

# STRESS MANAGEMENT FOR DISASTER VICTIMS

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## Abstract

Disaster such as wars, earthquakes, fire, flood can cause severe impact on human beings. Literature on traumatic events provides strong evidence that these events affect adversely the well being of victimized populations. Disaster have a significant number of affected persons require mental health services; develop posttraumatic stress disorder symptoms and psychopathology. Thus, there is a significant need to prepare the victims with stress management programs to prepare victims with a sense of control and a better future in life after tragedy. The purpose of this paper is to explore the various stress management programs that can adversely meet the well being of the disaster victims. It comprises a list of stress management programs, which can be used to reduce psychological and traumatic stress.

## INTRODUCTION

Disaster sources of disaster or trauma are increasingly being identified and understanding disaster encompass how they impact on organization, social system, culture and individual well as the time frames over which impact occurs, be they acute or extended (Raphael, 1991). The pursuit of this goal requires the realistic appraisal of the essential social, cultural, individual and institutional aspects of disaster response. The destruction and loss of life generated by disasters is widely acknowledged, as is the widespread psychological, social, community and economic problems they leave in their wake. In the past, disaster withstanding, the helping philosophies and interventions implemented to manage disaster have tended to be technological and/or economic in nature, with the underlying assumption being that social and psychological impacts will be managed in the process. Recently, increased academic and professional interest in understanding disaster and disaster impact is rectifying this imbalance and is supporting pressures for inter- and multi-disciplinary and integrated approaches to definitions and interventions. However, there is still some way to go before the objective of creating a truly integrated system is realized. Realizing the goal of an integrated disaster response capability will require the coordination of the activities of diverse agencies and professions many of whom have no contact in disaster contexts, let alone under the circumstances in which disaster relief activities are undertaken.

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Dalgleish et al., (2000) states that individuals exposed to traumatic events often experience extreme psychological stress. It was first discussed in the literature immediately following the First World War. Since these early writings, trauma-related psychological problems have been reported in war veterans (Schlangger et al, 1992), rape victims (Foa and Riggs, 1993), survivors of natural disasters (McFarlane, 1988). Ursano (2000) states that the study of emotional reactions to disaster began with observations of the oldest human-made disaster war. He further stated that in world Wars I and II, terms such as "shell shock," "battle fatigue," and "war-neurosis" was more common descriptors of the emotional responses to trauma.

The most frequent psychological problems following trauma include feelings of anxiety, guilt and depression, and the constellation of problems that constitute the diagnostic category of post-traumatic stress disorders (PTSD). In line with that, Sapora et al., (2000) relates the feeling of depression and anger of a fire victim for having revived memories of prior trauma. The victim also suffered feelings of denial, anger, and irritability and began to withdraw socially.

Mohammad Haji-Yusuf, Adi Fahrudin, Beddu Salam Baco, and Mohd Dahlan Hj A.Malek (2000) state that some of the victims develop psychiatric illnesses post-disaster. Such illnesses include those that are secondary to physical injury and sickness as well as specific trauma-related psychiatric disorders such as acute stress disorder. Posttraumatic stress disorder however is not the only psychiatric disorder associated with disaster. Major depression, substance abuse, generalized anxiety disorder and adjustment disorder has also been diagnosed in individual exposed to a disaster. Posttraumatic stress often has deleterious effects not only in a person's social and personal life, but also in his or her vocational life as well. The most deficit associate with Posttraumatic Stress Disorder (PTSD) is that of coping with stressors, especially those which have some similarity to the initial traumatic evenly.

Mohammad Haji-Yusuf et al., (2000) also state that the effect of chronic stress include physiological changes as well as such mental health problems as fear, demoralization, increased symptom reporting anxiety, and depression. While the direct victims of a disaster suffer many consequences, they are not the only ones who are wounded. Friends, relatives and other members of the community also experience survivor guilt, anxiety, fatigue and other symptoms of posttraumatic and chronic stress. Thus, there is a significant need to prepare victims and friends, relatives and other members of the community with stress management programs for a significant number of them require mental health services and develop posttraumatic stress disorder symptoms or psychopathology. Using a variety of strategies such as offerings to direct victims and others, developing follow-up programs, organizing support group activities and providing consultations and education is essential in disaster intervention. The purpose of this paper is to investigate the various stress management programs that can adversely meet the well being of the disaster victims. It comprises a series of stress management programs, which can be used to reduce psychological and emotional stress of the disaster victims.

## SIGNAL OF PSYCHOLOGICAL TRAUMATIC STRESS

Weaver (1999) states that it is very common for people to experience emotional or physical reactions when they have passed through a disaster event. The stress reactions may appear immediately after the traumatic event or a few hours or a few days later. As in the case of victims of a landslide in Kampong Lok Banau, Sabah, Malaysia, the emotional experience appear immediately after the traumatic event. Borneo Post (2001) states that the relatives of the landslide victims could not control their emotion and cried hysterically. As a result, villagers and fire and rescue services personnel had a hard time consoling the two grieving relatives. The relatives of victims of the massive earthquake that struck Ahmedabad, India also experienced the immediate emotional experience. The massive earthquake that struck Ahmedahab has caused distraught parents to remain at the site throughout the night (Borneo Post, 2001). Rescue workers were struggling to reach thousands of people, including 30 school children trapped by a massive earthquake that claimed more than 7,000 lives. The *massive social class* among Dayak tribal and Madura immigrant ethnic in Sampit, Central Kalimantan, Indonesia also has caused traumatic stress and for the long time, the victim and silence victim also will be getting the PTSD (Time, 12 Mac 2001).

A similar argument can be applied to traumatic incidents occurring within professional and workplace contexts. Research in this area has highlighted the need to consider traumatic outcomes in terms of the interaction between the individual and the complex social systems they inhabit, with growing interest in exploring the preventative and/or support capabilities afforded by the characteristics and operating procedures inherent within the social system. For example, professionals working in disaster and traumatic contexts may experience disasters and traumatic events in a more positive light than was previously considered (Moran and Colless, 1995). By more actively researching the factors underpinning positive resolution and adaptation, valuable insights into the nature of the personal, event and environmental precursors of adaptation can be described. Once identified, they can serve as a basis for the screening, preparation and support of those likely to experience exposure to disaster or traumatic events repeatedly. This work is indicative of a trend towards exploring the salutogenic characteristics of the environments within which disaster or traumatic exposure occurs (Paton and Bishop, 1996; Paton and Stephens, 1996).

Moreover, research undertaken on the basis of this philosophy will furnish information that can be used to facilitate more effective use of support interventions for those groups and individuals who do experience problems. The critical issue that arises here involves defining what individual, social, organizational and community factors constrain or hinder the use of recovery resources such as social support, debriefing, coping and treatment (Raphael, 1996). For example, organizational and cultural constraints may be operating through perceptions, expectations and unwritten rules about performance and the discussion of emotions and feelings. Once these factors have been delineated, and the mechanisms by which they exert their influence defined, steps can be taken to develop more effective recovery management processes (Paton and Stephens, 1996). By adopting

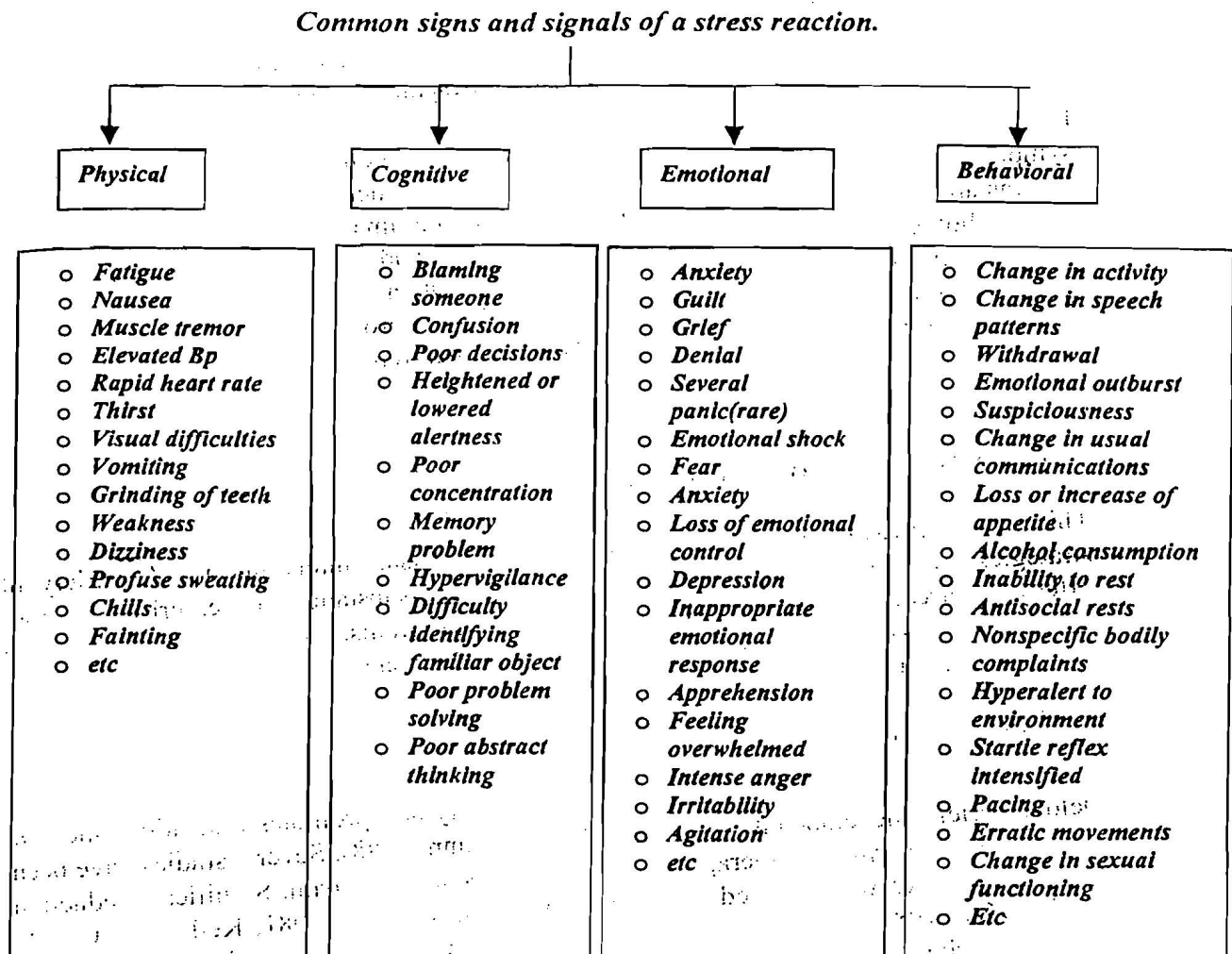
such a framework, the important role of potential helpers, counselors and therapists, as well as partners, family members, colleagues and friends is also indicated.

This is not to say that we should neglect the fact that some of those affected may require specialist referral. There is an urgent need to extend current treatments, both psychological and pharmacological, to encompass recovery and rehabilitation, as well as prevention, and to acknowledge that psychiatric assessment or medication may be necessary in this process, taking into account all the physical, psychological and social needs of survivors (Raphael, 1996). Expanding horizons to explore the interaction between events and individuals, with greater emphasis on environmental precursors and mediators, may open up new avenues for understanding disaster and trauma impact.

Moreover this work shows considerable promise from the point of view of developing interventions that can prevent or minimize pathology and promote adaptation and growth. Such work also opens up new opportunities for collaborative, multi-disciplinary work. The issues debated about traumatic amnesia and recovered memories and the efficacy of critical incident stress debriefing. Such controversies, and the debate they stimulate, are important devices for promoting the growth and development of professional communities, affording new opportunities for research collaboration and for the development and evaluation of interventions. Encouraging such debate and welcoming opportunities to explore new areas, ask new questions, and reappraise existing ideas and interventions is important from the point of view of avoiding complacency and "becoming trapped in prevailing paradigms without being able to see their shortcomings" (van der Kolk, et al. 1996; p xviii).

Nor should we forget the legal and ethical implications of the issues that underpin the airing of these concerns and controversies. The work of disaster and trauma professionals of increasing interest to policy makers and to members of the legal community, as well as to members of academic and professional bodies. Encouraging debate within the professional community, and providing a resource that can contribute to public awareness and understanding, is a goal of this journal. At a practical level, there are organizational and administrative issues that must be addressed; consultation, communication and liaison processes; and how policies, plans, education and information need to be organized in a manner appropriate for responding to significant incidents (Raphael, 1996). It is hoped that the likelihood of these goals being achieved will be enhanced by the availability of a medium for both their debate and discussion and their dissemination to those charged with the responsibility for formulating policy and responding to disasters and traumatic events.

Anyway, it is also very common, in some cases; stress reactions may appear weeks or months after the incident. Sapora et al., (2000) relates how a fire victim began to experience feelings of denial, anger a few months after the tragedy. With the understanding and the support of loved ones, stress reactions usually pass more quickly. Occasionally, the traumatic event is so painful that professional help may be necessary. Below are some very common signs and signals of a stress reaction after a disaster.



**Figure 1:** Adapted from Los Angeles Department of Mental Health (1999). Critical Incident Stress Information Sheet., <http://www.trauma-pages.com/cisinfo.htm>

Individuals who have experienced traumatic events often suffer psychological and emotional stress related to the event. In most cases, these are normal to abnormal reactions. Individuals should consider seeking professional help if they are unable to regain control of their lives. Some warning signs of trauma-related stress are given below (American Psychiatric Association, 1987).

- Recurring thoughts or nightmares about the event.
- Having trouble sleeping or changes in appetite
- Experiencing anxiety and fear, especially exposed to events or situations reminiscent of the trauma
- Being on edge, being easily startled or becoming overly alert
- Feeling depressed, sad and having low energy.

- Experiencing memory problems including difficulty in remembering aspects of the trauma
- Feeling "scattered" and unable to focus on work or daily activities.
- Feeling irritable, easily agitated, or angry and resentful
- Feeling emotionally "numb" withdrawn, disconnected or different from others.
- Spontaneously crying, feeling a sense of despair and hopelessness.

Figley (1985) states that disaster victims who have acquired PTSD have a variety of symptoms. One of the main features is the re-experiencing of trauma in the forms of dreams and uncontrollable and emotionally distressing images. This eventually will lead to psychological numbing, and lost of interest and involvement in interpersonal relationships and increased absenteeism in work. Other symptoms include memory and concentration problems, hyper alertness, depressive syndromes, survivor guilt, and loss of ability for intimacy and avoidance of activities, which remind the person of the traumatic event.

## STRESS MANAGEMENT FOR THE VICTIMS

This article presents various strategies used in disaster intervention. A variety of strategies such as therapeutic touch, telling stories, substance abuse, crises support, offering outreach service, developing follow-up programs, organizing support group activities are essential in preparing the victims with a sense of control as to meet their well-being and face the reality of the tragedy.

### Therapeutic touch

Therapeutic touch has been used to decreased anxiety and promotes relaxation, since Dr Delores Krieger developed it, in the early 1970s (Quinn, 1988). Several studies have been conducted to determine if therapeutic touch reduces stress or pain. Significant reduction in these variables was reported in at least four studies (Heidt, 1981, Keller and Ozdek, 1986, Quinn, 1982, 1984 in Quinn,). Olson (1994) states that therapeutic touch may be a unique contribution to stress reduction techniques for practitioners because it is one of the few non-chemical interventions that require no cognitive effort on the part of the client. It can be used with persons before they are ready for guided imagery or progressive muscle relaxation. And when the client is ready, it can be combined with those interventions, and may increase the relaxation effects of both methods. Therapeutic touch is easily taught to health care professionals and has no known side effects.

### Stories, rituals, philosophical

Many survivors have used stories, rituals, philosophical reflections and theological contemplation's to find meaning in the trauma and long-term consequences of a natural disaster. Echterling (1989) states that telling a story is one way of restoring the victim's own emotional equilibrium. Telling and sharing one's story is more than merely recounting the events of one's personal encounter with disaster. It offers the victim an opportunity to face, accept, and acknowledge powerful situations. Hearing the victim's

Story is a process that helps the victims in beginning to reorganize the enormity of what has happened and its consequences. The telling and sharing of a story about a disaster is being used as one of the various coping skills used in meeting the well being of the victim. It also relates the personal growth of the victim due to the incident.

### **Crisis support**

A growing body of research has examined that social support following stressful events is associated with decreased vulnerability to the development of subsequent psychological problems. Social or crisis support has been found to be adaptive following rape (e.g. Burgess and Holmstrom, 1974), disaster (e.g. Cook and Bickman, 1990). The consensus (e.g. Raphael, 1986) is that the support environment offers survivor's the opportunity to talk about their experiences, and there is growing evidence that the opportunity to natively talking this way is the important factor in the promotion of recovery.

Indeed, a number of studies (e.g. McFarlane, 1988) have found that avoiding discussing the traumatic event with members of the support environment is associated with increased PTSD symptomatology. Rachman (1980) state that such emotional processing seems to serve two purposes. The first is the link between trauma memories and feelings of extreme fear and anxiety weakened through repetition. The second purpose is that the individual is provided with an opportunity to integrate the traumatic representations into his or her conceptions of the self and the world. Griffiths and Watts (1992) found that emergency workers who had been debriefed following bus crashes had significantly higher symptom scores one year later, than those who were not debriefed.

These findings, in combination with findings of psychological sequel in emergency service personnel, six months following debriefing (Sloan et al., 1994), suggest that debriefing alone, is not effective in preventing adverse outcomes. Thompson and Solomon (1991), who found that a body recovery team had lower symptom scores compared to other similar teams suggest other aspects of prevention. They attributed this to careful selection, training, and ongoing managerial support as well as critical incident debriefing sessions, which were managed as part of the group routine. Such findings support recent suggestions (e.g. Raphael, Meldrum and McFarlane, 1995) that, whatever the contribution of psychological debriefing to the reduction of posttraumatic stress symptoms, there are other variables in the environment which also contribute to recovery and must be considered by responsible organizations and health professionals.

In accordance with these suggestions, Harvey (1996) has proposed a multidimensional definition of trauma recovery. She suggests that the efficacy of an intervention depends upon its fit with the recovery environment and accordingly, provides an ecological model of trauma recovery that includes person, event and environmental factors taking into account whether the officers have ever attended a debriefing or not. The personal characteristics suggested by previous research (Smith and Ward, 1986) to have impact on behavior in stressful situations in police officers are gender, length of service, membership of a branch of the service, and educational qualifications. The event characteristics are the number of traumatic events experienced (Vrana and Lauterbach,

1995). The environment characteristics is, the ease of talking about trauma at work, attitudes to expressing emotion in the work place, social support from peers and from supervisors. These have been proposed in a related report (Stephens and Long, 1996) to be important recovery environment characteristics in an organizational context.

### **Emotional expression**

A number of theoretical models concerned with the processing of emotional events that the failure to confide and disclose the details of the event are associated with increased health and psychological problems. For example, Rachman (1980) in his discussion of emotional processing, suggest that the need to suppress strong emotion may impede the processing or resolution of emotionally upsetting experiences.

### **Cognitive tasks**

Cognitive theories of posttraumatic stress suggest that increased posttraumatic stress symptomatology is also associated with biases in the processing of trauma-related information of which the individual is unaware. There is a consensus among cognitive theorist of PTSD such as Janoff-Bulman (1992) that PTSD reflects the fact that the models of the world and the self the individual carried into the trauma have been severely compromised by what happened during the event, and that the individual is going through a process of reconciling what happened with these preexisting views of the world and the self.

### **Group discussion**

Sapora et al., (2000) used group discussion to help victims cope with a fire tragedy. In the group discussion, members were able to share their feelings and ideas about the fire tragedy. In the group discussions, it was found that members were willing to reveal their feelings of the fire tragedy and how the victims were able to regain their sense of control. Here, members were free to reveal their past, present and future feelings concerning the tragedy.

### **Progressive Relaxation**

It is a technique used to induce nerve-muscle relaxation. This technique has proven effective in helping people relax and does not require any special requirement. In addition, progressive relaxation has been shown to have both physiological and psychological benefits. Cox et al., (1975) have found progressive relaxation effective in treating tension headaches and migraine headaches. Progressive relaxation has been demonstrated to have wide-ranging effects upon psychological well-being as well as upon behavioral change. Further, both depression and anxiety were lessened in people trained in progressive relaxation. Even insomniacs were helped to sleep by using relaxation technique.

### Meditation

Greenberg (1983) states that meditation is simply a mental exercise that affects body processes. Meditation has certain physical benefits and the purpose of it is to gain control over the individual's attention so that he/she can choose what to focus upon rather than being subject to the unpredictable ebb and flow of environmental circumstances.

### Substance abuse

A number of survivors of disasters have been found to use coping strategies that involve the use of prescribed and non-prescribed drugs. Non-prescribed substances include alcohol and tobacco, and prescribed substances include psychotropic drugs such as antidepressants, tranquilizers, and sleeping tablets. Dalglish et al., (2000) suggested that there was an increase in substance use for a majority of survivors in his sample in the immediate aftermath of the disaster. Although levels of substance use appeared to decrease over the next 18 months, the use of cigarettes and most especially alcohol maintained their increased levels relative to other substances. For example, 73% reported increased alcohol consumption in the 6 months immediately subsequent to the disaster and 58% increase.

## CRITICAL INCIDENT STRESS DEFUSING AND DEBRIEFING

It may be the most widely used formal used formal group pastrami intervention in the world for the mitigation of posttraumatic stress in high-risk occupational groups (Everly, 1993). Everly and George (1995) states that CISD has direct applicability for mental health counselors working with victims of disaster and trauma (i.e. victims of floods, hurricanes, riots, wars and other natural or manmade disaster).

CISD is a means of mitigating posttraumatic stress in high-risk occupational groups. Originally it was used almost exclusively by emergency services such as law enforcement, fire and emergency medical personnel to reduce the risk of posttraumatic stress. The effectiveness of CISD was demonstrated through direct application within local trauma values. The CISD intervention has specifically been used, for example in response to the Wisconsin tornado in 1984, the Mexico City earthquake in 1985, the El Salvador earthquake in 1986, the Palm Bay, Florida, mass shooting in 1987, the Los Angeles riots in 1989, the New York City fire bombing in 1990, Hurricane Hugo in 1990, Hurricane Andrew and Hurricane Iniki in 1992, and the World Trade Center bombing in 1993. The intensive use and success of CISD has generated other debriefing models.

### Defusing

Weaver (1999) suggested that defusing is the term given to the process of *talking it out* - taking the fuse out of an emotional bomb (explosive situation). It involves allowing victims and workers the opportunity to ventilate about their disaster related memories, stresses, losses, and methods of coping, and be able to do so in a safe and supportive

atmosphere. The defusing process usually involves informal and impromptu sessions. A DMH worker might witness an emotional interchange between a victim and another staff member and, soon afterward, approach one or both of them and open a dialogue. They will, in turn, help folks release thoughts and feelings that might not otherwise be expressed. Suppression or repression of this kind of highly charged material might lead to the development of any number of stress-related physical and/or mental illnesses.

Greeting a victim who is waiting in line at a disaster service center and offering a snack or a drink, or playing a game with a child in an emergency shelter, or making a purchase from a clerk at a store in a disaster area, or even ordering a meal while in the field, can be enough of an opportunity to open a dialogue with someone who is anxious to tell his or her story. Running into a coworker at the copy machine offers the same chance. So does going out to eat with other staff members. Although informal and immediate, the defusing often becomes a mini-debriefing and can follow the same format discussed in the next section. Because the allotted time is often too brief, the defusing session is simply a starting point. Further intervention is often required and this can be anything from offering ongoing support (e.g., briefly touching base with the persons/groups in the coming days/weeks) to scheduling and providing formal debriefing sessions.

### Debriefing

Weaver (1999) states that the debriefing is a formal meeting, done individually or in small groups. It is generally held shortly after an unusually stressful incident, strictly for the purpose of dealing with the emotional residuals of the event. Any location that is large enough to accommodate the group, and which can be secured so as to assure privacy, is appropriate for use. This session may require a block of time that is several hours in length, particularly if a process such as Mitchell's (1983) formal Critical Incident Stress Debriefing (CISD) model is used (Mitchell and Dyregrov, 1993).

Whenever possible, everyone involved in the crisis should attend the debriefing(s). Many organizations recommend or even require attending defusing or debriefing sessions, whenever certain types of incidents occur. American Red Cross (ARC), for instance, offers defusing, as necessary, throughout a person's tour of duty at a disaster scene. ARC also strongly recommends (but does not require) having a debriefing before leaving for home. Once ARC workers get home, their local ARC Chapters usually offer them another debriefing (if that area has a DMH team).

At the morgue following the 1994 crash of Flight 427 near Pittsburgh, volunteer *trackers* and *scribes* (persons who escorted the remains of the 132 victims through the I.D. process) were offered graphic pre-briefings (a form of stress inoculation). They were also required to attend debriefings at the end of their shifts. Many expressed their gratitude and all seemed to value the opportunity to be debriefed. The original Mitchell process was designed for *first responders* (police, fire fighters, emergency medical technicians, etc., to help them overcome the emotional aftereffects of *critical incidents* (e.g., line-of-duty deaths). Sessions were usually held within the first 24-72 hours after the traumatic event, with follow-up sessions as needed. Given the nature of disasters, we do not always

identify all of the victims that quickly. Fortunately, the debriefing process is still beneficial, even when the sessions are held long after the event. Most mental health professionals have not been taught about defusing and debriefing and report being amazed at how helpful these simple but powerful tools become in their day-to-day practices.

There are now several debriefing models. While they differ in the number and type of phases (or stages), they all get at the same basic elements that Mitchell's original process sought to examine. This is done to help people cope with the sights, sounds, smells, thoughts, feelings, symptoms, and memories that are all part of a normal stress reaction to a traumatic event.

### **The Stages of CISD**

The formal CISD process consists of seven stages or phases (Everly and George, 1995). They are the introduction phase, fact phase, thought phase, reaction phase, symptom phase, teaching phase, and re-entry phase

***Introduction phase.*** Individuals are assured that everything discussed during the debriefing will be kept confidential. Nothing said in the debriefing will affect their job any way

***Facts.*** Individuals get to go over actual details of the critical incidents

***Reactions:*** The group members discuss their reactions about what happened.

***Symptoms:*** The members are encouraged to discuss any mental, physical or emotional symptoms they experienced during the incident.

***Teaching.*** The debriefs help the member sort out their feelings and the symptoms they described. They help them see to see that their reactions are normal.

***Reentry.*** The debriefs evaluate information discussed in the meeting and offer suggestion as how to participants can deal with the stresses and actually help them form a plan for returning to their job. If needed, plans are made for follow-up activities or treatment.

***Follow-up.*** Follow-up can be held week or months later if needed to address any unresolved issues.

A sample handout based upon the original Jeffrey Mitchell model (1983). Some of the other, more current models (including the Multiple Stressor model currently recommended by the Red Cross) are presented below:

### ***MULTIPLE STRESSOR DEBRIEFING MODEL***

#### **Introductions**

Phase 1 - Disclosure of Events

Phase 2 - Feelings and Reactions

Phase 3 - Coping Strategies

Phase 4 - Termination [see Armstrong, Lund, McWright, Tichenor (1995), p. 85]

**MITCHELL MODEL CISD (current revision of process)**

- Stage 1 - Introduction
- Stage 2 - Fact Phase
- Stage 3 - Thought Phase
- Stage 4 - Reaction Phase
- Stage 5 - Symptom Phase
- Stage 6 - Teaching Phase
- Stage 7 - Re-Entry Phase [see Everly (1995), pp. 288-289]

**MASS DISASTER / COMMUNITY RESPONSE VARIATION OF CISD**

- Stage 1 - Introduction
- Stage 2 - Fact Phase
- Stage 3 - Thought Reaction Phase
- Stage 4 - Emotional Reaction Phase
- Stage 5 - Reaffirming Phase
- Stage 6 - Teaching Phase
- Stage 7 - Re-entry Phase [see Everly (1995), pp. 289-290]

A debriefing should include everyone involved in the incident; nurses, police, EMS workers, fire and rescue personnel. In some case it may even be appropriate to include spouse, as they are the ones who are so frequently exposed to the after effects of critical incident stress. Whatever model you use, allow lots of time for folks to ventilate, especially during the initial stages/phases when facts, thoughts, and feelings are being discussed. Encourage expression of the most vivid or graphic, negative images and memories. Think of it as cleaning out an emotional wound before allowing it to try to heal with foreign material still on the inside. Improper procedure with a cut might promote infection. Improper procedure here will mean the emotional wound can be easily reopened by future stressful events and it will lessen the ability to avert PTSD. Normalize their experiences. Teach them about stress reactions and provide stress inoculation about anniversary reactions and other problems that they will eventually face. Offer lots of support and try to anchor a positive image and outlook for their successful recovery. End by thanking them for coming and joining in the debriefing process - shake their hands and/or give a hug as each person leaves the session.

**Mechanisms of CISD's effectiveness.**

Mitchell and Everly (1995) state 10 principal factors that may contribute to CISD's effectiveness. They are early intervention, opportunity for catharsis, opportunity to verbalise the trauma, behavioural structure, cognitive-affective structure, group process, peer support, demonstration of caring, feelings of hope and control generated, follow-up allowed.

This session has been scheduled to help everyone come to terms with the thoughts and feelings that arose out of the recent tragic situation that you all faced. The format for the

session is based upon the original Critical Incident Stress Debriefing (CISD) model put forth by Jeffrey Mitchell (1983). (Fill in the name of the sponsoring organization) has provided the workers who will serve as facilitators for today's debriefing. The session will probably last from one to two hours and it will cover these six areas:

1. **Initial Phase** - introductions, a discussion about confidentiality, an explanation of the purpose of the session, and a review of some other guidelines for the session. Some general rules in addition to the need to maintain confidentiality are:

- Please speak only for yourself.
- There is no rank during the session.
- No press and no outsiders are allowed in the session (if anyone feels he or she does not belong in the session, please speak up about it right away).
- Once we begin, there will be no break until we end the session.
- No beepers and no phone calls, or other interruptions are allowed.
- This will not be a time of investigation or critique.
- Feel free to ask questions any time.
- Please plan to stick around for the whole session.
- No one has to talk, if they do not want to do so.

2. **Fact Phase** - review of what actually happened during and after the incident (e.g., what each person heard, saw, smelled, touched, thought, and did).

3. **Feeling Phase** - review of the feelings each person had at the time of the incident and in the time since the incident.

4. **Symptom Phase** - examination of the physical and psychological aftereffects of the incident.

5. **Teaching Phase** - used to remind everyone that the symptoms they are experiencing are normal responses to the abnormally stressful situation they have faced.

6. **Re-entry Phase** - this is the time to wrap-up, answer any questions, and develop a plan for any future action that may be needed.

## DISASTER STRESS INTERVENTION

Echterling (1998) states that using a variety of strategies, such as offering outreach services to direct victims and others, developing follow-up programs, organizing support group activities, and providing consultation and education, is essential in disaster counseling. He also states that whatever the strategy employed, there are three important themes that disaster interveners emphasize. They are;

- o Survivors are experiencing normal reactions to an abnormal situation
- o Survivors are not alone; there are people and services available to help and
- o Survivors can deal with posttraumatic and chronic stress in healthy and positive ways.

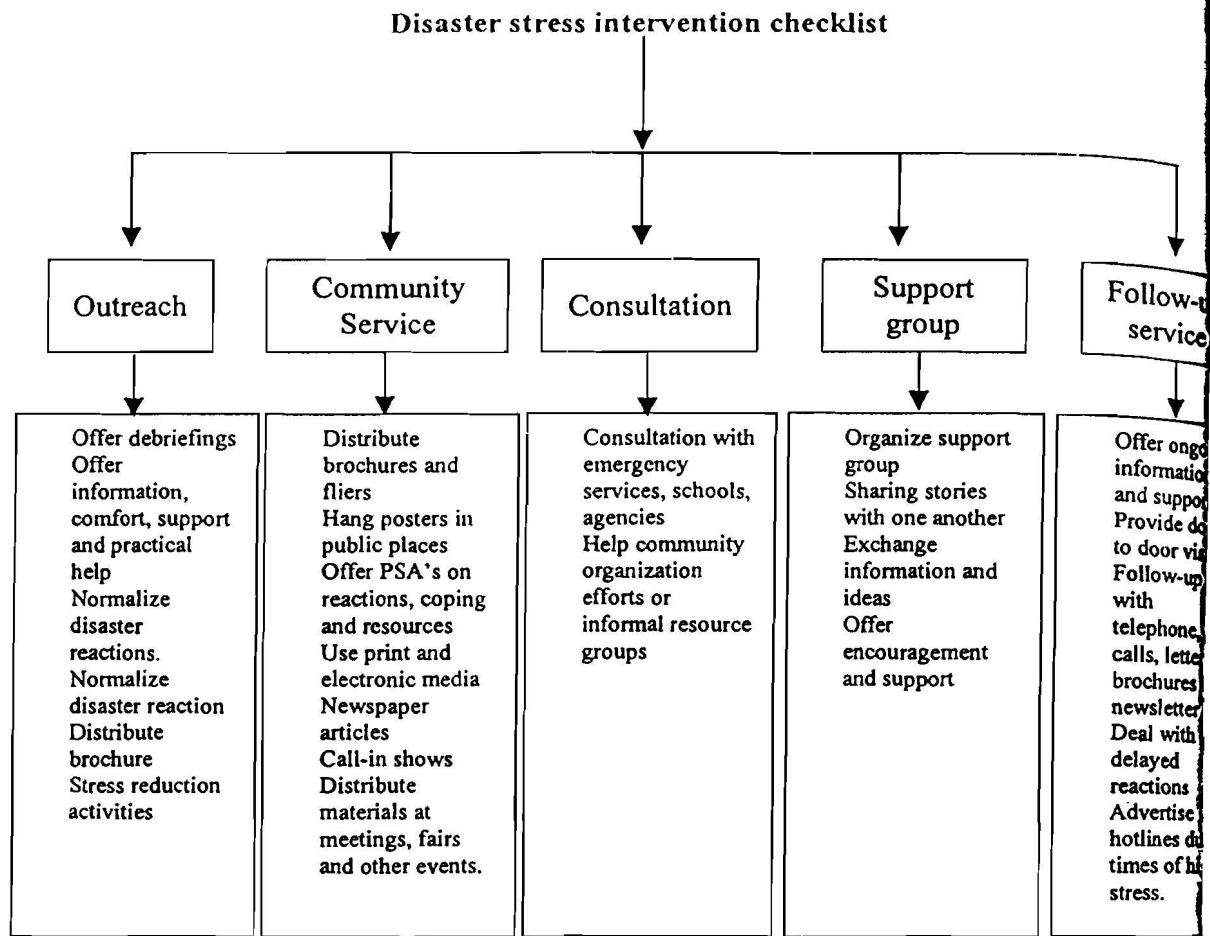


Figure 2: Adapted from Echterling .(1998).Hidden Wounds, Hidden Healing of Disaster., <http://www.cep.jmu.edu/vadisaster/hidden.htm>

**CONCLUSION**

Disaster can cause severe impact on the well being of human lives. This has caused the affected persons to require mental health services. Thus, there is a need to prepare victims and friends, relatives and other members of the community with stress management programs for a significant number of them require mental health services and develop posttraumatic stress disorder symptoms or psychopathology. This paper has looked into some stress a management program, which can be used to reduce psychological and emotional stress of the disaster victims.

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