

# Australian Disaster Resilience Handbook Collection

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Australian Institute for  
**Disaster Resilience**



**Guidelines for  
Psychological Services:  
Emergency Managers Guide**

**Archived**

**PART III**  
**Emergency Management Practice**  
**Volume 3 — Psychological Services in the**  
**Disaster Context**

**Manual 9**

**EMERGENCY MANAGERS GUIDE**

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EMERGENCY MANAGEMENT AUSTRALIA

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# THE AUSTRALIAN EMERGENCY MANUALS SERIES

The first publication in the original AEM Series of mainly skills reference manuals was produced in 1989. In August 1996, on advice from the National Emergency Management Principles and Practice Advisory Group, EMA agreed to expand the AEM Series to include a more comprehensive range of emergency management principles and practice reference publications.

The Australian Emergency Series has been developed to assist in the management and delivery of support services in a disaster context. It comprises principles, strategies and actions, compiled by practitioners with management and service delivery experience in a range of disaster events.

The series has been developed by a national consultative committee representing a range of State and Territory agencies involved in the delivery of support services and sponsored by Emergency Management Australia (EMA).

Parts I to III are provided as bound booklets to State and Territory emergency management organisations, students, community organisations, appropriate government departments for further dissemination to approved users including local government and over 70 countries around the world.

Parts IV and V (skills and training management topics) are normally only issued as training guides in loose-leaf (amendable) form to all relevant State agencies through each State and Territory Emergency Service.

## AUSTRALIAN EMERGENCY MANUALS SERIES STRUCTURE AND CONTENT

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### PART I – THE FUNDAMENTALS

Manual 1	Emergency Management Concepts and Principles (3rd edn)	U/R
Manual 2	Australian Emergency Management Arrangements (6th edn)	A
Manual 3	Australian Emergency Management Glossary	A
Manual 4	Australian Emergency Management Terms Thesaurus	A

### PART II – APPROACHES TO EMERGENCY MANAGEMENT

#### *Volume 1 – Risk Management*

Manual 1	Emergency Risk Management – Applications Guide	A
Manual 2	Implementing Emergency Risk Management – <i>A facilitator's guide to working with Committees and Communities</i>	A

#### *Volume 2 – Mitigation Planning*

Manual 1	Planning Safer Communities	A
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#### *Volume 3 – Implementation of Emergency Management Plans*

	Titles to be advised	P
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### PART III – EMERGENCY MANAGEMENT PRACTICE

#### *Volume 1 – Service Provision*

Manual 1	Emergency Catering	A
Manual 2	Disaster Medicine (2nd edn)	A
Manual 3	Disaster Recovery	A/R

#### *Volume 2 – Specific Issues*

Manual 1	Evacuation Planning	A
Manual 2	Safe and Healthy Mass Gatherings	A
Manual 3	Health Aspects of Chemical, Biological and Radiological Hazards	A

Manual 4	Post Disaster Survey and Assessment	A
Manual 5	Community Emergency Planning (3rd edn)	A/R
Manual 6	Urban Search and Rescue Concepts and Principles	A
Manual	Civil Defence	D
Manual	Lifelines	D
<b>Volume 3 – Guidelines</b>		
Guide 1	Multi-Agency Incident Management	A
Guide 2	Community and Personal Support Services	A
Guide 3	Managing the Floodplain	A
Guide 4	Flood Preparedness	A
Guide 5	Flood Warning	A
Guide 6	Flood Response	A
Guide 7	Emergency Management Planning for Floods Affected by Dams	A
Guide 8	Reducing the Community Impact of Landslides	A
Guide 9	Psychological Services: Emergency Managers' Guide	A
Guide 10	Psychological Services: Mental Health Practitioners' Guide	A
Guide 11	Disaster Loss Assessment Guidelines	A
Guide 12	Economic and Financial Aspects of Disaster Recovery	A
Guide	Community Development	D
Guide	Gathering Community Information	D
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**PART IV – SKILLS FOR EMERGENCY SERVICES PERSONNEL**

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Manual 4	Land Search Operations (2nd edn – Amdt 1)	A
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Manual 11	Vertical Rescue (2nd edn)	A
Manual	Structural Collapse Search and Rescue	D

**PART V – THE MANAGEMENT OF TRAINING**

Manual 1	Small Group Training Management (2nd edn)	A
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Key to status: A = Available A/R = original version Available/under Review  
 D = under Development; P= Planned; R = under Review/Revision  
 U/R = Unavailable/under Review



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# CHAPTER 1

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## Introduction

The need for guidelines for psychological services in disasters is due to the different context in which psychological services need to be delivered to disaster affected persons. In the disaster context, psychological services are delivered within a community structure which is typically disrupted whereas these services are normally delivered within a functioning social structure in an orderly patterned existence. Where formal intervention is required it is usually delivered in a clinical, office based setting. Disaster generates varying degrees of chaos and renders many everyday systems and coping mechanisms dysfunctional or impotent. Service delivery therefore has to be flexible, mobile and creative. In these guidelines the terms “disaster” and “emergency” are synonymous.

As psychological services inform all aspects of disaster management services, guidelines for the delivery of psychological services have been developed in two publications – Psychological Services Emergency Managers’ Guide and Mental Health Practitioners’ Guide. This publication, Psychological Services Emergency Managers’ Guide, has been developed to offer service providers, managers and practitioners with a guide to the delivery of psychological services practice in the disaster context.

The purpose of these guidelines is to offer insights, principles and strategies in key facets of assessment and delivery of psychological services in the disaster context. They aim to prevent unnecessary suffering, facilitate recovery, ensure ethical practice and to protect disaster affected people and support workers in their respective roles. The guidelines have been endorsed by the Community Services Ministers Advisory Council and the Australasian Society for Traumatic Stress Studies (ASTSS).

These guidelines have been developed to supplement the information available in the Australian Emergency Manual – Disaster Recovery and the Community and Personal Support Guidelines within the Australian Emergency Management series.

While the overviews in these documents provide adequate information on recovery processes and likely helpful activities, further information is considered necessary for those involved in the provision of or understanding of the utility of psychological services. Because of the increased amount and sophistication of such information, it was deemed necessary to develop these guidelines.

To that effect, the Disaster Recovery Sub-committee of the Community Services Ministers Advisory Council (then the Standing Committee of Community Services and Income Security Administrators) and The Australasian Society for Traumatic Stress Studies, with funding under the National Studies Program of Emergency Management Australia, formed a steering committee which identified key areas to be addressed. Participants at a subsequent workshop represented a cross-section of managers and service providers from the range of government and non-government agencies involved in the delivery of psychological services in the disaster context. Professional disciplines represented included psychiatry, psychology, social work and

other related fields.

The steering committee collated the data from the workshop in development of these guidelines. In addition, they draw on the Mental Health National Action Plan, the Royal Australian and New Zealand College of Psychiatrists Position Statement 35 on the Role of Psychiatrists in Disasters, the Victoria Disaster Support and Recovery Unit discussion paper on Personal Support Guidelines and the World Health Organisation project on disaster management.

These guidelines should be read not only by those providing psychological services, but also by all involved government departments, agencies and individuals. Although these guidelines have been produced to encourage consistency in the delivery of psychological services in an Australian context, that is, across the boundaries of States, government and non-government organisations and professional disciplines, the prevailing management systems must be respected. It must be understood too, that psychological services are but part of a recovery process with which they need to integrate.

It is acknowledged that the body of knowledge in these guidelines is in the process of development and consequently this document is a dynamic document intended to be reviewed and updated periodically or as new information comes to light.

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# **CHAPTER 2**

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## **Recovery Management Principles**

In 1979 the then the Standing Committee of Social Welfare Administrators (now the Community Services Ministers Advisory Council) endorsed principles of disaster recovery management which have provided a successful management context for recovery managers. Those principles are summarised as:

Disaster recovery is most effective when:

- management arrangements recognise that recovery from disaster is a complex, dynamic and protracted process.
- agreed plans and management arrangements are well understood by the community and all disaster management agencies.
- recovery agencies are properly integrated into disaster management arrangements.
- community service and reconstruction agencies have input to key decision making.
- conducted with the active participation of the affected community.
- recovery managers are involved from initial briefings onwards.
- recovery services are provided in a timely, fair, equitable and flexible manner, and
- supported by training programs and exercises.

These principles provide the overall context in which psychological services will be provided within a disaster affected community. The planning, management and delivery of psychological services to disaster affected communities must be congruent with these principles.

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# **CHAPTER 3**

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## **Basis for the Provision of Psychological Services**

This chapter addresses the basis for the provision of psychological services to individuals and communities affected by disaster. It first defines the term “psychological services” as used in this publication and then deals with the aims and rationale of specialist psychological services, the logistics of service delivery in the disaster context, its integration with emergency management and the need for self-monitoring by psychological service providers.

### **3.01 Psychological Services**

For the purposes of this publication the term “psychological services” refers to those specialist psychological services which apply skills ranging from psychological first aid to long term clinical treatment provided by personnel trained to the level appropriate to the task.

### **3.02 Aims and Rationale**

Psychological services in disasters aim to encourage “wellness” by addressing psychological vulnerability and limiting the development of psychopathology. Alternately, they help affected populations to shift the balance from maladaptive or traumatic responses to adaptive ones. In each case the aim is to preempt later pathology and to alleviate it should it occur.

### **3.03 Logistics of Service Delivery**

While orthodox treatments often take the form of patterned, office-based, individual clinical therapies, in the disaster context social structures and patterns may be disrupted, there may be a rapid increase in client numbers and the psychological service resources may be overtaxed. Therefore, service delivery needs to be flexible, mobile, creative and extensive, while at the same time being capable of prioritisation.

An initial outreach approach to all in the affected community is cost effective as it can identify the need to prioritise services to the vulnerable and those with established dysfunctions. Secondly, outreach may be able to prevent more widespread distress and help prevent dysfunctions by providing information about the nature and sense of common stress responses and what can be done about them.



Psychological services should be a special but integral part of established response and recovery services. The logistics of service delivery is in the context of disaster management as a whole. To accomplish their goals, psychological service staff must have special skills in “seeing the bigger picture” and to apply flexibility, mobility and creativity, the ability to communicate along hierarchical lines and across services, as well as to liaise and integrate with the response and recovery services as a whole. In addition psychological service staff have consultancy and healing roles toward the service network and its personnel.

Special skill and sensitivity are required to communicate with those who may previously have had no contact with any aspect of psychological services. Skill is also needed to distinguish the majority of people who do not require professionally based formal psychological support but may simply benefit from information, those who may require help in the future and those who suffer current fresh or reopened wounds. Professional sensitivity, skill, ethical standards and self-monitoring must be of an exceptional order to provide what is needed to those who need it and to desist from offering help where it is not needed.

### **3.04 Nature of Specialist Psychological Services as Integral to Emergency Management**

Emergencies and disasters typically have a wide range of impacts on individuals and communities, examples include the impacts of evacuation, damage to community infrastructure, personal loss and financial hardship. There is a psychological component to each of these impacts which may require local attention as well as attention at the management level.

Reciprocally, the planning, management and delivery of emergency services by disaster managers in many areas in all disaster phases have the potential to have serious psychological consequences for individuals and affected communities.

Therefore positive consequences can be enhanced and negative ones avoided, or at least alleviated, through disaster managers being informed by specialist psychological consultancy of the psychological consequences of their decisions.

Indeed, it is critical that the psychological dimension informs understanding, planning, training, assessment, decision making and service delivery components of emergency management. This should occur in an integrated way, from local to regional state national and international levels as required. In addition, psychological services may be utilised by managers to deal with secondary stresses within their own sub-systems.

### **3.05 Capacity of Psychological Service Providers to Self-monitor**

Special skills are required of psychological service providers to self-monitor their own feelings, stresses and functioning. This ensures maintenance of their own health and effectiveness towards affected persons. Self-monitoring facilitates the major principle “First do no harm”.

Specialist training is required to accurately discern and appropriately act on the wide range of biopsychosocial stress responses evoked in providers themselves. For instance, intense emotions and sensations may need to be appraised either as information about other persons’ states, or as reflecting one’s own stress responses. Such appraisals facilitate measured professional intervention rather than acting on unprocessed instinctive responses.

Because empathy requires receptivity, openness and reverberation with others, responses within oneself are inevitable. Self-monitoring on a prolonged basis is often insufficient and must be supplemented by peer group and/or individual supervision. This can prevent being over-identified, over-committed and overburdened and thus becoming a secondary victim and a burden on those supposed to be helped.

The intense relationships developed with those being helped in disasters also brings up special ethical questions. Therefore in addition to the usual mental health professional code of ethics, additional ethical monitoring is required. (See Appendix C for the code of ethics of the Australasian Society for Traumatic Stress Studies.)

In summary, specialist psychological services are needed in disasters, in order to:

- Recognise, assess and deal with different dimensions of biological, psychological and social stresses outside the usual paradigms.
- Deal with unstructured and exacting logistical and organizational demands.
- Be able to liaise properly with other workers and interact advantageously with management.
- Be able to productively self-monitor oneself and one's organisation.

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# **CHAPTER 4**

## **Conceptualisation of the Psychological Effects in Disasters**

This chapter addresses the conceptualisation of the psychological effects of disasters and illustrates them within the three dimensional biopsychosocial framework (Triaxial Framework) depicted in Appendix A. The three dimensions are the process, parameter and depth axes.

### **4.01 Psychological Disaster Effects**

Disasters cause major environmental, societal and personal upheavals. Most disturbances are in the nature of strains and distress and are often called stresses. Situations which give rise to stresses may be called critical incidents or stressors. Stresses may be curtailed or reversed by adaptive stress responses. Stress responses may be parts of survival and preservation strategies such as fight, flight, rescue and attachment and thus may be called survival strategies. When stress responses are insufficient or inappropriate, stresses may “give” and irreversible disruptions of various magnitudes called traumas may develop. The event in which traumas develop is a traumatic event and the situation in which this occurs is a traumatic situation. Stressors which lead to traumas are called traumatic stressors. As disasters as a whole are stressors which, almost by definition, lead to trauma, disasters are often implied to be traumatic stressors.

Stresses and traumas have biological, psychological and social (actually integral biopsychosocial) ripple effects. Like ripples from a pebble in the pond, they radiate through the different dimensions of disasters.

### **4.02 Conceptualising Disaster Effects**

Stress responses both adaptive and maladaptive, biological, psychological and social, of the various strategies of survival may be conceptualized to ripple along three dimensions. The three-dimensional ripple view of disaster responses forms the framework for the view of disaster effects. The three dimensions represent the skeleton of the framework. Survival strategy responses flesh out the skeleton.

### **4.03 Three-Dimensional View of Disasters (the triaxial framework) (Refer Appendix A)**

The first dimension or axis (called the parameter axis) describes the parameters (what, when, who) of disasters. The “what” of the disaster describes the nature of the disaster (ie bushfire, flood, shooting etc). The nature of the disaster determines the “culture” of responses. The “when” of disasters describes disaster phases (ie preimpact, impact, post-impact, recovery). The “who” of disasters describes the social system levels of who was affected (ie individuals, families, and whether children, adults or workers are a special group).

The second dimension or **process axis** describes the dynamics of the ripple process and makes sense of how and why various biological, psychological and social stress responses progress at different points either to fulfilling results or symptoms and dysfunctions.

The third dimension, the **depth axis** orientates responses along human developmental levels, ranging from instincts to spirituality. Examples of these levels include moral judgements, identity, beliefs, meanings and purpose.

#### **4.04**      ***Survival Strategies***

The choice of survival strategies determines the specific nature of stress responses and their particular adaptive and maladaptive biological, psychological and social ripples. The variety of survival strategies and their various ripple effects across the three dimensions, determine the great variety and complexity of traumatic stress responses in disasters.

However, each traumatic stress response is characteristic of a specific survival strategy response at specific intersections of the triaxial framework. Sense can be made of such responses by orienting them on the triaxial framework and tracing them back to specific survival strategies evoked in the context of traumatic events.

Specific survival strategies are fight, flight, rescue/caretaking, attachment, assertiveness/goal achievement, adaptation/goal surrender, competition and co-operation.

The table in Appendix B indicates how survival strategies may be used to classify adaptive and maladaptive biological, psychological and social responses in disasters.

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# **CHAPTER 5**

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## **Psychological Service Providers in the Field**

Firstly, psychological service providers should be able to assess

- The adequacy and capacity of existing community agencies to undertake necessary tasks,
- The capacities and dynamics of the service provider community, and
- The capacity of available resources to meet identified and emergent needs.

Integration of local and external psychological service providers needs to be maintained by regular network meetings with management. Integration of proven and trusted service providers may reduce convergence by a multitude of service providers unfamiliar with specific requirements in disasters.

Critical to the success of any aspect of the recovery process is effective inter and intra agency coordination, communication and role clarity. To facilitate effective communication between agencies, providers of psychological services need to meet regularly to undertake a range of tasks, including:

- Coordinating and streamlining assessments and intervention outcome information,
- Ensuring effective coordination of ongoing services, and
- Planning for timely withdrawal of services.

In the absence of current accreditations for specialised psychological service providers and the frequency of unsolicited groups and individuals who offer psychological services in disaster areas, the following guidelines are offered to assess the suitability of psychological service providers for disaster work. The guidelines should be used by organisations and individuals who contemplate offering psychological services to disaster areas and by managers who may need to determine the suitability of those proffering help at disaster sites. In the latter situation managers should also consult senior psychological service personnel trained in disaster work.

Broadly, similar principles apply to assessment of psychological service providers as to those who offer other specialist emergency management services.

As a guide, the following questions should be answered satisfactorily with respect to those wanting to help:

- To what extent have they had prior experience, training and ability to perform the specialised psychological services in disasters described in these guidelines?
- If not specially disaster trained, to what extent do individuals/groups have a secure professional identity (such as psychiatrist, clinical psychologist, social worker, etc.), matured professional experience and skills, knowledge of their own limitations and a secure supportive agency and work-base which will enable the workers to stay as long as needed?
- Will they have sufficient rosters and supports to give continual service? Will they have capacity to travel to disaster sites and work out of hours in less than optimal conditions?
- What are their coping styles, defences and blind spots? How have they coped in previous disasters and with personal disasters? Have their own traumas been attended?
- Do they have the necessary flexibility, ingenuity, and capacities to prioritise?
- To what extent will they fit with the culture of the population, other emergency and recovery service workers and with the community and established psychological services?
- To what extent do they have group process skills?
- Will they accept lines of responsibility and accountability within the disaster management framework? Do they understand the prevailing State Emergency Management arrangements?
- Do they accept self-monitoring concepts (debriefs, supervision)? Will they have supervision by more senior people suitably trained and experienced in emergency and trauma work?
- Will they maintain proper duty of care in the context of informed consent and confidentiality? Can they balance the need to communicate with other services and avoid duplication, yet maintain the privacy rights of their clients? Can they curtail imposition of unwanted help?
- Are they bound by professional ethics of their own association? Will they accept the ethics of the managing agency and the ethical guidelines for trauma work?
- Do they accept that their prime responsibility is to the affected population, not third parties?
- Will they declare other interests and their source of remuneration?

These considerations will help to assess the extent to which the potential service providers' skills capacities and attributes can fulfill needed roles and match the needs of particular disaster populations at particular times.

If it is assessed that those offering their services can be utilised for psychological services, they should be assisted to establish themselves into existing networks with their skill levels matched to appropriate tasks. Once accepted service providers should be supported, monitored, supervised and given opportunities to deal with their stresses throughout their tours of duty.

# CHAPTER 6

## Assessment

Psychological service providers have a brief for ongoing continual assessment of the needs of disaster affected persons from pre-impact to recovery. In the disaster context this assessment is a complex process which must take into account predictable and unpredictable fluctuations within multiple social levels. Social levels comprise the community as a whole and its components of families and individuals be they adults or children.

### 6.01 Definition of Psychological Service Assessment

Psychological service assessment may be defined as evaluation of the impact of a disaster at a particular time on individuals, families and communities, with the purpose of determining needs for psychological service interventions. Assessment is a continuing process from pre-impact to healing. It is a complex, dynamic multidimensional inquiry which takes into account adaptive and maladaptive biological, psychological and social responses to threats of survival and to what is cherished in life.

### 6.02 Assessment in the Disaster Context

Assessment of the various factors inherent within the particular disaster context needs to be part of an overall coordinated recovery management process. Assessments involve the multi-factorial and dynamic and biological psychological and social disaster responses within the three dimensions of the triaxial framework.

While the basic aim of assessment is to ensure that appropriate psychological services are provided and referrals made as needed, outreach/educative engagement is also required. This is necessary to help individuals and communities understand the dimensions of the psychological impact of the disaster and the psychological dimensions of the processes of recovery. It should also ensure that a healing psychological climate exists and provide an understanding of psychological interventions and how they can assist at all levels throughout the recovery process.

Reactions/responses to the event may be appropriate in one phase in the recovery process but not in another. Each person's response will be individual and likely to be complex, dynamic, and variable over time. Individual responses will be affected by disaster survival responses, different aspects of personality and functioning and a heightened sense of morality, values, dignity, meanings and spirituality. Reactions need to be assessed within this wide context.

The aim and mode of assessments may vary and might need to be tailored according to the phase of the disaster (from initial "triage," in the immediate aftermath of a disaster, through to detailed clinical assessment later).

It should also be noted that assessment is in itself an intervention into the disaster affected community. Service providers cannot assume that such an assessment/intervention is necessarily a positive experience or helpful for affected persons.



### 6.03 Key Considerations

Given the complexity and variety of psychological responses to disaster there can be no simplistic proforma model for assessment. However, the triaxial framework informs assessments. Other key considerations in disaster context assessments include:

- Disaster managers and psychological service providers must have close liaison through all phases of disasters and share all available pertinent information,
- assessment in the disaster context is different from other forms of clinical assessment,
- assessment needs to be managed on the basis of an awareness that it is an intervention and therefore will have an impact on the client group,
- affected individuals must be given the opportunity to express their most pressing needs in their own language without preconception or judgement,
- experience indicates that parents and teachers often underestimate the nature of the impact and distress that children experience,
- specific vulnerabilities within children and families must be considered (e.g. deaths, chronic ill health, neurotic symptoms, overly quiet child),
- the impact of a disaster may have significant resource implications for availability of services/service providers,
- assessments must be coordinated to ensure there is no unnecessary repetition,
- where feasible, review assessments should be undertaken by the same person,
- assessment in the disaster context should begin with no pre-determined assumptions and include the use of appropriate personnel,
- assessments include that of the community,
- assessments include the matching of needs with available resources and service providers,
- a window of opportunity may exist for the integration of service providers into a disaster affected community. If this opportunity is missed assessment and service provision may be skewed in its conclusions, or unacceptable to the affected community,
- assessment should be made of adaptive natural processes as well as assessment of disrupted or disruptive maladaptive processes of recovery,
- vulnerabilities should be identified but not increased, and
- resilience and coping skills within individuals, families and communities should be assessed and supported.

With this range of issues in mind, service providers must be flexible, in order to assess the unique characteristics of each situation. This requires consideration of the unique requirements of the particular event, local issues and dynamics, availability of resources and conceptual frameworks as described above. Ultimately, assessment must identify the needs of the individuals affected by the disaster, rather than any potential needs of the provider to fit the situation into a prior orthodox framework.

In assessing the need for psychological support and intervention, a number of key questions should be addressed. These include:

- What are the specific assessment foci for children/adults/family groups in disasters?
- Why are particular services needed?
- How might they best be provided/delivered?

In addition, it is imperative to determine any special circumstances of the client and also identify/determine when specialised assistance/ 'counselling' is NOT required.

#### 6.04 Assessments of Different Social System Levels

The following section provides guidelines on assessment procedures for specific social groups.

It should be noted that:

- The underlying intention is to assess needs at any given time at any given level so as to specifically match them with appropriate interventions.

This can only be an approximation as both phases and social systems overlap and impact on each other in a dynamic system. For instance, events in one phase influence those in subsequent ones and social systems impact on each other.

### Community

Community level assessment is a complex process taking into account multiple dynamic factors and their interaction. There are many groups in most disasters. Community identity can be confusing because people can belong to multiple groups and have multiple roles (such as a person being a firefighter, local community member and father of a family).

For the purposes of assessment in a disaster context communities may be identified in a number of ways. These include:

- geographic groupings,
- cultural affinities,
- special interest groups - ethnic, religious, school, aged, etc
- various socio-economic groupings,
- isolated, marginalised, vulnerable groups, and
- communities of association; eg. retirement villages; nursing homes, caravan parks, schools.

Critical to effective assessment of community need is a determination of the nature of networks, leadership and hierarchies, to ascertain how information is processed and transmitted and the interaction between groups, their role within the community and capacity of that particular group to respond and recover. The underlying intention is to match interventions appropriate to the community's needs at any given time.

When assessing communities it is important not to assume that any one individual is responding the same way as the community as a whole or subsumed into the group. Individual reactions need to be differentiated from the group process.

It is also important to develop an assessment style that is relevant to the particular community being assessed (such as civilian / military / urban/ rural). Community assessment can involve:

- assessing tone/ mood of community (cohesion, morale, anger etc), and
- assessing common psychological problems that are experienced by many individuals in the community.

These two features will require different interventions at a community level.

## Family

A multi-dimensional assessment process needs to take into account the family's context, culture, lifestyle, values and developmental stage. It is critical that assessment be undertaken recognising the importance of the family's links with all local networks, groups and existing services. Information and feedback should be sought from each of these groups.

Assessment must be both of the family as a unit and its members as individuals. There is a need to place emphasis on family functioning because this influences children's response and recovery. For instance, some children are used as the flagship of family distress.

A critical aspect of the assessment process is to identify and support a family's normal recovery processes, identifying ways in which they can be aided and further supported. Similarly assessment should be undertaken of the capacity of the individual and family to identify their own needs for support. In this manner assessment may be used to guide people in their own recovery and to prevent future difficulty. In the course of assessment families may be enabled to recognise potential needs in the future and be able to access specialist assistance.

Finally, it is critical to ensure that all members of the family are included in the assessment, including children from infancy to late adolescence, the older generation and even the extended family.

## Adults

As with each of the other groups outlined, the assessment of adults affected by disaster should be undertaken within the triaxial biopsychosocial framework. Individual responses to a disaster and the resultant circumstances may be both adaptive or maladaptive. Within the one individual a range of combinations of responses are possible and may fluctuate (such as an individual may help others at one point in time but at another feel helpless and focus on themselves). Consequently, the purpose of assessment of adults is to determine the nature and degree of stress responses and psychological need. An effective assessment will support planning of service delivery, including identification of need and resources.

In addition, disaster affected people will not always recognise or report their difficulties. As such, it is necessary to provide means to encourage communication of problems. Education and information provision are an integral part of facilitating this process.

An individual may belong to a number of groups. There needs to be an assessment of the individual's functioning in various roles, within various groups (i.e. may be functioning well in one context but not in another; such as individual parental, carer roles).

The psychological impact of a disaster on adults is likely to go through a number of stages. Research indicates that after a period of initial distress only a proportion of people affected by disaster will have persistent psychological problems. It is also likely that some distresses lasting for more than a week may be predictive of longer-term adjustment. (For example stressor induced dissociative symptoms and other traumatic reactions: fight/flight and separation reactions.)

Key factors in the assessment of adults and their needs in a disaster context include:

- a variety of biopsychosocial responses in the triaxial framework. For instance, assessments include pre-existing and concurrent problems, vulnerabilities and strengths,

- cognitive and emotional responses,
- verbal and non-verbal communications such as body language,
- reading displaced emotions as reflections of one's own, and
- family/organisational/ community dynamics.

A further consideration is the potential impact of a disaster on families, friends and colleagues of those directly affected, as they may not be able to provide the social support normally available following a more isolated event such as a car accident. In addition the potential also exists for an individual's distress to affect those around them. In this regard consideration must be given to the collective dimension of the disaster impact on individuals and their environments.

Assessment must be undertaken in a manner and context congenial to the person. Privacy, confidentiality, dignity and rights of the disaster affected person should be respected at all times.

Finally, there is also a need to evaluate the assessment process. Key questions to be asked in reviewing its efficiency include:

- Is the process appropriate to the task?
- Is it creating potential additional trauma?
- Is it meeting affected persons' needs?

## Children

As with any psychological assessment in a disaster context, the consideration of the impact of a disaster on children and any subsequent psychological needs is a "mapping process" over time. Any assessment process should bring to bear knowledge of the child from key local people such as teachers, guidance officers, clergy/leaders, child carers and parents. In addition practitioners/assessors should draw upon disaster and trauma knowledge and their experience and observations from previous events.

It is important to remember that the key people in the child's life can also be affected by the disaster and their judgment may be skewed, usually minimising the extent of problems in children. Consequently, it is important that assessment of current parental response and family functioning be undertaken as well as assessment of individual children's responses to the disaster.

Specialist knowledge of child/ adolescent/ family developmental stages, as well as how children communicate eg play, drawing, nonverbal family communication, are also critical to effective assessment.

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# CHAPTER 7

## Interventions

The purpose of psychological service interventions in disaster affected populations is to enable affected people to maintain and retrieve their biological, psychological and social selves and to emerge with existentially meaningful lives.

Dealing with fresh wounds, gives opportunities to preempt serious pathology and excessive scarring. Further, even if pathology develops, its recent onset and relatively clear causation may lend themselves to efficacious healing.

While psychological services are provided in a manner which empowers individuals and communities in the management of their own recovery, effective service delivery is also reliant upon recognition and understanding of the impacts of disaster on adults, children, families and communities in their various social and cultural contexts and provides help to minimise the impact and reestablish self-direction.

Expert advice and consultancy are provided throughout all aspects of the disaster recovery process. This ensures that services are delivered in a psychologically informed manner to facilitate and enhance overall community recovery.

Expert advice and consultancy need to be provided at all hierarchical levels, including to emergency managers, particularly recovery managers.

Types of interventions thus range from psychological first aid and support, to long term clinical treatment of affected persons, as well as secondary consultation to services dealing with affected persons. The means of delivery of such interventions should be preplanned to be delivered through a seamless, holistic service.

### 7.01 Particular Treatment Interventions

Psychological support, crisis counselling, defusing and debriefing and long term counselling have been considered as special types of trauma therapy in the AEM – Disaster Recovery. These terms are revisited below. However in these guidelines rather than sticking to fixed treatment formats, common ingredients of the above treatments are elaborated and tailored to different social systems.

#### Psychological Support

Psychological support can be provided by relatives and friends and non-clinical support staff. It includes constructive interest, expression of a bond and a desire to protect and nurture the person. Clinical psychological support may include the above but goes beyond this by the use of empathic listening and emotional attunement to recognise, assess and understand people's distress in order to be able to offer skilled help as needed.

## **Crisis Counselling**

Counselling provides a relationship in which the affected persons' disaster experiences are able to be examined in detail together with other issues in their lives in order to assist them to understand the effects the experiences have had and the meaning they have given them. It can then provide them with an alternative set of understandings. This may also extend to other aspects of the recovery process, such as the impact of change and stress on relationships, personal identity and values. Counselling involves a structured relationship which is provided by someone trained to understand the nature of the difficulties the person is presenting and can anticipate the needs and the methods necessary to assist them. Most crisis counselling is focussed on some specific aspects of the crisis situation and seeks to provide immediate remedies.

## **Defusing, Debriefing and Worker Support**

These special techniques have been developed to assist recovery workers who have been affected by their experiences and have developed potential or actual traumatic stress, sometimes called critical incident stress. Debriefings may use structured methods by those with specific training whose aims are to ensure that the details of the experience are reviewed, together with the thoughts, emotions and behavioural reactions they have caused. They are then normalised in the disaster context.

Services whose workers are offered debriefing include police, firefighters, hospitals, nursing homes and community service agencies. Debriefing has also been offered to disaster affected persons, not only service personnel. People affected by a disaster caused by known and expected hazards are more likely to benefit from debriefing than people who have not had any expectation of the trauma they have suffered and are in a traumatised, distressed or disorganised state. In such cases it may be of assistance in a modified form as part of a network of other services.

Debriefing has come under critical scrutiny in recent times, as many inexperienced providers applying debrief packages have converged on disaster sites causing distress rather than mitigation of stresses. It is important to understand that no treatment is a panacea and that knowledgeable professional sensitive tailoring of good principles is more important than prescribed techniques.

## **Traumatic Stress Treatment; Longer Term Counselling**

Post-traumatic stress and post-traumatic stress disorder are complex and potentially severe and disabling conditions. They need to be carefully assessed and treated by clinicians trained in the field. Usually these conditions become compounded with pre-existing and subsequent problems and form a complex set of difficulties.

Even without going so far as traumatic stress illnesses, complex personal and family problems often emerge during the recovery period. As well emotional problems which may have been adequately managed in normal circumstances may become major difficulties in the context of the disaster stresses. These often require more extensive counselling or other forms of psychological treatment provided by experienced clinicians.

## 7.02 Interventions in different Social System Levels

Because assessments and interventions overlap, many principles applicable to assessments at different social levels also apply to interventions. For instance, interventions in communities need to be applied taking into account the nature of the community, its mood, morale and culture and organised and applied at different hierarchical levels. Similarly at the family level, interventions are applied as necessary to all family members, even if one member is chosen to symbolise family distress. With children play and drawing techniques may be used in treatment akin to in assessments.

Like assessments, interventions are informed by the triaxial framework. Thus interventions in all groups which follow are tailored to adaptive and maladaptive biological, psychological and social responses and include dimensions ranging from the survival strategy responses to spiritual issues.

### Communities

It is desirable that all types of service interventions be psychologically informed. Expert psychological advice and consultancy needs to be provided at all hierarchical levels, ranging from government, through emergency and recovery managers, to affected communities. Information through consultancy and through other media should be dispersed about usual post-disaster community responses such as post-disaster euphoria, tendency to find scapegoats and convergence phenomena. Myths about the frequency of panic, looting, unbounded heroism and capacity to recover, as well as pessimistic assessments of permanent damage need countering with objective information. Special care should be taken that media reporters are properly informed and that they themselves are not overoptimistic or on the other hand overwhelmed.

Information is widely distributed about the ubiquity, normality and sense of many biological, psychological and social responses, negative judgements such as guilt, shame and sense of injustice, as well as emergence of negative meanings. All means of communication are utilised, including radio, television, newspapers, internet, telephone hotlines, newsletters, pamphlets (such as the Red Cross pamphlets distributed at Australian disasters), posters, community meetings and interpersonal communication.

Realistic causes of the disaster and realistic stocktaking of losses and public mourning for them should be facilitated, helping progress in the assimilation of the disaster.

Many agencies providing material and financial aid as well as individuals stream into the area. Help may be harnessed if it can be well tailored, but it may have adverse effects if part of the convergence phenomena and competition for clients. Psychological service providers may counter these phenomena by bringing them to the attention of managers and helping them to be discerning about the aid offered. They may help to coordinate quality aid and to halt inappropriate help and voyeurism.

Psychological services can foster communities and workers to have a mutual understanding of losses, needs, available resources and knowledge of the systems by which to access and distribute them. Aid workers can be facilitated to tailor expeditious and efficient distribution of resources according to need and priorities. Consultation may ensure that aid is given with compassion yet generosity of spirit, with grace, maintaining dignity and respect for the helped. All the above may preempt later community tensions, anger, envy, greed and sense of unfairness and injustice.

Vulnerable groups such as orphans, bereaved, homeless, isolated, non-English speaking, should be identified and early specialist treatment (e.g., crisis counselling, bereavement counselling) provided. Secondly affected groups, such as relatives, should be identified and catered for, as should those who have left the district.



Psychological service providers may educate aid workers and the communities they cater for about the natural ambivalence to aid. The effects may compound with earlier disaster states and add to previous states of helplessness and rage. Psychological service providers may diagnose and ameliorate these interactions, build helpful bridges, educate, resolve conflicts or advocate on behalf of some disaster affected people.

Existing communication channels should be encouraged to be used and enlarged to increasingly empower communities to seek their own help and eventually to help themselves. This decreases a sense of dependency and increases self-esteem.

Aid workers should themselves be educated about secondary stress effects and their prevention and help given them as required.

## **Families**

Psychological services to families are most efficiently provided on an outreach basis. Disaster affected families should be visited in their homes or in other shelters.

It is helpful if two workers with different fields of expertise can visit families together as part of a “buddy system”. Together they should make sure that the biological, psychological and social needs of all family members are catered for and that the family dynamics are fully understood, for instance an individual’s symptoms may be seen as a vehicle to signal family distress. Vulnerable family members need special attention.

Family needs must be attended both on the level of the family as a whole and on the basis of all their individual members.

If stress responses are due to ongoing stressors, they need to be identified and if possible ameliorated. This may involve arranging for comforts such as food, shelter, warmth, toilet facilities and medicine. Reuniting within families is still very important. So is reuniting families with familiar social and helping networks and new networks.

If it has been assessed that the family is tense and dysfunctional since the disaster, stress responses still active from the impact phase of the disaster need to be made overt and ameliorated. Support and crisis counselling should be instituted in a family setting.

Typically, in a safe environment facilitated by the therapeutic relationship, detailed cognitive emotional and behavioural recognition of what the family went through is achieved. Which survival strategies worked, when, in what interaction and which did not, why, and with what consequences, is ascertained and validated with family members. The sense and normality of their responses in the disaster context is pointed out, as is the reason for lack of need to maintain such responses currently.

Family members may express to each other how they saw the disaster from their personal perspectives and express feelings to each other from such perspectives. Understanding of each other may resolve guilts and angers and strengthen mutual esteem and bonds. Family dignity and identity are preserved or even enhanced. Adaptive meanings of the experiences may well emerge. Vulnerable family members need special attention. Nevertheless, if the individual’s symptoms are used as vehicles to signal family distress, this needs attention.

## **Adults**

The same principles apply to individual adults as for families and may occur contiguously with family healing. Thus reuniting with families and with social networks is beneficial to individuals as well as to whole families. However, intimate one to one counselling relationships allow more personal issues to be addressed in more depth.

While stress responses experienced by individuals may be able to be placed in logical context as ripples from disaster, personal counselling often deals with situations where the connections to such contexts may be hidden. Then people may appear to suffer irrational biological, psychological and social manifestations or symptoms. Reasons for the disconnections may be protection against reliving traumatic events (eg sense of imminent death, deaths of others, helpless abandonments) accompanying negative judgements (guilt, shame, rage, outrage) or unacceptable meanings of oneself and the world. The connection may be retrieved through offering skilled and deep recognition of the symptoms, their origins and deep empathic understanding as to why memories of the event are disconnected. Connections of symptoms to the original event are retrieved through hope engendering reassessment of traumatic feelings, cognitions, judgements and meanings and seeing that they are not warranted today. Retrieval of connections to the traumatic event then allows understanding the symptoms in terms of rational biological, psychological and social survival responses in abnormal situations. With reconciliation of past and present, individuals tend to develop new realistically positive meanings and views of self and the world.

Such acute trauma therapy may prevent long term fragmentations of the mind and development of many entrenched symptoms and illnesses. Therapeutic skills require empathetic listening, ability to decipher covert communications and knowledge of the way the mind deals with trauma. Additionally therapists need to be able to include dealing with past vulnerabilities and meanings, defences personality styles and cultures, all of which compound with the way affected people present.

Note that it may not be enough to simply reassure that symptoms are normal. Such reassurance may only be meaningful when all healing principles are applied as well. This results in full cognitive and emotional awareness of causes, consequences, connections and reasons between disaster and symptoms as well as full cognitive and emotional awareness of the safety and hopefulness of the present environment. This results in a narrative story of the disaster and its consequences from a position of control and purposeful future.

## Children

Reuniting with parents and family and provision of physical and practical needs are even more urgent for children than for adults. Next, it is important to establish an environment of security, routine, education, contacts with peers and opportunities for play and drawing to express the children's experiences.

As for adults, it is important to give children opportunities to express themselves in one to one situations. Their physical and social reenactments may then be connected to particular child versions of traumatic events, judgements and their meanings. For instance, children may feel that the disasters, deaths and subsequent parental strains and irritability are due to their badness. They may combine their concerns with atavistic meanings of predatory worlds, and monsters and witches.

Again acute therapy, this time tailored to children, may prevent such symptoms and meanings becoming entrenched. Interventions need to be congruent with children's developmental phases and using their special modes and means of communication such as play and drawing.

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# CHAPTER 8

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## Research

Research into the effects of disasters and the benefits of various psychological assessments and interventions is critical to the continued development of best practice in service delivery. In particular, sound research contributes to the development of the knowledge base and will inform intervention at all levels.

One goal of research may be the development of minimum national data on the profile of psychological responses in Australia and development of standardised and comparable assessment, intervention and outcome measures. Nevertheless, research must be well considered and not interfere with current recovery. The following principles are offered as a guide in any consideration of research in the disaster recovery area:

**FIRST DO NO HARM.** Like assessments and interventions, research may involve interpersonal interaction which may burden stress or retraumatise affected people. Even non-personal research instruments may cause much distress. Therefore,

- Research must recognise the needs of affected people and disaster workers and must never compromise their healing or disaster management.
- Disaster managers should be appraised of the advantages of the research and their cooperation enlisted. They should consider potential convergence of researchers seeking access to affected communities and ensure minimal disruption to individuals, families and the community through multiple researchers and their projects.
- Research ethics and procedures need to be explicitly specified so that proper standards are maintained. Researchers must adhere to guidelines and procedures of all organisations, government departments, tertiary education institutions or non-government organisations which may be involved in the research. General professional and specific disaster codes of ethics (see Appendix C) must also be adhered to in research.
- Subjects of research must give informed consent and their confidentiality must be maintained.
- Research goals should be informed from a base of current knowledge and existing literature on all aspects of disasters.
- Research should occur through established ethical research channels such as the Australian Emergency Management Institute and universities or at least be supervised by them.
- Results of research should be freely available, including to the subjects themselves, other researchers and agencies and to bodies building up data profiles in Australia.
- Research should be subject to quality assurance, best practice standards and scrutiny as to whether they help to improve assessments and effectiveness of interventions.

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# APPENDICES

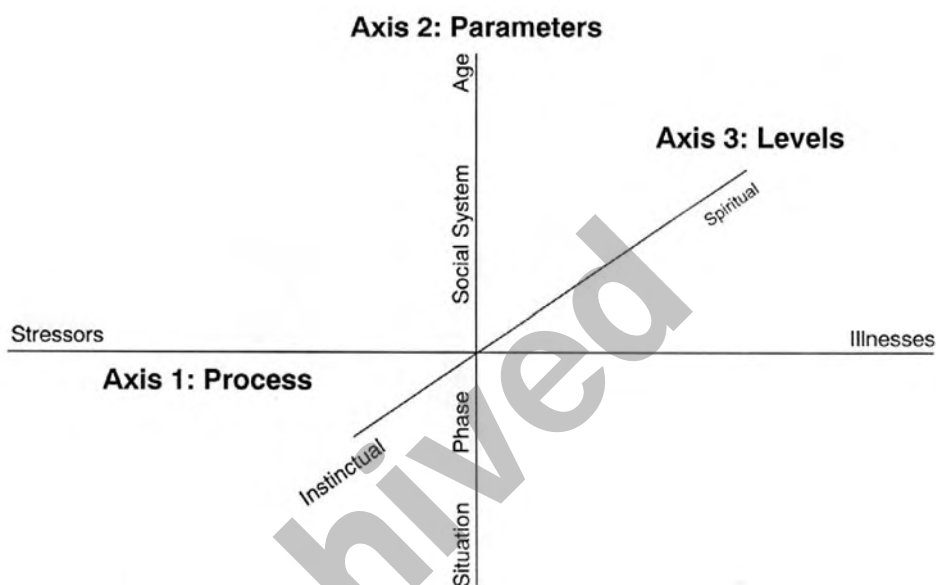
## Appendix A

### Three Dimensional (Triaxial) Biopsychosocial Framework

The three dimensional view of traumatic stress includes three axes. The three axes are depicted in Figure 1

**Triaxial View of Traumatic Stress**

Figure 1



The components of the three axes or of the triaxial framework are depicted in Table 1.

### Triaxial View of Traumatic Stress

<i>Process axis</i>	<i>Parameters axis</i>	<i>Depth axis</i>
1. Stressors	1. Factors in traumatic situations	1. Basic instincts, drives
2. Appraisals	2. Phases of traumatic situations	2. Survival Strategies
3. Stress Responses	3. Social system levels including helpers	3. Judgements and Morality
4. Strengths & vulnerabilities	4. Developmental phases	4. Basic meanings
5. Trauma		5. Ideals, values and principles
6. Defences		6. Codes, dignity, rights
7. Memories		7. Spirituality, religion, ideology, beliefs
8. Illnesses		8. Identity
9. Secondary spirals		9. Symbols
		10. Creativity, esthetics
		11. Sacredness
		12. Wisdom, knowledge, truth

Table 1: Components of the Triaxial Framework

#### Process Axis Components

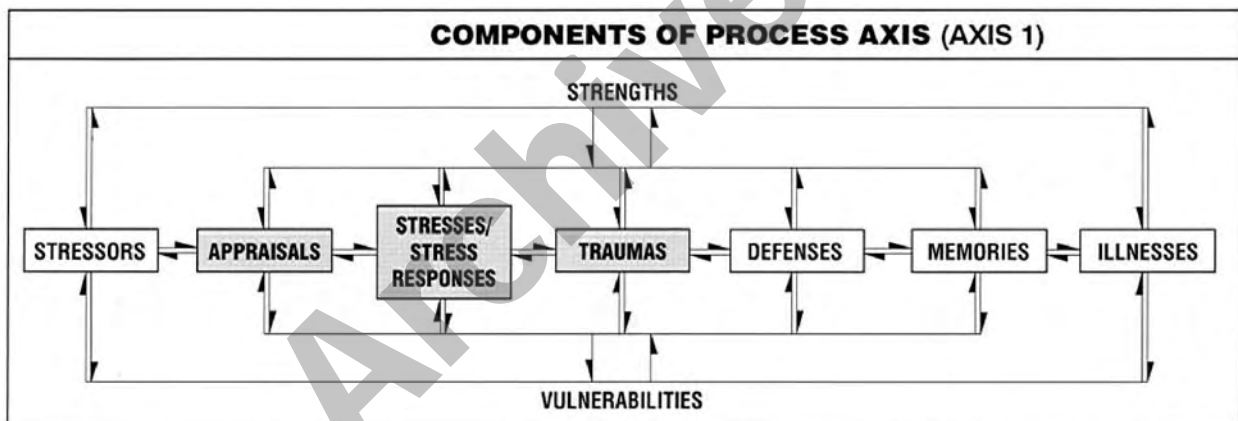


Figure 2

## Appendix B

### Survival Strategies

The variety of survival strategies, appraisals which evoke them and their adaptive and maladaptive manifestations are depicted in Table 2. Judgement columns indicate the potential of classifying adaptive and maladaptive ramifications of survival strategies along human function levels on the depth axis (Table 1).

<i>Appraisals</i>	<i>Survival Strategies</i>
1. Must rescue others	1. Rescuing
2. Must be rescued by others	2. Attaching
3. Must achieve goals	3. Asserting
4. Must surrender goals	4. Adapting
5. Must remove danger	5. Fighting
6. Must move from danger	6. Fleeing
7. Must obtain scarce essentials	7. Competing
8. Must create scarce essentials	8. Cooperating

Table 2: Survival Strategies and the Appraisals which evoke them

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## Appendix C

### Australasian Society for Traumatic Stress Studies

#### Code of Ethics

##### Definition

Trauma therapy is help administered by professionals to traumatised people in order to help them with the prevention, amelioration, healing and reduction of the consequences of trauma.

Traumatised people have experienced threat of any or all of physical, mental or social annihilation. Trauma sequelae result in an indefinite loss of a previous equilibrium for a less life enhancing one. They result in biological, psychological and social symptoms and illnesses.

Professionals are people trained to help traumatised victims. Their prime motive and obligation is to apply their expertise for the welfare of their clients or patients. They put the latter's interests before their own or the interests of any other third party(ies). The rewards for their efforts are fees, or payments in some other culturally agreed to currency. Professional here will mean professional trauma therapists.

##### Specific Ethical Principles

*In Relation to Clients, Patients.*

1. **First do no harm.**
2. **Primacy of clients' or patients' welfare.** Whatever is best for clients should take primacy. In particular the vulnerability of their traumatised state should not be exploited for financial, academic, organisational or personal rewards. The impulse to help should be balanced by likely benefits and disadvantages to victims.
3. **Collaboration with clients or patients.** To the degree possible trauma therapy should be collaborative and reciprocal, clients being able to control the occurrence of the therapy and having equal power in it. When clients are approached as part of an outreach process, its rationale should be explained very early and permission to continue be asked for. If clients are unable to give informed consent to therapy, a prime goal should be to help them to be able to do so. The rights as well as special needs of children, the elderly, the ill and ethnically unassimilated should be respected.
4. **Confidentiality.** Whatever knowledge or information a professional derives during therapy remains confidential unless it involves threats to the lives of others or is subject to criminal law. Any divulgence of information must be with the written consent of the client or guardian.
5. **Length of therapy.** This should be determined by clients' welfare and mutual negotiation. To the extent possible, it should not be curtailed or extended for the benefit of therapists or third parties.
6. **Rewards.** Payments should be through mutual negotiation.
7. **Third parties.** It should be clear that the welfare of clients and patients is paramount, even if third parties pay. If therapists' motivation or obligation is toward an organization this, as well as any potential conflicts of interest with the individual client, must be declared. If therapy is not agreed to by clients under such circumstances or if their benefit from therapy is curtailed, therapy should not occur.

*In Relation to Peers.*

1. **Collegial Respect.** Due respect and deference should be given to colleagues' skills. These should not be denigrated to other clients or in public.
2. **Respect for Service Networks.** Practitioners need to know local government and non-government helper networks and rules and cooperate with them as much as possible.
3. **Advertising and Competition.** Practitioners have the right to let potential clients know of their skills, but these should not be exaggerated or plied in a commercial manner. Similarly, others' skills should not be denigrated and territoriality should be avoided. Benefit to clients is again primary. Skills, training and references should be shared and supplied on request.
4. **Limitations on Unprofessional Conduct.** If it comes to the notice of practitioners that others are acting in unethical and dangerous manner, education, personal approach and as a last resort legal avenues should be taken to protect clients and patients.

*In Relation to the Community.*

1. **Trauma Prevention.** The community should be educated about what makes it vulnerable to trauma, how to prevent it, and how to prepare for it.
2. **Education.** The community should be educated about trauma, trauma therapy, its skills and ethics. Advice may be given about tailoring needs and available skills. Training of trauma therapists should be set in train.
3. **Ethics Education.** Interchange with the community about dilemmas in trauma therapy should take place. Ethics committees should be set up by professional trauma associations whose members practise trauma therapy in order to learn, teach and update knowledge on ethical issues.

*In Relation to Self.*

1. **Recognition of Skills of Trauma Therapy.** The professional recognises that trauma therapy requires special knowledge and skills which are not fulfilled simply by having a mental health professional qualification. Practitioners ensure that they acquire such knowledge and skills to whatever degree possible.
2. **Tailor Skills and Type of Trauma Therapy.** It should be recognized that there are many types of traumatic situations and types of therapy. Skills may not generalise across all situations. Practitioners are obliged to make sure that best available skills are applied to specific situations, and assess whether they are the best people to fill them.
3. **Limitations of Skills and Referrals.** When professionals are the best placed persons under the circumstances to help, they are obliged to do so, but also to declare to the degree appropriate their limitations. Otherwise they should alert clients to other options and be willing to refer clients to them, ask them to help, or ask them for second opinions.
4. **Declaration of Skills through Professional Network.** Professionals should declare their skills through a professional trauma network, so that they may be asked to help in appropriate situations.
5. **Maintaining Professional Skills and Fitness.** It is incumbent on professionals to keep up with their knowledge, make sure their standards are maintained and their mental health remains adequate. To this effect professionals should take part in peer group education, supervision, debriefing and have a good understanding of their own traumas.

*In Relation to Research.*

1. **First Do No Harm.** Because traumatised people are in a highly vulnerable state, they are open to exploitation of others' interests. Welfare of victims must always precede the interests of professionals. Research should in no way prejudice healing.
2. **Research Goals.** The goal of research must be the obtaining and free dispersion of knowledge which will help future generations of victims. The goal should not be partisan to a particular form of therapy, drug, method, person or group. Lack of benefits, side effects and negative effects should be reported as much as positive ones. Potential biases such as funding bodies and institutional and relevant group attachment should be declared.
3. **Consent.** Client or guardian consent should always be obtained. The nature of the research, its goals, benefits and risks, should be explained.
4. **Informed Research.** Because research always siphons some energy from patient welfare, its value over and above knowledge already available should be assessed. Repeating previous research on the one hand and on the other not paying attention to established principles should be avoided.
5. **Confidentiality.** People's identities must be preserved from recognition. This is particularly important in high profile disasters involving high profile identities.

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## GLOSSARY

**assessment.** Psychological service assessment may be defined as evaluation of the impact of a disaster at a particular time on individuals, families and communities, with the purpose of determining needs for psychological service interventions. Assessment is a continuing process from preimpact to healing. It is a complex, dynamic multidimensional inquiry which takes into account adaptive and maladaptive biological, psychological and social responses to threats of survival and to what is cherished in life.

**community.** A group with a commonality of association and generally defined by location, shared experience or function.

**comprehensive approach.** The development of emergency and disaster arrangements to embrace the aspects of prevention, preparedness, response and recovery (PPRR). PPRR are aspects of emergency management not sequential phases.

**convergence.** The propensity for emergency services personnel and others to be physically drawn to an emergency site and the over-use of communications near the site.

**crisis counselling.** Counselling provides a relationship in which the disaster affected persons' experiences are able to be examined together with other issues in their lives in order to assist them to understand the effects the experiences have had and the meaning they have given them. It can then provide them with an alternative set of understandings.

**critical incident.** Any situation faced by emergency workers (or others) that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later.

**critical incident stress.** An acute stress reaction caused by exposure to a traumatic event.

**critical incident stress debriefing.** The process of ensuring the welfare of emergency service and other personnel following a potentially traumatic event.

**defusing, debriefing and worker support.** These special techniques have been developed to assist workers who have been affected by their experiences and have developed potential or actual traumatic stress. Debriefings may use structured methods by those with special training whose aims are to ensure that the details of the experience are reviewed, together with the thoughts, emotions and behavioural reactions they have caused.

**disaster.** A serious disruption to community life which threatens death or injury in that community and/or damage to property which is beyond the day-to-day capacity of the prescribed statutory authorities and which requires special mobilisation and organisation of resources other than those normally available to those authorities.

**disaster affected persons.** People. Other than emergency management personnel, who experience losses or injury or are affected by a disaster. Usually understood to exclude the deceased.

**disaster management.** The body of knowledge and administrative decisions and operational activity which pertain to the various stages of a disaster at all levels.

**personal support services.** The process of assisting the diverse, immediate as well as longer-term personal needs of persons affected by a disaster. Such needs may encompass provision of information, practical advice on a range of issues and emotional support.

**post traumatic stress disorder.** An anxiety disorder, beyond the normal response to stress, caused by exposure to a highly traumatic event that has been excessively demanding.

**psychological services.** The specific forms of assistance, ranging from initial support through to longer-term clinical treatment, provided by trained personnel within this framework.

**psychological support.** Psychological support is used as empathetic listening and emotional attunement and can be provided by relative, friend and non-clinical support staff. It is a sophisticated recognition and reverberation to affected people.

**stressors.** Particular agents in disasters which lead to stresses and traumas.

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