in the context of one's daily life and vocation.

In **Stage One** of the program, through regular group meetings and individual consultations, relationships are established with other group members and the Consultation Circle facilitator. Throughout Stage One, participants work collaboratively with a team of wellness advisors and the Circle facilitator to develop a personal prescription for growth and renewal by establishing attainable goals in the areas of physical, spiritual and mental wellness as well as a vocational calling. Participants also take part in educational forums and in a comprehensive assessment to identify areas of health strengths and risks to provide a basis for the development of personal goals.

Stage Two begins the implementation of one's personal prescription plan, which is designed to enhance identified strengths and provide opportunities for growth and change in the areas of deficiency. To support the identified health and wellness goals, one would follow a schedule of tasks, activities, and prescribed practices. During this stage, each Consultation Circle reconvenes on a monthly basis for educational forums, mutual accountability, and collegial support.

MODEL SELF-CARE PROGRAMS

Stage Three involves the application of learned insights and newly established skills and habits in the context of one's professional life. Participants are encouraged and supported in making such applications; they are also guided in well-established processes for responding to issues and crises specific to one's faith community, as well as those of the wider community. One's Consultation Circle would reconvene on a monthly basis for these purposes, as well as continued accountability and collegiality.

Program Availability

The program is available to faith-based organizations who are interested in contracting for this one-year self-care accountability model program.

Consultation Circles Program Evaluation and Resources

Group Facilitators respond to the question:
  "What was the most outstanding outcome as a result of the program?"
  • *"The program clearly served as a motivator to alter members' behaviors and health needs."*
  • *"It has the potential to be a bellwether in spiritual care and support."*
  • *"The participants high level of investment in the process."*
  • *"The program gave a way for participants to respond to unpressured and non-judgmental self-examination."*

Participants respond to the question:
  • "What aspect of the program was most helpful?"
  • *"The fact that I was accountable to and supported by a group of colleagues who were also sharing in their experiences."*
  • *"Someone was there to listen and support me."*
  • *"The process was flexible and yet accountability based."*
  • *"The positive change in my personal life that occurred as a result of my participation."*
  • *"The openness of the group process."*
  • *"My commitment to the process. I blocked it out on my calendar as my time."*
  • *The professional skill of the facilitator to be there but not to interfere with the process."*

Resources from this program are available by contacting the Lutheran Counseling Center at **www.lcc132.org**. or (**ausmam@aol.com**)

STANDARDS OF SELF-CARE PROGRAMS

These Standards of Self Care from the Academy of Traumatology Green Cross[4], based at Florida State University, are intended as interventions to be followed – for oneself – throughout all phases of a disaster.

I. Purpose of the Guidelines

As with the standards of practice in any field, the practitioner is required to abide by standards of self-care. These Guidelines are utilized by all members of the Green Cross. The purpose of the Guidelines is twofold: First, **do no harm to yourself** in the line of duty when helping/treating others; Second, **attend to your physical, social, emotional, and spiritual needs** as a way of ensuring high quality services for those who look to you for support as a human being.

II. Ethical Principles of Self-Care in Practice: These principles declare that it is unethical *not* to attend to your self-care as a practitioner, because sufficient self care prevents harming those we serve.

1. Respect for the dignity and worth of self: A violation lowers your integrity and trust.
2. Responsibility of self-care: Ultimately, it is your responsibility to take care of yourself, and no situation or person can justify neglecting it.
3. Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

III. Standards of Humane Practice of Self-Care

1. Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
2. Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
3. Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
4. Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since it can compromise their competence as a helper.

IV. Standards for Expecting Appreciation and Compensation

1. Seek, find, and remember appreciation from supervisors and clients: These and other activities increase worker satisfaction that sustain them emotionally and spiritually in their helping.
2. Make it known that you wish to be recognized for your service: recognition also increases worker satisfactions that sustain them.
3. Select one or more advocates: They are colleagues who know you as a person and as a helper and are committed to monitoring your efforts at self care.

V. Standards for Establishing and Maintaining Wellness

Section A. Commitment to self care

1. Make a formal, tangible commitment: Written, public, specific, and measurable promise of self-care.
2. Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
3. Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Section B: Strategies for letting go of work

1. Make a formal, tangible commitment: Create a written, public, specific, and measurable promise of letting go of work in off hours and embracing rejuvenation activities that are fun, stimulating, inspiriting, and generate joy of life.
2. Set deadlines and goals: The "letting go of work" plan should set deadlines and goals connected to specific activities of self-care.
3. Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

STANDARDS OF SELF-CARE PROGRAMS

Section C. Strategies for gaining a sense of self care achievement

1. Strategies for acquiring adequate rest and relaxation: The strategies are tailored to your own interest and abilities which result in rest and relaxation most of the time.
2. Strategies for practicing effective daily stress reductions method(s): The strategies are tailored to your own interests and abilities in effectively managing your stress during working hours and off-hours with the recognition that they will probably be different strategies.

VI. Inventory of Self Care Practice — Personal

Section A: Physical

1. Body work: Effectively monitoring all parts of your body for tension and utilizing techniques that reduce or eliminate such tensions.
2. Effective sleep induction and maintenance: An array of healthy methods that induce sleep and a return to sleep under a wide variety of circumstances including stimulation of noise, smells, and light.
3. Effective methods for assuring proper nutrition: Effectively monitoring all food and drink intake and lack of intake with the awareness of their implications for health and functioning.

Section B: Psychological

1. Effective behaviors and practices to sustain balance between work and play.
2. Effective relaxation time and methods.
3. Frequent contact with nature or other calming stimuli.
4. Effective methods of creative expression.
5. Effective skills for ongoing self-care:
   a. Assertiveness
   b. Stress reduction
   c. Interpersonal communication
   d. Cognitive restructuring
   e. Time management
6. Effective skill and competence in meditation or spiritual practice that is calming.
7. Effective methods of self-assessment and self-awareness.

Section C: Social/interpersonal

1. Social supports: At least five people, including at least two at work who will be highly supportive when called upon.
2. Getting help: Knowing when and how to secure help – both informal and professional – and knowing that the help will be delivered quickly and effectively.
3. Social activism: Being involved in addressing or preventing social injustice that results in a better world and a sense of satisfaction for trying to make it so.

VII. Inventory of Self Care Practice – Professional

1. Balance between work and home: Devoting sufficient time and attention to both without compromising either.
2. Boundaries/limit setting: Making a commitment and sticking to it regarding:
   a. Time boundaries/overworking
   b. Therapeutic/professional boundaries
   c. Personal boundaries
   d. Dealing with multiple roles (both social and professional)
   e. Realism in differentiating between things one can change and accepting those things that one cannot change or that can only be changed by others

STANDARDS OF SELF-CARE PROGRAMS

3. Getting support/help at work through:
    a. Peer support
    b. Supervision/consultation/therapy
    c. Role models/mentors
4. Generating work satisfaction by noticing and remembering the joys and achievements off the work

VIII. Prevention Plan development
1. Review current self-care and prevention functioning.
2. Select one goal from each category.
3. Analyze the resources for and resistances to achieving goal.
4. Discuss goal and implementation plan with support person.
5. Activate plan.
6. Evaluate plan weekly, monthly, yearly with support person.
7. Notice and appreciate the changes.

CLERGY BURNOUT INVENTORY

Editor's Note: In the interest of faithfulness to the author's work and research, we have chosen to leave the survey instrument as it was written rather than rewriting (and changing) a research instrument to be one with more inclusive language.

CLERGY BURNOUT INVENTORY (CBI)
Developed by Roy M. Oswald, The Alban Institute, Inc.

For each question, circle the number from 1 to 6 that best describes you. Then add all your answers for your total score.

1. The extent to which I am feeling negative or cynical about the people with whom I work.

1	2	3	4	5	6
Optimistic about parishioners					Cynical about parishioners

2. I enjoy my work and look forward to it regularly.

1	2	3	4	5	6
High internal energy for my work					Loss of enthusiasm for my job

3. The extent to which I invest myself emotionally in my work in the parish.

1	2	3	4	5	6
Highly invested emotionally					Withdrawn and detached

4. The extent to which fatigue and irritation are part of my daily experience.

1	2	3	4	5	6
Cheerfulness, high energy much of the time					Tired and irritated much of the time

5. The extent to which my humor has a cynical, biting tone.

1	2	3	4	5	6
Humor reflects a positive joyful attitude					Humor is cynical and sarcastic

6. The extent to which I find myself spending less and less time with my parishioners.

1	2	3	4	5	6
Eager to be involved with parishioners					Increasing withdrawal from parishioners

7. The extent to which I am becoming less flexible in my dealings with members of my house of worship.

1	2	3	4	5	6
Remaining open and flexible with parishioners' needs and wants					Becoming more fixed and rigid in dealing with parishioners

8. The extent to which I feel supported in my work.

1	2	3	4	5	6
Feeling fully supported					Feeling alone and isolated

CLERGY BURNOUT INVENTORY

9. The extent to which I find myself frustrated in my attempts to accomplish tasks important to me.

1	2	3	4	5	6
Reasonably successful in accomplishing tasks					Mainly frustrated in accomplished tasks

10. The extent to which I am invaded by sadness I can't explain.

1	2	3	4	5	6
Generally optimistic					Sad much of the time

11. The extent to which I am suffering from physical complaints (e.g., aches, pains, headaches, lingering colds, etc.).

1	2	3	4	5	6
Feeling healthy most of the time					Constantly irritated by physical ailments

12. The extent to which sexual activity seems more trouble than it is worth.

1	2	3	4	5	6
Sex is a high					Sexual activity is just another responsibility

13. The extent to which I blame others for problems I encounter.

1	2	3	4	5	6
Minimal blaming or scapegoating					Others are usually to blame for the malaise I'm feeling

14. The extent to which I feel guilty about what is not happening in this parish or with parishioners.

1	2	3	4	5	6
Guilt free					Feeling guilty much of the time

15. The extent to which I am biding my time until retirement or a change of job.

1	2	3	4	5	6
Highly engaged in my work					Doing what I have to to get by

16. The extent to which I feel used up and spent.

1	2	3	4	5	6
High source of energy for my work					Feeling empty and depleted

Total score (sum of all numbers circled) _____

CLERGY BURNOUT INVENTORY

Total score (sum of all numbers circled) _____

0-32   **Burnout is not an issue**
33-48   **Bordering on burnout**
49-64   **Burnout is a factor in my life**
65-80   **You are a victim of extreme burnout. Your life needs a radical**
              change so you can regain your health and vitality.

Before going on, take a minute to fully absorb the meaning of your total score. If you have a score of forty or less, burnout is not really a factor in your life as a spiritual leader. If your stress and strain scores are of concern to you, you may want to focus more on the self-care strategies that deal with stress.

If you have a score of fifty or more, the recommendation is that you seriously look at the impact that burnout is having on your ministry and primary relationships and what is causing you to be burned out. The following reflection questions may help you focus:

1. Because burnout usually creeps up on us unaware, recall the times when you were not experiencing this condition. What changes took place in your life and/or work to help bring this about?

2. What are some options that could help to alleviate the symptoms of burnout?

3. Who are the individuals or resources you can turn to for help in reversing the burnout trends in your life?

COMPASSION SATISFACTION/FATIGUE SELF-TEST

COMPASSION SATISFACTION/FATIGUE SELF-TEST FOR HELPERS

Helping others puts you in direct contact with other people's lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test helps you estimate your compassion status: How much at risk you are for burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your correct situation. Print a copy of this assessment so that you can fill out the numbers and keep them for your future use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics in the last week. Then follow the scoring directions at the end of the self-assessment

0–Never   1–Rarely   2–A Few Times   3–Somewhat often   4–Often   5–Very Often

Items about You

_____   1. I am happy.
_____   2. I find my life satisfying.
_____   3. I have beliefs that sustain me.
_____   4. I feel estranged from others.
_____   5, I find that I learn new things from those I care for.
_____   6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
_____   7. I find myself avoiding certain activities or situations because they remind me of a trauma.
_____   8. I have gaps in my memory about frightening events.
_____   9. I feel connected to others.
_____ 10. I feel calm.
_____ 11. I believe that I have a good balance between my work and my free time.
_____ 12. I have difficulty falling or staying asleep.
_____ 13. I have outbursts of anger or irritability with little provocation.
_____ 14. I am the person I always wanted to be.
_____ 15. I startle easily.
_____ 16. While working with a victim, I thought about violence against the perpetrator.
_____ 17. I am a sensitive person.
_____ 18. I have flashbacks connected to those I help.
_____ 19. I have good peer support when I need to work through a highly stressful experience.
_____ 20. I have had first-hand experience with traumatic events in my adult life.
_____ 21. I have had first-hand experience with traumatic events in my childhood.
_____ 22. I think that I need to "work through" a traumatic experience in my life.
_____ 23. I think that I need more close friends.
_____ 24. I think that there is no one to talk with about highly stressful experiences.
_____ 25. I have concluded that I work too hard for my own good.
_____ 26. Working with those I help brings me a great deal of satisfaction.
_____ 27. I feel invigorated after working with those I help.
_____ 28. I am frightened of things a person I helped has said or done to me.
_____ 29. I experience troubling dreams similar to those I help.
_____ 30. I have happy thoughts about those I help and how I could help them.
_____ 31. I have experienced intrusive thoughts of times with especially difficult people.
_____ 32. I have suddenly and involuntarily recalled a frightening experience while working.

COMPASSION SATISFACTION/FATIGUE SELF-TEST

0–Never   1–Rarely   2–A Few Times   3–Somewhat often   4–Often   5–Very Often

_____   33. I am pre-occupied with more than one person I help.
_____   34. I am losing sleep over a person I helped through a traumatic experiences.
_____   35. I have joyful feelings about how I can help the victims I work with.
_____   36. I think that I might have been "infected" by the traumatic stress of those I help.
_____   37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
_____   38. I remind myself to be less concerned about the well being of those I help.
_____   39. I have felt trapped by my work as a helper.
_____   40. I have a sense of hopelessness associated with working with those I help.
_____   41. I have felt "on edge" about various things and I attribute this to work with certain experience.
_____   42. I wish that I could avoid working with some people I help.
_____   43. Some people I help are particularly enjoyable to work with.
_____   44. I have been in danger while working with people I help.
_____   45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment

_____   46. I like my work as a helper.
_____   47. I feel like I have the tools and resources that I need to do my work as a helper.
_____   48. I have felt weak, tired, run down as a result of my work as helper.
_____   49. I have felt depressed as a result of my work as a helper.
_____   50. I have thoughts that I am a "success" as a helper.
_____   51. I am unsuccessful at separating helping from personal life.
_____   52. I enjoy my co-workers.
_____   53. I depend on my co-workers to help me when I need it.
_____   54. My co-workers can depend on me for help when they need it.
_____   55. I trust my co-workers.
_____   56. I feel little compassion toward most of my co-workers.
_____   57. I am pleased with how I am able to keep up with helping technology.
_____   58. I feel I am working more for the money/prestige than for personal fulfillment.
_____   59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
_____   60. I find it difficult separating my personal life from my helper life.
_____   61. I am pleased with how I am able to keep up with helping techniques and protocols.
_____   62. I have a sense of worthlessness/disillusionment/resentment associated with my role.
_____   63. I have thoughts that I am a "failure" as a helper.
_____   64. I have thoughts that I am not succeeding at achieving my life goals.
_____   65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
_____   66. I plan to be a helper for a long time.

COMPASSION SATISFACTION/FATIGUE INTERPRETATION SCALE

Interpreting Your Score

The Compassion Satisfaction/Fatigue Self Test measures the following:

• Compassion Satisfaction
• Compassion Fatigue
• Burnout

Scoring

• **Circle** the following 23 items: 4, 6-8, 12-13, 15-16, 18, 20-22, 28-29, 31-34, 36, 38-40, 44.
• **Put a check** by the following 16 items: 17, 23-25, 41-42, 45, 48, 49, 51, 56, 58, 60, 62-65.
• **Put an X b**y the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.

Add the numbers you wrote next to the items for each set of items and note.

Interpretation

• Add all **circled** numbers for your **Compassion Fatigue** risk factor.

                                                      TOTAL=_____

      26 or less=extremely low risk;
      27-30=low risk;
      31-35=moderate risk;
      36-40=high risk;
      41 or more=extremely high risk.

• Add all numbers with **checks** beside them for your **Burnout** risk:

                                                      TOTAL=_____

      36 or less=extremely low risk;
      37-50=moderate risk;
      51-75=high risk;
      76-85=extremely high risk.

• Add all numbers marked with an **"X"** for your **Compassion Satisfaction** factor:

                                                      TOTAL=_____

      118 and above=extremely high potential;
      100-117=high potential;
      82-99=good potential;
      64-81=modest potential;
      Below 63-0=low potential.

Adapted with permission from Figley, C.R., (1009) *Compassion Fatigue*, New York: Brunner/Mazel B. Hubnall Stamm, Traumatic Stress Research Group, 1995-1998.

Radical Hospitality:

HOUSES OF WORSHIP RESPONDING TO DISASTER

4

BY THE REVEREND LYNDON F. HARRIS

The Reverend Lyndon F. Harris is a priest in the Episcopal Church. He was priest of the parish at St. Paul's Chapel near Grand Zero, which became a comfort and hospitality center for recovery workers following 9/11.

Editor's note: This chapter deals with preparing the members of one's house of worship for either of two events, or both: The first is preparing for one's own disaster within one's house of worship (fire, flooding, etc.); the second is preparing the worshipping members to help others in the event of a disaster elsewhere in your community.

I. Introduction

While the world's great religions rarely agree on the particulars of faith, they do agree on the importance of service. To love one's neighbor as oneself is one of the benchmarks of the Abrahamic faiths of Judaism, Christianity and Islam, and virtually all of the world's religions. Service, for communities of faith, comes naturally. This was proven to be true during the tragedy of September 11, 2001, and has been re-proven many times since then.

Communities of all faiths from all over the metropolitan New York area, as well as those from around the world, worked together to respond to the crises of the moment. September 11, 2001 happened and it was covered by every media outlet in the world, but the equally important story is the story of September 12: the day we decided to get out of bed as individuals and as a nation to respond to the terrorists' violent attacks with hearts of compassion and service, to find and rescue any survivors and, ultimately, to lovingly recover the remains of the dead. For the communities of faith, September 12 and the ensuing months were shining moments of hope in the midst of despair, of courage in the midst of terror, and of hospitality in the midst of devastation.

Many faith communities and faith-based organizations provided a wide variety of services through numerous venues throughout the recovery effort after 9/11. And while our offerings were not perfect, what we were privileged to witness was nothing short of a glimpse of the kingdom of God in which all God's children of differing faiths and perspectives pulled together to make a difference. We were called to serve and serve we did. We called it *Radical Hospitality*: to give without any expectation of anything in return.

But how does one prepare for such events? How do communities of faith offer hospitality? There is a wide variety of possibilities when responding to the needs of a disaster-stricken community and this spectrum of response will be considered in this chapter. Certainly not every house of worship will need to transform its sanctuary into a respite center, but some will.

What does preparedness look like for a local house of worship? How does one prepare one's community of faith for responding to the needs of a wider community dealing with a disaster – whether man-made such as a terror attack, or natural, such as a hurricane or tornado or an earthquake. Being prepared to serve in such a time is an act of radical hospitality – embracing the great commandment to love one's neighbor as oneself.

Being prepared to respond can lessen the loss of life, as well as hasten the healing process.

In this chapter, I offer some thoughts on preparedness for houses of worship and explore what one might expect to experience in the life-cycle of a disaster at the level of a local house of worship. I have also interspersed some thoughts on best practices as they pertain to a house of worship's readiness to serve in the event of a disaster.

PREPAREDNESS PHASE

II. Preparing your House of Worship to Respond

As religious leaders in your community, you will have a unique opportunity to be agents of healing in the event of a disaster. This chapter is intended to be a resource to aid in spiritual care and emotional support for your community. Depending on your proximity to a given disaster, you could be called upon to serve in a variety of ways as pastoral caregivers and volunteers in all phases of the life cycle of a disaster. It is vital that self-care be exercised. Burnout and exhaustion are neither good for you, nor for the people you love and serve. Don't forget to pray, to read your tradition's sacred texts and to practice spiritual disciplines, especially when you feel that you "don't have time." These practices not only help keep you healthy and safe, but they also prepare you to be a "non-anxious presence" for those in your care. You cannot care for others if you do not care for yourself.

A. Preparing for a disaster in which your house of worship is directly affected (when it's happening to you)

The first step in disaster preparedness is to develop a plan for your own house of worship in case the disaster happens to you. Being prepared to respond can lessen the loss of life, as well as hasten the healing process. One of the most important responsibilities for those who lead is being prepared to care for the members of one's house of worship in the aftermath of a disaster. This is most effective through advanced planning.

Each house of worship should develop a disaster plan for itself. It's a good idea to review that plan with the local fire safety official and law enforcement for an evaluation.

The leadership of the laity is essential for the success of the plan because you, as the religious leader, will be overwhelmed by the demands on your time should a disaster happen to you. Encourage and delegate leadership to the laity, who are your best resource. Remember – people want to help and need tasks they can accomplish to feel helpful and not helpless!

Houses of worship are encouraged to have members trained for CPR and Emergency First Aid. These courses are readily available through the local chapter of the Red Cross and other such organizations. It's also helpful to collect the names of members who are emergency professionals and medical practitioners for possible reference in the event of a disaster.

Developing a plan for your house of worship for its own needs

Steps for developing a plan *(please see Appendix B of this chapter for a disaster plan template)*:

1. Appoint a disaster response coordinator and a disaster response committee for your house of worship who will coordinate and oversee preparedness efforts, communications, and any actual response to an emergency or disaster. Preparedness should not be limited to the religious leader. The participation of lay leaders is not only appropriate but vital. The administrative committee responsible for property, if there is one, is a natural choice for involvement here.

2. Begin by making an inspection of the buildings. Are exits clearly marked? Are fire extinguishers up-to-date? Do the smoke alarms have fresh batteries?

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In the event
of a disaster,
public worship
opportunities should
be offered as soon
as possible.

3. Have the disaster response committee complete the following risk survey. Preparedness means anticipating possible emergent situations based on an understanding of the disaster history of your geographic location.

   A. List the local disasters and emergencies that have happened in the last ten years in your area.

   B. Identify what disasters and emergencies are most likely to occur in your community. Identify potential areas of vulnerability. Consideration should be given to physical proximity to potential dangers. Examples include the proximity to a river or other significant body of water and the potential for flooding, or the proximity to a nuclear power plant and the radius of potential fallout.

   C. Discuss with religious and lay leadership the potential impact of such disasters.

4. Formulate plans for evacuation in case of an emergency or disaster. There should be a plan for evacuating the buildings during the week (emphasis is on staff and personnel), and on the day of worship when member traffic is high. These plans should be rehearsed and reviewed on a periodic basis. They should also be shared with all groups that use the facilities like Alcoholics Anonymous or a Boy and/or Girl Scout troop.

5. Write the disaster plan and distribute it to key leadership.

6. A communications network is essential. Each house of worship should establish a communications mechanism for reaching all members in the event of an emergency or disaster, providing for a means of communication both during and after an incident. A roster of members, along with all available contact numbers should be kept up to date and copies of this list should be stored in several protected places. Members with

special needs should be checked on at the very earliest possible moment.

7. The house of worship's disaster plan should be reviewed and updated annually.

8. Encourage members to maintain "GO Kits" and to prepare a family emergency plan. Guidelines for the creation of a GO Kit and for the development of a family emergency plan are provided in the appendices.

Being prepared to care for one's own house of worship is crucial. Then, if possible, houses of worship should be opened as community centers with available religious leaders on hand to respond to the pastoral needs of the community in the aftermath of a disaster. The ministry of presence, especially in the event of a disaster, should not be underestimated. In the event of a disaster, public worship opportunities should be offered as soon as possible. It is particularly important to hold public worship as soon as possible following a disaster, even if it is necessary to secure an alternate location for worship because your building has been damaged or compromised. This is an act of hope that affirms that God is at work even in the midst of the destruction.

Being prepared for a disaster is an important pastoral obligation. By preparing for a disaster, the house of worship is demonstrating God's love for both its own members and for the surrounding community.

An outreach to the community strengthens the capacity for emergency responders to perform more quickly and with better support.

B. Responding to the Needs of the Community

After developing a preparedness plan for one's own house of worship, it is helpful for houses of worship to consider serving as a ready respite center for the local community if the need should warrant. An outreach to the community strengthens the capacity for emergency responders to perform more quickly and with better support. A house of worship can become a respite center for the community by:

1. In advance, and in consultation with the members of your house of worship, consider whether your building and/or facility has the capacity to be a shelter (shower/bathing facilities are generally necessary), feeding center, or storage space in a disaster. If your facilities warrant, consider becoming a certified disaster shelter. There is a certification process through the Red Cross and the Office of Emergency Management for becoming an emergency shelter. Do not be afraid to contact them for the details and to see whether your house of worship can help in this way.

2. Encourage your worshipping members to take training courses available through the Red Cross and the Office of Emergency Management in order to become familiar with various aspects of relief and recovery in the community.

3. Consider stocking emergency supplies (especially water) at your facility.

4. Keep an up to date list of worshipping members who are licensed and/or certified in life saving, health, law enforcement, fire and emergency services in case there is a need to call on them.

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS

It sounds simple and obvious, but the first step is to identify whether the disaster is happening to you or to the wider community – adrenaline can inhibit thought and work against you. Take a deep breath and gather as much factual information as possible.

RESPONSE PHASE

On the day and days immediately following **a disaster to the house of worship**:

- Find out as much as you can about the nature of the disaster.
- Assemble disaster response committee.
- Implement house of worship's disaster plan.
- Pay attention to the needs of your family and loved ones.
- Practice self-care. Remember, you cannot care for others if you do not care for yourself.
- Be aware of your own emotional state.
- Pray.
- Assess damage to home, house of worship, and community. Contact your insurance company.
- Be in communication with local officials. Ask for whatever help you may need.
- Make contact with woshipping members, especially those with special needs and those who have suffered recent loss of life in their families.
- Begin planning opportunities for public worship. This is an act of hope and faith in God at work even in the midst of devastation. Public worship can be instrumental in healing.
- Practice self care.
- Attend to the members of one's house of worship pastorally offering theologically nuanced messages on tragedy and occasions for worship that facilitate meaning making and healing.
- Use pastoral skills to help those suffering loss. Help them process and alleviate emotional pain. Active and empathetic listening is key.

Radical Hospitality **44**

Radical hospitality is very demanding at times, but the irony is that we receive so much more than we give.

• If possible, serve as a chaplain at the disaster site and invite the members of your house of worship to participate in the recovery efforts.

After a disaster strikes a community, the members of the community may be overwhelmed. One of the most pastoral responses is to listen. By listening, the religious leader is able to assist those affected in the process of "meaning making" as well as to discern what needs they may have. "Meaning making" is the struggle to come to terms with the disaster and the repercussions for life afterwards. This is a long-term process.

RECOVERY PHASE

• Assess short term and long term needs of those in your care. Assess what resources are available for recovery and make connections for the members of your house of worship.
• Continue to offer theologically nuanced sermons and worship opportunities for your house of worship. These opportunities assist in meaning, making, and integration.
• Remember the Disaster Life Cycle: "Years, Not Months."
• Reflect on your experiences and talk about them with your community and family. Are there insights to be considered that might assist in mitigating future disasters?

Practicing the "other-directed love" essential for radical hospitality is a fine art. It requires preparedness and a willing spirit for service. Radical hospitality is very demanding at times, but the irony is that we receive so much more than we give. In the aftermath of the September 11 attacks there was, naturally, much concern over how our children were coping with the trauma. The average child must have watched the towers attacked countless times as it was played over and over again on the news. Before he died, someone asked Mr. Rogers for his wisdom on how to help the children cope and heal. His response was to tell them to keep their eyes on the helpers, the courageous men and women of our fire departments, police departments, emergency medical services and others. Sage advice. **May we also keep our eyes on the helpers as we seek, in our own way, to serve as helpers too.**

RESOURCES

American Red Cross in Greater New York: **www.arcgny.org**

Church World Service: **www.churchworldservice.org**

FEMA Website: **www.fema.gov/areyouready/why_prepare**

Go-Bags (essentials to have packed and ready to take with one in the event of a disaster):
   Ready New York: **http://home2.nyc.gov/html/oem/html/ready/prepared_gobag.shtml**
   Lutheran Disaster Response New York: **www.ldrny.org**

NYC Office of Emergency Management:
   Ready New York
   CERT
   http://www.nyc.gov/html/oem/html/home/home.shtml

New York Disaster Interfaith Services (NYDIS): **www.nydis.org**

This Chapter has the following Appendices:

Appendix A: Go Bag Contents

Appendix B: House of Worship Preparedness Checklist

Ready-2-Go BACKPACK Contents, aka, (GO Bag):

Standard Backpack – 600 denier polyester with water repellent vinyl backing, dual zippered main compartment, two front pockets, two side pockets with Velcro closure and padded back straps. 12" X 15" X 5"

Safety	First Aid	Personal Hygiene Kit*	Vital Information
1 Contents Bag*	1 First Aid Guide	1 Toothbrush	1 ID Holder – zippered vinyl pouch with split ring (attach to backpack)*
1 Life Light Flashlight	1 Tweezers	1 Toothpaste	
1 Battery Operated Glo-Lite-waterproof*	5 Bandage Strips	1 Razor	
Energy Bar–400 Cals.	1 Knuckle Bandage	1 Comb	3 ID and Personal/Family Information Cards – PVC*
Emergency Drinking Water w/pouch	1 Fingertip Bandage	2 Wash up Towlettes	
2 16.9 oz. Bottled water	5 Gauze Pads	1 Purell Hand Sanitizing Wipe	1 DNA/Fingerprint/Photo Identification Kit*
1 Signal Whistle	1 ABD Pad	1 Shout Wipe	1 Zippered Vinyl Portfolio with imprinted document checklist (14" X 11")*
1 N95 Disposable Respirator	1 Roll Adhesive Tape	1 Sewing Kit	
1 pr Nitrile Protective Gloves	2 Antiseptic Wipes	1 Kleenex Travel Pack	1 Pen – Sharpie Waterproof Twin Tip*
1 pr Industrial Gloves	2 Wash up Towelettes		
Rain Poncho w/hood	2 Alcohol Wipes		1 Note Pad and Pencil with vinyl cover*
1 Mylar Blanket	2 Safety Pins		
1 Hand Warmer Packet	1 Pain Reliever Packet		1 Disposable Camera*
1 Ice Pack			1 Disaster Response Brochure
1 Ice Pack			
1 Safety Vest			
1 Reflective Arm Band*			
1 Multi-Function Tool - pliers, knife,screwdrivers, saw, bottle opener*			
1 Radio/Flashlight/Compass on Lanyard*			
Additional radio batteries			
Carbon Monoxide Detector Disposable*			
Duct Tape			

* Imprintable. Many items OSHA and/or US Coast Guard Approved

Note: The list of contents on this page has been developed by Lutheran Disaster Response New York (LDRNY) on the basis of research and interviews with emergency managers.

Additionally, a simpler list can be found by entering 'go bags' on the search field at the **www.nyc.gov** *website, which also has additional preparedness links.*

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Appendix B: House of Worship Disaster Preparedness Checklist

(Adapted from the Episcopal Diocese of East Tennessee)

The following table is a useful model for keeping track of what needs to be done and who is responsible for getting it done, as well as when the item is completed or the issue is resolved. It provides space for any details that others should know that would be helpful and/or for the next time that an item needs to be done:

Item/Issue	Person respon-sible for taking action	Action to be Taken	Date Completed	Notes

We have put the actual preparedness checklist into this format – feel free to adapt it in the way that is most helpful to you.

1. Committee/Task Force		
Coordinator(s)	Phone Numbers	Notes
1. 2.		
Members	Phone Numbers	Notes
1. 2. 3. 4. etc		

2. House of Worship communications network		
Persons responsible	Phone Numbers	Notes
1. 2. 3. etc.		
Methods of communication	Persons responsible	Phone numbers
1. 2. 3. etc		

3. Annual review date of Disaster Preparedness Plan: _____

4. Regular meeting schedule: _____

5. Last 10 years disaster history		
Type/Event	Date	Notes
1. 2. 3. 4. 5. etc.		
6. Disasters most likely to occur		
Type	Potential Impact on House of Worship's building or facility	Potential Impact on Community
1. 2. 3. 4. etc		

7. Inventory of Property and Holdings					
Inventory Date	Photos	Video	Person(s)	Phone Numbers	Inventory storage
1. 2. 3. etc.					
8. Insurance Provider(s)					
Carrier(s)	Policy Numbers		Contact	Phone Numbers	Notes
1. 2. 3. etc					
9. Insurance Review					
Date	Person(s) Responsible		Phone Numbers	Date Completed	Notes

10. Property Survey				
High Risk Problems	Smoke/Fire Alarms	Fire Extinguishers	Security System	Items on surge Protectors & locations
1. 2. 3. 4.				
Musical Instruments	Insured	Waterproof covering?	Location(s)	Wiring?
1. 2. 3. etc.				
Furniture	Insured	Waterproof covering?	Locations	Notes
1. 2. 3. etc.				
Vestments/Robes (Religious leaders)	Insured	Location	Water/Fireproof location	Notes
1. 2. 3. etc.				
Vestments/Robes (Choir)	Insured	Location	Water/Fireproof location	Notes
1. 2. 3. etc.				
Records/Documents	Off-site location	Copies in office	Photos made?	Notes
1. 2. etc.				
Computers	Backed-up	Person responsible	Offsite Storage Location	Notes
Other				

11. Shutting Down The Facility			
Electricity	**Shutoff location**	**Instructions How**	**Notes**
Fuses Circuit breakers Building Feed Other			
Gas	**Shutoff Location**	**Instructions How**	**Notes**
Appliances Building Feed Other			
Water	**Shutoff Location**	**Instructions How**	**Notes**
Water Main Bathroom Bathroom Showers Showers Kitchen Other			
Heating	**Shutoff Location**	**Instructions How**	**Notes**
Furnace Oil Gas Electric Other			
Alarm	**Shutoff Location**	**Instructions How**	**Notes**
Other	**Shutoff Location**	**Instructions How**	**Notes**

11. Exit signs and exits clearly marked.   Yes____No____

12. Emergency Lighting tested annually.   Yes____No____

13. Copy of disaster plan sent to: House of Worship's overseeing body.   Yes____No____

14. Copy of disaster plan and floor plan(s) filed with local emergency agencies
   (Fire Department, Police Department, EMS)   Yes____No____

American Red Cross Affiliation/Training

15. Is the House of Worship able to be any of the following:

     15A. Shelter provider?   Yes___No___.

     15B. Storage provider?   Yes___No___.

     15C. Mass care food center?   Yes___No___.

     15D Other:_____.

Person responsible for coordinating congregants to take American Red Cross Courses:

Name:_____ Phone Number:_____

17. Emergency Supplies					
Food Type	Amount	Expiration Date	Location	Person Responsible	Phone Number(s)
1. 2. etc.					
Water	Amount	Expiration Date	Location	Person Responsible	Phone Number(s)
Clothing	Type		Location	Person Responsible	Phone Number(s)
1. 2. etc.					
Assess for Need	Person Responsible		Phone Number(s)	Notes	
Distribution	Method		Person(s) Responsible	Phone Number(s)	Notes
1. 2. etc.					

18. First Aid				
First Aid Kit (type)	Location(s)	Person responsible	Phone Number	Notes
1. 2. etc.				
Persons trained in CPR	Adult CPR	Child CPR	Infant CPR	Phone Numbers
1. 2. 3. etc				
Other				
Other				

19. Person(s) responsible for obtaining disaster preparedness materials from relief agencies such as American Red Cross in Greater New York, FEMA, NYDIS, NYC Office of Emergency Management, etc., and disseminating them to the members of the house of worship:

Name:_____Numbers:_____.

20. Any other actions or recommendations for this House of Worship:

21. Other Notes:

Developing Cultural Competence in Disaster Mental Health Programs

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (SAMHSA)

5

Disaster mental health services must be provided in a manner that recognizes, respects, and builds on the strengths and resources of survivors and their communities.

Editor's Note: This Chapter is comprised of excerpts from the US Department of Health and Human Services Guide, "Developing Cultural Competence in Disaster Mental Health Programs" (DHHS Pub. No. SMA 3828) [1]. For the full guide and much more detail, please **visit www.samhsa.gov**.

Disasters—earthquakes, hurricanes, chemical explosions, wars, school shootings, mass casualty accidents, and acts of terrorism—can strike anyone, regardless of culture, ethnicity, or race. No one who experiences or witnesses a disaster is untouched by it.

Peoples' reactions to disaster and their coping skills, as well as their receptivity to crisis counseling, differ significantly because of their individual beliefs, cultural traditions, and economic and social status in the community. For this reason, workers in our Nation's public health and human services systems increasingly recognize the importance of cultural competence in the development, planning, and delivery of effective disaster mental health services.

The increased focus on cultural competence also stems from the desire to better serve a U.S. population that is rapidly becoming more ethnically and culturally diverse. To respond effectively to the mental health needs of all disaster survivors, crisis counseling programs must be sensitive to the unique experiences, beliefs, norms, values, traditions, customs, and language of each individual, regardless of his or her racial, ethnic, or cultural background. Disaster mental health services must be provided in a manner that recognizes, respects, and builds on the strengths and resources of survivors and their communities.

The Crisis Counseling Assistance and Training Program (CCP) is one of the Federal Government's major efforts to provide mental health services to people affected by disasters. Created in 1974, this program is currently administered by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Federal Emergency Management Agency (FEMA). The Program provides supplemental funding to States for short-term crisis counseling services to survivors of federally declared

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> The major objective of disaster mental health operations is to mobilize staff to disaster sites so that they can attend to the emotional needs of survivors.

disasters. Crisis counseling services provided through the Program include outreach, education, community networking and consultation, public information and referral, and individual and group counseling. The CCP emphasizes specialized interventions and strategies that meet the needs of special populations such as racial and ethnic minority groups.

The purpose of this guide is to assist States and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters of all scales. It complements information previously published by FEMA and CMHS on disaster mental health response and recovery. FEMA provided the funding for this guide as part of the agencies' ongoing effort to address the needs of special populations in disaster mental health response and recovery. "Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations" is part of a series of publications developed by CMHS.[2]

BACKGROUND AND OVERVIEW

Disasters affect hundreds of thousands of people in the United States annually. Between 1993 and 1998, the American Red Cross responded to more than 322,000 disaster incidents in the United States and provided financial assistance to more than 600,000 families (American Red Cross, 2000). In 1997 alone, the Federal Emergency Management Agency (FEMA) responded to 43 major disasters in 27 States and three western Pacific Island territories (FEMA, 2000). In recent years, human-caused disasters have been a major challenge. Such events include the 1992 civil unrest in Los Angeles, the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, and the September 2001 terrorist attacks on the World Trade Center in New York and the Pentagon in Arlington.

Disaster crisis counseling is a specialized service that involves rapid assignment and temporary deployment of staff who must meet multiple demands and work in marginal conditions and in unfamiliar settings such as shelters, recovery service centers, and mass care facilities. The major objective of disaster mental health operations is to mobilize staff to disaster sites so that they can attend to the emotional needs of survivors. In the past, these responses tended to be generic; little or no effort was made to tailor resources to the characteristics of a specific population. With time and experience, however, service providers and funding organizations have become increasingly aware that race, ethnicity, and culture may have a profound effect on the way in which an individual responds to and copes with disaster. Today, those in the field of disaster mental health recognize that sensitivity to cultural differences is essential in providing mental health services to disaster survivors.

Integrating cultural competence in the temporary structure and high-intensity work environment of a disaster relief operation is a challenge. Increasing cultural competence, not a one-time activity, is a long-term process that requires fundamental changes at the institutional level. Because both culture and the nature of disasters are dynamic, these changes must be followed by ongoing efforts to ensure that the needs of those affected by disaster are met.[3]

UNDERSTANDING CULTURE

Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us. Culture involves shared customs, values, social rules of behavior, rituals and traditions, and perceptions of human nature and natural events. Elements of culture are learned from others and may be passed down from generation to generation.

Many people equate race and ethnicity with culture; however, the terms "race" and "ethnicity" do not fully define the scope and breadth of culture. Race and ethnicity are indeed prominent elements of culture, but there are important distinctions between these terms. For example, many people think of "race" as a biological category and associate it with visible physical characteristics such as hair and skin color.

Physical features, however, do not reliably differentiate people of different races (DHHS, 2001). For this reason, race is widely used as a social category. Different cultures classify people into racial groups on the basis of a set of characteristics that are socially important (DHHS, 2001). Often, members of certain social or racial groups are treated as inferior or superior or given unequal access to power and other resources (DHHS, 2001).

"Ethnicity" refers to a common heritage of a particular group. Elements of this shared heritage include history, language, rituals, and preferences for music and foods. Ethnicity may overlap with race when race is defined as a social category. For example, because Hispanics are an ethnicity, not a race, ethnic subgroups such as Cubans and Peruvians include people of different races (DHHS, 2001).

"Culture" refers to the shared attributes of a group of people. It is broadly defined as a common heritage or learned set of beliefs, norms, and values (DHHS, 2001). Culture is as applicable to groups of whites, such as Irish Americans or German Americans, as it is to racial and ethnic minorities (DHHS, 2001). People can share a culture, regardless of their race or ethnicity. For example, people who work for a particular organization, people who have a particular physical or mental limitation, or youth in a particular social group may share cultural attributes.

A culture can be defined by characteristics such as:
- National origin;
- Customs and traditions;
- Length of residency in the United States;
- Language;
- Age;
- Generation;
- Gender;
- Religious beliefs;
- Political beliefs;
- Sexual orientation;
- Perceptions of family and community;
- Perceptions of health, well-being, and disability;
- Physical ability or limitations;
- Socioeconomic status;
- Education level;
- Geographic location; and
- Family and household composition.

Elements of culture are learned from others and may be passed down from generation to generation.

TABLE 2-2[4]

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.

Culture changes continuously. For example, immigrants to the United States bring with them their own beliefs, norms, and values, but through the process of acculturation gradually learn and adopt selected elements of the dominant culture. An immigrant group may develop its own culture while becoming acculturated. At the same time, the dominant culture may change as a result of its interaction with the immigrant group (DHHS, 2001).

DIVERSITY AMONG AND WITHIN RACIAL AND ETHNIC MINORITY GROUPS

...People who find themselves in the same racial or ethnic group— either by census category or through self identification...

Four racial and ethnic minority groups— African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans— accounted for approximately 30 percent of the U.S. population in the year 2000 and are expected to account for nearly 40 percent of the U.S. population by 2025 (DHHS, 2001). Although there are important differences among these four groups, there also is broad diversity within each group. In other words, people who find themselves in the same racial or ethnic group—either by census category or through self identification— do not always have the same culture. Examples follow:

- American Indians and Alaska Natives may belong to more than 500 tribes, each of which has a different cultural tradition, language, and ancestry (DHHS, 2001).
- Asian Americans and Pacific Islanders may identify with any of 43 subgroups and speak any of 100 languages and dialects (DHHS, 2001).
- Hispanics may be of Mexican, Puerto Rican, Cuban, Central and South American, or other heritage (DHHS, 2001).

Furthermore, the broad category labels are imprecise (DHHS, 2001). For example, people who are indigenous to the Americas may be called Hispanic if they are from Mexico or American Indian if they are from the United States (DHHS, 2001). In addition, many people in a particular racial or ethnic minority group may identify more closely with other social groups than with the group to which they are assigned by definition (DHHS, 2001). Finally, many people identify with multiple cultures that may be associated with factors such as race, ethnicity, country of origin, primary language, immigration status, age, religion, sexual orientation, employment status, disability, geographic location, or socioeconomic status.

Recognizing the limitations of the traditional broad groupings, the U.S. Census Bureau revised the categories used to report race and ethnicity in the 2000 Census. For the first time, individuals could identify with more than one group (U.S. Office of Management and Budget, 2000). The U.S. Census Bureau anticipated that this change would result in approximately 63 categories of racial and ethnic identifications (DHHS, 2001).

Appendix C lists additional resources offering statistical and demographic data on racial and ethnic populations and subpopulations.

CULTURAL COMPETENCE: SCOPE AND TERMINOLOGY

We use many terms to refer to concepts associated with cultural competence and with interactions between and among people of different cultures, including "cultural diversity, cultural awareness, cultural sensitivity, multiculturalism, and transcultural services." Although the differences in the meanings of these terms may be subtle, they are extremely important. For example, the term "cultural awareness" suggests that it may be sufficient for one to be cognizant, observant, and conscious of similarities and differences among cultural groups (Goode et al., 2001).

"Cultural sensitivity," on the other hand, connotes the ability to empathize with and understand the needs and emotions of persons of one's own culture, as well as those of others, and to identify with emotional expressions and the problems, struggles, and joys of someone from another culture (Hernandez and Isaacs, 1998).

Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

The term "cultural competence" suggests a broader concept than "cultural sensitivity" implies. As previously defined in this section, the word "culture" refers to the shared attributes—including beliefs, norms, and values—of a group of people (DHHS, 2001). The word "competence" implies the capacity to function effectively, both at the individual and organizational levels. "Competence" is associated with "culture" to emphasize that being aware of or sensitive to the differences between cultures is not sufficient. Instead, service providers must have the knowledge, skills, attitudes, policies, and structures needed to offer support and care that is responsive and tailored to the needs of culturally diverse population groups.

Many people and organizations have developed definitions of cultural competence. The following definition blends elements of definitions used by SAMHSA (DHHS, 2001), the Health Resources and Services Administration (DHHS), the Office of Minority Health (DHHS, 2000a), and definitions found in the literature (Bazron and Scallet, 1998; Cross et al., 1989; Denboba, 1993; Evans, 1995; Roberts et a al.,1990; Taylor et al., 1998):

Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Cross and colleagues (1989) note that culturally competent organizations and individuals:

- Value diversity;
- Have the capacity for cultural assessment;
- Are aware of cross-cultural dynamics;
- Develop cultural knowledge; and
- Adapt service delivery to reflect an understanding of cultural diversity.

At the individual level, cultural competence requires an understanding of one's own culture and worldview as well as those of others. It involves an examination of one's attitudes, values, and beliefs, and the ability to demonstrate values, knowledge, skills, and attributes needed to work sensitively and effectively in cross-cultural situations (Goode et al., 2001).

At the organizational and programmatic levels, cultural competence requires a comprehensive, coordinated plan that cuts across policymaking, infrastructure building, program administration and evaluation, and service delivery. Culturally competent organizations and programs acknowledge and incorporate the importance of culture, assess cross-cultural relations, are aware of dynamics that can result from cultural differences and ethnocentric attitudes, expand cultural knowledge, and adopt services that meet unique cultural needs (DHHS, 2000d).

THE CULTURAL COMPETENCE CONTINUUM

Cultural competence is not a matter of being politically correct or of assigning one person to handle diversity issues, nor does it mean simply translating materials into other languages. Rather, it is an ongoing process of organizational and individual development that includes learning more about our own and other cultures; altering our thinking about culture on the basis of what we learn; and changing the ways in which we interact with others to reflect an awareness and sensitivity to diverse cultures.

The Cultural Competence Continuum was developed by Cross et al. (1989) for mental health professionals. Today, many other public health practitioners and community-based service providers also find it a useful tool. The continuum assumes that cultural competence is a dynamic process with multiple levels of achievement. It can be used to assess an organization's or individual's level of cultural competence, to establish benchmarks, and to measure progress.

The negative end of the continuum is characterized by **Cultural Destructiveness**. Organizations or individuals in this stage view cultural differences as a problem and participate in activities that purposely attempt to destroy a culture. Examples of destructive actions include denying people of color access to their natural helpers or healers, removing children of color from their families on the basis of race, and risking the wellbeing of minority individuals by involving them in social or medical experiments without their knowledge or consent. Organizations and individuals at this extreme operate on the assumption that one race is superior and that it should eradicate "lesser" cultures.

Organizations and individuals in the **Cultural Incapacity** stage lack the ability to help cultures from diverse communities. Although they do not intentionally seek to cause harm, they believe in the superiority of their own racial or ethnic group and assume a paternalistic posture toward "lesser" groups. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Employment practices of organizations in this stage of the continuum are discriminatory.

Cultural Blindness is the midpoint of the continuum. Organizations and individuals at this stage believe that color or culture makes no difference and that all people are the same. Individuals at this stage may view themselves as unbiased and believe that they address cultural needs. In fact, people who are culturally blind do not perceive, and therefore cannot benefit from, the valuable differences among diverse groups. Services or programs created by organizations at this stage are virtually useless to address the needs of diverse groups.

Culturally pre-competent organizations and individuals begin to move toward the positive end of the continuum. They realize weaknesses in their attempts to serve various cultures and make some efforts to improve the services offered to diverse populations. Pre-competent organizations hire staff from the cultures they serve, involve people of different cultures on their boards of directors or advisory committees, and provide at least rudimentary training in cultural differences. However, organizations at this stage run the risk of becoming complacent, especially when members believe that the accomplishment of one goal or activity fulfills the obligation to the community. Tokenism is another danger. Organizations sometimes hire one or more workers from a racial or ethnic group and feel that they have done all that is necessary.

...Cultural competence is a dynamic process with multiple levels of achievement.

Culturally Competent organizations and individuals accept and respect differences, and they participate in continuing self-assessment regarding culture. Such organizations continuously expand their cultural knowledge and resources and adopt service models that better meet the needs of minority populations. In addition, they strive to hire unbiased employees, and seek advice and consultation from representatives of the cultures served. They also support their staff members' comfort levels when working in cross-cultural situations and in understanding the interplay between policy and practice.

Culturally Proficient organizations hold diversity of culture in high esteem. They seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Culturally proficient organizations hire staff members who are specialists in culturally competent practice. Achieving cultural competence and progressing along the continuum do not happen by chance. Policies and procedures, hiring practices, service delivery, and community outreach must all include the principles of cultural competence. For these reasons, a commitment to cultural competence must permeate an organization before a disaster strikes. If the concepts of cultural competence and proficiency have been integrated into the philosophy, policies, and day-to-day practices of the mental health provider agency, they will be much easier to incorporate into disaster recovery efforts.

Achieving cultural competence and progressing along the continuum do not happen by chance.

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.

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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, Fuller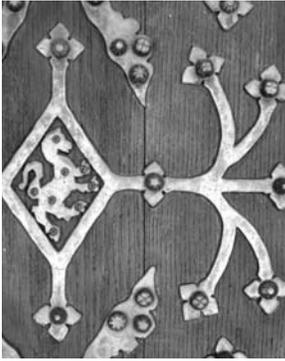ton et al., 1994). Individuals may exhibit courage, selflessness, gratitude, and hope that they may not have shown or felt before the disaster.

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).

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 nondisaster circumstances. Therefore, they may be unfamiliar with the social and cultural mechanisms of receiving assistance and remain outside the network of aid.

> Community often is extremely important for racial and ethnic minority groups, and it may dramatically affect their ability to recover from disaster.

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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.

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.

Poverty makes people more susceptible than others to harm from disaster and less able to access help.

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.

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).[5]

> Disaster mental health plans that identify and address diverse needs within a community can save valuable time and avert many problems.

TABLE 1-4

Questions to Address in a Disaster Mental Health Plan[6]

Community demographic characteristics	Mental health resources	Nongovernmental organizations' roles in disaster
Who are the most vulnerable persons in the community? Where do they live?	What mental health service providers serve the community?	What are the roles of the American Red Cross, interfaith organizations, and other disaster relief organizations?
What is the range of family composition (i.e., single-parent households)?	What skills and services does each provider offer?	What resources do non-government agencies offer, and how can local mental health services be integrated into their efforts?
How could individuals be identified and reached in a disaster?	What gaps, including lack of cultural competence, might affect disaster services?	What mutual aid agreements exist? n How can mental health providers collaborate with private disaster relief efforts?
Are policies and procedures in place to collect, maintain, and review current demographic data for any area that might be affected by a disaster	How could the community's mental health resources be used in response to different types of disasters?	

Cultural groups	Government roles and responsibilities in disaster	Community partnerships
What cultural groups (ethnic, racial, and religious) live in the community?	What are the Federal, State, and local roles in disaster response?	What resources and supports would community and cultural/ethnic groups provide during or following a disaster?
Where do they live, and what are their special needs?	How do Federal, State, and local agencies relate to one another?	Do the groups hold pre-existing mutual aid agreements with any State or county agencies?
What are their values, beliefs, and primary languages?	Who would lead the response during different phases of a disaster?	Who are the key informants/gatekeepers of the impacted community?
Who are the cultural brokers in the community?	How can mental health services be integrated into the government agencies' disaster response?	Has a directory of cultural resource groups, natural helpers, and community informants who have knowledge about diverse groups been developed?
Socioeconomic factors	What mutual aid agreements exist?	
Does the community have any special economic considerations that might affect people's vulnerability to disaster?	Do any subgroups in the community harbor any historical or political concerns that affect their trust of government?	Are the community partners involved in all phases of disaster preparedness, response, and recovery operations?
Are there recognizable socio-economic groups with special needs?		
How many live in rental property?		
How many own their own homes?		

GUIDING PRINCIPLES AND RECOMMENDATIONS[7]

This SAMHSA Guide goes on to discuss each of nine guiding principles for cultural competence in disaster mental health programs and suggests ways to integrate them into disaster mental health planning and crisis counseling programs.

Editor's Note: The nine guiding principles are included here to identify them for you. For a fuller description of these principles and additional material, please consult the full SAMHSA document as referenced at the beginning of this chapter.

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.

GUIDING PRINCIPLES FOR CULTURAL COMPETENCE IN DISASTER MENTAL HEALTH PROGRAMS

Principle 1: Recognize the importance of culture and respect diversity.

Principle 2: Maintain a current profile of the cultural composition of the community.

Principle 3: Recruit disaster workers who are representative of the community or service area.

Principle 4: Provide ongoing cultural competence training to disaster mental health staff.

Principle 5: Ensure that services are accessible, appropriate, and equitable.

Principle 6: Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.

Principle 7: Involve as "cultural brokers" community leaders and organizations representing diverse cultural groups.

Principle 8: Ensure that services and information are culturally and linguistically competent.

Principle 9: Assess and evaluate the program's level of cultural competence.

This Chapter has the following Appendices:

Appendix A: Cultural Competence Resources and Tools

Appendix B: Disaster Mental Health Resources from the Center of Mental Health Services

Appendix C: Sources of Demographic and Statistical Information

Appendix D: Sources of Assistance and Information

American Psychological Association (1990).
APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations. Washington, DC: American Psychological Association. Offers recommendations on working with ethnic and culturally diverse populations to providers of psychological services.

Child Welfare League of America (1993).
Cultural Competence Self-assessment Instrument. Washington, DC: Child Welfare League of America. A tool designed to help organizations providing family services identify, improve, and enhance cultural competence in staff relations and client service functions. The instrument, which has been field-tested, provides a practical, easy-to-use approach to addressing the major issues associated with delivering culturally competent services.

Cohen, R. (1992).
Training mental health professionals to work with families in diverse cultural contexts. *Responding to Disaster: A Guide for Mental Health Professionals.* Washington, DC: American Psychiatric Press, Inc. Explores cultural considerations for mental health workers and disaster survivors in the immediate and longer-term aftermath of a disaster. Examines issues of loss, mourning, separation, coping, and adaptation as they relate to disaster survivors from various cultures.

Cross, T. L. (1989).
Towards a Culturally Competent System of Care. Vol. I: A Monograph of Effective Services for Minority Children who are Severely Emotionally Disturbed. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center. One of the first documents to provide practical information on operationalizing cultural competence. Provides definitions for competence, introduces the concept of a cultural competence continuum, and provides information that can be used at individual and organizational levels.

Giger, J., and Davidhizar, R. (1999).
Transcultural Nursing: Assessment and Intervention. St. Louis, MO: Mosby, Inc. Provides tools that can be used to evaluate cultures' perceptions and needs related to communication, space, social organization, time, environmental control, and biological variations. Giger and Davidhizar were among the first to develop the concept of cultural competence in

the nursing profession. Now in its third printing, the publication is used by a number of other disciplines.

Goode, T. D. (1999).
Getting Started: Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings, Implications for Policy Makers and Administrators. Washington, DC: Georgetown University, National Center for Cultural Competence. A checklist that can assist programs and organizations in initiating strategic development of policies, structures, procedures, and practices that support cultural and linguistic competence.

Health Resources and Services Administration (1998).
Health Care Rx: Access for All. Washington, DC: Health Resources and Services Administration. A chart book that provides a picture of the health of racial and ethnic minority Americans and the cascade of factors that limit access to health care, hamper workforce diversity, and limit culturally competent services.

Hernandez, M., and Isaacs, M. (1998).
Promoting Cultural Competence in Children's Mental Health Services. Baltimore, MD: Paul H. Brookes Publishing. Provides an excellent framework for developing a culturally competent mental health system. Focuses on the need to develop organizational infrastructures that support and further cultural competence and the need to ensure that programs are meaningful at the community and neighborhood levels. Also addresses special issues related to serving culturally diverse populations. Designed for planners, program managers, policy makers, practitioners, parents, teachers, researchers, and others who are interested in improving mental health services for families.

Hicks, Noboa-Rios (1998).
Cultural Competence in Mental Health: A Study of Nine Mental Health Programs in Ohio. Columbus, OH: Outcomes Management Group, Ltd. Provides an assessment of nine culturally competent programs that were funded to encourage the provision of cultural sensitivity training to the mental health community and to develop nontraditional, culturally sensitive methods of delivering services to persons of color. Prepared for the Multi-Ethnic Behavioral Consortium of the Ohio Department of Mental Health.

Nader, K., Dubrow, N., and Stamm, H. (1999).
Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss. Ann Arbor, MI: Brunner/Mazel. Discusses the treatment of trauma and loss while recognizing the importance of understanding the cultural context in which the mental health professional provides assistance.

Perkins, J., Simon, H., Cheng, F., et al. (1998).
Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. Los Angeles, CA: National Health Law Program.
An informative discussion on linguistic issues that can impede effective service delivery. Covers the importance of language access, use of community volunteers, limitations of interpretation, linguistic barriers in mental health, and effective use of written materials.

Substance Abuse and Mental Health Services Administration (2000).
Cultural Competence Standards in Managed Mental Health Care for Underserved/Under-represented Racial/Ethnic Groups Washington, DC: Western Interstate Commission for Higher Education and Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
Provides information on cultural competence guidelines, performance indicators, and potential outcomes in the areas of triage and assessment, care planning, treatment plans, treatment services, communication styles, and cross-cultural linguistic and communication support.

Substance Abuse and Mental Health Services Administration (2000).
Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health* (2000 Series, Vol. 1). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
Examines promising practices of five American Indian children's mental health projects that integrate traditional American Indian helping and healing methods with the systems of care model.

U.S. Department of Health and Human Services (1992-1999).
Cultural Competence Series. Monograph series sponsored by Bureau of Primary Health Care, Health Resources and Services Administration; Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services

Administration; and Office of Minority Health.

Van der Veer, G. (1995).
Psychotherapeutic Work with Refugees. New York: Plenum Press.
Suggests that the trauma that a refugee experiences in a disaster may not be an isolated incident, but part of a series of ongoing traumatic events. Stresses that overcoming cultural difference is essential in working with traumatized refugees and that such work requires creatively adjusting a variety of existing techniques.

The following publications and videos on disaster response and recovery planning for special populations were developed by the Emergency Mental Health and Traumatic Stress Services Branch of CMHS. To download these documents or order copies, please visit the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site at www.samhsa.gov

PUBLICATIONS

ADM 86-1070R *Psychosocial Issues for Children and Adolescents in Disasters*

ADM 90-538 *Training Manual for Mental Health and Human Service Workers in Major Disasters, Second Edition*

SMA 94-3010R *Disaster Mental Health Response and Recovery: A Strategic Guide (May not be available; revised edition in press)*

SMA 95-3022 *Psychosocial Issues for Children and Families: A Guide for the Primary Care Physician*

SMA 96-3077 *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster*

SMA 99-3323 *Psychosocial Issues for Older Adults in Disasters*

SMA 99-3378 *Crisis Counseling Programs for the Rural Community*

VIDEOS

ESDRB-2 Children and Trauma: The School's Response

OM 00-4070 Voices of Wisdom: Seniors Cope with Disaster

OM 00-4070S Voices of Wisdom: Seniors Cope with Disaster (Spanish Version)

OM 00-4071 Hurricane Andrew: The Fellowship House Experience

GENERAL MATERIALS

CMHS Program Guidance Series

Appendix C: Sources of Demographic and Statistical Information

The following World Wide Web resources offer demographic and statistical information useful for developing disaster mental health community profiles:

STATISTICS ABOUT IMMIGRATION PATTERNS

Immigration and Naturalization Service,
U.S. Department of Justice:
http://uscis.gov/graphics/shared/aboutus/statistics/index.htm

**NATIONAL, STATE, AND COUNTY STATISTICS AND DEMOGRAPHIC
DATA BY AGE, RACIAL, ETHNIC, AND LINGUISTIC SUBGROUPS**

U.S. Bureau of the Census:
www.census.gov/population/www/index.html

UNEMPLOYMENT INFORMATION BY GENDER, RACE, AND AGE

Bureau of Labor Statistics:
http://stats.bls.gov/

DEMOGRAPHIC INFORMATION BY ZIP CODE

PeopleSpot:
http://peoplespot.com/statistics/demographics.htm

GENERAL INFORMATION

Government Information Sharing Project,
Oregon State University:
http://govinfo.kerr.orst.edu/index.html

National Center for Health Statistics,
Centers for Disease Control and Prevention:
www.cdc.gov/nchs/

Federal Healthfinder ®:
www.healthfinder.gov/

Appendix D: Sources of Assistance and Information

FEDERAL GOVERNMENT ORGANIZATIONS AND RESOURCES

Federal Emergency Management Agency (FEMA)
FEMA coordinates with other State and Federal agencies to respond to presidentially declared disasters. It provides disaster assis-tance for individuals, businesses (through the Small Business Administration), and communities (through the Robert T. Stafford Disaster Relief and Emergency Assistance Act).

Federal Emergency Management Agency
Human Services Division
500 C Street, SW
Washington, DC 20472
Phone: 202.566.1600
www.fema.gov

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA)
Through an interagency agreement with FEMA, CMHS provides consultation and technical assistance for the Crisis Counse-ling Assistance and Training Program. Publications and videotapes on disaster human response are available through SAMHSA's National Mental Health Information Center.

Center for Mental Health Services Emergency Mental Health and Traumatic Stress Services Branch
5600 Fishers Lane, Room 17C-20
Rockville, MD 20857
Phone: 301.443.4735
Fax: 301.443.8040
www.samhsa.gov

SAMHSA's National Mental Health Information Center
P.O. Box 42557
Washington, DC 20015
Phone: 1.800.789.2647
Fax: 301.984.8796
TDD: 1.866.889.2647
www.mentalhealth.samhsa.gov/

Federal Communications Commission (FCC)
445 12th Street, SW
Washington, DC 20554
Phone: 202.418.1771 or 1.888.225.5322
TTY: 202.418.2520 or 1.888.835.5322
Fax: 202.418.0710 or 1.866.418.0232
www.fcc.gov

Health Resources and Services Administration (HRSA)
Office of Minority Health
5600 Fishers Lane
Room 14-48
Rockville, MD 20857
Phone: 301.443.3376 or 1.888.275.4772
www.hrsa.gov

Indian Health Service (IHS)
Office of Public Health
The Reyes Building
801 Thompson Avenue
Suite 400
Rockville, MD 20852-1627
Phone: 301.443.3024
www.ihs.gov

National Institute on Deafness and Other Communication Disorders (NIDCD)
31 Center Drive
MSC 2320
Bethesda, MD 20892
Phone: 301.496.7243
www.nidcd.nih.gov

NIDCD Information Clearinghouse
1 Communication Avenue
Bethesda, MD 20892
Phone: 1.800.241.1044
TTY: 1.800.241.1055
www.nidcd.nih.gov

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F
Hubert H. Humphrey Building
Washington, DC 20201
Phone: 202.619.0257 or 1.877.696.6775
www.hhs.gov/ocr

**Office of Public Health and Science
U.S. Office of Minority Health Resource Center**
U.S. Department of Health and Human Services
P.O. Box 37337
Washington, DC 20013-7337
Phone: 301.443.5084 or 1.800.444.6472
Fax: 301.251.2160
www.omhrc.gov

Appendix D: Sources of Assistance and Information

Rural Information Center Health Service
National Agricultural Library
10301 Baltimore Avenue
Room 304
Beltsville, MD 20705-2351
Phone: 301.504.5547 or 1.800.633.7701
Fax: 301.504.5181
TDD/TTY: 301.504.6856
www.nal.usda.gov/ric

NATIONAL ORGANIZATIONS

American Red Cross (ARC)
ARC has chapters in most large cities and a State chapter in each capital city. Every local Red Cross chapter is charged with readiness and response responsibilities in collaboration with its disaster partners. Disaster services include preparedness training, community education, mitigation, and response. ARC chapters help families with immediate basic needs (food, clothing, and shelter) and provide supportive services and longer-term interventions. Contact the local chapter for assistance or the chapter in your State capital.

American Red Cross National Headquarters
2025 E Street, NW
Washington, DC 20006
Phone: 202.737.8300 General Information
Phone: 202.303.4498 Public Inquiry
Phone: 703.206.7460 Disaster Services
www.redcross.org

PROFESSIONAL PRIVATE SECTOR ORGANIZATIONS AND RESOURCES

African American Mental Health Research Center Institute for Social Research
University of Michigan
426 Thompson, Room 5118
Ann Arbor, MI 48106
Phone: 734.763.0045
Fax: 734.763.0044
http://rcgd.isr.umich.edu/prba

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
Phone: 202.336.5510 or 1.800.374.2721
TDD/TTY: 202.336.6123
www.apa.org

Cross Cultural Health Care Program
270 S. Hanford Street
Suite 100
Seattle, WA 98134
Phone: 206.860.0329
Fax: 206.860.0334
www.xculture.org

National Alliance for Hispanic Health
1501 16th Street, NW
Washington, DC 20036
Phone: 202.387.5000
www.hispanichealth.org

National Asian American and Pacific Islander Mental Health Association
1215 19th Street
Suite A
Denver, CO 80202
Phone: 303.298.7910
Fax: 303.298.8180
www.naapimha.org

National Association for Rural Mental Health
3700 W. Division Street
Suite 105
St. Cloud, MN 56301
Phone: 320.202.1820
Fax: 320.202.1833
www.narmh.org

National Association of Social Workers
750 First Street, NE
Suite 700
Washington, DC 20002-4241
Phone: 202.408.8600 or 1.800.638.8799
www.naswdc.org

Appendix D: Sources of Assistance and Information

National Center for American Indian and Alaska Native Mental Health Research
University of Colorado Health Sciences Center
Department of Psychiatry, North Pavilion
4455 E. 12th Avenue
Campus Box A011-13
Denver, CO 80220
Phone: 303.724.1414
Fax: 303.724.1474
www.uchsc.edu/sm/ncaianmhr

National Center for Cultural Competence
Georgetown University Center for
Child and Human Development
3307 M Street, NW
Suite 401
Washington, DC 20007-3935
Phone: 202.687.8635 or 1.800.788.2066
Fax: 202.687.8899
TTY: 202.687.5503
http://gucchd.georgetown.edu

National Indian Health Board
101 Constitution Avenue, NW
Suite 8-B09
Washington, DC 20001
Phone: 202.742.4262
Fax: 202.742.4285
www.nihb.org

National MultiCultural Institute
3000 Connecticut Avenue, NW
Suite 438
Washington, DC 20008-2556
Phone: 202.483.0700
Fax: 202.483.5233
www.nmci.org

National Rural Health Association
One West Armour Boulevard
Suite 203
Kansas City, MO 64111-2087
Phone: 816.756.3140
www.nrharural.org

STATE AND LOCAL GOVERNMENT AGENCIES

Departments of Mental Health
Contact the State agency responsible for mental health services. A State disaster mental health coordinator may be designated to manage the Crisis Counseling Program. The main office will be located in your State's capital city.

Emergency Services
The emergency services agency is the lead agency delegated by the State's governor to carry out day-to-day emergency management responsibilities. Contact the Office of Emergency Services in your capital city.

UNIVERSITY AND MEDICAL UNIVERSITIES

Academic practitioners with general training in stress, coping, and counseling often express interest in offering assistance to communities that have experienced a disaster. Undergraduate and graduate students are usually very interested in serving as crisis counselors. Caution is advised to ensure that survivors are treated appropriately and not enlisted into research studies or given treatments designed for traditional psychiatric disorders. Contact your local university's departments of psychiatry, psychology, or social work.

RELIGIOUS ORGANIZATIONS

Churches, synagogues, other faith-based organizations, and interfaith organizations are valuable resources for identifying and serving disaster survivors. Often, they are the most productive and rapid responders for immediate basic needs. Most denominations have some kind of disaster relief program. Contact the district office for major denominations in your area.

MEDIA

Television, radio, and newspapers can provide a list of resources and supports in major disasters.

Appendix D: Sources of Assistance and Information

VOLUNTARY ORGANIZATIONS

The National Voluntary Organizations Active in Disasters (NVOAD) has made disaster response a priority. Member organizations provide effective services and avoid service duplication by coordinating response efforts. Member organizations include:

Adventist Community Services (ACS)
American Red Cross (ARC)
American Relay League, Inc. (ARL)
AMURT (Ananda Marga Universal Relief Team)
Catholic Charities USA (CC)
Christian Disaster Response, AECCGC
Christian Reformed World Relief CommitteeCRWRC)
Church of the Brethren (CB)
Church World Service (CWS)
The Episcopal Church (EC)
Friends Disaster Service (FDS)
Inter-Lutheran Disaster Response (ILDR)
Mennonite Disaster Service (MDS)
Nazarene Disaster Response (NDR)
The Phoenix Society (PS)
The Points of Light Foundation (PLF)
Presbyterian Church, USA (PC)
REACT International, Inc. (REACT)
The Salvation Army (SA)
Second Harvest National Network of Food Banks (SHNNFB)
Society of St. Vincent de Paul (SSVP)
Southern Baptist Convention (SBC)
United Methodist Church Committee of Relief (UMCOR)
Volunteers of America (VOA)
World Vision (WV)

ADDITIONAL RESOURCES

Building Cultural Competence: A Blueprint for Action
Washington State Department of Health
Maternal and Child Health Community
and Family Health
New Market Industrial Campus, Building #7
P.O. Box 47880
Olympia, WA 98504-7880
Phone: 360.236.3504 or 206.389.3052
Fax: 360.586.7868

The Diversity Journal
Harvard Pilgrim Health Care
Office of Diversity
Brookline, MA 02146-7229
Phone: 617.730.7710
Fax: 617.730.4695

A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations
The Technical Assistance Center for the
Evaluation of Children's Mental Health System
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone: 617.232.8390
Fax: 617.232.4125

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[1] U.S. Department of Health and Human Services. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations.* DHHS Pub. No. SMA 3828. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

[2] DHHS Pub. No. SMA 3828. Rockville, MD, pp. 1-2.

[3] Ibid, p4-5.

[4] Ibid., p. 25.

[5] Ibid., pp. 8-20.

[6] Ibid., p. 21.

[7] Ibid., p. 22.

Response and Recovery Phases

II

Conflict Transformation:

MITIGATING THE IMPACT OF DISASTER ON THE SOCIAL FABRIC OF A COMMUNITY

6

BY RUTH YODER WENGER

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Forward

Editor's Note: Because this Chapter falls in both the mitigation/preparedness and recovery phases, we have included it here. The Chapter deals with the topic of Peacebuilding, which supports the development of networks of relationships at all levels of society to help people meet their needs, protect their rights, and constructively address conflict and crisis.

Peacebuilding creates the capacity within communities to meet human needs and human rights without obstructing the needs and rights of others. Whether ameliorating conflict during a time of disaster, or preparing for disaster and the conflicts it may bring, leaders can help their communities focus on meeting needs and protecting human rights in a way that recognizes interdependence, fosters relationships of partnership rather than domination, and limits all forms of violence.

Background

Communities who know how to handle trauma and conflict in healthy ways will be much more resilient than those who do not. The more proactively peacebuilding is integrated into preparation for disaster, the less reactively it will need to be applied during and following a disaster. Individuals within communities can learn ways of coping with traumatic stress that do not lead to violence "acted in" against themselves (e.g., substance abuse, depression, denial) or "acted out" against others (e.g., domestic abuse, high risk behavior, blaming).

Religious leaders responding to disaster can play a crucial role in shaping the community's response and in supporting the community's ability to survive and thrive. Religious leaders can help to understand common responses to trauma, practice effective trauma interventions, and reflect on the meaning of the trauma in ways that **promote healing and resilience rather than more violence and trauma.**

Disasters which are perceived as human-originated hold especially high potential for conflict resulting in more violence because of the very normal human sense of balance and fairness. **Unhealed, unaddressed trauma can distort and misdirect the desire for balance into a demand for revenge or retribution, by which violence once more victimizes; the "new" victims seek "balance" through revenge and retribution; and the cycle of violence continues.**

In preparing for disaster, communities can build their own capacity to respond, through education, training, and development. Religious leaders who are aware of the role of trauma in the cycle of violence can help their communities prevent violence among themselves and/or toward others. Understanding how unmet human needs and human rights violations can fuel conflict and lead to a cycle of violence can help in addressing and correcting root causes of conflict. **Education for religious leaders is crucial for supporting resilience and promoting recovery within themselves, their members, and their communities.**

Rationale for Peacebuilding [1]

Disaster traumatizes individuals, groups and communities. The conflicts that result can be waged in ways that challenge and transform, or in ways that damage and create more victims.

This chapter starts from the premise that **trauma will lead to changes in a system**, whether within an individual, among members of a group, or among communities. The trauma itself does not determine the direction of the changes. **The direction of the changes is determined by the way the trauma is interpreted** by the individual, the group, or the community.

Someone has said that if trauma is experienced and interpreted primarily as **a threat**, it leads to **aggression and violence**. If trauma is experienced primarily as **a loss**, it leads to **depression and despair.** If trauma is experienced primarily as a **challenge** to be reckoned with, new insights can emerge, along with new energies that lead through healing to **growth and transformation**.

While many traumas present elements of all three – threat, loss, and challenge – the **caregivers and religious leaders of a community can influence the direction of change** by helping their members process their responses in ways that lessen the possibility of violence.

Unaddressed, unhealed trauma can contribute to an ongoing cycle of violence, especially if the trauma event is seen as originating in human intention. Victims of violence, if not supported in finding their way toward healing and transformation, will almost inevitably create new victims. They will "re-enact" the violence they have experienced, either projecting it outside themselves and onto others, or directing it inward toward themselves, moving into hopelessness, an inability to cope and move on, or self-destructive behaviors.

Religious leaders can help their communities make interpretations and choices that promote well-being for all their members, through resolving conflict non-violently and supporting sustainable peace.

Definitions

- **Conflict transformation seeks to prevent, reduce, transform, and support recovery from violence in all forms** - even structural violence that has not yet led to massive civil unrest. Both structural and direct forms of violence disrupt or deny people's efforts to meet their human needs.

- **The field of peacebuilding is like an umbrella, offering processes and frameworks to increase collaboration between people working to build peace in different aspects of society. Preventing violence** may require a whole range of approaches, depending on the capacities and skills of a community and its leaders:

  A. **Waging Conflict Non-Violently**: Nonviolent activists seek to gain support for a group's needs and rights, increasing a group's power to address these issues, and ripen the conditions needed to transform relationships.

  B. **Reducing Violence**: Efforts to reduce direct violence aim to contain perpetrators of violence, prevent and relieve the immediate suffering of victims of violence, and create a safe space for other peacebuilding activities.

  C. **Transforming Relationships**: The fields of conflict transformation, restorative and transitional justice, and trauma healing use an array of processes to build relationships that address trauma, transform conflict, and do justice. These processes give people opportunities to create long-term sustainable solutions to address their needs.

If trauma is experienced primarily as a challenge to be reckoned with, new insights can emerge, along with new energies that lead through healing to growth and transformation.

Community and religious leaders who have been trained in and understand the relationship between unhealed trauma and the cycle of violence can engage their communities in peacebuilding.

D. Capacity Building: Longer-term peacebuilding efforts enhance existing capacities to meet needs and rights and prevent violence through education and training, development, military conversion and transformation, research, and evaluation.

• **Effective disaster readiness, response and recovery will be enhanced by a community's capacity to constructively address conflict and crisis,** whether already latent in the community, or arising more immediately out of the disaster situation itself.

• **Peacebuilding skills include** self-reflection, empathic listening, assertive and diplomatic speaking, appreciative inquiry, creative problem-solving, dialogue, negotiation, and mediation, in addition to an array of trauma interventions.

Who uses or teaches others this practice?

Community and religious leaders who have been trained in and understand the relationship between unhealed trauma and the cycle of violence can engage their communities in peacebuilding.

Three examples of peacebuilding responses to the trauma of September 11 demonstrate the potential of communities and their leaders to reduce or prevent violence in the aftermath of a disaster.

A. Susie and the Arab stores: Several days after September 11, Susie, a long-term Bronx resident widely recognized in her diverse neighborhood as a community organizer, called her pastor:

Susie: Pastor, I need your help. I am so angry about what happened here. I am so angry. I am just full of rage and hatred and anger for what those people did to us. I want to get my friends together and go out into the neighborhood with baseball bats and trash the Arab stores over on Jerome. I want to get back at them. But I can't do

that now. You teach us that Jesus said we need to love our enemies. But what am I supposed to do with all the rage and anger and hatred I'm feeling inside?

Pastor: It's perfectly normal to experience all these feelings when something like this happens. Joe (a community health worker) is coming in tomorrow to do a workshop on how we as a church community can help each other and our neighbors get through this. Can you hold off for little longer?

Susie: Yeah, I guess I can tell my neighbors just to boycott the stores instead of trashing them.

Joe's workshop included a de-briefing component, followed by some very elemental training in self-reflection, active listening, and presence. He suggested that participants could help each other and their neighbors through the three H's: Hush. Hug. Hang around.

The next day, Susie put up flyers in the neighborhood inviting residents to a "prayer vigil" in a sheltered public-access walkway of the local hospital across the street from her basement apartment. Thirty people showed up, including a Muslim man who said, in tears as he removed his headpiece, "We are human beings, just like you. We are very sad about what happened. We just want to live in peace."

Susie had learned a peaceful way of moving through her very real emotions in response to trauma, which resulted not in more violence and victimhood, but in a measure of understanding and resolution.

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Trained leaders can understand and then help shape a community's response through training and practice, as they work at resilience and well-being on an ongoing basis.

B. In a very diverse and violence-prone Bronx neighborhood, a grassroots, parent-cooperative nursery school (the COVE – Community Organized with a Vision of Excellence) had for several years focused on peaceful conflict transformation in its curriculum. Two evenings after 9/11, children, parents, staff, board and neighbors gathered for a community meeting.

The agenda included a time for each participant to write a "journal" entry describing where they were, what they were doing, how they were feeling, and what they were thinking when the planes hit the Trade Center towers. They shared their entries in small groups, and talked about what they could do as a community in this crisis. Scriptures from the major faith traditions, emphasizing peaceful response to conflict and respectful relationships among humans, were read by leaders from these faith communities. Prayers and a candle-lighting ceremony ended the event.

In this volatile neighborhood, local civic and religious community leaders created a "safe" space for children, teens, parents, staff and neighbors to tell stories about what they had experienced. The process influenced how this community interpreted the meaning of the 9/11 events, and how people treated each other subsequently.

C. About three weeks after 9/11, a well-established and active community organization (Mosholu-Woodlawn South Community and Clergy Coalition) in a highly diverse Bronx neighborhood organized a meeting at the local public school for the purpose of responding in ways that would build the community rather than destroy it. The organizing committee included religious and lay leaders from various faith traditions and local organizations.

The event itself began with a "journal" activity, in which participants wrote about their actions, thoughts and feelings regarding 9/11, sharing them orally in small groups. The group activity led into a series of speeches by a local imam, a Pakistani Muslim community organizer, a Jewish professor of political science, a Catholic priest, and several civic leaders, all calling for peace, for mutual respect, for conscientious reflection, and for consideration, protection and support for neighbors who were being marginalized and harassed because of who they were.

The highlight of the evening came after the formal event: sharing food from "Rainbow," the local Pakistani deli, which had been boycotted by some residents after 9/11.

The outcome of this meeting was a 1960's-style "teach-in" sponsored by an emerging grassroots "peace" group on root causes of terrorism and alternatives to war.

These examples of peacebuilding responses to disaster trauma demonstrate the potential impact the actions of community and religious leaders can make in transforming conflict and communities. Individuals, groups, and communities can learn peacebuilding skills, both in preparation for disaster and in response to disaster.

Trained leaders can understand and then help shape a community's response through training and practice, as they work at resilience and well-being on an ongoing basis.

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS

Conflict and community transformation skills should be practiced during all stages of the Life-cycle of the Disaster, so that communities have the capacity to respond to crisis in healthy ways. Fortunately, the capacity for trauma intervention and healing work can begin at any point in the life-cycle of a disaster.

PREPARATION AND MITIGATION PHASES

In preparation for a disaster, communities and leaders can develop their capacities for conflict transformation through **education. Education, opportunities for personal healing, and strategies for building resilience** are tools available for **helping people move through trauma rather than getting stuck in repetitive cycles of victimhood and violence.**

Many programs offer training in conflict and community transformation. Trained leaders can build capacity within their communities, through education, modeling, and practice. Possibilities for training sessions might include:

- Workshops in Trauma Overview & Definitions
- Common Responses to Trauma: Cycles of Victimhood and Violence
- Transforming Trauma: Breaking the Cycles of Victimhood and Violence
- Trauma Interventions for Individuals, Communities, and Societies
- Self-Care for the Caregiver
- Restorative Justice as a Response to Trauma
- Trauma and Truth, Mercy, Justice, Peace (How do these principles work together in transforming conflict?)
- Security in an Insecure World: A Framework for Peacebuilding
- Facilitating Dialogue: How to Handle Difficult Conversations

The STAR program (Strategies for Trauma Awareness and Resilience) is one which offers training in various formats, depending on needs presented by a specific situation. Located within the Conflict Transformation program at Eastern Mennonite University, and developed within the Institute for Justice and Peacebuilding, STAR connects personal transformation with organizational, societal and global wellbeing.

RESPONSE PHASE

In response to a disaster, leaders who know and practice what to do for themselves in situations of crisis or ongoing stress will have the skills to be effective caregivers in times of crisis. Within communities, building capacity for conflict and community transformation through trauma healing work can happen in three "waves:" [2]

If you know and practice what to do for yourself in situations of crisis or ongoing stress, you have the skills to be an effective caregiver in times of crisis. Use the model of "Cycle of Violence/Harm" (Appendix C) and the "Trauma Healing Journey Model: Breaking the Cycles of Violence/Harm" (Appendix D), the analytical questions above and below, and your knowledge of neurobiology and trauma interventions to chart an action plan for helping in times of high stress and trauma. *Note that the *Waves are to be used only as a guide. More important is common sense and the specifics of the situation.*

Trained leaders can build capacity within their communities, through education, modeling, and practice.

A. Wave I

Coping and Stabilization (Days 1-10 and ongoing after a disaster)		
"Psychological first aid for disaster survivors"	Helping Individuals (body, mind, spirit)	Helping Groups (body, mind, spirit)
Recreate a sense of safety Encourage social support Re-establish a sense of efficacy Normalize responses to trauma ("This response is 'normal' in an 'abnormal' situation.") Caretakers need to do self care throughout this time	Be aware of different faith traditions' practices around burial and grieving of loss Be sure debriefing is being done for uniformed personnel (police, fire, EMT, etc.) – including different faith traditions Coordinate outside help to give EMT personnel rest and time for the debriefing Do what can be done to lessen the sense of chaos and bring an orderly response Educate the public about how they can help, how to stay out of the way, and where and how to volunteer	Encourage mayor's office to focus public statements so that the public is hearing the same information and message and not get mixed messages and confused information Police stationed at public gathering places to give sense of security, even normalcy Mayor's office coordinating an interfaith gathering to show cooperative "face" If pre-planned major events happen—ball games, concerts—encourage them to continue, but maybe with a meeting beforehand to talk about things, reinforcing a sense of community as well as awareness of loss Announce houses of worship which are open for people to go to pray and find spiritual help

B. Wave II

Stress Management (Days 2-15 and ongoing)		
Questions to stimulate thinking:	**Helping Individuals (body, mind, spirit)**	**Helping Groups (body, mind, spirit)**
Are there people in your family, place of worship, or your community who could benefit from learning about normal physical responses to trauma?	Continue to coordinate the team of counselors, etc. – and offer them the rest and debriefing they will need	Continue to coordinate the availability of food, emergency assistance, help for the onsite workers
What is the emotional state in your community?	Offer other meetings for religious leaders to debrief, find other resources for help, and know what else is being done in the area	Through mayor's office, perhaps, give help to the media to be positive and creative in their approach to continued reporting
Where is leadership? Whose attitudes and ideas are being adopted by the larger groups? Is it "high mode" or "low mode" thinking? Who has influence?	Be prepared to give them education and resources to know how to help people work through the trauma	Look for who the leaders in the community are, maybe the emerging leaders, and help them come together, coordinate their efforts, and speak with a common public voice
What is your role in leadership?	Offer other groups, such as police, similar education and resources, debriefing, rest, etc.	Organize creative public responses to any signs of ethnic/religious/cultural bias
What is the best point of entry? Trauma? Conflict? Justice? Violence containment?		
How can individuals best be strengthened in body, mind, spirit?		
Whose voices are heard, and whose are missing?		
Where are the potential "hot spots" for violence?		

C. Wave III

Grief and Trauma Resolution		
Questions		
Are people stuck? How can your knowledge of the cycle of violence/victimhood be helpful in your community?		

D. Wave IV

Loss Accommodation		
Questions	**Helping Individuals (body, mind, spirit)**	**Helping Groups (body, mind, spirit)**
Is there ambiguous grief? Frozen unnamed fear/grief? How do you engage other communities for this work?	Provide information and resources for helpers on how to sustain their services over time Provide information and resources for broader religious community leaders in how to help people heal Facilitate cooperation between interfaith leaders to monitor the religious environment in the community and creatively respond	Interfaith groups can give help when justice issues come up – for instance, if legal immigrants have lost proof of green cards Urge local and state government officials to be aware of injustice concerns Ask mayor/governor to appoint a commission of survivors to design a memorial Look at how to create a political and religious will to remember in healthy, creative ways as the community moves forward Develop long term strategies for how to protect and help heal children in the community – through schools, preschools, etc.

*Source: Green Cross Foundation: Field Traumatology, Kathleen Reagan Figley, MS. MT & Intermediate STAR participants (October, 2004).

The most effective interventions integrate body, mind and spirit, addressing the whole person.

RECOVERY PHASE

As communities move into **long-term recovery (not days, but months and years after the traumatic event),** their leaders can support resilience as they:

- Normalize panic, denial, shock, fear: i.e., "It's normal to feel panic, shock, denial, fear when something like this happens."
- Help name the loss: i.e., "We lost some of our most precious possessions in the flood."
- Recognize the anger, shame, humiliation and guilt: i.e., "Anger is normal response that helps us make things right again. We refuse to live this way any longer!"
- Encourage expression of grief and fear, including their own: .e., "Now is the time for us to hold each other as we weep together in our pain."
- Call on individuals' assets, strengths, and deeper purpose: i.e., "We have been through tough times together before. Let's take stock of the resources we have that will help us meet this challenge."
- Encourage a desire for fairness, discouraging revenge: i.e.,"What they did was harmful, unjust, and immoral. How can we take care of our feelings without harming others in return?"
- Present the gray areas and complexity of the situation/humanize the enemy: i.e.,"What's going on here that we need to ask about?"
- Denounce "justified" violence: i.e.,"Violence of any kind always carries a cost. We can choose other ways to respond."

As their communities are able to move through trauma, religious leaders may help them integrate trauma experiences into new self/group identity:

- Create rituals and safe places to grieve and memorialize over time.
- Help the group get clearer about their losses as well as their remaining resources.
- Ask questions about the aggressor: What has been their experience?
- Help identify risks that could be taken in encountering "the other," and create a structure of accountability for aggressors/offenders.
- Teach the importance of interconnectedness and tolerance.
- Create opportunities to face offenders in a safe place, if appropriate (needs to be handled very carefully, but can be highly effective in healing , for example, Truth and Reconciliation-style processes).
- Educate about forgiveness – healthy forgiveness that does not traumatize.
- Support ways to make the situation "right," addressing harm done to victims and requiring accountability for "wrong" done within the community.
- Facilitate initiatives where involved individuals can create a new, collective narrative about the event/s.
- Be available to assist in reconciliation.
- Encourage individuals to share their stories of healing, transformation, and hope.

GENERAL NOTES:

OPPORTUNITIES FOR PERSONAL HEALING:
Effective trauma interventions are myriad. Just as there are many identifiable common responses to trauma (See Appendix E), there are many appropriate ways for individuals to take care of themselves – **emotionally, cognitively, behaviorally, physically and spiritually**. (See Appendix F: "What You Can Do To Take Care of Yourself"). **The most effective interventions integrate body, mind and spirit, addressing the whole person.**

As these trauma interventions help to release "stuck" or "frozen" responses, individuals, groups and communities can generate from within their own experience the **creative strategies that build resilience and enable them to transcend trauma**.

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Resilient individuals, groups, and communities will be those who have worked at peacebuilding ahead of time...

BUILDING RESILIENCY:

A. Trauma awareness education before a disaster including the cycles and the healing path AND
  • Regular practice of relaxation response skills
  • Regular spiritual practice
  • A robust theology (e.g., not equating God's presence only with prosperity and a good life). Spiritual resilience comes from faith in:
    – the goodness of God
    – other human beings
    – self (that one can survive and overcome)
    – the future
    – a meaningful religion
  • Strong social networks
  • Community and religious leader networks across faith lines with feedback loops
  • Disaster preparedness planning by individuals, communities, and societies

B. Basics of resilience for caregivers
  • Functional social support
    – Attachment
    – Social integration
    – Opportunity for nurturance
    – Reassurance of worth
    – Sense of reliable alliance and guidance
  • Structural/social support: a friendship network in which several people in that network also know each other
  • Family cohesion
  • Work team cohesion

Conclusion

When disaster strikes, trauma occurs. Resilient individuals, groups, and communities will be those who have worked at peacebuilding ahead of time, through increasing their capacity to wage conflict non-violently, reduce violence, transform relationships, and build resilience.

A key component of that peace-building process is understanding trauma and its potential to perpetuate a vicious, energy-draining cycle of violence, or transform pain and suffering into a fruitful transcendence which generates wellbeing for individuals, groups and communities.

Editor's Note: The resources and websites provided here are provided by the authors as resources for issues raised in this chapter. For a list of all the resources provided in this manual, please refer to Chapter 10, just before the Reference Section.

RESOURCES

Talking about Difficult Topics

The following websites provide resources on difficult topics. Some provide principles and guidelines for leading controversial discussions. If you are aware of other good websites on dialogue, please let us know.

The Choices Curriculum at Brown University has excellent resources. **www.choices.edu**

The Public Conversations Project (PCP) provides workshops on leading dialogues of difficult topics. **www.publicconversations.org**

Sojourners, a community in Washington DC, produces a magazine and on this website has study guides/resources on non-violent action, urban violence, justice, and peacebuilding from an evangelical, social-justice Christian perspective. **www.sojo.net**

The website of the Muslim Peace Fellowship, this site contains thought-provoking articles and relates teachings from the Koran to current issues. **www.mpfweb.org**

Thought-provoking articles and a newsletter are offered on this site from a Jewish perspective. **www.jewishpeacefellowship.org**

This site contains free materials on facilitating dialogues on controversial issues. There are guidelines for facilitators plus excellent materials and a process for studying difficult topics. **www.studycircles.com**

This Chapter has the following Appendices:

Appendix A: Integrated Framework for Peacebuilding

Appendix B: Peacebuilding Processes

Appendix C: Cycles of Violence / Harm

Appendix D: Trauma Healing Journey: Breaking the Cycles of Violence / Harm

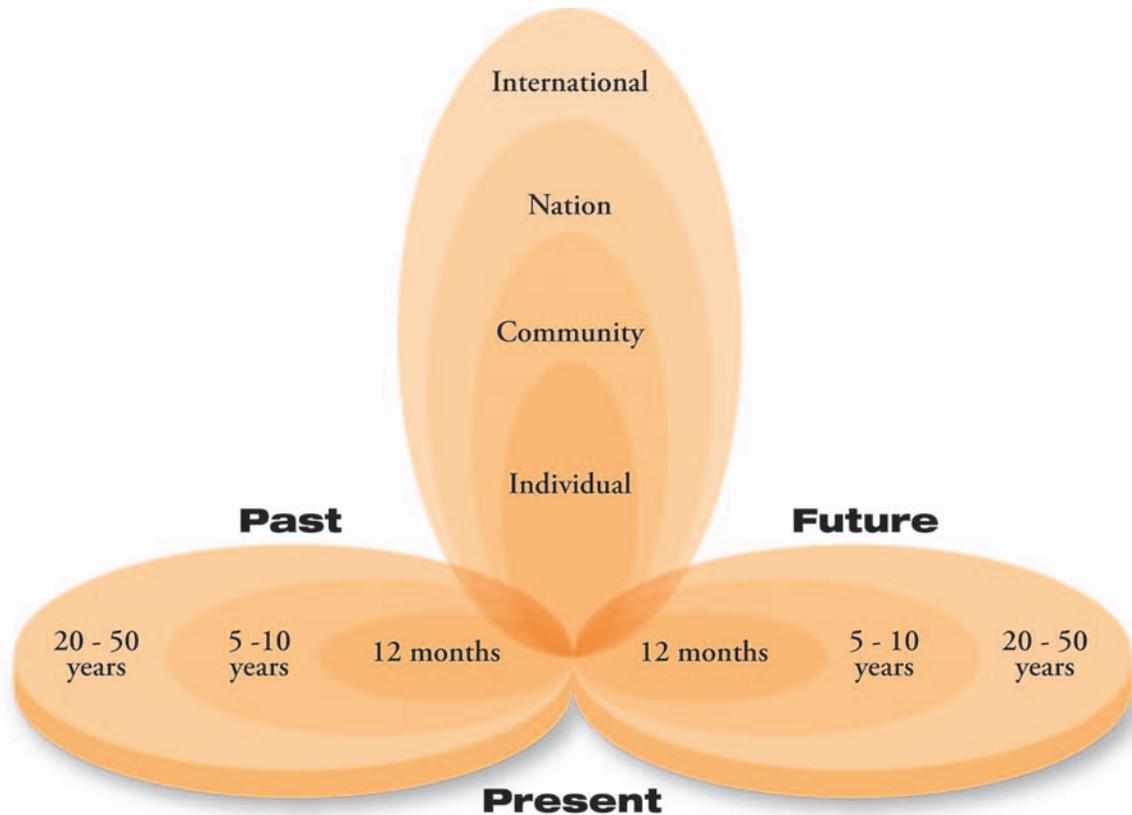Appendix E: Common Responses to High Stress and/or Trauma

Appendix F: What You Can Do to Take Care of Yourself

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1 This material is adapted from Schirch, Lisa, The Little Book of Strategic Peacebuilding, Intercourse, PA: Good Books, 2004.

2 This material is based on Green Cross Foundation: Field Traumatology, Kathleen Reagan Figley, MS. MT , incorporating anaylsis by Intermediate STAR participants (October, 2004).

Integrated Framework for Peacebuilding

International

Nation

Community

Individual

Past

Future

20 - 50 years

5 -10 years

12 months

12 months

5 - 10 years

20 - 50 years

Present

Analysis

International:

What are the material, social, cultural or spiritual needs of people in different areas of the world that fed into the crisis? How well do international structures and relationships meet these needs?

National:

What are the material, social, cultural or spiritual needs of people within this nation? How well do national structures and relationships meet these needs?

Community:

What are the material, social, cultural or spiritual needs of people within this community? How well do local structures and relationships meet these needs?

Individual:

What are my needs as an individual? How mentally, emotionally, physically and spiritually ready am I to intervene in this crisis?

Design of Peacebuilding

International:

What new international structures, policies and relationships can we foster to help meet global needs that feed into the crisis?

National:

What new national structures, policies and relationships can we foster to help meet the needs of people within this nation?
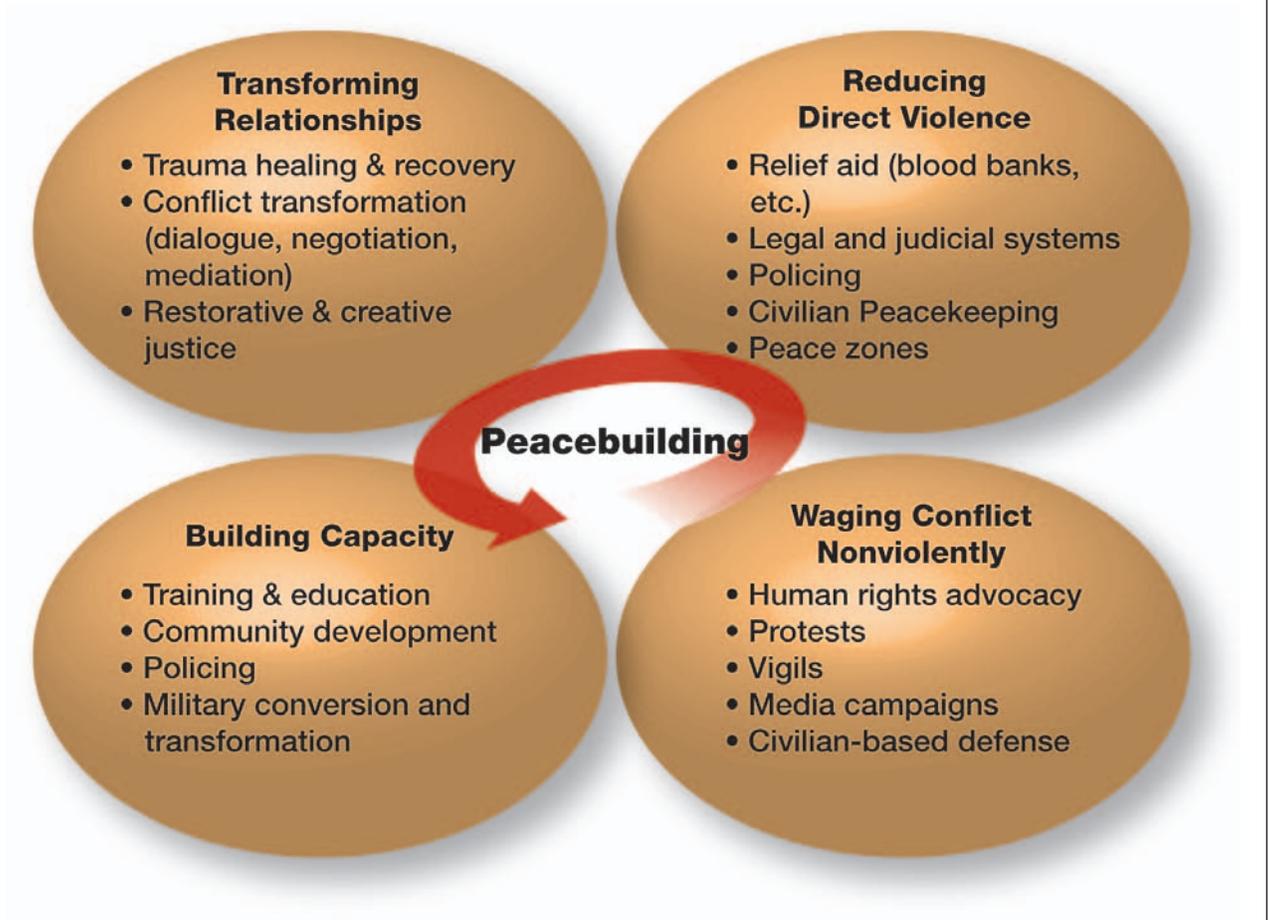
Community:

What new local structures, policies, processes and relationships can we foster to help meet the needs of people within our community? How do we manage the immediate crisis and prevent further violence?
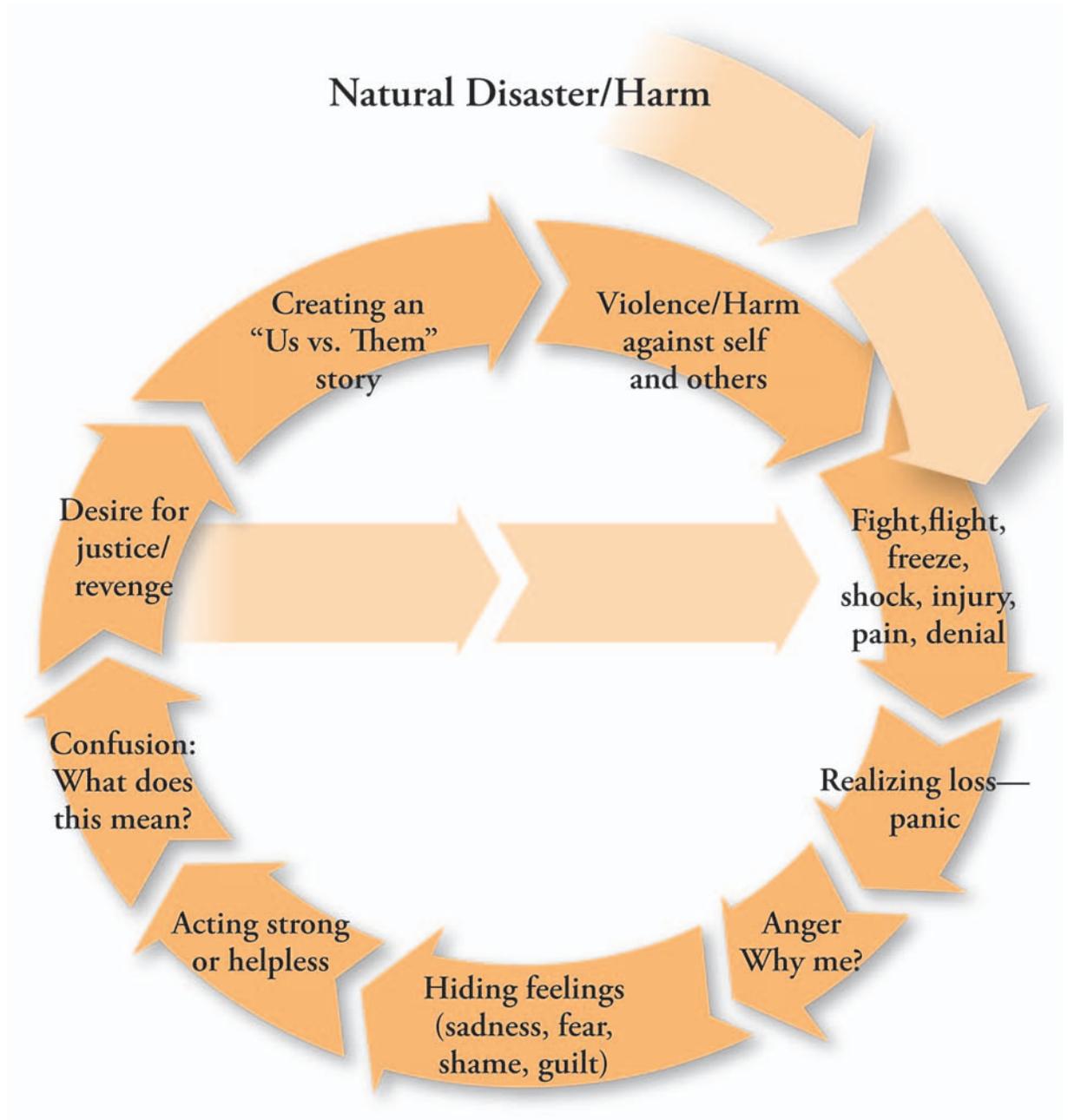
Individual:

What do I need mentally, emotionally, physically and spiritually in order to be an effective peacebuilder in this crisis?
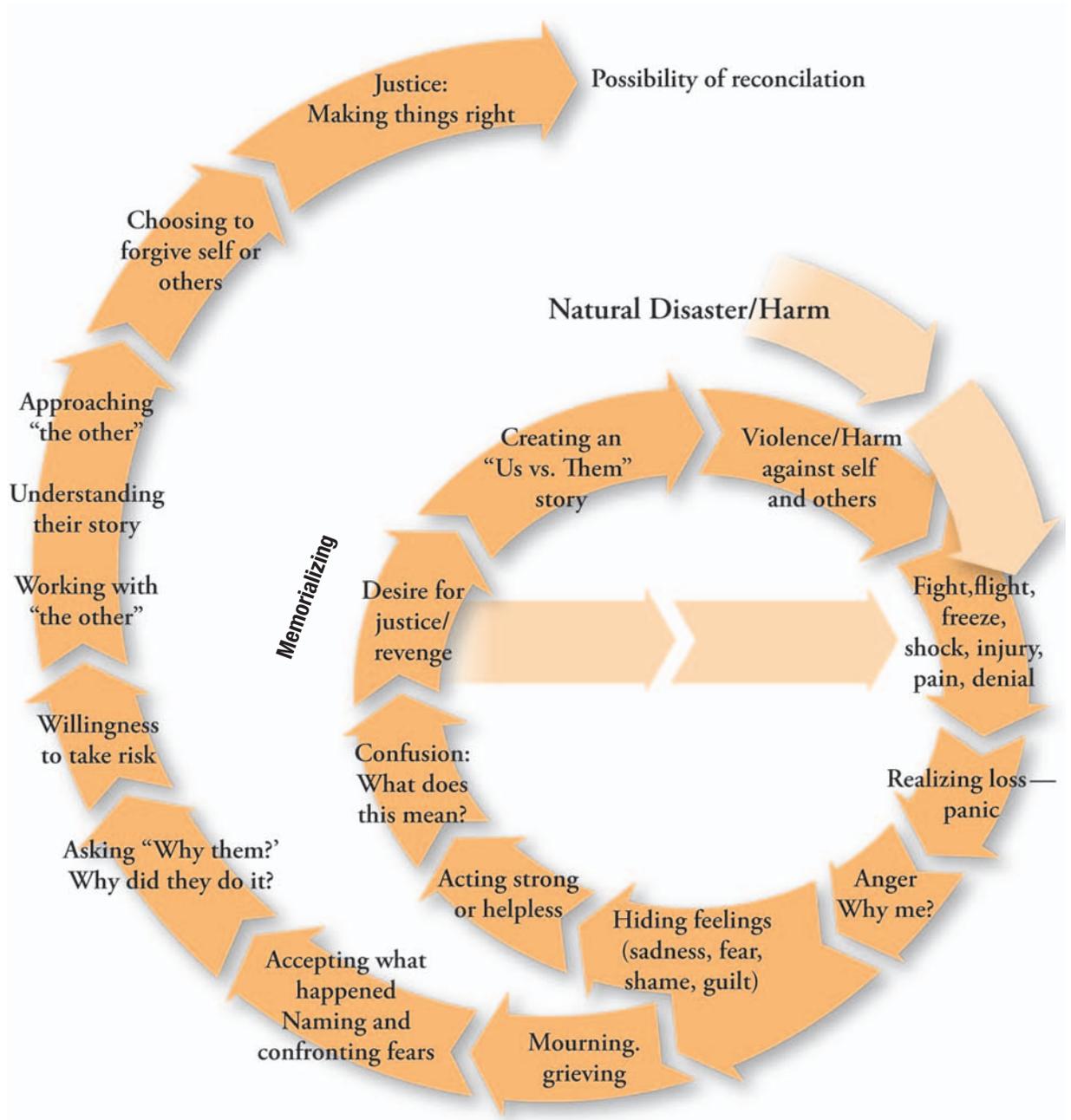
Peacebuilding Processes

Transforming Relationships
- Trauma healing & recovery
- Conflict transformation (dialogue, negotiation, mediation)
- Restorative & creative justice

Reducing Direct Violence
- Relief aid (blood banks, etc.)
- Legal and judicial systems
- Policing
- Civilian Peacekeeping
- Peace zones

Peacebuilding

Building Capacity
- Training & education
- Community development
- Policing
- Military conversion and transformation

Waging Conflict Nonviolently
- Human rights advocacy
- Protests
- Vigils
- Media campaigns
- Civilian-based defense

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Cycles of Violence / Harm

Natural Disaster/Harm

- Creating an "Us vs. Them" story
- Violence/Harm against self and others
- Fight, flight, freeze, shock, injury, pain, denial
- Realizing loss— panic
- Anger Why me?
- Hiding feelings (sadness, fear, shame, guilt)
- Acting strong or helpless
- Confusion: What does this mean?
- Desire for justice/ revenge

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Trauma Healing Journey: Breaking the Cycles of Violence / Harm

Possibility of reconciliation

Justice:
Making things right

Choosing to
forgive self or
others

Natural Disaster/Harm

Approaching
"the other"

Creating an
"Us vs. Them"
story

Violence/Harm
against self
and others

Understanding
their story

Working with
"the other"

Memorializing

Desire for
justice/
revenge

Fight, flight,
freeze,
shock, injury,
pain, denial

Willingness
to take risk

Confusion:
What does
this mean?

Realizing loss—
panic

Asking "Why them?"
Why did they do it?

Acting strong
or helpless

Anger
Why me?

Accepting what
happened
Naming and
confronting fears

Hiding feelings
(sadness, fear,
shame, guilt)

Mourning.
grieving

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Common Responses to High Stress and/or Trauma

After experiencing a tramatic event, or in response to cummulative stressors, it is common to experience a wide range of emotional, cognitive, physical and spiritual reactions. These responses may appear immediately after the event(s) *or some time later*. ***These are noraml reactions to difficult situations. The following are some of the more common responses:***

Emotional	Cognitive (thinking)	Behavioral (doing)	Physical	Spiritual	Societal Effects
•Fear •Terror •Anxiety •Panic/ paranoia •Anger/ rage •Apprehension •Depression •Vengeful •Shame •Guilt •Sadness •Grief •Emotional shock •Loss of emotional control •Feelings of hopelessness or helplessness •Feeling numb •Irritability •COURAGE	•Confusion •Nightmares •Hypervigilance •Suspiciousness •Flashbacks •Overly sensitive •Difficulty concentrating/ making decisions, spaciousness •Memory problems •Shortened attention span •Overly critical •Blaming others •Poor problem solving •Poor abstract thinking •Preoccupied with the event(s) •Inability to recall all or parts of the event •Disorientation of time, place or person •Heightened or lowered awareness	•Withdrawal: avoiding usual activities •Antisocial acts •Inability to rest, pacing •Hype- alertness •Erratic movement •Suspiciousness •Emotional outbursts •Excessive use of humor •roblems at work •Change in speech patterns •Increased alcohol/ drug use •Avoiding thoughts, feelings related to the event •Difficulty trusting •Impaired sexual functioning •Loss or increase of appetite •Feeling uncoordinated •Domestic violence •CARING FOR OTHERS	•Thirst/ dry mouth •Twitches •Vomiting •Weakness •Chest pain •Elevated blood pressure •Rapid heart rate •Muscle tremors •Visual difficulties •Nausea/ diarrhea •Shallow breathing •Dizziness or faintness •Chill or sweating •Easily startled •Fatigue •Changes in appetite •Sleep disturbances or nightmares •Headaches •Grinding teeth •Inability to rest •Illness	•Emptiness •Loss of meaning •Doubt •Anger at God •Feeling unforgiven •Martyrdom •Feeling punished •Loss of faith in humanity •Looking for magic •Sudden turning to God •Belief that God is powerless •Belief that we have failed God •Loss of direction •Cynicism •Apathy •Needing to "prove" self •Alienated •Mistrust •Crisis of faith •Familiar faith practices seem empty •GROWTH DEEPERFAITH REILIENCE	•Apathy •Silence/ impaired communication suppression of truth •Denial •Aggression •Gangs •Isolation •Lack of empathy •Low energy, and productivity •Inflexibility •High rates of alcoholism, drug abuse, domestic abuse, (untreated) mental health issues (depression, sexual dysfunction, etc) •High rates of stress related health issues (and medication use) •Intergenerational transmission of pain •SPIRITUAL GROWTH, WISDOM

Adapted from the work of Jim Norman, M.ED, C.T.S., Oklahoma City, OK. And others by Carolyn Yoder

What You Can Do To Take Care of Yourself

Adapted from the work of Jim Norman, M.ED, C.T.S Oklahoma City, OK, who credits it "to the survivors of the bombing of the Murrah Building and the good people of Oklahoma City."

The same five areas in which you experience the effects of trauma are also areas to focus efforts to help yourself cope. The following are some ideas others have found useful. Add to it those you have found helpful.

Emotional (feelings)	Cognitive (thinking)	Behavioral (doing)	Physical	Spiritual
•Practice moderation •Allow yourself to experience what you feel (cry, shake, breathe deeply) •Label what you are experiencing •See a counselor •Be assertive when needed but check with a trusted person to see if you're overreacting •Practice relaxation-response exercises •Keep communication open with others •Remember you have choices •Develop your sense of humor •Find a vent-partner" •Use "positive" words and language •Go fishing •YOUR IDEAS:	•Practice moderation •Write things down •Be patient with yourself •See the decisions you are already making •Make small, daily decisions •See a counselor who does EMDR, (Eye Movement Desensitization and Repressing) •Get the most info you can to help make decisions •Plan the future •Anticipate needs •Remember you have choices •Review previous successful problem solving •Break large tasks into smaller ones •Ask for help from friends and family •Go bass fishing •YOUR IDEAS	•Practice moderation •Balance time spent with others with time for yourself/with God •Limit demands on time and energy •Help others with tasks •See a counselor •Do activities that were previously enjoyable •Take trips or different routes to work •Remember you have choices •Ask others how they think you're doing •Find new activities that are enjoyable and (mildly) challenging •Set goals, have a plan •Do things that relax you and bring you joy •Get involved with others in working for a justice that restores •Go crappie fishing •YOUR IDEAS	•Practice moderation •See your doctor and dentist •Exercise •Maintain regular sleep patterns •Minimize caffeine •Eat well-balanced and regular meals •Drink water •Wear less restrictive clothing •Remember you have choices •Engage in some physical luxuries-spas, massage, exercise trainers, baths •Practice relaxation response exercises •Dance •Go catfish fishing •YOUR IDEAS	•Practice moderation •Discuss your beliefs with spiritual leaders •Pray •Meditate •Practice the rituals of your beliefs •See a counselor •Attend spiritual retreats •Visit new places of worship •Remember you have choices •Ask the hard questions boldly •Pass on or teach your spiritual beliefs •Read spiritual literature •Read stories of other survivors who overcame hard times •Sing •Paint •Write poetry •Go trout fishing •YOUR IDEAS:

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The Role of Religious Leaders in Crisis Response:

CARING FOR THE SOUL

7

BY THE REVEREND WILLARD ASHLEY, D.MIN. AND THE REVEREND SUSAN LOCKWOOD

1. Introduction

- In a disaster, religious leaders are front-line, trusted caregivers to whom people look for assistance and support for healing.
- A primary function of religious leaders is the care of the soul, which involves showing compassion and empathy for people in times of crisis by offering comfort, support, clarity, direction and spiritual resources.
- The religious leader is in a unique position to respond to people who are impacted by a disaster because she or he is already in an established role, has a core of relationships, and brings a faith perspective that speaks to the need for meaning that is so pervasive in the human experience of suffering.

We learned from 9/11 that people really do turn to religious leaders for support.

In a poll conducted by the American Red Cross of individuals emotionally impacted by the attacks on the World Trade Center:
- 59 percent said they were likely or most likely to turn to a religious leader or spiritual guide for help;
- 45 percent said they would turn to a physician;
- 40 percent said they would turn to a mental health professional.
- Anecdotal information substantiates similar experiences with recovery workers at Ground Zero and families in the Family Assistance Centers.

Additional research, predating the September 11 terrorist attacks, supports the ARC findings:

- 43-60% of people who have emotional problems turn first to religious leaders for help;
- 94% of Americans believe in God;
- Prayer and faith are the most widely used methods of coping with traumatic life events.

Religious Leaders' Roles In Disaster Spiritual Care

The type of caregiving provided by religious leaders to persons impacted by a disaster will depend upon training and skill.
- **At the very basic level, religious leaders are called upon to provide psychological/spiritual "first aid"** that will help the person impacted by a disaster with stabilization, normalization and adaptation, as well as with processing what has happened and with making meaning of the experience.

- **Optimally, religious leaders will not only have basic pastoral/spiritual care training and skills** from seminary or other theological/religious education, but will also have specialized training in crisis intervention and trauma response and will be able to companion a person to a positive outcome, even growth, after a catastrophic event.

The type of caregiving provided by religious leaders to persons impacted by a disaster will depend upon training and skill.

• **Religious leaders without advanced clinical training should be clear about the limits of their role as caregivers**—that they are not psychotherapists or pastoral counselors, and should refer those with severe symptoms to a trained mental health professional or pastoral counselor.

While religious leaders should not diminish the value of their role or stand on the sidelines in assisting with the healing process, they should above all else, do no harm.

II. Recognizing Serious Problems

It is important to learn the signs and symptoms of anxiety and grief responses to disaster. Recognizing severe symptoms of anxiety and grief that need referral for professional treatment is an extension of care, not a sign of failure.

1. Normal **Emotional** Responses to Grief
   • Denial, disbelief, feeling unreal
   • Anger, blaming
   • Difficulty concentrating
   • Inability to organize
   • Guilt
   • Preoccupation with the deceased or object of loss
   • Feelings of abandonment

2. Normal **Physical** Responses to Grief
   • Sleep disturbance
   • Restlessness or agitation
   • Fatigue
   • Loss of Appetite
   • Diarrhea
   • Rapid heart rate
   • Headaches
   • Numbness

3. Signs of **Possible Prolonged or Unresolved Grief**
   • Feels sick or that one is "losing one's mind"
   • Life seems over, or meaningless
   • Marked psychomotor retardation
   • Uninvolved and uninterested
   • Profound denial
   • Delusions and illusions
   • Active suicidal ideation
   • Loss of faith, spiritual/religious crisis

4. **Post Traumatic Stress Disorder (PTSD)**
   Editor's note: Please refer to Chapter 3 (Self-Care) for a description of PTSD.

   Religious Leaders can help those with Acute Stress Disorder and/or PTSD by:
   • Knowing the signs and symptoms of PTSD.
   • Referring appropriately to a mental health professional.
   • Connecting those with special problems to communal and social supports.
   • Appreciating the usefulness of medication.
   • Offering spiritual resources.
   • Continuing caregiving relationship after referral.

It is important to learn the signs and symptoms of anxiety and grief responses to disaster.

5. **Alcohol & Drug Use**
   - Substance abuse may increase following a disaster.
   - Virtually all post-disaster substance abuse has been found to have pre-existed before the disaster.
   - Disasters provide a more acceptable platform for people to acknowledge and obtain treatment for substance abuse.

   Religious leaders can help by acknowledging the problem, seizing the opportunity, and referring substance abusers for treatment while providing communal and caregiving support.

6. **Domestic Violence**
   - Virtually all post-disaster domestic violence has been found to have already existed before the disaster.
   - Disasters provide a more acceptable platform for people to acknowledge and obtain treatment for domestic violence.

   Religious leaders can help by not avoiding the problem, seizing the opportunity, and referring the victim and abuser for treatment while providing communal and ongoing caregiving support.

(Some information in this section came from a project sponsored by the September 11th Fund entitled, *Short Term Crisis Intervention Skill Building for the Caregiver*. The Project was managed by the Council of Churches of the City of New York , under the name "Care for the Caregivers Interfaith Project." The Rev. Willard Ashley, D.Min., was the Project Director.)

7. **Suicide**

Suicide is relatively rare following a disaster, according to studies of disaster mental health trends (www.astho.org/pubs/disasterMN.pdf), but should be on the religious leader's radar when there are such risk factors as mental illness, severe physical illness, substance abuse, previous attempts, job loss, financial distress, relationship loss, hopelessness, isolation and lack of support.

A. **Four facets of pastoral care to suicidal persons:**
   - Recognizing when persons are suicidal
   - Providing emergency crisis intervention or getting professional help.
   - Continuing pastoral care to help the person deal with the underlying causes of suicide.
   - Helping loved ones to deal with the destructive consequences of incomplete or complete suicide.

B. **Signs of suicidal behavior:**
   - Obvious suicidal threats. All suicidal threats must be taken seriously.
   - Covert suicidal threats; feelings of emptiness and meaningless.
   - Depression.
   - Crushing losses and pathological grief.
   - Psychological disturbances and chronic illnesses.

C. **In counseling with suicidal or suspected suicidal persons, *always ask about suicidal impulses, fantasies, or intentions.***

D. **The only time in counseling when you break a confidence entrusted to you is when the life of someone is in danger, either by suicidal impulses or killing impulses.**
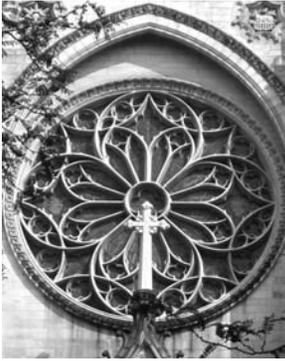
Make your house of worship a safe space for sharing feelings, and a welcoming environment so that those experiencing trauma can be connected to others and to the spiritual.

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS

Survivors

- Many survivors of disasters can be helped to re-evaluate life goals and directions, which may include addressing pre-existing concerns as well as new issues.
- Many survivors may be open to broadening their faith, as well as becoming more sensitive to the suffering of others.
- Unlike other helping professionals, religious leaders can be available for continuing care post-disaster—the religious leader as long-term companion on the journey to healing and wholeness.

Positive Outcomes from experiencing disasters

Disaster research findings show that:
- Some people report they have grown as a result of a disaster.
- Disasters can bring out the best in people and communities.
- Most people describe some positive outcome from catastrophic events.
- People are resilient; even after the most severe disasters, most people do not develop long term issues.

(Some information in this section was taken from *Short Term Crisis Intervention Skill Building for the Caregiver*.)

MITIGATION AND PREPAREDNESS PHASES: Education and Training

The task is to be effective in the role of trusted caregiver.
- Educate self and houses of worship about common emotional reactions to disasters by attending workshops and trainings in pastoral crisis intervention, trauma response, etc.

- Promote the idea of resiliency. Research shows that even after the most severe disasters, most people do not develop mental illness, and symptoms subside with time. In fact, only 7%-35% of people experience significant distress after a trauma/disaster.
- Make your house of worship a safe space for sharing feelings, and a welcoming environment so that those experiencing trauma can be connected to others and to the spiritual.
- Train staff and a team of caregivers such as deacons or lay ministers in disaster spiritual care so that they can be quickly mobilized in a disaster.

RESPONSE PHASE: Basic Support and Listening

The task is to help persons understand and normalize what has happened.

- Help stabilize a person through the ministry of presence. Be an anchor, stay calm and non-anxious. Think of yourself as a companion.
- Give basic support to reduce stress by helping solve immediate problems, such as obtaining concrete information, finding loved ones, providing food or drink, using the telephone, etc. Serve as a liaison or advocate if needed.
- Active/Supportive Listening
  - Be open to listening to the telling, or retelling, of stories about what has happened.
  - Stay present in the moment as you listen, rather than thinking ahead to what you will say.
  - Invite thoughts and gently probe details with interest, but don't force feelings. Let them come, and be prepared for intense emotions.
  - Offer empathetic and reflective responses to what is expressed; normalize the situation (i.e. "it's normal to feel this way after this kind of experience").
  - Respect personal and cultural boundaries and differences (e.g. touch, disclosure).

Crisis Response **95**

• Offer to pray if it seems appropriate, but do not rush or force the issue. Ask first.
• Help facilitate further care:
  – Link individual up with family, friends, colleagues, or house of worship to provide connections for additional support.
  – If after evaluating a person's mental, behavioral, and spiritual status, you sense the person has deeper or special needs, make a referral to a mental health or pastoral/spiritual care professional.
• Family and close friends may be less supportive in a disaster situation due to their own involvement and may be more needy than helpful.

RECOVERY PHASE: Short Term

The task is to encourage coping and doing the "work of mourning"

Coping & Stress Management

• Lend permission to cry, feel bad, be nonproductive, focus on self for a period of time.
• Help regain control of some aspect of life; restore routine.
• Utilize social supports.
• Encourage appropriate use of humor.
• Suggest down time, relaxation, pleasurable activities.
• Point out the need for self care: sleep, meals, hygiene, exercise, habits, time off, balance.
• Utilize religious resources (prayer, meditation, reading of sacred texts, music, etc.).

Caring for the House of Worship

• The religious leader should not underestimate the power of ritual for comfort and healing, and for the binding of anxiety. This includes:
  – Commemorations and anniversaries
  – Sacraments, Ordinances of healing, Communion
  – Pastoral prayers of intercession
  – Rituals of confession

  – Rituals of forgiveness
• The religious leader can utilize the worship context to acknowledge and normalize the experience of trauma and grief—name the elephant in the room.
• The religious leader can interpret, reframe, and offer contextual meaning to disaster events, drawing upon sacred texts and religious traditions.
• The religious leader can assist with the spiritual questions on the hearts and minds of the members of the worshipping community after a disaster:
  – Where is God?
  – Where is God's sense of justice in this matter?
  – Why do bad things happen to good people?
  – How safe am I?
  – Where will I find inner strength during this time?
• The religious leader can arrange for the worshipping community to be offered workshops, groups, and other opportunities for education, healing, and recovery.

Religious leaders are most effective when they help people find spiritual resources and their own inner strength.

LONG TERM RECOVERY

The task is not merely overcoming loss or sadness, but redefining how to live life.

Problem Solving Assistance

- Make a list; prioritize.
- Weigh advantages and disadvantages of potential choices.
- Try new behaviors and develop new skills.
- Try more than one approach; allow a backup if Plan A doesn't work.
- One step at a time—manageable units first.
- Keep sight of larger perspective and progress.
- Identify religious resources.

Find Meaning & Perspective

- Explore the person's values that facilitate this process.
- Listen to the person's language in self description, such as victim, survivor, rescuer, etc.
- Find spiritual/religious meaning in the disaster.
- Explore how trauma/the experience has changed the person.
- Consider the healing dimensions of forgiveness, if appropriate.

Some Helpful Reminders

- All need caring for—emergency personnel, victims, survivors, families, and yourself.
- It is not the job of the religious leader to have all the answers or to fix people and their problems.
- Don't over-help; it disempowers victims.
- Religious leaders are most effective when they help people find spiritual resources and their own inner strength.
- Keep confidences; never reveal information shared in caregiving situations without permission of the person/s involved.

Editor's Note: The resources and websites provided here are provided by the authors as resources for issues raised in this chapter. For a list of all the resources provided in this manual, please refer to Chapter 10, just before the Reference Section.

RESOURCES

Models of Best Practices

A. Other Models from Various Faiths or Providers
    1. Pastoral Crisis Intervention: a basic and advanced training program of the International Critical Incident Stress Foundation that provides skills and didactic training for religious leaders.
    2. Short Term Crisis Intervention Skill Building for the Caregiver: a project that was sponsored by the September 11th Fund and managed by the Council of Churches of the City of New York under the name Care for the Caregivers Interfaith Project. The Rev. Willard Ashley, D. Min. was the Project Director.
    3. Emotional and Spiritual Care in Disaster Operations: provided by the National Disaster Training Program of the Salvation Army.

B. Contact Information
    1. International Critical Incident Stress Foundation **www.icisf.org.**

    2.Care for the Caregivers Interfaith Project **www.cccny.net**.

    3. The National Emergency Disaster Services Coordinator
       The Salvation Army National Headquarters
       615 Slaters Lane, Box 269
       Alexandria, VA 22313-0269
       703.684.5500

Websites

Care for the Caregivers Interfaith Project: **www.cccny.net**.

Centers for Disease Control and Prevention: Disaster Mental Health Resources **www.bt.cdc.gov/mentalhealth**.

Church World Service provides an introduction to some of the stressors, defines stress and trauma, describes symptoms, discusses what to do after you experience a traumatic event, offers aid to the management of cumulative stress, and offers links and on-line resources. **www.churchworldservice.org**.

International Critical Incident Stress Foundation provides training in Critical Incident Stress Management (CISM) and provides information for coping with traumatic events and has a bookstore listing of reading materials useful for crisis intervention. **www.icisf.org**.

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration: **www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/.**

National Institute of Mental Health **www.nimh.nih.gov/healthinformation/anxietymenu.cfm** (Anxiety).

National Voluntary Organizations Active in Disaster
www.nvoad.org/documents.php#planning www.nvoad.org/documents.php#planning.

The New York Disaster Interfaith Services, provides information about training events in the Greater New York Area. **www.nydis.org.**

The QPR Institute offers comprehensive suicide prevention training programs along with educational and clinical materials for the general public, professionals and institutions. **www.qprinstitute.com/.**

Recursos Educativos Cristianos / Christian Education Resources: Suicidal Crisis **www.receduc.com/counseling/suicide.html.**

The Salvation Army
www.usc.salvationarmy.org/usc/www_usc_eds.nsf/vw-text-index/bc49c1d9f0841f14802570580006a191?opendocument.

Books

Braiker, Harriet. *The September 11 Syndrome: Seven Steps to Getting a Grip in Uncertain Times*. McGraw-Hill, 2002. Deals with the "new normal" and provides a number of practical coping exercises.

Brende, J.O. *Post-traumatic symptoms and trauma recovery in the Bible.* Trauma Recovery Publications, 1991. Recommended by ICISF's PCI training.Fleischman, P.R. The healing spirit. Paragon, 1989. Recommended by ICISF's PCI training.

Herman, Judith. *Trauma and Recovery: The aftermath of violence—from domestic abuse to political terror.* Basic Books, 1997. A classic that provides valuable information on trauma and the stages of recovery.

Nouwen, Henri. *Lifesigns.* Image Books, 1986. Recommended resource by ICISF's PCI training.

Pargament, K. *Psychology of religion and coping.* Guilford, 1997. Recommended resource by ICISF's PCI training.

Parkinson, Frank. *Post-Trauma Stress: A personal guide to reduce the long-term effects and hidden emotional damage caused by violence and disaster.* Fisher Books, 2000. Grew out of his experience of working with a multidisciplinary team who worked together before and after the Gulf War; deals with the debriefing process.

Sinclair, N.D. *Horrific Traumata: A pastoral response to the post-traumatic stress disorder.* Haworth Pastoral Press, 1993. Recommended resource by ICISF's PCI training.

Wilder-Smith. A.E. *Why does God allow it?* TWFT Publishers, 1980. Recommended resource by ICISF's PCI training.

Mental Health Response to a Disaster

BY ALI GHEITH

8

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Forward

The purpose of this reference is to provide religious leaders with a general understanding of the mental health response to a disaster, and to assist in meeting the challenges of providing mental health support to people affected by a disaster. It offers the basics of disaster mental health and describes reactions and needs of all those affected by a disaster. Furthermore, it explains how religious leaders can help to relieve emotional suffering of congregants and provide guidance for when and how to refer for mental health services.

Introduction

Natural or human-made disasters are by definition disturbing and unexpected. Most people react to a perceived threat or environmental challenge with stress. Stress reactions are normal in most cases, but may differ depending upon the severity of the situation. Stress reactions are experienced as physical *(body reactions), emotional (feelings), cognitive (thinking and decision making), behavioral (action), and spiritual (belief and values)* - see Table 1.

As members of the community, religious leaders are in a good position to provide help to people affected by a tragedy. In their daily interaction with others, religious leaders show compassion, willingness, and interest in helping those in need. Similar to other disaster responders, religious leaders can be affected by a disaster, and in order to provide efficient mental health support to

the members of their house of worship, religious leaders themselves need to be supported and cared for through training and skill building.

Signs of disaster stress reactions and survivor needs following a traumatic event

Natural or human-made disasters cause many similar predictable stress reactions to the traumatic event. Traumatic events are characterized by a sense of horror, helplessness, serious injury, or the threat of serious injury or death. Traumatic events affect survivors, rescue workers, and friends and relatives of victims who have been directly involved. In addition to potentially affecting those who suffer injuries or loss, they may also affect people who have witnessed the event either firsthand or on television. Stress reactions following a traumatic event are common and resolve within days or few weeks following a disaster. Affected persons reactions and needs are similar. These are:

- A concern for basic survival.
- Difficulty understanding and accepting what has happened.
- Grief over loss of loved ones or loss of valued and meaningful possessions.
- Being unable to stop thinking about the event.
- Being easily reminded of the event by things that are not very related.
- Reliving the smells and sounds, seeing details of the incident.
- Increased difficulty controlling emotions.
- Being easily irritated or startled.
- Fear and anxiety about personal safety and physical safety of loved ones.

Traumatic events affect survivors, rescue workers, and friends and relatives of victims who have been directly involved.

- Sleep disturbances, often including nightmares and imagery from disaster.
- Concerns about relocation and related isolation or crowded living conditions.
- Concerns about backlash and social alienation.
- A need to talk about the events and feelings associated with disaster, often repeatedly.[1]
- A need to feel one is part of the community and its recovery efforts.

Peoples' response following a traumatic event

While the responses outlined above are normal, they can also interfere with a person's ability to return to their pre-disaster level of functioning. By providing compassionate support for people affected by a traumatic event, we can help reduce their stress and make an essential contribution to their recovery.

Examples of ways people cope with a traumatic event:
- Seeking help from others or offering help to others.
- Talking about their experiences.
- Trying to make sense of what happened.
- Hiding until the danger has passed.
- Seeking information about the welfare of their loved ones.
- Gathering their remaining belongings.
- Beginning to repair the damage.
- Burying or cremating the dead.
- Following their religious practices.
- Setting goals and making plans to accomplish them.
- Maintain regular routines.
- Using defenses like denial to reduce the perceived impact.
- Remaining fearful and alert to any further danger.[2]

Phases of stress reaction following a traumatic event

Most people respond to traumatic events in predictable phases. There is a gradual transition from one phase to another depending upon the severity of the symptoms. The duration of the phase may vary from person to person. It is, however, important to note that these phases do not always occur, nor do they always appear in a specific order.

A person exposed to severe stress may pass through one or more of the following phases:

Stress Reaction Phase 1: Immediate response

- Lasting minutes, hours, or days.
- Post traumatic distress: strong emotions, numbness, disbelief, fear, anxiety and confusion.
- Persisting stress response may lead to loss of flexibility in behavior and thinking. "Thinking may become disorganized resulting in fight and flight reflex or a freeze response. During this phase, the risk of panic or acute outbreak of medically unexplained symptoms is at its peak."
- Stress reaction may affect the way people act. It can create narrow-mindedness and make behavior more rigid. The loss of flexibility can cause irritability, anger or in some cases, excessive high spirits.
- Irritation and anger - causes suspicion and the need to look for a scapegoat, or someone to blame when something goes wrong.
- Rigid behavior - complicates communication with others and may lead to withdrawal.
- Feeling of uselessness and helplessness - may lead to restlessness.

By providing compassionate support for people affected by a traumatic event, we can help reduce their stress and make an essential contribution to their recovery.

Stress Reaction Phase 2: Intermediate Response: Adaptation, Arousal Avoidance

- Lasting one week to several months after the event.
- Intrusive symptoms: anxiety, restlessness, recollection of events, associated with hyper arousal, insomnia, nightmares, and hyper-vigilance.
- Behavioral distress: increased visits to primary care providers, new symptoms or worsening the old ones.
- Emotional symptoms: anger irritability and apathy.
- Disturbing thoughts about survival, relief, guilt, grief.
- Muscular tension, tremors, and exaggerated startle response.
- Social withdrawal and depression.

Stress Reaction Phase 3: Long-term Response: Recovery, Impairment and Change

- Lasting up to a year or more.
- Some express feelings of disappointment and resentment; continued posttraumatic distress may lead to development of psychiatric disorders.
- Majority rebuild their lives and focus on future.[3]

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS:

Helping people affected by traumatic events, their family members, and emergency rescue personnel requires preparation, sensitivity, assertiveness, flexibility, and common sense. Explain that their symptoms are normal, especially right after the traumatic event, and then encourage a person to:

- Identify concrete needs and attempt to help. Traumatized persons are often preoccupied with concrete needs (e.g., How do I know if my friends made it to the hospital?).
- Keep to their usual routine.

- Keep medical appointments and take medications as prescribed.
- Help identify ways to relax. Rely on regular exercise to help relieve stress. Walking everyday, and managing stress with relaxation techniques can make a big difference in how a person feels.
- Do things they enjoy like renting a movie, reading a book, listening to music, etc.
- Eat right, get enough sleep, and share their thoughts and feelings with people around them.
- Learn how others are coping. This will help a person feel less alone.
- Take the time to resolve day-to-day conflicts so they do not build up and add to their stress.
- Educate people about the negative effect of abusing alcohol/drugs, tobacco, or even taking more medication than a doctor prescribes. People who turn to alcohol and drugs to cope with their feelings following a traumatic disaster are more likely than others to develop serious problems.
- Refer individuals to a mental health professional in your area who has experience treating the needs of survivors of traumatic events (See Referral Section).
- Provide education to help people identify symptoms of anxiety, depression, and PTSD (see resources). [4]
- Follow-up as appropriate.

TABLE 1

Cognitive	Emotional	Physical	Behavioral	Spiritual
Poor concentration	Shock	Nausea	Suspicion	Anger at God
Confusion	Numbness	Lightheadedness	Irritability	Feeling distant from God
Disorientation	Feeling overwhelmed	Dizziness	Arguments with friends and loved ones	Withdrawal from place of worship
Indecisiveness	Depression	Gastro-intestinal problems	Withdrawal	Uncharacteristic religious involvement
Shortened attention span	Feeling lost	Rapid heart rate	Excessive silence	Sudden turn toward God
Memory loss/	Fear of harm to self and/or loved ones	Tremors	Inappropriate humor	Familiar faith practices seem empty (prayer, Scripture, hymns)
flashbacks/intrusive images	Feeling nothing	Headaches	Increased/decreased eating	Religious rituals seems empty (worship, communion)
Unwanted memories	Feeling abandoned	Grinding of teeth	Change in sexual desire or functioning	Belief that God is powerless
Difficulty making decisions	Uncertainty of feelings	Fatigue	Increased smoking	Loss of meaning and purpose
Impaired thinking	Volatile emotions	Poor sleep	Increased substance use or abuse	Sense of isolation from God and religious community
Hypervigilance	Anxiety	Pain	Increase alcohol consumption	Questioning of one's basic beliefs
Nightmares	Guilt	Hyperarousal	Pacing	Anger at spiritual leaders
	Grief	Jumpiness	Erratic movement	Believing God is not in control
	Denial	Muscle tremors	Acting out	Believing God does not care
	Irritability/agitation	Chest pain/ difficulty breathing	Change in usual communication	Belief that we have failed God (5)
	Problem controlling ones' emotions	Profuse sweating	Restlessness	
			Emotional outburst	

It is especially important for helpers to be respectful, well-informed, and to dependably follow through on stated plans.

Persons who may be at potential risk for severe and longer lasting reactions to trauma:

- Some people are at greater risk than others for developing sustained and long-term reactions to a traumatic event, including such disorders as posttraumatic stress disorder (PTSD), depression, and generalized anxiety. Factors that contribute to the risk of long-term impairment are listed.
- Proximity to the event. Severe exposure to actual event leads to greater risk.
- Multiple or an accumulation of stressors may create more difficulty.
- History of trauma or previous experience with disaster may lead to higher risk of long-term impairment.
- Degree of harm to self or to loved ones.
- Meaning of the event in relation to past stressors. A traumatic event may activate unresolved fears or frightening memories.
- Persons with chronic medical illness or psychological disorders. Survivors with mental illness function fairly well following a disaster, if most essential services have not been interrupted. However, for others who may have achieved only a tenuous balance before the disaster, additional mental health support services, medications, or hospital-ization may be necessary to regain stability.
- Older people or people who are in group facilities or nursing homes during a disaster are susceptible to anxiety, panic, and frustration as a consequence of their limited mobility and dependence on caretakers. The impact of evacuation and relocation on those with health or functional impairments can be tremendous. Dependence on others for care or on medical resources for survival contributes to heightened fear and anxiety. Change in physical surroundings, caregiving personnel, and routines can be extremely difficult.
- Ethnic and racial minority groups can be at higher risk, because of socioeconomic conditions that force the community to live in housing that is particularly vulnerable. Language barriers, suspicion

of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values can present challenges for helpers in gaining access and acceptance. Cultural sensitivity is conveyed when disaster information and application procedures are translated into primary spoken languages and available in non-written forms. Cultural groups have considerable variation regarding views of loss, death, home, family, spiritual practices, grieving, celebrating, mental health, and helping. It is essential that helpers learn about the cultural norms, traditions, local history, and community politics from leaders and social service workers indigenous to the groups they are serving. Establishing working relationships with trusted organizations, service providers, and community leaders often facilitates increased acceptance. It is especially important for helpers to be respectful, well-informed, and to dependably follow through on stated plans.

- *First responders, including survivor support, law enforcement, local government, emergency response, experience considerable demands to meet the needs of the survivors and the community. Depending on the nature of the disaster and their role, relief workers may witness human tragedy, fatalities, and serious physical injuries. Over time, workers may show the physical and psychological effects of work overload and exposure to human suffering. They may experience physical stress symptoms or become increasingly irritable, depressed, over-involved or unproductive, and/or show cognitive effects like difficulty concentrating or making decisions.[5]*

The following are some examples of when to refer for mental health services:

- When a person hints or talks openly of suicide.
- When you realize the problem is beyond your capability or level of training.
- When a person seems to be socially isolated.
- When a person presents imaginary ideas or details of persecution.
- When you become aware of over-reliance on alcohol or drugs.
- When you see the person engaging in risk behavior (carelessness towards oneself/others).
- When you yourself become restless, confused and have persistent bad thoughts, worries, or dreams about the case.[6]

TABLE 2

How to make a referral to a mental health professional:	
As a rule, inform the person concerned about your intentions.	Let him/her know that you care and then explain the reasons for the referral.
If you have the option, you should present different possibilities of referral to the person concerned.	Discuss matters such as fees, location, accessibility, etc.
Assure the person that you will continue your support until the referral is complete.	You might even suggest accompanying him/her to the first visit with the professional.

References

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RESOURCES

NYC Office of Emergency Management: Ready New York Household Preparedness Guide
http://www.nyc.gov/html/oem/html/readynewyork/ready_guide.html

Community and Family Preparedness Publications **http://www.fema.gov/rrr/fampubs.shtm**

Disaster Preparedness For People with Disabilities **http://www.fema.gov/library/disprepf.shtm**

New York State Emergency Management Office **http://www.nysemo.state.ny.us**

American Red Cross: Tips On Managing Anxiety In Stressful Times
http://www.nyredcross.org/news/2004/040830_mental_health.asp

Coping With Trauma

Project Liberty **http://www.nyc.gov/html/doh/html/liberty/english.html**

National Institute of Mental Health-Information About Coping with Traumatic Events
http://www.nimh.nih.gov/healthinformation/traumaticmenu.cfm

National Center for Posttraumatic Stress Disorder (PTSD): Disaster Mental Health: Dealing with the Aftermath of
Terrorism **http://www.ncptsd.va.gov/disaster.html**

Posttraumatic Stress Disorder (PTSD) Alliance **http://www.ptsdalliance.org**

Public Health & Mental Health Preparedness

Terrorism and Mental Health **http://www.nyc.gov/doh**

World Health Organization: Public Health Response to Biological and Chemical Weapons: WHO Guidance
http://www.who.int/csr/delibepidemics/biochemguide/en/index.html

General Public Mental Health Information

National Mental Health Information Center: Center for Mental Health Services **http://www.ncptsd.va.gov/disaster.html**

The Center for Disease Control and Prevention: Coping With a Traumatic Event: Information for the Public
 http://www.bt.cdc.gov/masstrauma/copingpub.asp

Substance Abuse and Mental Health Services Agency (SAMHSA) **http://samhsa.gov**

National Institute of Mental Health (NIMH) **http://www.nimh.nih.gov**

Resources for Children

FEMA: FEMA for Kids **http://www.fema.gov/kids/**

American Red Cross: The Be Ready Book **http://www.prepare.org/children/bereadybook.pdf**

Further Reading

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Raphael B (1986) *When disaster strikes: How individuals and communities cope with catastrophe*, Basic Books, Inc. New York.

Sveaass N (2000), *Restructuring meaning after uprooting and violence. Psychosocial interventions in refugee receiving and in post-conflict societies*, Institute of Psychology, Faculty of Social Sciences, University of Oslo.

Worden J W (1996) *Children and grief - when a parent dies?* Guildford Press, NY.

World Health Organization (2000), *Declaration of co-operation, mental health of refugees, displaced and other populations affected by conflict and post-conflict situations*, WHO.

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[1] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters.

[2] International Federation of Red Cross and Red Crescent Societies, Psychological Support: best practices from Red Cross and red Crescent programmes.

[3] National Association of State Mental Health Program Directors-State Mental Health Response to Terrorism.

[4] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters.

[5] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters.

[6] International Federation of Red Cross and Red Crescent Societies.

[7] International Federation of Red Cross and Red Crescent Societies.

The Context for Going to Help:

DISASTER RESPONSE CHAPLAINS

BY RABBI ZAHARA DAVIDOWITZ-FARKAS

9

Rabbi Zahara Davidowitz-Farkas has been a key leader in providing disaster chaplaincy services following 9/11 and was instrumental in the establishment of Disaster Chaplaincy Services which provides ongoing disaster chaplaincy training. She is an experienced spiritual care trainer, works with the American Red Cross in its national spiritual care response, and was one of the original editors of this manual.

Note: Disaster Chaplaincy is a specialized ministry.

Due to the reality of dealing with multiple victims, multiple injuries, and the reaction and grief of multiple families, disaster chaplaincy is not for everyone.

If you believe that you are called to this ministry, please contact Peter Gudaitis, Executive Director and CEO of NYDIS at 212.669.6100 or pgudaitis@nydis.org for information on disaster chaplaincy training programs for New York City.

Disaster Spiritual Care

Spiritual Care is the support offered to people in a time of crisis. It assists them in drawing upon their spiritual resources in the midst of their pain. Often, spiritual questions are neither formalized nor faith specific. Depending upon the context, it may include religious care which is the provision of specific ritual and prayer within the context of a unique faith tradition.

By extension, disaster spiritual care aids in the relief of human suffering by assuring skilled, appropriate, multifaith, and inter-disciplinary spiritual care for all those affected by disaster. It respects the broad nature of spiritual response by responding to the human search for meaning in non-faith specific language.

Disaster spiritual care interventions are designed to mitigate the impact of spiritual, physical, emotional, and behavioral crisis experienced by survivors, family members, rescue/recovery personnel, and the community at large in the aftermath of a catastrophic event. The provision of disaster spiritual care is short term and functions as "spiritual first aid" for those impacted by the disruptive effects of a disaster.

This chapter focuses on the religious leader's role in responding as a **Disaster Response Chaplain** as part of the overall recovery effort. A Chaplain is a religious leader who serves in an institution that is not usually regarded as a house of worship. Chaplains serve in the military, hospitals, schools, prisons, and generally have received

Research shows that, in the midst of crisis, more people in the United States will go to their religious leader for aid than will go to either a physician or a mental health practitioner.

specialized training in addition to their theological education. As we experienced in the aftermath of September 11, Chaplains served at the Family Assistance Centers, the Respite Centers, and the Morgues. They made their presence and spiritual and religious resources available to all who were there - with the commitment that each Chaplain was there to serve anyone who requested help.

The Need for Providing Disaster Spiritual Care

Many Americans profess a belief in God. Others define their relationship to the world in spiritual terms, while still others profess no belief. Yet, in the event of public trauma, all of these individuals will experience existential distress in one form or another. The foundations which gave meaning and purpose to their lives are torn asunder. These devastated individuals will need a place of safety where they know they will not be judged in the midst of their pain, and a calm, compassionate presence who will respect them regardless of what they believe.

Additionally, research shows that, in the midst of crisis, more people in the United States will go to their religious leader for aid than will go to either a physician or a mental health practitioner.

Disaster Response Chaplains

Various types of Chaplains provide spiritual care in the event of disaster:

- Local uniformed services such as fire and police have their own departmental chaplains. These chaplains minister to their colleagues almost exclusively.
- Professional chaplains in the area may respond. Their training enables them to function as multifaith spiritual caregivers in a trauma environment.

- Local religious leaders, endorsed by their faith community and credentialed by a community-selected agency, respond within areas designated by the authorities as disaster sites.
- Spontaneous volunteers will respond. Generally, they fit into two categories:

  – **One:** those local religious leaders who have not been trained or credentialed in disaster response. They usually serve houses of worship and are respected leaders in the broader community. Their role in recovery and healing will be pivotal.

  Should these religious leaders wish to work as chaplains during the initial phase of a disaster response they will need to be screened and oriented on the specifics of the disaster, the basics of interfaith care, and their role as part of the overall response.

  – **Two:** the many non-local religious volunteers who will come to "lend a hand." After they are screened and oriented, they may work for a limited period of time. Their access ends at the completion of their tour.

The American Red Cross' National Spiritual Care Response Team may be deployed in the event of a large disaster involving transportation or technological accidents, mass casualty, or weapons of mass destruction. These volunteers have extensive training in the administration and management of disaster ministry. Their role is to support the religious leaders in the affected community by helping to create and maintain processes for the orienting, scheduling, credentialing and deployment of all religious leaders who are responding, other than those working with members of municipal services such as Fire, EMS, and Police.

Disaster Response Chaplains **109**

The events of 9/11 demonstrated the need for disciplined networking.

MITIGATION AND PREPAREDNESS PHASES:

Training

As stated above, **Disaster Chaplaincy is a specialized ministry**.

Due to the reality of dealing with multiple victims, multiple injuries, and the reaction and grief of multiple families, disaster chaplaincy is not for everyone.

If you believe that you are called to this ministry, please contact Peter Gudaitis, Executive Director and CEO of NYDIS, at 212.669.6100 or pgudaitis@nydis.org for information on disaster chaplaincy training programs for New York City.

Safety

Disaster sites are hazardous by nature. Safety procedures are implemented for the safety of all personnel who respond. Part of those safety procedures are intended to protect the victims and survivors against unwanted intrusive actions at a time when they are most vulnerable – directly after the disaster event.

Therefore, no unauthorized chaplain is permitted onto any disaster site or into and disaster response facility. **Do not self-deploy**. If something happens to you and you become a victim, who will know that you're there? Additionally, there may be specific needs or instructions for chaplains. **If you go on your own, you may very well jeopardize the presence of all chaplains at the site through your actions or you may find yourself arrested for trespass**.

Endorsement by Religious Denomination

• No person can become a credentialed chaplain unless their specific faith community has first endorsed them.

Screening

Once endorsed by one's religious denomination, each potential chaplain is screened to make certain that s/he will be able to function as a disaster chaplain and is likely to make a positive impact on the recovery effort.

Collegiality

Unfortunately, religious leaders tend to be "lone rangers," working independently within their own faith community. The events of 9/11 demonstrated the need for disciplined networking. Community religious leaders need to have a better sense of who their colleagues are and need to build trusting relationships with them. *(See Chapter 5 on Developing Cultural Competence)*.

• Learn who your colleagues are in all faith traditions and establish relationships with them.
• Create a support system for yourself.
• Create a comprehensive referral network.
• Create relationships with the fire and police departments, and other emergency responders that serve your local community.
• With your colleagues, plan for immediate, short-term, mid-term, and long-term responses.
• Be aware of the demographics of the broader community.
• Pool resources.

By definition, a disaster response is disciplined chaos.

GUIDELINES AND INTERVENTIONS FOR RELIGIOUS LEADERS

RESPONSE PHASE

Disaster Specific Orientation

- If a catastrophe occurs that requires deployment, job-specific orientations will take place as many times as necessary to accommodate locally credentialed and spontaneous volunteers.
- Every disaster is local, and every disaster has its own personality and culture, therefore no one orientation fits all situations.
- The orientation process may result in a job-specific credential which becomes invalid after the individual's termination of service.

Sites

Designated disaster sites will vary from event to event. However, there will always be a **Family Assistance Center (FAC)**, which is where the majority of chaplains are likely to be deployed. Additional sites may include respite centers for the response/recovery workers, morgues, and other sites as needed.

Self Care in a Disaster[1]

- Every chaplain is required to assure their personal well-being by taking breaks, maintaining a healthy diet, getting enough sleep and exercise, speaking with colleagues and supervisors to debrief, and taking opportunities to do what is re-creative for them, such as meditation and prayer.
- In order to avoid secondary trauma, every chaplain must be defused and/or debriefed on a regular basis. Debriefing helps insure the emotional, spiritual, and physical health of a disaster responder by providing a safe and non-judgmental place for them to talk about their experiences. Debriefing is not, nor should it, take the place of therapy; however, it can identify individuals who might need more help.

What the Chaplains can expect:

By definition, a disaster response is disciplined chaos. The magnitude and amount of grief can be overwhelming. The unexpected is the norm and the chaplain must be able to tolerate working in such an environment. Further, it is crucial that a deployed spiritual care provider be willing to serve as a team member in a paramilitary environment where they have no input in decision making. Flexibility is a virtue in a disaster and it is a defense against frustration and burnout.

Additionally, the chaplain can expect to encounter some or all of the following as part of the response phase:

A rigid bureaucracy: this is in place for your protection. Even though it may feel less concerned with the actual events, it is simplest to just follow the rules. The result is a smoother exit from their offices, and more time spent on doing what you signed up for: to help those affected by the disaster.

Poor information flow: Remember that it's a disaster. No one person knows what is happening in each part of the site. Rumors abound, and everyone, with the best intentions, will try to pass along information that may or may not turn out to be true. The best rule of thumb is that all you can really know is what you can see in front of you. And even then, you don't know how it fits into the rest of what's happening. Simply do what you came for.

Procedures that can change hourly: The reason for this is that the incident command may be changing, new information may have been discovered, the previous way turned out not to have been safe. Just go with the changes and provide support to those around you – they may be less secure with change than you are.

Disaster Response Chaplains **111**

RECOVERY PHASE

A Disaster Response Chaplain is by definition involved in the Response phase of a disaster. There may be some involvement in short term recovery, but generally, their work is done once the response phase moves into recovery, and they continue their work in the context of their local house of worship. *(See the chapters on Radical Hospitality, Self-Care, and Mental Health for more information on this aspect of care.)*

CONCLUSION

Disaster Response Chaplains must be endorsed by their religious denomination, screened for suitability for disaster response work, and trained to refine their chaplaincy skills for disaster response.

If denominational-specific questions are raised, then the Chaplain is expected to seek out or make a referral to a religious leader of that denomination to obtain the answers to the questions that were raised.

Cross-cultural knowledge is also important. To be most effective, a Chaplain should have a working knowledge of the cultural, ethnic, and religious diversity of the impacted community.

An ability to be supervised and to function appropriately in a multifaith environment are essential requirements for anyone wishing to function as a Disaster Chaplain.

Disaster response calls for an ability to interact collegially with Mental Health, Fire, Police, EMS, and other government agencies. It is essential to understand that chaplaincy, while an essential role, is not the most important function and that the Chaplain is operating under someone else's authority and as a part of the overall response effort.

Ideally, religious leaders should be integrated into local, state, and federal disaster response protocols. A clear working relationship between the religious leaders and members of these organizations must be developed so that the first time they meet is not in the middle of a major disaster. Such proactive organizing is valuable for the community on many levels, not the least of which is the confidence born out of a shared sense of preparedness.

> Ideally, religious leaders should be integrated into local, state, and federal disaster response protocols.

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[1] See Chapter 3, 'Self-Care' for more information on this subject. Ed.

Reference Section

III

Index of All Chapters' Resource Citations

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Editor's Note: Please refer to Chapter 15 for descriptions and webpages for agencies and organizations in NYC that respond to disaster.

Index Sections for Chapters' Resource Citations

I. Sources and Resources for Assistance and Information

  I.A Agencies providing support and resources for caregivers

  I.B Agencies providing support and resources to victims and their families

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II. Children's Resources

III. Coping with Trauma

IV. Cultural Competence Resources and Tools

V. Sources of Demographic and Statistical Information

VI. Facilitating Dialogue

VII. Mental Health and Counseling Resources

VIII. Preparedness and Training Information

IX. Suicide

X. Books and Articles

I. Sources and Resources for Assistance and Information

A. Agencies providing support and resources for caregivers

The Alban Institute provides a listing of resources available from the Alban Institute for laity and ordained alike. **www.alban.org** *(Ch 2)*

American Red Cross: Tips On Managing Anxiety In Stressful Times. **http://www.nyredcross.org/news/2004/040830_mental_health.asp** *(Ch 8)*

Care for the Caregivers Interfaith Project **www.cccny.net/caregivers/** *(Ch 7)*

The Centering Corporation provides resources for pastoral care to bereaved individuals as well as pastoral resources from grief as a result of a death or other non-death related loss. **www.centering.org** *(Ch 2)*

Church World Service provides an introduction to some of the stressors, defines stress and trauma, describes symptoms, discusses what to do after you experience a traumatic event, offers aids to the management of cumulative stress, and offers links and on-line resources to further resources.
www.churchworldservice.org *(Ch 2)*
www.cwserp.org/training/spcare/spcare.php *(Ch 7)*

International Critical Incident Stress Foundation provides training in Critical Incident Stress Management (CISM) and provides information for coping with traumatic events and has a bookstore listing of reading materials useful for crisis intervention. **www.icisf.org** *(Ch 2,7)*

The Lutheran Counseling Center (LCC) : The Lutheran Counseling Center, with support from LDRNY, has put together a comprehensive, holistic health and wellness pilot program designed especially for pastors. LCC's pastoral health and wellness program offers pastors tools to create personal health and wellness, through professional support, small groups of colleagues working with you, educational forums, interactive web site consultation. **www.lcc132.org** *(Ch 3)*

Lutheran Disaster Response New York (LDRNY): **www.ldrny.org** *(Ch 3, 4)*

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA): **http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf** *(Ch 3)*

National Voluntary Organizations Active in Disaster (NVOAD) **www.nvoad.org/documents.php#planning** *(Ch 7)*

NYC Office of Emergency Management (OEM): **http://www.nyc.gov/html/oem/html/home/home.shtml** *(Ch 4, 8)*
NYC Office of Emergency Management: Ready New York Household Preparedness Guide. **http://www.nyc.gov/html/oem/html/readynewyork/ready_guide.html** *(Ch 8)*

New York Disaster Interfaith Services provides information about training events in the Greater New York Area. **www.nydis.org** *(Ch 2)*

The Sidran Institute provides suggested essential readings in understanding trauma, treatment issues, trauma and memory, and provides links to training opportunities. **www.sidran.org/essential.html** *(Ch 2)*

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA): **www.samhsa.gov/** *(Ch 7)*
http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf *(Ch 3)*
www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/ *(Ch 7)*

B. Agencies providing support and resources to victims and their families

The American Red Cross *(Ch. 4, 5, 8)*
American Red Cross National Headquarters
2025 E Street, NW
Washington, DC 20006
Phone: 202.737.8300 General Information
Phone: 202.303.4498 Public Inquiry
Phone: 703.206.7460 Disaster Services
www.redcross.org

The American Red Cross in Greater New York:
www.arcgny.org *(Ch 4, 8)*

American Red Cross: Tips On Managing Anxiety In Stressful Times -
http://www.nyredcross.org/news/2004/040830_mental_health.asp
(Ch 8)

Church World Service provides an introduction to some of the stressors, defines stress and trauma, describes symptoms, discusses what to do after you experience a traumatic event, offers aids to the management of cumulative stress, and offers links and on-line resources to further resources. **www.churchworldservice.org** *(Ch 2*)
www.cwserp.org/training/spcare/spcare.php *(Ch 7)*

Federal Emergency Management Agency (FEMA) *(Ch. 5)*

Federal Emergency Management Agency
Human Services Division
500 C Street, SW
Washington, DC 20472
Phone: 202.566.1600
www.fema.gov

The Federal Emergency Management Agency provides current information about FEMA assistance programs, meetings, training events, and other useful up-to-date information on recovery assistance and disaster preparedness. Of particular interest is the "Are You Ready" guide prepared for citizen preparedness, which can be downloaded from **www.fema.gov/areyouready/why_prepare**.
(Ch 2, 4)
www.fema.gov *(Ch 2, 5)*

International Critical Incident Stress Foundation
provides training in Critical Incident Stress Management (CISM), as well as information for coping with traumatic events. It also has a bookstore listing of reading materials useful for crisis intervention. **www.icisf.org** *(Ch 2, 7)*

NYC Office of Emergency Management (OEM):
http://www.nyc.gov/html/oem/html/home/home.shtml *(Ch 4)*

New York State Emergency Management Office:
http://www.nysemo.state.ny.us *(Ch 8)*

The Salvation Army
The National Emergency Disaster Services Coordinator
The Salvation Army National Headquarters
615 Slaters Lane, Box 269
Alexandria, VA 22313-0269
703.684.5500
www.usc.salvationarmy.org *(Ch 7)*

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA):
http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf *(Ch 3)*
www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/
(Ch 7)

C. Other Agencies (Ch. 5)

FEDERAL GOVERNMENT ORGANIZATIONS AND RESOURCES

Federal Communications Commission (FCC)

445 12th Street, SW
Washington, DC 20554
Phone: 202.418.1771 or 1.888.225.5322
TTY: 202.418.2520 or 1.888.835.5322
Fax: 202.418.0710 or 1.866.418.0232
www.fcc.gov

Health Resources and Services Administration (HRSA)

Office of Minority Health
5600 Fishers Lane
Room 14-48
Rockville, MD 20857
Phone: 301.443.3376 or 1.888.275.4772
www.hrsa.gov

Indian Health Service (IHS)

Office of Public Health
The Reyes Building
801 Thompson Avenue
Suite 400
Rockville, MD 20852-1627
Phone: 301.443.3024
www.ihs.gov

**National Institute on Deafness and
Other Communication Disorders (NIDCD)**

31 Center Drive
MSC 2320
Bethesda, MD 20892
Phone: 301.496.7243
www.nidcd.nih.gov

NIDCD Information Clearinghouse

1 Communication Avenue
Bethesda, MD 20892
Phone: 1.800.241.1044
TTY: 1.800.241.1055
www.nidcd.nih.gov

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F
Hubert H. Humphrey Building
Washington, DC 20201
Phone: 202.619.0257 or 1.877.696.6775
www.hhs.gov/ocr

**Office of Public Health and Science
U.S. Office of Minority Health Resource Center**

U.S. Department of Health and Human Services
P.O. Box 37337
Washington, DC 20013-7337
Phone: 301.443.5084 or 1.800.444.6472
Fax: 301.251.2160
www.omhrc.gov

Rural Information Center Health Service

National Agricultural Library
10301 Baltimore Avenue
Room 304
Beltsville, MD 20705-2351
Phone: 301.504.5547 or 1.800.633.7701
Fax: 301.504.5181
TDD/TTY: 301.504.6856
www.nal.usda.gov/ric

PROFESSIONAL PRIVATESECTOR ORGANIZATIONS AND RESOURCES

**African American Mental Health Research Center
Institute for Social Research**

University of Michigan
426 Thompson, Room 5118
Ann Arbor, MI 48106
Phone: 734.763.0045
Fax: 734.763.0044
http://rcgd.isr.umich.edu/prba

American Psychological Association

750 First Street, NE
Washington, DC 20002-4242
Phone: 202.336.5510 or 1.800.374.2721
TDD/TTY: 202.336.6123
www.apa.org

Cross Cultural Health Care Program

270 S. Hanford Street
Suite 100
Seattle, WA 98134
Phone: 206.860.0329
Fax: 206.860.0334
www.xculture.org

National Alliance for Hispanic Health

1501 16th Street, NW
Washington, DC 20036
Phone: 202.387.5000
www.hispanichealth.org

National Asian American and Pacific Islander Mental Health Association
1215 19th Street
Suite A
Denver, CO 80202
Phone: 303.298.7910
Fax: 303.298.8180
www.naapimha.org

National Association for Rural Mental Health

3700 W. Division Street
Suite 105
St. Cloud, MN 56301
Phone: 320.202.1820
Fax: 320.202.1833
www.narmh.org

National Association of Social Workers

750 First Street, NE
Suite 700
Washington, DC 20002-4241
Phone: 202.408.8600 or 1.800.638.8799
www.naswdc.org

National Center for American Indian and Alaska Native Mental Health Research

University of Colorado Health Sciences Center
Department of Psychiatry, North Pavilion
4455 E. 12th Avenue
Campus Box A011-13
Denver, CO 80220
Phone: 303.724.1414
Fax: 303.724.1474
www.uchsc.edu/sm/ncaianmhr

National Center for Cultural Competence

Georgetown University Center for
Child and Human Development
3307 M Street, NW
Suite 401
Washington, DC 20007-3935
Phone: 202.687.8635 or 1.800.788.2066
Fax: 202.687.8899
TTY: 202.687.5503
http://gucchd.georgetown.edu

National Indian Health Board

101 Constitution Avenue, NW
Suite 8-B09
Washington, DC 20001
Phone: 202.742.4262
Fax: 202.742.4285
www.nihb.org

National MultiCultural Institute

3000 Connecticut Avenue, NW
Suite 438
Washington, DC 20008-2556
Phone: 202.483.0700
Fax: 202.483.5233
www.nmci.org

National Rural Health Association
One West Armour Boulevard
Suite 203
Kansas City, MO 64111-2087
Phone: 816.756.3140
www.nrharural.org

II. Children's Resources

American Red Cross: *The Be Ready Book -*
http://www.prepare.org/children/bereadybook.pdf   *(Ch 8)*

Aptekar L and Boore J (1990), *The emotional effects of disaster on children: A review of the literature*, International Journal of Mental Health, Vol 19, No 2, pp77-90. *(Ch 8)*

Bracken P and Petty C (Eds) (1998), *Rethinking the trauma of war, Save the Children*. *(Ch 8)*

FEMA: *FEMA for Kids -* **http://www.fema.gov/kids/** *(Ch 8)*

Worden J W (1996) *Children and grief - when a parent dies?* Guildford Press, NY. *(Ch 8)*

III. Coping with Trauma

National Institute of Mental Health, *Information About Coping with Traumatic Events -*
http://www.nimh.nih.gov/healthinformation/traumaticmenu.cfm
(Ch 8)

National Center for Posttraumatic Stress Disorder (PTSD): *Disaster Mental Health: Dealing with the Aftermath of Terrorism -* **http://www.ncptsd.va.gov/disaster.html** *(Ch 8)*

Posttraumatic Stress Disorder (PTSD) Alliance - **http://www.ptsdalliance.org** *(Ch 8)*

Project Liberty -
http://www.nyc.gov/html/doh/html/liberty/english.html *(Ch 8)*

IV. Cultural Competence Resources and Tools (Ch. 5)

American Psychological Association (1990). *APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations.* Washington, DC: American Psychological Association.

Child Welfare League of America (1993). *Cultural Competence Self-assessment Instrument.* Washington, DC: Child Welfare League of America.

Cohen, R. (1992). Training mental health professionals to work with families in diverse cultural contexts. *Responding to Disaster: A Guide for Mental Health Professionals.* Washington, DC: American Psychiatric Press, Inc.

Cross, T. L. (1989). *Towards a Culturally Competent System of Care. Vol. I: A Monograph of Effective Services for Minority Children who are Severely Emotionally Disturbed.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Giger, J., and Davidhizar, R. (1999). *Transcultural Nursing: Assessment and Intervention.* St. Louis, MO: Mosby, Inc.

Goode, T. D. (1999). *Getting Started: Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings, Implications for Policy Makers and Administrators.* Washington, DC: Georgetown University, National Center for Cultural Competence.

Health Resources and Services Administration (1998). *Health Care Rx: Access for All.* Washington, DC: Health Resources and Services Administration.

Hernandez, M., and Isaacs, M. (1998). *Promoting Cultural Competence in Children's Mental Health Services.* Baltimore, MD: Paul H. Brookes Publishing.

Hicks, Noboa-Rios (1998). *Cultural Competence in Mental Health: A Study of Nine Mental Health Programs in Ohio.* Columbus, OH: Outcomes Management Group, Ltd.

Nader, K., Dubrow, N., and Stamm, H. (1999). *Honoring Differences: Cultural Issues in the Treatment of Trauma and Loss.* Ann Arbor, MI: Brunner/Mazel.

Perkins, J., Simon, H., Cheng, F., et al. (1998). *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities.* Los Angeles, CA: National Health Law Program.

Substance Abuse and Mental Health Services Administration (2000). *Cultural Competence Standards in Managed Mental Health Care for Underserved/Under-represented Racial/Ethnic Groups* Washington, DC: Western Interstate Commission for Higher Education and Center for Mental Health Services, Substance Abuse and Mental ealth Services Administration, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration (2000). Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of Care: Promising Practices in Children's Mental Health* (2000 Series, Vol. 1). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

U.S. Department of Health and Human Services (1992-1999). *Cultural Competence Series.* Monograph series sponsored by Bureau of Primary Health Care, Health Resources and Services Administration; Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration; and Office of Minority Health.

Van der Veer, G. (1995). *Psychotherapeutic Work with Refugees.* New York: Plenum Press.

ADDITIONAL RESOURCES

Building Cultural Competence:
A Blueprint for Action

Washington State Department of Health
Maternal and Child Health Community and Family Health
New Market Industrial Campus, Building #7
P.O. Box 47880
Olympia, WA 98504-7880
Phone: 360.236.3504 or 206.389.3052
Fax: 360.586.7868

The Diversity Journal

Harvard Pilgrim Health Care
Office of Diversity
Brookline, MA 02146-7229
Phone: 617.730.7710
Fax: 617.730.4695

A Practical Guide for the Assessment of Cultural
Competence in Children's Mental Health Organizations

The Technical Assistance Center for the Evaluation of
Children's Mental Health System
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone: 617.232.8390
Fax: 617.232.4125

V. Sources of Demographic and Statistical Information (Ch. 5)

STATISTICS ABOUT IMMIGRATION PATTERNS

Immigration and Naturalization Service,
U.S. Department of Justice:
http://uscis.gov/graphics/shared/aboutus/statistics/index.htm

NATIONAL, STATE, AND COUNTY STATISTICS AND DEMOGRAPHIC DATA BY AGE, RACIAL, ETHNIC, AND LINGUISTIC SUBGROUPS

U.S. Bureau of the Census:
www.census.gov/population/www/index.html

UNEMPLOYMENT INFORMATION BY GENDER, RACE, AND AGE

Bureau of Labor Statistics:
http://stats.bls.gov/

DEMOGRAPHIC INFORMATION BY ZIP CODE

PeopleSpot:
http://peoplespot.com/statistics/demographics.htm

GENERAL INFORMATION

Government Information Sharing Project,
Oregon State University:
http://govinfo.kerr.orst.edu/index.html

National Center for Health Statistics,
Centers for Disease Control and Prevention:
www.cdc.gov/nchs/

Federal Healthfinder®:
www.healthfinder.gov/

VI. Facilitating Dialogue

The Choices Curriculum at Brown University has excellent resources. **www.choices.edu** *(Ch 6)*

The Public Conversations Project (PCP) provides workshops on leading dialogues of difficult topics. **www.publicconversations.org** *(Ch 6)*

Sojourners, a community in Washington DC, produces a magazine and on this website has study guides/resources on non-violent action, urban violence, justice, and peacebuilding from a challenging Christian perspective. **www.sojo.net** *(Ch 6)*

The website of the **Muslim Peace Fellowship** contains thought-provoking articles and relates teachings from the Koran to current issues. **www.mpfweb.org** *(Ch 6)*

Thought-provoking articles and a newsletter are offered on this site from a **Jewish perspective**. **www.jewishpeacefellowship.org** *(Ch 6)*

This site contains **free materials on facilitating dialogues on controversial issues**. There are guidelines for facilitators plus excellent materials and a process for studying difficult topics. **www.studycircles.com** *(Ch 6)*

VII. Mental Health and Counseling Resources

American Red Cross: *Tips On Managing Anxiety In Stressful Times*
http://www.nyredcross.org/news/2004/040830_mental_health.asp
(Ch 8)

Centers for Disease Control and Prevention: *Disaster Mental Health Resources* **www.bt.cdc.gov/mentalhealth** *(Ch 7)*

Centers for Disease Control and Prevention: *Coping With a Traumatic Event: Information for the Public -*
http://www.bt.cdc.gov/masstrauma/copingpub.asp *(Ch 8)*

National Mental Health Information Center: Center for Mental Health Services- *(Disaster)*
http://www.ncptsd.va.gov/disaster.html *(Ch 8)*

National Institute of Mental Health (NIMH)-
http://www.nimh.nih.gov *(Ch 8)*

National Institute of Mental Health *(Anxiety)*
www.nimh.nih.gov/healthinformation/anxietymenu.cfm *(Ch 7)*

Recursos Educativos Cristianos / Christian Education Resources: *Suicidal Crisis*
www.receduc.com/counseling/suicide.html *(Ch 7)*

The QPR Institute offers comprehensive suicide prevention training programs along with educational and clinical materials for the general public, professionals, and institutions. **www.qprinstitute.com** *(Ch 7)*

Terrorism and Mental Health - **http://www.nyc.gov/doh** *(Ch 8)*

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA)

US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration:
www.samhsa.gov *(Ch 3, 5, 7, 8)*
http://www.mentalhealth.samhsa.gov/publications/allpubs/tips/disaster.pdf *(Ch 3)*
www.mentalhealth.samhsa.gov/cmhs/EmergencyServices *(Ch 7)*

Center for Mental Health Services Emergency Mental Health and Traumatic Stress Services Branch
5600 Fishers Lane, Room 17C-20
Rockville, MD 20857
Phone: 301.443.4735
Fax: 301.443.8040
www.samhsa.gov

SAMHSA's National Mental Health Information Center
P.O. Box 42557
Washington, DC 20015
Phone: 1.800.789.2647
Fax: 301.984.8796
TDD: 1.866.889.2647
www.mentalhealth.samhsa.gov

World Health Organization: Public Health Response to Biological and Chemical Weapons: WHO Guidance
http://www.who.int/csr/delibepidemics/biochemguide/en/index.html *(Ch 8)*

Disaster Mental Health Resources from the Center for Mental Health Services (CMHS) (Ch. 5)

Editor's Note: The following publications and videos on disaster response and recovery planning for special populations were developed by the Emergency Mental Health and Traumatic Stress Services Branch of CMHS. To download these documents or order copies, please visit the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site at **www.samhsa.gov**

PUBLICATIONS

ADM 86-1070R *Psychosocial Issues for Children and Adolescents in Disasters*

ADM 90-538 *Training Manual for Mental Health and Human Service Workers in Major Disasters, Second Edition*

SMA 94-3010R *Disaster Mental Health Response and Recovery: A Strategic Guide (May not be available; revised edition in press)*

SMA 95-3022 *Psychosocial Issues for Children and Families: A Guide for the Primary Care Physician*

SMA 96-3077 *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster*

SMA 99-3323 *Psychosocial Issues for Older Adults in Disasters*

SMA 99-3378 *Crisis Counseling Programs for the Rural Community*

VIDEOS

ESDRB-2 Children and Trauma: The School's Response

OM 00-4070 Voices of Wisdom: Seniors Cope with Disaster

OM 00-4070S Voices of Wisdom: Seniors Cope with Disaster (Spanish Version)

OM 00-4071 Hurricane Andrew: The Fellowship House Experience

GENERAL MATERIALS

CMHS Program Guidance Series

VIII. Preparedness and Training Information

Academy of Traumatology:
http://www.traumatologyacademy.org *(Ch 3)*

American Red Cross: Tips On Managing Anxiety In Stressful Times -
http://www.nyredcross.org/news/2004/040830_mental_health.asp
(Ch 8)

The Association of Traumatic Stress Specialists provides a broad range of useful, published resources, including resources for training and study. **www.atss-hq.com** *(Ch 2)*

Church World Service provides an introduction to some of the stressors, defines stress and trauma, describes symptoms, discusses what to do after you experience a traumatic event, offers aids to the management of cumulative stress, and offers links and on-line resources to further resources.
www.churchworldservice.org *(Ch 2)*
www.cwserp.org/training/spcare/spcare.php *(Ch 7)*

Eastern Mennonite University provides information about training opportunities in the New York area as well as about the trauma awareness and resilience training offered on the EMU campus through the STAR (Seminars on trauma Awareness and Resilience) Program.
www.emu.edu/ctp/star_intro.htlm *(Ch 2, 6)*

The Federal Emergency Management Agency (FEMA) provides current information about FEMA assistance programs, meetings, training events, and other useful up-to-date information on recovery assistance and disaster preparedness. Of particular interest is the "Are You Ready" guide prepared for citizen preparedness, which can be downloaded at **www.fema.gov/areyouready/why_prepare**.
(Ch 2)
www.fema.gov *(Ch 2)*

FEMA - *Community and Family Preparedness Publications-*
http://www.fema.gov/rrr/fampubs.shtm *(Ch 8)*

FEMA - *Disaster Preparedness For People with Disabilities -*
http://www.fema.gov/library/disprepf.shtm *(Ch 8)*

The International Critical Incident Stress Foundation provides an abundant resource reading list on crisis intervention and stress management techniques.
http://www.icisf.org/ *(Ch 2, 7)*

Lutheran Disaster Response New York: **www.ldrny.org**
(Ch 4)

National Voluntary Organizations Active in Disaster (NVOAD) www.nvoad.org/documents.php#planning *(Ch 7)*

NYC Office of Emergency Management (OEM):
http://www.nyc.gov/html/oem/html/home/home.shtml *(Ch 4, 8)*

NYC Office of Emergency Management (OEM): Ready New York Household Preparedness Guide.
http://www.nyc.gov/html/oem/html/readynewyork/ready_guide.html
(Ch 8)

New York Disaster Interfaith Services (NYDIS), provides information about training events in the Greater New York Area. **www.nydis.org** *(Ch 2, 7)*

The QPR Institute offers comprehensive suicide prevention training programs along with educational and clinical materials for the general public, professionals and institutions. **www.qprinstitute.com** *(Ch 7)*

The Salvation Army

The National Emergency Disaster Services Coordinator
The Salvation Army National Headquarters
615 Slaters Lane, Box 269
Alexandria, VA 22313-0269
703.684.5500
www.usc.salvationarmy.org *(Ch 7)*
www.usc.salvationarmy.org/usc/www_usc_eds.nsf/vw-text index/bc49c1d9f0841f14802570580006a191?opendocument
(Ch 7)

Terrorism and Mental Health - **http://www.nyc.gov/doh**
(Ch 8)

World Health Organization: *Public Health Response to Biological and Chemical Weapons: WHO Guidance -*
http://www.who.int/csr/delibepidemics/biochemguide/en/index.html
(Ch 8)

IX. Suicide

Recursos Educativos Cristianos / Christian Education Resources: *Suicidal Crisis*
www.receduc.com/counseling/suicide.html *(Ch 7)*

The QPR Institute offers comprehensive suicide prevention training programs along with educational and clinical materials for the general public, professionals and institutions. **www.qprinstitute.com** *(Ch 7)*

X. Books and Articles

Adams, John D. *Understanding and Managing Stress* (San Diego: University
Associates, Inc., 1980). *(Ch 3)*

Bloom, Rabbi Jack H. *The Rabbi As Symbolic Exemplar: by the Power Vested in Me.* New York, The Haworth Press, 2002. *(Ch 3)*

Bracken P and Petty C (Eds) (1998), Rethinking the trauma of war, Save the Children. *(Ch 8)*

Braiker, Harriet. *The September 11 Syndrome: Seven Steps to Getting a Grip in Uncertain Times.* McGraw-Hill, 2002. *(Ch 7)*
Deals with the "new normal" and provides a number of practical coping exercises.

Brende, J.O. *Post-traumatic symptoms and trauma recovery in the Bible.* Trauma Recovery Publications, 1991. *(Ch 7)*
Recommended by ICISF's PCI training.

Bringing God's Presence to Trauma Victims from Church World Service. Order from **www.cwserp.org** *(Ch 2)*

Center for Mental Health Services (1996) *Responding to the needs of people with serious and persistent mental illness in times of major disaster*, Publication No. (SMA) 96-3077, US Department of Health and Human Services, Substance abuse and mental health services administration. *(Ch 8)*

Cooperative Faith–Based Disaster Recovery in Your Community from Church World Service. Order from **www.cwserp.org** *(Ch 2)*

Danieli Y, Rodley N S, Weisäth L (Eds) (1996), *International responses to traumatic stress*, Baywood Publishing Company, Inc. *(Ch 8)*

Danish Red Cross (1997), *Psychological first aid and other human support.* *(Ch 8)*

Domar, Alice D. *Self-Nurture: Learning to Care for Yourself as Effectively as You Care for Everyone Else.* New York: Penguin USA, 2001. *(Ch 3)*

Ehrenreich, John H., *Coping with Disasters: A Guidebook to Psychosocial Intervention*, Download from **www.mhwwb.org/copingwithdisaster.pdf**. *(Ch 2)*

Fleischman, P.R. *The healing spirit.* Paragon, 1989. *(Ch 7)*
Recommended by ICISF's PCI training.

Foa E B, Keane T M and Friedman M J (2000) *Effective treatments for PTSD*, Guildford Press, NY. *(Ch 8)*

Gentry, Eric, *Instructional Manual Version 4.3*, Traumotology Institute, University of South Florida Revised 3/07/02. *(Ch 3)*

Guide to Disaster Ministry in Your Congregation from Church World Service. Order from **www.cwserp.org** *(Ch 2)*

Haalas, Wagstrom Gwen *The Right Road…Life Choices for Clergy* Fortress Press, 2004. *(Ch 3)*

Hands, Donald R. and Fehr, Wayne L. *Spiritual Wholeness for Clergy: A New Psychology of Intimacy with God, Self, and Others.* Bethesda, Md.: The Alban Institute, 1994. *(Ch 3)*

Harbough, Gary, *Act of God, Active God*, This pocket guide addresses spiritual understandings of faith questions arising from natural disasters. Order from **www.augsburgfortress.org** *(Ch 2)*

Harbaugh, Gary, *Care for the Caregiver,* Augsburg Press, 2001 *(Ch 3)*.

Herman, Judith. *Trauma and Recovery: The aftermath of violence—from domestic abuse to political terror.* Basic Books, 1997. *(Ch 2, 7)*
A classic that provides valuable information on trauma and the stages of recovery.

International Federation of Red Cross and Red Crescent Societies (1998), *World disaster report* 1998, IFRC *(Ch 8)*

International Federation of Red Cross and Red Crescent Societies (2001), *Guidelines for the implementation of a psychological support program in emergencies*, IFRC *(Ch 8)*

Joseph, Judith C., *A Chaplain's Companion,*. This pocket-sized booklet describes the major faith traditions and rituals helpful to working in a hospital, nursing home, hospice, or long-term care facility. It also provides prayers appropriate to those faith traditions when operating in an inter-religious setting. It is particularly aimed for chaplaincy work. Contact: **www.conexuspress.com** *(Ch 2)*

Kornfeld, Margaret. *Cultivating Wholeness.* New York: The Continuum International Publishing Group, Inc., 2002. *(Ch 3)*

Marcella A J, Friedman M J, Gerrity E T and Scurfield R M (1996), *Ethnocultural aspects of posttraumatic stress disorder*, American Psychological Association, Washington DC. *(Ch 8)*

Melander Rochelle, & Eppley, H.*, The Spiritual Leader's Guide to Self-Care*, Bethesda, Md.: The Alban Institute, 2002. This resource is a companion for religious leaders, lay leaders, and others who would like guidance about how to make changes in their personal life and ministry with regard to vision, work, relationships, and spiritual and intellectual needs. *(Ch 2, 3)*

Norris F H (2002) *Psychosocial consequences of disasters*, PTSD Research Quarterly, Spring 2002. *(Ch 8)*

Nouwen, Henri. *Lifesigns.* Image Books, 1986. *(Ch 7)* Recommended resource by ICISF's PCI training.

Oswald, Roy M. *Clergy Self-Care: Finding a Balance for Effective Ministry.* Bethesda, Md.: The Alban Institute, 1991. *(Ch 3)*

Pargament, K. *Psychology of religion and coping.* Guilford, 1997. *(Ch 7)* Recommended resource by ICISF's PCI training.

Parkinson, Frank. *Post-Trauma Stress: A personal guide to reduce the long-term effects and hidden emotional damage caused by violence and disaster.* Fisher Books, 2000. *(Ch 7)* Grew out of his experience of working with a multidisciplinary team who worked together before and after the Gulf War; deals with the debriefing process.

Raphael B (1986) *When disaster strikes: How individuals and communities cope with catastrophe*, Basic Books, Inc. New York. *(Ch 8)*

Sinclair, N.D. *Horrific Traumata: A pastoral response to the post-traumatic stress disorder.* Haworth Pastoral Press, 1993. *(Ch 7)*

Recommended resource by ICISF's PCI training. Sveaass N (2000), *Restructuring meaning after uprooting and violence. Psychosocial interventions in refugee receiving and in post-conflict societies*, Institute of Psychology, Faculty of Social Sciences, University of Oslo. *(Ch 8)*

Wilder-Smith. A.E. *Why does God allow it?,* TWFT Publishers, 1980. *(Ch 7).* Recommended resource by ICISF's PCI training.

World Health Organization (2000), *Declaration of co-operation, mental health of refugees, displaced and other populations affected by conflict and post-conflict situations*, WHO. *(Ch 8)*

Vineyard, S. *How To Take Care of You,* Heritage Arts Publishing, Downers Grove, IL 1987. *(Ch 3)*

Glossary of Typical Emotional States

BY ALI GHEITH

11

The following glossary terms might help you recognize some of the most typical emotional reactions to trauma.

Anger

This is a very complex emotion, but it is related to frustration and comes about when people are denied something of great importance to them. This is why frustration often turns to anger, as a next step in the escalation of a conflict between people's goals or needs and their circumstances. Anger is a more energetic emotion than frustration and has the advantage of making the person feel some power to overcome the situation. At its worst, anger makes us feel like annihilating or eliminating those who obstruct us from our goals, and for this reason people are often embarrassed to talk about or even admit their anger. This can appear to be a very irrational response because it is also the most misunderstood emotion. Anger does not have to make sense. It just happens to motivate us to overcome threats to our survival or our well-being.

That is why people can be angry at a dead loved one for abandoning them or at an earthquake for causing such destruction.

Anxiety

Anxiety is usually a more diffuse, less intense form of fear. While it is always focused on unpleasant future outcomes, there may be no specific target for the anxiety. Anxiety can be expressed in restlessness (agitation), panicky feelings, or an inability to act (indecision). Unrelieved anxiety can become paralyzing, because it may prevent people from doing things that were previously a natural part of their daily routine. Chronic anxiety is very bad for the body as well and may lead to symptoms of physical illness.

Blame

This is when people feel at least partly responsible for bad things happening. People are blamed for not preventing or foreseeing the event or for not having helped others enough. People fear blame because it lowers them in the eyes of others, which is very painful. In most cases, feeling that you or others are to blame requires that there was some power or opportunity to have acted differently and that the outcome of those acts was predictable.

Depression

Pervasive feelings of hopelessness and despair, unshakable feelings of worthlessness and inadequacy, withdrawal from others, inability to engage in productive activity.

Disorientation

Daze, memory loss, inability to give date or time, state where he or she is, recall events of the past 24 hours or understand what is happening.

Dread

Disasters can give people cause for dread as they look into a future that includes unpleasant events, like burials, relocating from their communities or otherwise rebuilding their lives.

Fear

People often feel afraid if they are suddenly faced with something they think might harm them. This emotion is so powerful that it usually captures the full attention, leaving very little reserve for coping with anything else (also known as terror). The object of the fear is not always visible. The fear might also be concerned with the surroundings; fear of being left alone, fear for the loved ones' lives, fear that the event will happen again, or that it will never be overcome. Fear can leave such a strong imprint on a person that they are permanently changed by it. Chronic fear can lead to panic or emotional collapse.

Frustration

When people try to accomplish something and encounter an obstacle, they experience an emotional reaction called frustration. It is a form of anger. This emotion signals to the person that they must adjust in some way to the presence of the obstacle, usually by increasing their effort or trying something else. Unrelieved frustration leads either to heightened anger or the onset of depression.

Grief and mourning

People who have suffered a loss, especially of a loved one, experience a very painful reaction that interferes with their ability to go on with their lives. These emotions are so powerful that they seem impossible to hide. People have been known to show physical symptoms, such as shortness of breath, irregular heartbeat and fainting. Mourning often refers to the expressive or ritual behavior engaged in by grieving people or communities. Expressive rituals can be helpful or necessary for relieving these feelings.

Guilt

Guilt is felt when something unfair has happened for which the person was at least partly responsible. Often people feel guilty for not preventing or foreseeing the event or for not having helped others enough. Guilt may also be felt for not having expressed the right things to people before it was too late. One may also feel guilty for being in a more fortunate situation than others, again because it seems unfair. A specific kind of guilt found after disasters is called "survivor's guilt", in which a person feels guilty for having survived when others did not. Sometimes people feel guilty that they could not prevent the event, even though they realize that this is irrational. In this case the guilt expresses a wish to have acted differently or to have created a better outcome.

Loss

The name of this feeling actually describes the situation, for the person is reacting to losing something or someone. It is similar to grief or mourning and, this emotion robs people of energy and leaves them feeling empty inside, as though something is missing. It is common for such a person to think almost exclusively about that which they feel is lost, and to wish for its return.

Regret

This is a painful feeling resulting from reflecting on a past decision or behavior. People often feel some kind of regret after a disaster because they see how they might have chosen differently, though they may have had no way of knowing at the time. This can be seen as a way of wishing to have been more powerful in the face of overwhelming circumstances.

Sadness

These feelings share similarities with regret and grief and reveal a person who is mourning some loss. It is easy to recognize sadness because the person lacks energy and appears physically sunken in their face and posture.

Shame

Unlike guilt, shame does not focus on an unfair situation or misdeed, but rather is a person's feeling of being completely bad or inadequate in the eyes of others. A person who feels this way will find it very hard to talk about it, because he/she feels undeserving of being cared for or understood by others. Sometimes people feel shameful about how they behaved in the event, even though this may be unfounded. In this case the shame expresses a sense of personal inadequacy.

Vulnerability

When people are hurt physically and psychologically, they feel fragile or insecure. This means that they easily misinterpret their surroundings and that they generally feel misunderstood and betrayed. They may be low on patience and easily irritated. [10] [11]

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[10] International Federation of Red Cross and Red Crescent Societies, Psychological Support: best practices from Red Cross and red Crescent program

[11] SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters

Age-Specific Reactions and Interventions to a Disaster

BY ALI GHEITH

12

Age-Specific Reaction to disaster and intervention suggestions

Each age group is vulnerable in unique ways to the stresses of disaster. Different issues and concerns become relevant during the progression of phases in the post-disaster period. Some disaster stress reactions listed below may be experienced immediately, while others may appear months later. The following table describes possible disaster reactions of the different age groups and helpful responses to them.

Age-Specific Disaster Reactions

1-5 years old	6-11	12-18	Adults	Older adults
Resumption of bed-wetting, thumb sucking, clinging to parents	Decline in school performance	Decline in academic performance	Sleep problems	Withdrawal and isolation
Fears of the dark	Aggressive behavior at home or school	Rebellion at home/school	Avoidance of reminders	Reluctance to leave home
Avoidance of sleeping alone	Hyperactive or silly behavior	Decline in previous responsible behavior	Excessive activity level	Mobility limitations
Increased crying	Whining, clinging, acting like a younger child	Agitation or decrease in energy level, apathy	Crying easily	Relocation adjustment problems
Loss of appetite	Increased competition with younger siblings for parents' attention	Delinquent behavior	Increased conflicts with family	Worsening of chronic illnesses
Stomach aches		Social withdrawal	Hypervigilance	Sleep disorders
Nausea	Change in appetite	Appetite changes	Isolation, withdrawal	Memory problems
Sleep problems, nightmares	Headaches	Headaches	Fatigue, exhaustion	Somatic symptoms
Speech difficulties	Stomach aches	Gastrointestinal problems	Gastrointestinal distress	More susceptible to hypo- and hyperthermia
Tics	Sleep disturbances, nightmares	Skin eruptions	Appetite change	Physical and sensory limitations (sight, hearing) interfere with recovery
Anxiety	School avoidance	Complaints of vague aches and pains	Somatic complaints	
Fear	Withdrawal from friends, familiar activities	Sleep disorders	Worsening of chronic conditions	Depression
Irritability		Loss of interest in peer social activities, hobbies, recreation	Depression, sadness	Despair about losses
Angry outbursts	Angry outbursts		Irritability, anger	Apathy
Sadness	Obsessive preoccupation with disaster, safety	Sadness or depression	Anxiety, fear	Confusion, disorientation
Withdrawal		Resistance to authority	Despair, hopelessness	Suspicion
		Feelings of inadequacy and helplessness	Guilt, self doubt	Agitation, anger Fears of institutionaliza-tion
			Mood swings	Anxiety with unfamiliar surroundings

Age-Specific Intervention Suggestions

1-5 years old	6-11	12-18	Adults	Older adults
Give verbal assurance and physical comfort	Give additional attention and consideration	Give additional attention and consideration	Provide supportive listening and opportunity to talk in detail about disaster experiences	Provide strong and persistent verbal reassurance
Provide comforting bedtime routines	Temporarily relax expectations of performance at home and at school	Temporarily relax expectations of performance at home and school	Assist with prioritizing and problem-solving	Provide orienting information
Avoid unnecessary separations				Use multiple assessment methods as problems may be under reported
Permit the child to sleep in parents' room temporarily	Set gentle but firm limits for acting out behavior	Encourage discussion of disaster experiences with peers, significant adults	Offer assistance for family members to facilitate communication and effective functioning	Provide assistance with recovery of possessions
Encourage expression regarding losses (i.e., deaths, pets, toys)	Provide structured but undemanding home chores and rehabilitation activities	Avoid insistence on discussion of feelings with parents	Assess and refer when indicated	Assist in obtaining medical and financial assistance
Monitor media exposure to disaster trauma	Encourage verbal and play expression of thoughts and feelings	Encourage physical activities	Provide information on disaster stress and coping, children's reactions and families	Assist in reestablishing familial and social contacts
Encourage expression through play activities	Listen to the child's repeated retelling of a disaster event	Rehearse family safety measures for future disasters	Provide information on referral resources	Give special attention to suitable residential relocation
	Involve the child in preparation of family emergency kit, home drills	Encourage resumption of social activities, athletics, clubs etc.		Encourage discussion of disaster losses and expression of emotions
	Rehearse safety measures for future disasters	Encourage participation in community rehabilitation and reclamation work		Provide and facilitate referrals for disaster assistance
	Coordinate school disaster program for peer support, expressive activities, education on disasters, preparedness planning, identifying at-risk children	Coordinate school programs for peer support and debriefing, preparedness planning, volunteer community recovery, identifying at-risk teens		

(SAMHSA Field Manual for Mental Health and Human Service Working in Major Disasters)

New York City Government Response

While many City agencies will respond, the City agency charged with planning and coordinating the response is the New York City Office of Emergency Management (OEM). The following information is taken from their website. (**http://www.nyc.gov/html/oem/html/home/home.shtml**)

Their planning brochures and links are included as part of this manual.

Description

Established in 1996, the New York City Office of Emergency Management (OEM) works to mitigate, plan and prepare for emergencies; educate the public about preparedness; coordinate emergency response and recovery efforts; collect and disseminate critical information; and seek funding opportunities to support the overall preparedness of the City of New York.

To accomplish this mission, OEM maintains a disciplined unit of emergency management personnel, including responders, planners, watch commanders, and administrative and support staff, to identify and respond to various hazards.

Areas of Responsibility

Informing the Public

Ensuring New Yorkers are prepared for emergencies is OEM's top priority. Its educational campaigns aim to help residents prepare for all types of emergencies.

During an emergency, OEM works to ensure agencies involved in an emergency response provide a unified, accurate, and timely message to the public. OEM delivers emergency warnings through the broadcast media using the City's Emergency Alert System, and provides email alerts about current emergencies to subscribers. During large-scale emergencies, OEM opens a Joint Information Center (JIC)

to coordinate outreach to the media.

Planning for Emergencies

OEM develops contingency plans that guide New York City's response to natural and man-made emergencies, from extreme weather to labor disputes. Each plan focuses on three components of a disaster: preparedness, initial response, and recovery. The purpose of these plans is to keep New York City safe and, following a disaster, to return residents to their daily routines as quickly as possible.

When a plan is activated, OEM coordinates the skills of City, state, federal, and non-governmental agencies, to ensure the plan is effectively carried out. Large-scale citywide emergencies, like a transit strike or a coastal storm, can require the collaboration of dozens of agencies and thousands of emergency responders. Smaller incidents, such as localized power outages or water main breaks, may only require a handful of agencies to complete restoration.

OEM reviews, tests, and revises these plans as intelligence and resources change. The agency enlists subject matter experts from all City agencies, including the Police and Fire Departments, and other non-city groups to advise on aspects of each plan.

A large part of planning is what's done in addition to coordinating emergency responses. OEM works to inform the public of the potential hazards (**http://www.nyc.gov/html/oem/html/hazards/hazards.shtml**) in an effort to make sure New Yorkers know how to avoid disasters or act in the event of a disaster. OEM encourages New Yorkers to educate themselves and others about emergency preparedness.

The following links highlight the City's guidelines to handle some possible emergencies:

- Coastal Storm Plan -
  http://www.nyc.gov/html/oem/html/about/planning_coastal_storm.shtml
- A New York City Population Analysis -
  http://www.nyc.gov/html/oem/html/about/pop_analysis.shtml
- Utilities Disruptions Guide -
  http://www.nyc.gov/html/oem/html/about/planning_utilities.shtml

Emergency Response

Emergencies in a city as large and complex as New York require a coordinated response. OEM works to ensure information gathering, decision making, and resource allocations are carried out efficiently. There are many components that make up all of OEM's Emergency Response. Below are a few of the ways the agency handles emergencies:

Incident monitoring: OEM tracks incidents affecting New York City 24 hours a day, seven days a week. Through its Watch Command, OEM monitors radio frequencies used by the City's emergency responders, local and national news, weather conditions, and 911 calls, among other communications channels. It also maintains the City's communication link with local, state, and federal agencies, and notifies City officials when incidents or issues of concern arise.

Field response: OEM sends field responders to larger incidents to facilitate interagency communication and resource requests. OEM's on-scene coordinators also help ensure responding agencies follow incident command protocols.

Emergency Operations Center: During major emergencies and special events, OEM activates the City's Emergency Operations Center (EOC). With space for more than 100 representatives from local, state, and federal agencies and private and non-profit entities, the EOC functions as a central clearinghouse for information coordination, resource requests, and decision making.

Recovery and Relief: Following an emergency, OEM works with government agencies and nonprofit organizations to provide assistance to diaster victims and manage relief efforts, donations, and spontaneous volunteers.

Learn about OEM's Emergency Response Resources and Capabilities:

- Citywide Asset and Logistics Management System: CALMS -
  http://www.nyc.gov/html/oem/html/about/about_calms.shtml
- Citywide Incident Management System: CIMS -
  http://www.nyc.gov/html/oem/html/about/about_cims.shtml
- Emergency Operations Center: EOC -
  http://www.nyc.gov/html/oem/html/about/about_eoc.shtml
- Emergency Response Vehicles -
  http://www.nyc.gov/html/oem/html/about/about_mdc_icv_icc.shtml
- Geographic Information Systems: GIS -
  http://www.nyc.gov/html/oem/html/about/about_gis.shtml
- Private Asset and Logistics Management System: PALMS -
  http://www.nyc.gov/html/oem/html/about/about_emergency_palms.shtml
- Urban Search and Rescue: USAR -
  http://www.nyc.gov/html/oem/html/about/about_usar.shtml
- Watch Command & Field Operations -
  http://www.nyc.gov/html/oem/html/about/about_operations.shtml

OEM Programs

Preparedness: Ready New York

The Office of Emergency Management (OEM) is committed to educating New Yorkers about the hazards they face and ways they can better prepare themselves. Understanding your responsibilities before, during, and after an emergency is the best way to ensure you and your family are ready for any situation.

To further this process, OEM has created "Ready New York: A Household Preparedness Guide" — the centerpiece of a broad household preparedness campaign — to distribute to the City's more than eight million residents. Created in collaboration with more than 20 government, private and non-profit entities, "Ready New York" is built on three guiding principles — packing a **Go Bag**, assembling an **Emergency Supply Kit**, and creating a **Household Disaster Plan**.

"Ready New York" was introduced in 2003. The preparedness campaign outlines tips and information designed to help New Yorkers better prepare for all types of emergencies. Centered around a downloadable household preparedness guide, "Ready New York" spans a number of publications, televised public service announcements, outdoor ads, a speakers bureau, corporate partnerships, and training programs including Community Emergency Response Teams (CERT). For specific "Ready New York" publications, information, and downloads, please visit the OEM website at **http://www.nyc.gov/html/oem/html/home/home.shtml**.

CERT

NYC CERT teams are groups of neighborhood and community-based volunteers that undergo an intensive, 11-week training program in disaster preparedness and basic response skills. Several of the topics include Fire Safety, Search and Rescue, and Disaster Medical Operations. After completing training, these teams act to support their local communities by assisting the various emergency agencies that prepare for and respond to disasters.

As a rule, emergency services personnel are the best equipped to respond to emergencies. However, following a catastrophic disaster, CERT teams can handle initial emergency recovery while they wait for professional First Responders.

During non-emergency situations, CERT teams educate their communities on emergency preparedness.

CERT Mission Statement

The New York City Community Emergency Response Team (CERT) program trains neighborhood and community-based volunteer teams to:

- Inform, educate, and train their neighbors about disaster preparedness
- Assist public safety agencies and local community boards with public events
- Respond to local disasters in accordance with CERT protocols and support emergency personnel upon their arrival and request
- Assist agencies in managing spontaneous volunteers at a disaster site

CERT History

The CERT concept was developed and implemented by the City of Los Angeles Fire Department (LAFD) in 1985. It was first employed during the Whittier Narrows earthquake in 1987, when roads became impassable and communities were temporarily stranded.

LAFD then saw the need to train community members in basic rescue and survival skills. FEMA implemented the training program on their Web site, making it available to communities nationwide.

In 2003, the President created the concept of **Citizen Corps** to train and coordinate community volunteer teams. These teams make communities safer and better prepared to respond to any emergency, and CERT was designated as the initiative's key program.

In November 2003, NYC OEM received federal funding to provide Community Emergency Response Team training to New Yorkers.

Goal

One of the primary goals of NYC OEM is to establish one CERT team in each of the 59 Community Boards around NYC by the end of 2006. There are currently 31 teams recognized by NYC OEM as established and trained. For a full list of OEM-recognized and trained teams in NYC, please go to the OEM website at **http://www.nyc.gov/html/oem/html/home/home.shtml**.

CERT Program Partners

- **Citizens for NYC (CNYC)** –
  http://ccnyc.neighborhoodlink.com/ccnyc/index.html
  CNYC assists with recruitment of CERT teams
  throughout NYC. CNYC also offers team-building
  modules and resource information during and after
  training. CNCY provides teams with technical tools to
  build communication strategies for CERT members and
  their respective neighborhoods.

- **Fire Department (FDNY)** –
  http://nyc.gov/html/fdny/html/home2.shtml
  The FDNY facilitates the 11-week training program by
  offering seasoned FDNY and EMS personnel. They also
  provide experienced topic instructors for FDNY and EMS
  classroom-based and hands-on modules. In addition, the
  FDNY are also major contributors to the NYC CERT
  curriculum.

- **Police Department (NYPD)** –
  http://www.nyc.gov/html/nypd/
  The NYPD provide experienced police personnel from
  NYPD and the Auxiliary Police Unit to train police-
  related modules, such as Terrorism Awareness and Police
  Science. In addition, the NYPD are also contributors to
  the NYC CERT curriculum.

- **American Red Cross in Greater New York (ARC/GNY)** –
  http://www.nyredcross.org/
  ARC/GNY provides certified disaster mental health
  professionals to train participants of the program.
  ARC/GNY are also major contributors to the disaster
  mental health curriculum.

Resources:

http://www.nyc.gov/html/oem/

**Ready New York: Downloadable Ready New York
Preparedness Guides**
OEM's Ready New York preparedness campaign is designed
to help New Yorkers better prepare for all types of
emergencies. The following Ready New York preparedness
guides and brochures are available online, most in multiple
languages:

- Household Preparedness Guide
  www.nyc.gov/html/oem/html/ready/household_guide.shtml

- Beat The Heat Guide
  www.nyc.gov/html/oem/html/ready/heat_guide.shtml

- Ready New York for Seniors and People with Disabilities
  www.nyc.gov/html/oem/html/ready/seniors_guide.shtml

- Hurricanes and NYC
  www.nyc.gov/html/oem/html/ready/hurricane_guide.shtml

- Ready New York for Business
  www.nyc.gov/html/oem/html/ready/biz_guide.shtml

- Ready New York for Pets
  www.nyc.gov/html/oem/html/ready/pets_guide.shtml

- Pocket Guide
  www.nyc.gov/html/oem/html/ready/pocket_guide.shtml

Primary National Volunteer Response Organizations

14

BY JACK HERRMANN

Editor's Note: This Chapter is the continuation of an adaptation of a state plan for disaster preparation and response. In total, the original chapter comprises Chapters, 1, 14, 16-18.

While local, state, and federal agencies have the responsibility and the burden of preparing for and responding to disasters, there are a variety of other private and public organizations with disaster response missions. The American Red Cross is probably the most noted with its disaster relief history of more than a century.

The American Red Cross

The American Red Cross is a humanitarian organization of volunteers that provides relief to survivors of disaster. The Red Cross helps people prevent, prepare for, and respond to emergencies and provides such services consistent within its Congressional Charter and under the principles of the International Red Cross and Red Crescent Movement.

In 1905, the Red Cross was chartered by Congress to "carry on a system of national and international relief in time of peace and apply the same in mitigating the sufferings caused by pestilence, famine, fire, floods, and other great national calamities, and to devise and carry on measures for preventing the same."

This Charter is not only a grant of power, but also an imposition of duties and obligations to the nation, to disaster survivors, and to those donors who support its work.

Red Cross disaster relief focuses on meeting an individual's immediate disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. The Red Cross also feeds

emergency workers, handles inquiries from concerned family members outside the disaster area, provides blood and blood products to disaster victims, and helps those affected by disaster access other available resources.

What is most important to remember about the role of the Red Cross in disaster relief is that the Red Cross supplements the resources and services of the local, state, and federal government and does not override or substitute for the local, state, and federal governments' responsibilities in times of disaster.

American Red Cross at the Local Level

Most counties across the country have active Red Cross Chapters, which meet the day-to-day needs of individuals affected by community emergencies such as single-family house fires and small floods. These needs typically include short-term shelter, food, and clothing and the provision of mental health and physical health services.

American Red Cross at the State and National Level

When a disaster exceeds the human and material resources of a given Red Cross Chapter, the affected chapter can look to neighboring chapters or other chapters within the state for assistance. In those situations where the incident exceeds that which the state can accommodate, the Red Cross may deploy resources from within its service area (e.g., the Northeast Region) or from across the country.

American Red Cross and Disaster Mental Health

In 1992, the American Red Cross developed a disaster mental health component to its disaster relief branch. Licensed mental health practitioners, acting as volunteers, are trained to recognize a disaster's emotional impact on survivors and disaster workers and provide appropriate interventions to mitigate or resolve such symptoms. On a local level, disaster mental health volunteers may respond and support individuals involved in house fires or other community emergencies. On large-scale disasters, mental health professionals may be deployed to hurricanes, floods, tornados, forest fires, incidents involving weapons of mass destruction or other disasters.

In most cases, the local governmental authority in the disaster area coordinates the disaster response and relief efforts. There are instances, however, in which the American Red Cross authority in disaster response supersedes that of the local governmental unit. This occurs in the coordination of mental health services following aviation and other transportation disasters.

The Aviation Disaster Family Assistance Act of 1996 (ADFAA)

In 1996, the National Transportation Safety Board (NTSB) was assigned the role of integrating the resources of the federal government with those of local and state authorities and the airlines to meet the needs of aviation disaster victims and their families. As a result, the **Federal Family Assistance Plan for Aviation Disasters** was developed and implemented. This plan describes the airline and federal responsibilities in response to an aviation crash involving a significant number of passenger fatalities and/or injuries.

In addition, the ADFAA mandates that the NTSB identify a human service organization to coordinate family assistance and mental health services to surviving victims and the families of the deceased and to coordinate a non-denominational memorial service. The NTSB, in turn, has named the American Red Cross to oversee the coordination of these services. In the event an aviation disaster meets the above criteria and the ADFAA is enacted, the national headquarters of the American Red Cross will deploy a Critical Response Team to engage the **Federal Family Assistance Plan for Aviation Disasters.[1]** This team will work with local, state, and federal resources to meet the mental health and spiritual care needs of those involved.

American Red Cross and Disaster Spiritual Care

The American Red Cross recognizes the importance of spiritual care support during times of disaster, especially in those events resulting in mass casualties and fatalities. While the American Red Cross does not specifically provide spiritual care support directly through its volunteer resources, Red Cross chapters across the country are encouraged to collaborate with faith-based organizations in their communities to ensure that spiritual care services are offered and provided to those requesting and requiring such support.

In the event of an aviation disaster, where the Federal Family Assistance Plan for Aviation Disasters is engaged, the American Red Cross will deploy specially training disaster spiritual care professionals. While it is not the role of these individuals to provide direct spiritual care assistance, these individuals will assist the community in organizing the provision of spiritual support to disaster victims, their family members and the general community through the use of community faith-based organizations.

The Salvation Army

Role in Emergency Disaster Services

Federal law has reaffirmed The Salvation Army's authority to provide disaster assistance with the passage of the Robert T. Stafford Emergency and Disaster Assistance Act, which also created the Federal Emergency Management Agency (FEMA). This Act specifically names The Salvation Army as a relief and disaster assistance organization.

Several factors guide The Salvation Army's role in responding to disasters. These guiding factors include:

The Salvation Army has an established right to provide disaster relief services. That right is recognized by public law and through signed Memorandums of Understanding and Agreements (MOUs) with government agencies and other voluntary organizations.

- The Salvation Army's disaster relief services are supported solely by donations.
- The Salvation Army is not a first responder; rather, it supports first responders.
- The Salvation Army is a mass-care support agency.

Goals in Emergency Disaster Services

When The Salvation Army initiates a disaster relief operation, the first aim is to meet the basic needs of those who have been affected, both survivors and first responders (such as firefighters). Even at this level, The Salvation Army's workers are ministering in that they serve as a means of expressing God's love. The Salvation Army's goals are to offer:

• Material comfort
• Physical comfort
• Emotional comfort
• Spiritual comfort

The Salvation Army provides help as an outgrowth of faith and as an act of obedience to God, but no service is withheld because of a recipient's beliefs. If disaster relief recipients ask for prayer or spiritual counseling, The Salvation Army can provide these. The Salvation Army's service might be described as a "ministry of presence," just as the Apostle Paul wrote to the Romans, "Rejoice with those who rejoice, and mourn with those who mourn." (Romans 12:15)

EMERGENCY DISASTER SERVICE ACTIVITIES

The Salvation Army provides numerous disaster relief services. Each disaster creates its own unique circumstances. The Salvation Army's disaster response is community based, varying from place to place based upon the community's situation and the magnitude of the disaster.

In a disaster, The Salvation Army has the ability to provide both immediate emergency assistance and long-term recovery help . Emergency response services are activated on short notice according to an agreed-upon notification procedure, while long-term recovery is strategically planned in response to the situation, through working and partnering and many other community entities.

Even with the ability to be flexible and to respond based upon the community's situation, there are several basic services that The Salvation Army offers in most major disasters. These services, described below, form the core of The Salvation Army's disaster services program.

Food Service

The most visible of The Salvation Army's disaster services is the delivery of meals and drinks to disaster victims and emergency workers. Food may be prepared and served at congregate feeding sites (such as a Salvation Army corps building, camp or shelter) or from one of the Army's mobile feeding units/canteens, which are essentially kitchens on wheels. Nourishment is provided at other types of events, such as:

• Search and rescue operations
• Law enforcement activities
• School violence incidents
• Disaster drills
• Training exercises
• Special Events

Hydration Service

Hydration service provides beverages which replenish electrolytes (minerals such as potassium), enhance energy and which meet general hydration requirements for those served. Hydration service is offered to affected people and service providers. Hydration service is often used to augment disaster food service. In some situations, however, hydration may be all that is required. Some situations where hydration service is provided alone include:

• Where food is not the most immediate basic need, such as at public events where people may become victims of heat exposure.
• When consumption of food is not safe, such as when air borne contaminants are present.
• Where and when a local Department of Health restricts the serving of food.
• When security management does not allow food service.

Emergency Shelter

When necessary, The Salvation Army provides shelter in a facility identified by the local emergency management personnel. These facilities include:

• Municipal shelters, such as schools
• Salvation Army buildings
• Other facilities that are predetermined by authorities

Cleanup and Restoration

The Salvation Army supports people as they restore and rebuild after a disaster. Cleanup and restoration services include:

• Distribution of cleanup supplies such as mops, brooms, buckets, shovels, detergents, and tarps.
• Coordination of volunteer rebuilding teams.
• Set up of warehouses to distribute reconstruction supplies such as lumber and sheetrock.

Donations Management

The Salvation Army is one of the nation's leaders in collecting, sorting, and distributing donated goods. During a disaster, The Salvation Army may:

- Open disaster warehouses to receive and sort donations.
- Establish distribution centers to dispense goods directly to disaster victims.
- Use donations to support other disaster programs, such as mass feeding and cleanup.

Spiritual and Emotional Care

The Salvation Army provides spiritual comfort and emotional support to disaster victims and emergency workers coping with the stress of a disaster. Salvation Army counselors, who are often ordained as clergy (officers), may simply offer a "ministry of presence," but often people who know about The Salvation Army as representatives of God may ask for prayer or help from the Bible. At Ground Zero following 9/11, one of the most critical ministries of The Salvation Army was counseling firefighters, police, and morgue workers who were struggling with the enormity of the tragedy. Other examples of spiritual and emotional care activities include:

- Comforting the injured and bereaved
- Conducting funeral and memorial services
- Providing chaplaincy service to disaster workers and emergency management personnel

Disaster Social Services

The Salvation Army provides direct financial assistance to disaster victims through a system of trained caseworkers. This assistance is available for:

- Essential living supplies, such as food, clothing, medicine, bedding, or baby products
- Emergency housing needs
- Disaster-related medical or funeral expenses

Emergency Communications (SATERN)

Through The Salvation Army Team Emergency Radio Network (www.SATERN.org) and other amateur radio groups, The Salvation Army helps provide emergency communications when more traditional networks, such as telephones, are not operating. These teams:

- Relay critical information about the disaster.
- Transmit welfare inquiries from friends and family

members who are otherwise unable to reach loved ones in the disaster area.

Administration

This service provides the support to keep the other services functioning and includes:

- Clerical and office support
- Purchasing and accounting
- Statistics and reports
- Documentation for authorities
- Personnel, staff and trained volunteers
- Management of spontaneous volunteers

National Voluntary Organizations Active in Disaster (NVOAD) [2]

Many states and U.S. territories have a Voluntary Organizations Active in Disaster (VOAD) program whose main mission is to coordinate the planning efforts of that state or territory's voluntary organizations committed to disaster response. The National Voluntary Organizations Active in Disaster (NVOAD) is the national coordinating body of these state and territory affiliates. During times of disaster, NVOAD, or its affiliate, will encourage the participating voluntary organizations to engage their disaster response services and will assist in coordinating these services with other local, state, and federal disaster response agencies. Participating organizations in NVOAD include the American Red Cross, Salvation Army, Catholic Charities USA, Mennonite Disaster Services, and a host of other human service and faith-based organizations.

National Faith-Based Disaster Service Organizations

Although faith-based organizations are the primary long-term disaster assistance providers, their contributions to disaster work are as varied as their spiritual practices. Below is a partial list of organizations that have program and contact information available to the public.

- ***Adventist Community Services (ACS) –**
  Disaster Response; National Office: Silver Spring, MD
  – Services: emergency goods/supplies and warehouse operations
  – Contact: acsnydirector@hotmail.com, **www.nadadventist.org/acs/disaster-response.htm**, 877.227.2702, 301.680.6438.

- **American Baptist Men (ABM) –**
  Disaster Relief; Headquarters: Springfield, IL
  – Services: housing assessment, debris removal, and housing cleanup
  – Contact: **www.abmen.org**, 800.222.3872 x2452.

- **American Jewish World Service (AJWS) –**
  Headquarters: New York, NY
  – Services: fosters civil societies sustainable development and human rights for all internationally
  – Contact: **www.ajws.org**, 212.792.2900 or 800.889.7146.

- **American Red Cross (ARC)-Spiritual Response Team (SRT) –**
  Headquarters: Washington, D.C.
  – Services: volunteer chaplaincy for aviation incidents
  – Contact: **www.redcross.org**, 202.303.4498.

- ***Catholic Charities USA –**
  Headquarters: Alexandria, VA
  – Services: multi-service agency; distribution of funds to support long-term case management
  – Contact: **www.catholiccharitiesusa.org**, 703.549.1390.

- **Christian Contractors Association (CCA) –**
  International Headquarters: Brooksville, FL
  – Services: home construction/rebuilding
  – Contact: **www.ccaministry.org**, 800.278.7703, 800.270.4227 or 352.799.7856

- ***Christian Reformed World Relief Committee (CRWRC) –**
  DRS; US Head Office: Grand Rapids, MI
  – Services: needs assessment, home reconstruction, work camps and training for recovery organizations
  – Contact: **www.crwrc.org/relief**, 800.848.5818, 800.552.7972 or 616.241.1691

- **Church of Jesus Christ of Latter Day Saints –**
  LDS Philanthropies; Headquarters: Salt Lake City, UT
  – Services: warehousing & distribution of emergency goods
  – Contact: **www.lds.org/ldsfoundation**, 800.525.8074, 801.240.5567 or 801.240.3544.

- **Church of the Brethren –**
  Emergency Response/Service Ministries; Headquarters: New Windsor, MD
  – Services: childcare for impacted families and volunteer home reconstruction
  – Contact: **www.brethren.org/genbd/ersm**, 800.451.4407 x4.

- ***Church World Service (CWS) –**
  Emergency Response Program (ERP); Headquarters: New York, NY
  – Services: support & training to long-term recovery organizations and staff, warehousing & distribution of donated goods, and maintenance of extensive online training and preparedness resources
  – Contact: **www.cwserp.org**, 800.297.1516 x222 or 212.870.3151.

- ***Episcopal Relief and Development (ERD) –**
  Headquarters: New York, NY
  – Services: redevelopment and recovery program funding
  – Contact: **www.er-d.org**, 800.334.7626 x5129.

- **Friends Disaster Service (FDS) –**
  Headquarters: Peninsula, PA
  – Services: volunteer labor coordination and victim advocacy
  – Contact: **www.friendsdisasterservice.org**, 717.859.2210.

- **International Orthodox Christian Charities (IOCC) –**
  Headquarters: Baltimore, MD
  – Services: funding to long-term recovery organizations, and emotional and spiritual care
  – Contact: **www.iocc.org**, 410.243.9820 or 877.803.4622.

- ***Islamic Circle of North America-Relief (ICNA Relief) –**
  Headquarters: Jamaica, NY
  – Services: long-term recovery case management & humanitarian aid
  – Contact: **www.reliefonline.org**, 718.658.7028.

- ***Lutheran Disaster Response –**
  Headquarters: Chicago, IL
  – Services: long-term recovery case management and work camp coordination
  – Contact: **www.ldr.org**, 773.380.2748.

- ***Mennonite Disaster Service (MDS) –**
  Bi-National Office:Akron,PA
  – Services: housing cleanup, home repair, and
  reconstruction
  – Contact: **www.mds.mennonite.net**, 717.859.2210 or
  800.241.8111.

- **Mercy Corps –**
  USA Headquarters: Portland, OR
  – Services: emergency relief
  – Contact: **www.mercycorps.org**, 800.292.3355.

- **National Disaster Interfaith Network (NDIN) –**
  Headquarters: New York, NY
  – Services: a network of local, regional, and state
  interfaith disaster organizations
  – Contact: **www.n-din.org**, 212.669.6100

- **Nazarene Disaster Response (NDR) –**
  Headquarters: Kansas City, MO
  – Services: volunteer labor coordination and long-term
  recovery support
  – Contact: **www.ncm.org/min_ndr.aspx**, 888.256.5886

- **Presbyterian Disaster Assistance (PDA) –**
  Presbyterian Church (U.S.A.); Headquarters: Louisville, KY
  – Services: work camp coordination, recovery program
  funding and capacity building
  – Contact: **www.pcusa.org/pda**, 888.728.7228 x5839 or
  800.872.3283

- ***The Salvation Army –**
  Headquarters:Alexandria,VA
  – Services: emergency relief and feeding, long-term case
  management, and distribution of goods
  – Contact: **www.salvationarmyusa.org**.

- ***Sikh Coalition –**
  National Headquarters: New York, NY
  – Services: civil rights/liberties advocacy and backlash
  mitigation education
  – Contact: **www.sikhcoalition.org**.

- ***Society of St. Vincent de Paul (SVDP) –**
  Headquarters: St. Louis, MO
  – Services: long-term recovery case management and
  distribution of clothing & donated goods
  – Contact: **www.svdpusa.org**, 314.576.3993.

- **Southern Baptist Convention (SBC) –**
  NAMB Disaster Relief Program; Headquarters:
  Alpharetta, GA
  – Services: feeding programs and coordination of home
  repair/rebuilding
  – Contact: **www.namb.net/dr**, 800.634.2462 or
  770.410.6000.

- ***Taiwan Buddhist Tzu Chi Foundation –**
  Northeast Regional Office: Flushing, NY
  – Services: distribution of food and donated goods,
  support for medical services, and counseling
  – Contact: **www.tzuchi.org**, 718.460.4590.

- ***United Jewish Communities (UJC) –**
  National Office: New York, NY
  – Services: funding for Jewish long-term recovery and
  redevelopment organizations
  – Contact: **www.ujc.org**, 877.277.2477 or 212.284.6500.

- **United Church of Christ (UCC) –**
  Disaster Response; Headquarters: Cleveland, OH
  – Services: funding and capacity building for
  environmental and technological disasters and long-term
  recovery organizations
  – Contact: **www.ucc.org/disaster**, 216.736.3211 or
  866.822.8224 x3211.

- ***United Methodist Committee on Relief (UMCOR) –**
  Headquarters: New York, NY/Washington, D.C.
  – Services: long-term recovery case management,
  warehousing and distribution of donated goods, home
  rebuilding and repair
  – Contact: **www.umcor.org**, umcor@gbgm-umc.org,
  800.554.8583.

- ***United Sikhs –**
  Headquarters: New York, NY
  – Services: humanitarian relief and coordination of
  recovery volunteers
  – Contact: **www.unitedsikhs.org**, 888.243.1690 or
  646.338.5996.

- ***World Vision –**
  Headquarters:Federal Way,WA
  – Services: warehousing and distribution of donated
  goods
  – Contact: **www.worldvision.org**, 888.551.6548

* Has a local office or headquarters in New York City

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[1] For more information on the Federal Family Assistance Plan for Aviation Disasters, refer to the Web site **www.ntsb.gov/publictn/2000/spc0001.pdf**.

[2] For information on the National Voluntary Organizations Active In Disaster, refer to the Web site **www.nvoad.org**.

Primary National Volunteer Response **140**

New York City Disaster Response Agencies and Organizations

The following are the agencies likely to respond to a disaster in New York City, depending on the scale and nature of what the disaster might be. This is a partial list; **not all agencies will respond to every situation.**

American Red Cross in Greater New York (ARCGNY)
www.arcgny.org
The American Red Cross in Greater New York (ARCGNY) supplements the efforts of city agencies to ensure that the citizens of New York are safe and have the assistance they need. Volunteers help those affected by disaster with food, clothing and shelter, as well as mental health support and financial assistance.

Con Edison (Con Ed)
www.coned.com
Consolidated Edison Company of New York (Con Edison), a regulated utility, provides electric service in New York City (except for a small area of Queens), and most of Westchester County. Con Ed provides natural gas service in Manhattan, the Bronx, and parts of Queens and Westchester. Con Edison also owns and operates the world's largest district steam system, providing steam service in most of Manhattan.

Department of Design and Construction, (DDC)
http://www.ci.nyc.ny.us/html/ddc/home.html
The DDC was created in October 1995 by Local Law 77, which authorized it to assume responsibility for certain construction projects formerly performed by the Departments of Transportation, Environmental Protection, and General Services (now Citywide Administrative Services). The Department delivers the City's construction projects in an expeditious, cost-effective manner, while maintaining the highest degree of architectural, engineering, and construction quality.

Department of Environmental Protection (DEP)
http://www.ci.nyc.ny.us/html/dep/home.html
DEP is a very diverse agency whose primary mission is to deliver water to and treat the effluent of more than 8 million City and upstate residents. DEP is also responsible for enforcement of the air, noise and hazardous materials laws and rules; billing and collection of water and sewer use charges; review of environmental impact statements; and administration of the Environmental Control Board.

Disaster Mortuary Operational Team (D-Mort)
http://oep-ndms.dhhs.gov/dmort.html
The National Response Plan assigns the National Disaster Medical System (NDMS) section under Emergency Support Function #8 (ESF #8) to provide victim identification and mortuary services. These responsibilities include: temporary morgue facilities; victim identification; forensic dental pathology; forensic anthropology methods; processing; preparation; disposition of remains.
In order to accomplish this mission, Disaster Mortuary Operational Response Teams (DMORTs) were developed. DMORTs are composed of private citizens, each with a particular field of expertise, who are activated in the event of a disaster.

Emergency Medical Services (EMS)
http://www.nycremsco.org/default.asp
http://www.nyc.gov/html/fdny/html/home2.shtml
EMS provides pre-hospital care to the citizens and visitors of New York City. They are the Emergency Medical Technicians (EMTs) and Paramedics who respond to all disasters, and they respond to calls made to the 911 system. In New York City, EMS is comprised of the private, municipal, and volunteer sectors, and is overseen by the Regional EMS council.

Federal Bureau of Investigation (FBI)
www.fbi.gov
The mission of the FBI is to protect and defend the United States against terrorist and foreign intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies and partners. If the disaster is deemed to have been of terrorist origin, the FBI will be present and investigating.

Federal Emergency Management Agency (FEMA)
www.fema.gov
FEMA's continuing mission within the Department of Homeland Security is to lead the effort to prepare the nation for all hazards and effectively manage federal response and recovery efforts following any national incident. FEMA also initiates proactive mitigation activities, trains first responders, and manages the National Flood Insurance Program.

Fire Department of the City of New York (FDNY)
http://www.nyc.gov/html/fdny/html/home2.shtml
As first responders to fires, public safety and medical emergencies, disasters, and terrorist acts, the FDNY protects the lives and property of New York City residents and visitors.

Department of Health and Mental Hygiene (DOHMH)
www.nyc.gov/health
The DOHMH created the Office of Mental Health Disaster Preparedness and Response to develop plans and training to meet the mental health needs of New Yorkers during times of disaster. To learn more about this office, visit the website at www.nyc.gov/health or call 212.219.5400.

Department of Homeland Security (DHS)
www.dhs.gov
The mission of the DHS is to lead the unified national effort to secure America. DHS will prevent and deter terrorist attacks and protect against and respond to threats and hazards to the nation. DHS will ensure safe and secure borders, welcome lawful immigrants and visitors, and promote the free-flow of commerce.

Human Resources Administration (HRA)
http://www.nyc.gov/html/hra/html/home/home.shtml
The Human Resources Administration/Department of Social Services (HRA/DSS) enhances the quality of life for all New Yorkers by providing temporary help to eligible individuals and families with social service and economic needs in order to assist them in leading independent lives. These goals are accomplished through the effective administration of a broad range of social welfare programs including food, shelter, temporary financial assistance, medical care, counseling, and other essential services.

Human Services Council (HSC)
http://www.humanservicescouncil.org/
The Human Services Council works to build broad recognition and support for the substantial and essential contributions of the not-for-profit human service sector to the citizens and the fabric of New York City. Through HSC, the human services sector is able to act in concert on issues of mutual concern. It is the focal point for the sector's emergency preparedness and response. Working in cooperation with federal, State and City agencies, as well as other local and regional groups, HSC coordinates preparedness activities and coordinates disaster-recovery services following a major disaster.

International Critical Incident Stress Foundation/ Critical Incident Management Teams (ICISF/CISM)
www.icisf.org
The International Critical Incident Stress Foundation, Inc. (ICISF) is a non-profit, open membership foundation dedicated to the prevention and mitigation of disabling stress through the provision of: Education, training and support services for all Emergency Services professions; Continuing education and training in Emergency Mental Health Services for the Mental Health Community; and Consultation in the establishment of Crisis and Disaster Response Programs for varied organizations and communities worldwide. CISM teams may be on-site to debrief first responders.

Keyspan Energy (Keyspan)
www.keyspanenergy.com
Provides gas service in Brooklyn, Queens, and Staten Island

New York Cares
www.nycares.org
New York Cares meets pressing community needs by mobilizing caring New Yorkers in volunteer service. New York Cares is the lead agency in mobilizing and managing spontaneous unaffiliated volunteers in response to disasters in New York City, with the help of NYCVOAD's Disaster Volunteerism Task Force. The New York Cares website (www.nycares.org) is the citywide resource on spontaneous volunteer needs, linking interested volunteers with appropriate agencies and projects. Individuals who wish to assist in the recovery effort after disaster can sign up for projects online, or call the New York Cares office at 212.229.5000.

National Volunteer Organizations Active in Disaster (NVOAD) members (VOAD)
www.nvoad.org
Many states and U.S. territories have a Voluntary Organizations Active in Disaster (VOAD) program whose main mission is to coordinate the planning efforts of that state or territory's voluntary organizations committed to disaster response. The National Voluntary Organizations Active in Disaster (NVOAD) is the national coordinating body of these state and territory affiliates. During times of disaster, NVOAD, or it's affiliate, will encourage the participating voluntary organizations to engage their disaster response services and will assist in coordinating these services with other local, state, and federal disaster response agencies. Participating organizations in NVOAD include the American Red Cross, Salvation Army, Catholic Charities USA, Mennonite Disaster Services, and a host of other human service and faith-based organizations. (see Jack Herrmann, "The Federal Response to Disaster", p. 140)

New York Disaster Interfaith Services (NYDIS)
www.nydis.org
NYDIS is a faith-based federation of service providers and charitable organizations who work in partnership to provide disaster services. NYDIS' mission is to develop and support faith-based disaster readiness, response, and recovery services for New York City. In preparation for and in response to disasters, NYDIS convenes its leadership to network with local, state, and national agencies involved in disaster management to facilitate the delivery of services, resources, and information to religious communities, under-served victims, and impacted communities. NYDIS provides services through three principal program areas:
• DISASTER ADVOCACY on behalf of disaster victims (particularly vulnerable and under-served individuals) and impacted communities.
• DISASTER PLANNING & TRAINING includes mitigation education and preparedness training for faith-based communities, including houses of worship, religious leaders and their neighborhoods, and partner agencies.
• RESPONSE & LONG-TERM RECOVERY through direct victim services, training and support of case workers, religious leaders, and caregivers.

New York City Office of the Chief Medical Examiner (OCME)
http://www.ci.nyc.ny.us/html/ocme/html/dirmedex.html
The Office of Chief Medical Examiner investigates cases of persons who die within New York City from criminal violence; by casualty or by suicide; suddenly, when in apparent good health; when unattended by a physician; in a correctional facility; or in any suspicious or unusual manner.

New York City Office of Emergency Management (OEM)
http://www.nyc.gov/html/oem/html/home/home.shtml
Please refer to Section F in the Reference Section for a fuller description of OEM and its programs.

New York City Police Department (NYPD)
http://www.nyc.gov/html/nypd/
The Mission of the New York City Police Department is to enhance the quality of life in our City by working in partnership with the community and in accordance with constitutional rights to enforce the laws, preserve the peace, reduce fear, and provide for a safe environment. Their presence at a disaster is to secure the site, investigate the cause, and keep the other responders safe.

New York City Department of Sanitation (DSNY)
http://nyc.gov/html/dsny/html/home/home.shtml
DSNY provides essential services at disaster sites that are not always fully understood or recognized. They are generally the ones who clean up afterward, keep the area around the site clean and are the ones who ensure that oil spills, aftermath of traffic accidents, etc., are cleaned up and that others can travel safely on our roads.

New York City Voluntary Organizations Active in Disaster (NYCVOAD)
http://www.nvoad.org/member.php?memberid=108
NYCVOAD is a chapter of a national organization with state and local affiliates. NYCVOAD provides effective responses and less duplication in service through coordination and planning before disasters occur. NYCVOAD engages members in various planning committees. The national website is www.nvoad.org and has excellent resources. For more information about NYCVOAD, contact NYDIS at 212.669.6100.

Occupational Safety and Health Agency (OSHA)
http://www.osha.gov/
OSHA's mission is to assure the safety and health of America's workers by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual improvement in workplace safety and health. OSHA are the ones who will be making certain that first responders – and chaplains – are using proper protective equipment in hazardous situations.

Port Authority Police Department (PAPD)
http://www.panynj.gov/AboutthePortAuthority/PortAuthorityPolice/
The PAPD patrols and polices the Holland and Lincoln tunnels, Newark, JFK and LaGuardia airports, the PATH trains, the Port Authority Bus Terminal, and the World Trade Center. If there is a disaster at any of these sites, PAPD will be there.

Regional EMS Council (REMSCO)
www.remsco.org   See EMS above.

US Department of Substance Abuse and Mental Health Services Agency (SAMHSA)
www.samhsa.gov
See Ali Geith's Chapter on Mental Health.

The Salvation Army in Greater New York
http://www.salvationarmyusa.org
(Chapter 14)

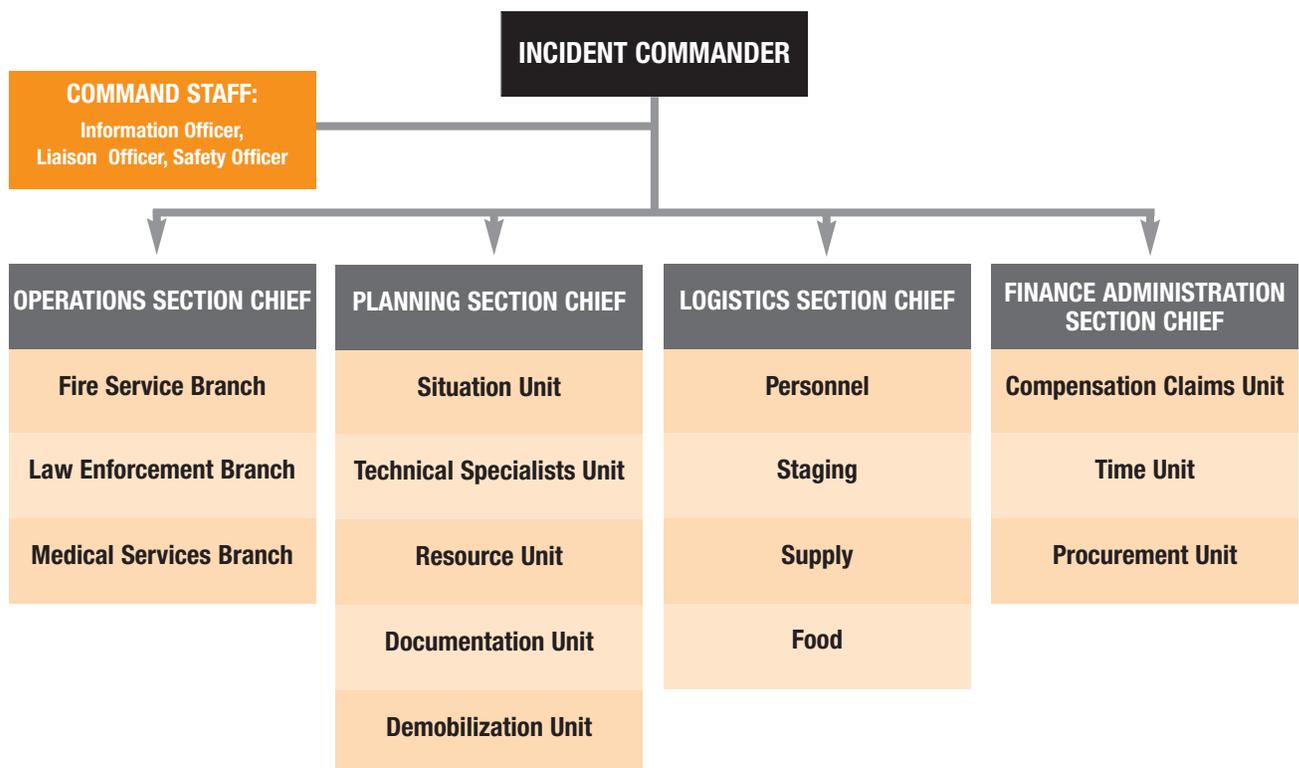# Incident Command System (ICS)

BY JACK HERRMANN

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Editor's Note: This Chapter is the continuation of an adaptation of a state plan for disaster preparation and response. In total, the original chapter comprises Chapters, 1, 14, 16-18.

Incident Command System

Editor's Note: The Incident Command System (ICS) is the organizing model for disaster response. We have included it here in the Reference Section of this manual so that religious leaders understand both that there is a coordinated response plan for their community, as well as how things work during a disaster. Technically, this information would come as part of the mitigation and preparation phase.

The Incident Command System (ICS)[1] is a formalized management structure that lends consistency, fosters efficiency, and provides direction during a disaster or emergency response. ICS is used by all levels of government—federal, state, local, and tribal nations—and by many private sector and nongovernmental organizations. The Incident Command System defines the structure of the incident response as well as the coordination of the responding agencies. The ICS is built around a number of critical components with someone identified as the lead for each component. The illustration that follows provides an overview of the structure.

INCIDENT COMMANDER			
COMMAND STAFF: Information Officer, Liaison Officer, Safety Officer			
OPERATIONS SECTION CHIEF	**PLANNING SECTION CHIEF**	**LOGISTICS SECTION CHIEF**	**FINANCE ADMINISTRATION SECTION CHIEF**
Fire Service Branch	Situation Unit	Personnel	Compensation Claims Unit
Law Enforcement Branch	Technical Specialists Unit	Staging	Time Unit
Medical Services Branch	Resource Unit	Supply	Procurement Unit
	Documentation Unit	Food	
	Demobilization Unit		

ICS Command System

ICS Component	Responsibilities
Incident Commander	• Set objectives and priorities. • Assume overall responsibility at the incident or event.

Operations Section	• Implement the Incident Action Plan (IAP).
	• Manage tactical operations at the incident site with the objectives of:
	  1.Reducing the immediate hazard.
	  2.Saving lives and property.
	  3.Establishing situation control.
	  4.Restoring normal conditions.

Planning Section	• Collect and evaluate information. • Develop Incident Action Plans. • Maintain resource status.
Logistics Section	• Provide support to meet incident needs. • Provide resources and all other services needed to support the incident.
Finance/Administration Section	• Monitor costs related to incident. • Provide accounting Procurement Time recording cost analyses.

Incident Commander

The Incident Commander is the individual in charge of the overall response to the disaster scene. Typically, this responsibility is assumed by the local Fire Chief, though in some jurisdictions the local police chief may be placed in the role of Incident Commander. The Incident Commander ensures that human and material resources are provided to adequately support the needs of the response. Within the Hospital Incident Command System, there is also an identified Incident Commander. This person, typically the Hospital CEO, Senior Administrator, or their designee, will coordinate the health care systems response to the disaster and ensure the needs of disaster victims and others are met, as well as coordinate the provision of the hospital's human and material resources.

County Emergency Manager

At the same time the community's Incident Commander is assessing the response needs at the disaster scene, he or she is determining whether or not the situation justifies alerting the County Emergency Manager. The County Emergency Manager is a local governmental representative responsible for overseeing any disaster response where the assets of the county will be required. During non-disaster times, the County Emergency Manager is responsible for the overall coordination of the county's disaster planning and preparedness activities. During times of local emergencies or disasters, the County Emergency Manager usually reports to a County Manager or County Executive and will work in concert with him or her to identify the need to open the County's Emergency Operation Center, commonly referred to as the County EOC.

Usually, the County Emergency Manager oversees the development and implementation of the County's Disaster Plan. A county's disaster plan should clearly articulate how county resources will be managed and delivered during times of disaster and how other county public and private agencies with disaster relief missions will provide supplemental support. While there may be multiple agencies responding to the needs of those affected by disaster, it is the county's responsibility to coordinate disaster relief efforts and ensure and protect the community's well-being.

County Emergency Operation Center (EOC)

The County EOC represents the physical location where the coordination of information and resources to support incident management activities takes place. The County EOC is organized by major functional departments or agencies (fire, law enforcement, medical services, public

health, mental health, etc.) or by jurisdiction (city, county, region, etc.), or a combination thereof. The County EOC can also be staffed with representatives from other agencies and organizations such as the American Red Cross, the Salvation Army, the Department of Aging, Agriculture, Transportation, etc. The County EOC is usually directed by the County Emergency Manager in conjunction with the County Manager or County Executive.

Hospital Emergency Operation Center

The hospital's EOC represents the physical location where the hospital's coordination of information and resources to support incident management activities takes place. As seen in the HICS flow chart, the hospital EOC is organized by major functional areas (Operations, Logistics, Planning, Finance, etc.). Hospital administrators and other personnel serving in these roles ensure that adequate material and human resources are available to meet the needs of the disaster. Communication with the County's EOC and more specifically, the County's Director of Public Health is critical in coordinating the disaster response efforts of the local health care system.

County Department of Mental Health

The County Department of Mental Health and its director is responsible for developing and implementing the county's mental health disaster plan. The Department has a responsibility to address and respond to the mental health needs of a community during times of disaster. Often the Director, or his designee, is located at the County EOC to provide consultation to the County Emergency Manager around mental health issues. The Director coordinates the mental health response through the collaboration of private and public community-based mental health agencies and resources within the county.

County Department of Public Health

Disasters place tremendous strain on the public health systems of a community. The County Department of Public Health and its director are responsible for developing and implementing the county's public health disaster plan. The Department has a responsibility to address and respond to the public health needs of a community during times of disaster. Often the Director, or his designee, is located at the County EOC to provide consultation to the County Emergency Manager and the community's health care systems around public health issues. The Director coordinates the public health response through the collaboration of private and public community-based public health agencies and resources within the county.

The Local Hospital Response

Local hospitals are part of a community's public health system and play an integral role in responding to disasters especially those resulting in mass casualties or public health consequences. All health care facilities are required to develop and maintain a written emergency management plan describing the process of disaster readiness and emergency management, and know how to implement that plan when appropriate. These plans must also include provisions for responding to the acute health care needs of a community in the event the disaster directly affects the hospital itself. The importance of hospital disaster planning received significant visibility following the devastating impact hurricane Katrina had on the health care facilities in Louisiana and its neighboring surrounding states. Because of the critical role hospitals and other acute care facilities play in responding to a community disaster, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)[2] has set in place a more focused process to review hospital disaster plans during scheduled site visits. This additional performance measure makes health care facilities more accountable and ensures that hospitals will be able to not only be able to provide the human and material resources necessary during times of disaster, but sustain that effort as well.

The Hospital Incident Command System (HEICS)

Editor's Note: While this information and system is written for hospitals, the same organizing principles can be applied toward houses of worship. Please also refer to Chapter 4 (Radical Hospitality) for specific plans and mitigation for houses of worship.

In an effort to respond in a timely and efficient manner to acute health care needs of disaster victims, many hospitals have adopted a command structure for disaster response, similar to the community's Incident Command System. This specific health care response structure is known as the Hospital Emergency Incident Command System (HEICS)3, though it is also referred to as HICS-Hospital Incident Command System. HEICS is an emergency management system that describes a logical management

structure, defined responsibilities and reporting channels for hospital disaster managers and responders, and common terminology to help unify hospitals with other emergency responders. The illustration that follows provides an overview of the HICS structure.

Mental health and spiritual care workers play an integral role in providing supportive care to disaster victims and hospital personnel within the hospital's incident command system. Hospital social workers, psychiatric nurses, clergy and other mental health and spiritual care staff may be deployed to emergency departments, family reception centers, ambulatory care facilities, or other acute health care delivery sites to address the mental health needs of victims of disaster and hospital personnel. The roles of these workers and other mental health and spiritual care activities are more fully described earlier in this manual.

When disaster strikes, and depending upon the size and magnitude of the disaster, hospitals will respond by engaging their disaster plans. Human and material resources are deployed to meet the needs of the disaster along with a process to continually assess and evaluate these needs. In the event the hospital's material or human resources face the risk of being depleted or severely compromised, early communication with the County EOC, the County Public Health Director, and other area health care resources must occur to avoid the disruption of critical health care services.

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[1] For more information on the Incident Command System, refer to the National Incident Management System document at **www.fema.gov/pdf/nims/nims_doc_full.pdf**.

[2] More information on the JCAHO's disaster planning and response guidelines can be found on their website at **www.jcaho.org/about+us/public+policy+initiatives/emergency.htm**.

[3] Refer to the Hospital Emergency Incident Command website at www.heics.com or to the Greater New York Hospital Association website at **www.gnyha.org/eprc/general/ics/2003_NSLIJ_HEICS_Module1.pdf**.

New York State Response to Disaster

BY JACK HERRMANN

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Editor's Note: This Chapter is the continuation of an adaptation of a state plan for disaster preparation and response. In total, the original chapter comprises Chapters, 1, 14, 16-18.

The Regional and State Response

In some situations, a community or health care facility may not be able to fully initiate or sustain its disaster response due to the scope and magnitude of a disaster and the resources required to bring the incident under control. In those circumstances, communities and their health care facilities may need additional assistance and the incident response is raised to the next level.

When the incident requires resources that exceed what the community can expend, the Incident Commander or County Emergency Manager will look to the resources of neighboring communities or the state for assistance.

When resources from the state are requested, the *State Emergency Management Office* (SEMO) will activate the *State Emergency Operation Center*. Typically, the County EOC has been in close communication with its regional SEMO representative and this individual is a conduit between the County EOC and the *State EOC*. The regional SEMO representative provides the state with the necessary information to determine when and if State resources will be needed.

When the mental health or public health resources of a community or health care system are limited or the disaster exceeds that which can be adequately provided, the County Departments of Mental Health and Public Health may also need to raise their response to the next level.

State Office of Mental Health and Department of Health

During large-scale disasters, the County Mental Health and Public Health Directors continually evaluate and monitor the mental and public health of the community and advise County officials when additional mental health and public health resources are needed. When a health care facility determines that its mental health or public health resources have been depleted, additional resources may be requested from the County Mental Health or Public Health Directors. Should such county mental health or public health resources become depleted or unsustainable, the County Mental Health or Public Health Directors work in collaboration with their respective *Regional Field Offices* and *State Offices* to evaluate and request additional resources.

State Emergency Management Office (SEMO)
http://www.semo.state.ny.us/
The mission of the New York State Emergency Management Office (SEMO) is to protect the lives and property of the citizens of New York State from threats posed by natural or man-made events. To fulfill this mission, SEMO coordinates emergency management services with other federal and State agencies to support county and local governments. SEMO routinely assists local government, volunteer organizations, and private industry through a variety of emergency management programs. These programs involve hazard identification, loss prevention, planning, training, operational response to emergencies, technical support, and disaster recovery assistance.

The Federal Response to Disaster

BY JACK HERRMANN

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The Federal Response

There are some disasters that are so large they warrant a massive rescue and recovery response, which under most circumstances would exceed any given community's or state's resources. Under those situations, the disaster response must be raised to a national level and the state may request assistance from the Federal government. This assistance and the process by which it is provided is described below.

The National Incident Management System (NIMS)

The National Incident Management System (NIMS)[1] provides a consistent nationwide template to enable federal, state, local, and tribal governments and private sector and nongovernmental organizations to work together effectively and efficiently to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity, including acts of catastrophic terrorism.

The NIMS represents a core set of doctrine, concepts, principles, terminology, and organizational processes that enable effective and collaborative incident management at all levels. It is not an operational incident management or resource allocation plan. By September 30, 2006, federal, state, local, tribal, private sector and non-governmental first responders and disaster workers (including Emergency Medical Service personnel, firefighters, hospital staff, law enforcement personnel, public health personnel, public works/utility personnel, skilled support personnel, and other emergency management response, support, volunteer personnel) will be required to complete a series of courses offered by the Federal Emergency Management Agency (FEMA). These courses will describe in more detail the NIMS, the Incident Command System, and the National

Response Plan as they relate to disaster response.

The National Response Plan

The National Response Plan (NRP)[2] provides a framework for incident management at all jurisdictional levels. It establishes protocols and forms the basis for how the federal government coordinates with state, local, and tribal governments and the private sector during disasters.

The Federal Emergency Management Agency (FEMA)

The Federal Emergency Management Agency (FEMA)[3], a federal agency since 1979, became part of the new Department of Homeland Security (DHS) on March 1, 2003. FEMA's mission within the DHS is to lead the effort to prepare the nation for all potential disasters and to manage the federal response and recovery efforts following any national incident — whether natural or human-caused.

The Robert T. Stafford Act

In 1974, the ***Robert T. Stafford Disaster Relief and Emergency Assistance Act***[4] was enacted to support state and local governments and their citizens when disasters overwhelm them. This law:

• Establishes a process for requesting and obtaining a Presidential Disaster Declaration.
• Defines the type and scope of assistance available from the federal government.
• Sets the conditions for obtaining that assistance.

FEMA is tasked with coordinating the national response to disaster under both the NIMS and the Stafford Act.

Presidential Declaration

In order for federal assets to be released to a disaster affected state, a Presidential Declaration must be requested and approved. The Robert T. Stafford Act establishes a process by which States can request federal assistance. The Stafford Act requires that all requests for a Presidential declaration be made by the governor of the affected state. Based on the Governor's request, and the supporting documentation regarding the extent of the damage, the President may declare that a major disaster or emergency exists, and activate an array of federal programs to assist in the response and recovery effort.

Federal Assistance

Not all federal programs are activated for every disaster. The determination of which programs are activated is based on the needs found during the Preliminary Damage Assessment and any subsequent information that may be discovered.

The federal assistance coordinated by FEMA, falls into three general categories.

- **Individual Assistance** provides aid to individuals, families, and business owners.
- **Public Assistance** provides aid to public (and certain private non-profit) entities for certain emergency services and the repair or replacement of disaster-damaged public facilities.
- **Hazard Mitigation Assistance** provides funding for measures designed to reduce future losses to public and private property.

Emergency Medical Services

The **National Disaster Medical System** (NDMS)[5] is a section within the U.S. Department of Homeland Security, Federal Emergency Management Agency, Response Division, Operations Branch, and is responsible for supporting federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters.

There are three (3) primary components of the NDMS:

- Medical response to a disaster area in the form of teams, supplies, and equipment.
- Patient transport from a disaster site to unaffected areas of the nation.
- Definitive medical care at participating hospitals in unaffected areas.

In the event of a large scale disaster, teams of health care professionals may be deployed by the federal government to supplement the personnel of the local community and health care system. These teams, known as the **Disaster Medical Assistance Teams** (DMAT)[6] also include mental health professionals trained to respond during large, catastrophic events.

The **Metropolitan Medical Response System** (MMRS)[7] was established to develop or enhance existing locally based emergency preparedness systems. This system coordinates public health, medical and mental health, local law enforcement, emergency management and first-responder personnel to more effectively respond in the first 48-72 hours of a public health crisis and until federal assets arrive.

Mental Health Counseling Services

Under federally declared disasters, immediate and short-term mental health financial assistance to states may also be available from the federal government. Only the state (as a governmental unit) has the authority to apply for such federal assistance. This assistance is known as the Crisis Counseling Assistance and Training Program (CCP).

FEMA/Center for Mental Health Services Crisis Counseling Assistance and Training Program

The **Crisis Counseling Assistance and Training Program**[8], authorized by the Stafford Act and administrated by FEMA and the Substance Abuse and Mental Health Services Administration's (SAMHSA)Center for Mental Health Services (CMHS), is designed to provide supplemental funding to states for short-term crisis counseling services to people affected in a Presidentially declared disaster.

Two separate portions of the CCP can be funded: Immediate Services and Regular Services. A state may request either or both types of funding.

- The **Immediate Services Program** is intended to enable the state or local agency to respond to the immediate mental health needs of disaster survivors with screening, diagnostic, and counseling techniques, as well as outreach services such as public information and community networking.
- The **Regular Services Program** is designed to provide up to nine months of crisis counseling, community outreach, and consultation and educational services to people affected by a *presidentially* declared disaster. Funding for this program is separate from the immediate services grant.

To be eligible for crisis counseling services funded by the CCP, the disaster survivor must be a resident of the designated area or must have been located in the area at the time the disaster occurred. The survivor also must be experiencing psychological distress that was caused or aggravated by the disaster or its aftermath.

During times of disaster, the process by which a Presidential Declaration is approved can take days, weeks, or even months. As you can see, a wide range of services that might be significantly helpful to individuals relies on a Presidential Declaration. The period between when a disaster declaration is requested and when it is approved can be an extremely stressful time for both disaster relief workers and disaster survivors. Further, rejection of a Presidential Declaration or limiting the services offered by the Presidential Declaration can pose significant challenges for mental health professionals who are caring for disaster survivors.

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[1] For more information about NIMS, refer to the Web site **www.fema.gov/nims/** and click on the Frequently Asked Questions link.

[2] For more information about the NRP, refer to the Web site **www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml**.

[3] For more information about FEMA, refer to the Web site **www.fema.gov/**.

[4] For more information about the Stafford Act and disaster declaration, you may refer to the Web site **www.fema.gov/library/stafact.shtm**.

[5] For more information about the National Disaster Medical System, refer to the Web site **http://www.oep-ndms.dhhs.gov/**.

[6] For more information about the Disaster Medical Assistance Team, refer to the Web site **www.oep-ndms.dhhs.gov/dmat.html**.

[7] For more information about the Metropolitan Medical Response System, refer to the Web site **www.mmrs.fema.gov/default.aspx**.

[8] For more information about the Crisis Counseling Assistance and Training Program, refer to the Web site **www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/progguide.asp**.

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