edited by Jane M. Webber
J. Barry Mascari

Fourth Edition

DISASTER MENTAL HEALTH COUNSELING

A Guide to Preparing and Responding

AMERICAN COUNSELING ASSOCIATION

WILEY

edited by **Jane M. Webber**
J. Barry Mascari

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MENTAL HEALTH COUNSELING
A Guide to Preparing and Responding

6101 Stevenson Avenue, Suite 600 | Alexandria, VA 22304 | www.acafoundation.org

Fourth Edition

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A Guide to Preparing and Responding

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For our colleagues who continue to do unselfish acts that improve the lives of often anonymous people without asking for recognition or reward.

And for our students who energize us with their empathy and compassion, and delight in seeing our names in print,

We are indeed fortunate to love the work we do and do the work we love as servants to humanity, leaving our legacy to the next generation of counselors.

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Foreword

Charles R. Figley[1]

I live across from the London Avenue Canal in New Orleans, one of the four drainage canals and one of two ruptured (in two places) in the wake of Hurricane Katrina in 2005. At least 1,245 people died, with total property damage of more than $108 billion. The lower parts of the city flooded and left a muddy mess; thousands of folks had homes that marinated in floodwaters for weeks. The disaster was the costliest natural disaster and one of the deadliest in U.S. history; yet, the flooding could have been prevented with proper preparation and maintenance. The same can be said for disaster mental health: Proper preparation and maintenance/training can increase mental health resilience.

This fourth edition builds on lessons from 9/11, Katrina, the Sandy Hook Elementary School shooting, and other tragedies. In this newly named book, *Disaster Mental Health Counseling: A Guide to Preparing and Responding*, there are original and revised chapters that serve as additional evidence to the first edition published by the American Counseling Association (ACA) Foundation, which remains a classic book critical to practitioners, practitioner educators, and scholars.

Jane M. Webber is a nationally known leader in trauma and disaster education, training, and practice, and she is a seasoned and certified Disaster Response Crisis Counselor in New Jersey—the first such state credential in the country. Dr. Webber served as Associate Editor of the *Journal of Counselor Preparation and Supervision* (published by the North Atlantic Region Association for Counselor Education and Supervision), ACA North Atlantic Region Chair, and a member of the ACA Governing Council, and she currently serves on the ACA Trauma Interest Network Leadership Board. As ACA Foundation Chair in the aftermath of 9/11, Dr. Webber advocated for creating the groundbreaking ACA Foundation book, *Terrorism, Trauma, and Tragedies: A Counselor's Guide to Preparing and Responding*. She served on the advisory committee that developed trauma-informed education competencies in the 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards, the first such effort in the world that is now the standard of practice.

[1]Charles R. Figley is the Paul Henry Kurzweg, MD chair in Disaster Mental Health, at Tulane University, New Orleans.

J. Barry Mascari is also a nationally known leader in trauma and disaster education, training, and practice. Dr. Mascari was a long-time member of the State of New Jersey's counselor licensing board for 10 years and was chair for 8 years. This experience, together with serving as president of the American Association of State Counseling Boards in 2006–2007, has strengthened his influence on state and national standards. He completed service on the CACREP Board when disaster and trauma response were again included in the 2016 Standards.

In 2009, Webber and Mascari published an article that has been widely read explaining the implications of the new CACREP standards for disaster, trauma, and crisis counseling for counseling professionals. Who knows better? Their conceptualizations in collaboration with dozens of experts have served as an important map to the postmodern era for both understanding trauma in general and recognizing that disasters are separate events leading to individual and mass trauma. Moreover, crisis counseling is based on an understanding of both the context of the crisis that caused the trauma and the application of neurobiological and relational knowledge about traumatic stress and resilience to it.

Webber and Mascari's careers have each spanned more than 45 years, and together they have conducted more than 120 disaster mental health and trauma trainings and workshops across the country. They have consistently advocated for disaster and trauma skills to have a central and pivotal role in counselor training as well as in counseling and mental health professions. In this revised edition, Webber and Mascari continue to promote general guidelines in developing disaster and trauma curricula that they make available to readers on a dedicated website supporting this book. These guidelines are converted to learning objectives for trauma-competent counselors. They emphasize that trauma-informed courses, training, and supervision always start with the following objective: "Understand the principles and purposes of disaster response, trauma counseling, and crisis intervention and their differences." This book carries the reader through the chapters that collectively note the importance of disaster- and trauma-focused ethical guidelines, disaster response organizations, and markers for demonstrating competencies as practitioners (i.e., disaster response, trauma counseling, and crisis intervention). Other topics include networking, interprofessional collaboration with responders, and guidelines for educators preparing to teach this counseling specialty in classes.

This extensively revised and expanded edition integrates principles and new understandings about neurobiology's impact on disaster and trauma to improve resilience and to promote trauma recovery. Webber and Mascari properly apply evidence-based practice to trauma response that is stage and context/hazard specific so that counselors can respond effectively to those individuals affected by mass violence and terrorism. Such a response must be appropriate for vulnerable populations and communities, require multiple options that are the best fit in practice, and connect to local and cultural strengths in response to posttrauma community needs. At the same time, disaster mental health professionals need to care for themselves and fellow trauma workers to build resilience to compassion fatigue and other unwanted consequences of helping others. Webber and Mascari continue to raise trauma awareness by sharing the narratives and lived experiences of therapists and disaster mental health responders. They also prepare for the future by using web-based knowledge and multimedia approaches to teach about the above matters and to disseminate needed information rapidly.

The London Avenue Canal can provide some comfort to those of us living nearby. We can also expect that this book, in its fourth edition, will continue to serve as the critical guide to disaster and trauma education and practice for many years to come. Such a guide will make all of us more resilient to trauma by knowing we are not alone.

Preface

In the 8 years since the publication of the third edition of *Terrorism, Trauma, and Tragedies: A Counselor's Guide to Preparing and Responding*, the landscape of disaster has rapidly changed. While parts of the country experienced repeated natural disasters by devastating storms, fires, and floods, other places were in shock from intentional and often random shootings that inflicted enormous suffering, injuries, and deaths.

Advances in disaster mental health (DMH) counseling have unified what was a patchwork of well-meaning compassionate practices into a distinct counseling specialty with a formal body of knowledge, standards, and protocols. Since 9/11, milestones in the development of DMH counseling include the standardization of training and responding by the Federal Emergency Management Agency; the infusion of disaster, trauma, and crisis competencies in the 2009 Standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP); and the expanded role for counselors in DMH preparation, response, and recovery at the local, state, national, and international levels. To emphasize this comprehensive proactive approach to preparation and response, we have revised the title of the fourth edition to *Disaster Mental Health Counseling: A Guide to Preparing and Responding*.

The original book published in 2002 provided urgently needed resources for counselors in the aftermath of 9/11. In the second edition in 2005, we continued to provide information and practices for the long-term recovery after the terrorist attacks. The third edition in 2010 added lessons learned after Hurricane Katrina and the tragedies at Virginia Tech and other universities.

In this fourth edition, we have revised and expanded the book to achieve four major goals. First, with the collaboration of 27 contributors, we have developed a graduate counseling textbook and resource of current DMH and trauma knowledge and practice that addresses the CACREP 2016 Standards for graduate training. Second, we provide practical DMH skills and strategies for counselors and mental health professionals working in a range of settings: agencies, schools, universities, private practice, and international deployment. Third, we have created a compendium of state-of-the art information, research, resources, and practices

in DMH counseling for professional development and training. Fourth, we have shared the learned experiences of responders in the field that reflect the expanding professional scope and roles of DMH and trauma counselors. The fourth edition continues to infuse an experiential approach that blends DMH and trauma concepts and practices with the practicality that has been this book's signature. Each chapter includes case studies and questions for discussion.

At the end of each chapter, we present brief personal stories called "In Our Own Words" that are free of the constraints of formal writing and research. These narratives and essays in the authors' own voice reflect their journeys through disasters, traumatic events, and real-world experiences. In addition, new and updated chapters by internationally recognized clinicians, trainers, and responders working in the field add a contemporary global perspective that addresses refugees and complex humanitarian crises.

We will also have two companion resources available to instructors in winter 2017: (1) a dedicated website to access chapter outlines, test questions, and resources, and (2) a curriculum guide for use in addressing the 2016 CACREP Standards. For further information, contact the editors at disastermhc@gmail.com.

SECTION 1: DISASTER MENTAL HEALTH COUNSELING: FOUNDATIONS

In Chapter 1, "Understanding Disaster Mental Health," we (Jane M. Webber and J. Barry Mascari) describe the importance of DMH as a counseling specialty and define disaster stages of recovery and roles of DMH responders. In Chapter 2, "Disaster Mental Health Counseling: Skills and Strategies," we (Jane M. Webber and J. Barry Mascari) and Julia K. Runte explain the differences between traditional clinical mental health counseling and DMH counseling, and we describe psychological first aid and crisis counseling, with a focus on somatic techniques for stabilization. In Chapter 3, Carol M. Smith describes "How the Brain and Body Change After a Disaster," providing both a scientific and practical understanding and application to somatic treatments. In Chapter 4, I (Jane M. Webber)—with Mike Dubi, Julia K. Runte, and Mindi Raggi—offer methods for "Assessing the Needs of Disaster-Affected Persons," focusing on psychological first aid and PsySTART, the American Red Cross All Hazards Color System. We address criteria for acute stress disorder and posttraumatic stress disorder as well as intermediate and long-term interventions. In Chapter 5, "Compassion Fatigue: Our Achilles' Heel," J. Eric Gentry, Anna B. Baranowsky, and I (Jane M. Webber) examine the negative impact on DMH counselors who work with trauma- and disaster-affected persons, and we present a model for compassion fatigue recovery. We also describe the positive effects of resilience and the potential for posttraumatic growth. In Chapter 6, "Ethics Narratives From Lived Experiences of Disaster and Trauma Counselors," Vilia Tarvydas, Lisa Lopez Levers, and Peter R. Teahen develop disaster-focused ethical standards and illustrate applications through personal narratives of lived experiences in humanitarian crises.

SECTION 2: DISASTER AND TRAUMA RESPONSE IN THE COMMUNITY

In this section, we focus on DMH counseling with several populations. In Chapter 7, we (Jane M. Webber and J. Barry Mascari) and Samuel Sanabria address the growing DMH response to mass bombings and shootings in "Responding to Mass

Violence and the Pulse Nightclub Massacre." In Chapter 8, we (J. Barry Mascari and Jane M. Webber) and Mike Dubi focus on "Counseling Veterans and Their Families" during stages of deployment, with a focus on reintegration. We address the critical role of civilian counselors working with veterans—especially National Guard and Reserve members returning from Iraq and Afghanistan and experiencing multiple deployments. In Chapter 9, Jennifer Baggerly presents developmentally appropriate interventions after disasters for "Children and Adolescents in Disasters: Promoting Recovery and Resilience." In Chapter 10, "Counseling Survivors of Hurricane Katrina," Barbara Herlihy and Angela E. James continue to chronicle long-term disaster and trauma recovery through the experiences of four survivors in New Orleans.

In Chapter 11, Rachael D. Goodman, Colleen K. Vesely, and Bethany Letiecq examine the multiple issues and needs of "Counseling Refugees" and follow the stories of two women who experienced the traumatic impact of war and political conflict through violence, trauma, separation from family and home, physical injury, and sexual abuse. In Chapter 12, "International Deployment and Disaster Mental Health Counselors," Karin Jordan outlines the DMH hierarchy of needs and describes stages and challenges of international disaster response in the context of the tsunami response in Sri Lanka.

SECTION 3: DISASTERS AND MASS VIOLENCE AT SCHOOLS AND UNIVERSITIES

In Chapter 13, we (J. Barry Mascari and Jane M. Webber) develop the evolving role of counselors in "School Disaster Mental Health" as they engage in comprehensive planning, prevention, and response to natural disasters and human-caused violence. With more school shootings occurring in recent years, two new chapters specifically address this topic. In Chapter 14, Deb Del Vecchio-Scully and Melissa Glaser chronicle "Disaster Recovery in Newtown: The Intermediate Phase," examining multilevel family and community interventions after the shootings at Sandy Hook Elementary School. In Chapter 15, Richard Reyes chronicles and analyzes from a law enforcement perspective the proliferation of school violence in "School Shootings in Perspective." In Chapter 16, Gerard Lawson describes the development of crisis and long-term response with a focus on the shooting at Virginia Tech in "University Disaster Mental Health Response," offering lessons learned for preparation, crisis intervention, and recovery in higher education settings. In Chapter 17, "Disaster Mental Health and Trauma Counseling: The Next Decade," we (J. Barry Mascari and Jane M. Webber) provide our perspective on the importance of integrating DMH and trauma counseling practice because DMH cannot be adequately addressed without understanding the impact of trauma. As this specialty continues to grow, we offer recommendations for future development.

IN OUR OWN WORDS

At the end of each chapter, we honor counselors' personal stories and their journeys as disaster and trauma counselors through "In Our Own Words." In the tradition of the first three editions, the fourth edition gives testimony to the commitment of counselors in responding to disasters and tragic events and their lived experience. In Section 1 after Chapter 1, Tom Query reflects on compassion fatigue in "Ground Hero: A Story of Compassion Fatigue After September 11th." After

Chapter 2, Emily Zeng updates her experiences in her native province in "Interventions With Children After the Earthquake in China." After Chapter 3, Carol M. Smith describes "Inadvertently Studying Trauma for 35 Years," and Robert G. Mitchell shares his first-hand account of the tornado's impact in "Evergreen Got Slammed." After Chapter 4, Mike Dubi describes his career direction in "A Strange Beginning," and Juneau Mahan Gary describes "The Emotional Roller Coaster of Surviving Superstorm Sandy." After Chapter 5, J. Eric Gentry and Anna B. Baranowsky chronicle their professional journeys in "Two Decades of Compassion Fatigue Treatment, Prevention, and Resilience" and "Confessions of a Trauma Responder," respectively. After Chapter 6, Peter R. Teahen reflects on "Evolving."

In Section 2, after Chapter 7, Samuel Sanabria shares his reactions as a responder in "Self-Care and Guilt in the Wake of the Orlando Shooting." After Chapter 8, mental health counselor Rachel Oelslager shares the tragic death of her veteran husband in "Wounds You Cannot See." After Chapter 9, Jennifer Baggerly describes her journey in "Helping Children Heal." After Chapter 10, Barbara Herlihy and Angela E. James present their own survival experiences in New Orleans in "Weren't You Scared?" and "When Are We Going Home?," respectively. After Chapter 11, Rachael D. Goodman reflects on "Trauma Counseling as Social Justice." After Chapter 12, Karin Jordan describes her DMH experiences abroad and their personal impact in "A Day in the Life of a Relief Worker: Expect the Unexpected."

In Section 3, after Chapter 13, I (J. Barry Mascari) chronicle my professional career path in "I Never Thought I Would Become So Focused on Disaster and Trauma," and Joel M. Baker updates his reflection on "From Clifton High School: Fifteen Years After September 11" about the death and legacy of his brother-in-law. In Chapter 14, Deb Del Vecchio-Scully and Melissa Glaser share their reactions in "Reflecting on the Sandy Hook School Shooting" and "Focus on Faith Not Fear," respectively. After Chapter 15, Richard Reyes describes his experiences as a police officer and his commitment to "Recognizing the Importance of Crisis Intervention," and after Chapter 16, Gerard Lawson reflects on his own experiences and reactions at Virginia Tech in "Prepare for the Worst, Then Do Your Best." After Chapter 17, I (Jane M. Webber) share my professional and personal counseling journey in "'I Discovered Within Me an Invincible Summer.'"

MOVING FORWARD

Since 2009, CACREP has provided standards for disaster and trauma response for counseling programs and continues to confirm the importance of disaster and trauma preparation for counselor trainees in the 2016 Standards. This fourth edition gathered evidence of these developments that have significantly raised the level of DMH counseling, knowledge, and best practices for counseling professionals and for the people we serve. As we continue to share in this important DMH counseling project, we welcome your thoughts and suggestions (send e-mails to jmascari@kean.edu and jwebber@kean.edu).

—Jane M. Webber and J. Barry Mascari

Jane M. Webber, PhD, LPC, DRCC, and **J. Barry Mascari, EdD, LPC, LCADC, DRCC,** hold New Jersey Disaster Response Crisis Counselor Certification and serve on New Jersey's disaster mental health response team. Together, they are leaders in disaster mental health and trauma counseling training and practice and popular national presenters who have delivered more than 250 national, international, and state workshops and conference sessions. They are accomplished writers (together and individually), publishing groundbreaking articles such as "CACREP [Council for Accreditation of Counseling and Related Educational Programs] Accreditation: A Solution to Counselor Identity and License Portability Problems"; "Critical Issues in Implementing the New CACREP Standards for Disaster, Trauma, and Crisis Counseling"; "Moving Forward: Issues in Trauma Response and Treatment"; "Salting the Slippery Slope: What Licensing Violations Tell Us About Preventing Dangerous Ethical Situations"; and "Lessons Learned, The Best Laid Plans: Will They Work in a Real Crisis?" They are editors of the third edition of the American Counseling Association (ACA) Foundation book *Terrorism, Trauma, and Tragedies: A Counselor's Guide to Preparing and Responding* and primary authors of the *New Jersey School Counselor Initiative: A Framework for Developing Your Comprehensive School Counseling Program*, sharing the 1992 American School Counselor Association Writer/Researcher of the Year for the first edition. They authored the *NJSCA School Counselor Evaluation Model*, the first professional association model approved by the New Jersey Department of Education. Drs. Webber and Mascari have been quoted on disaster and trauma issue in the national media, recently in *Counseling Today* and *CNN Online,* as well as on National Public Radio. Together they anchored the ACA's full-day learning institute on disaster response and have championed bringing disaster and trauma skills to school and mental health counselors. In addition to being long-time professional colleagues, Jane and Barry are married and have four children—combined.

Jane M. Webber, PhD, LPC, DRCC, is a Lecturer in the Counselor Education Department at Kean University (Union, NJ) and is a New Jersey Licensed Professional Counselor. She was a member of the ACA Task Force for Crisis Response

Planning and served on the Advisory Committee for Emergency Preparedness for the 2009 CACREP Standards. Dr. Webber was Guest Editor of the Traumatology Special Section of the *Journal of Counseling & Development* (Summer 2017) and was primary author of the *Journal of Counseling & Development* article "Traumatology Trends: A Content Analysis of Three Counseling Journals 1994–2014." As ACA Foundation Chair during September 11, 2001, she advocated for the ACA Foundation publication *Terrorism, Trauma, and Tragedies: Counselor's Guide to Preparing and Responding*, and she coedited the second and third editions.

Dr. Webber is a former Chair of the ACA Foundation, North Atlantic Region; International Committee; Human Rights Committee; and the Public Awareness and Support Committee, as well as a member of the Governing Council. She was a National Assembly Delegate of the National Association for College Admissions Counseling, National Membership Chair, and Member of the Bylaws Committee. She is a life member of Chi Sigma Iota.

Dr. Webber is former President of the New Jersey Counseling Association, the New Jersey Association for College Admission Counseling, the New Jersey Association of Counselor Educators and Supervisors, and the New Jersey Association for Specialists in Group Work. She worked for more than 35 years as a college counselor, school counselor, school counseling supervisor, and private practitioner. She has published numerous articles and chapters on disaster mental health, trauma counseling, sand tray therapy, and school counseling—including "Integrating Sand Therapy Into Trauma Counseling: Historical Influences"—and she coauthored "Healing Trauma Through Humanistic Connection" in the award-winning book *Humanistic Perspectives on Contemporary Counseling Issues*.

J. Barry Mascari, EdD, LPC, LCADC, DRCC, is Chair of the Counselor Education Department at Kean University (Union, NJ) and is a New Jersey Licensed Professional Counselor and Licensed Clinical Alcohol and Drug Counselor. He has more than 30 years of counseling-related experience in schools and outpatient treatment, and he participated in the development of the New Jersey Department of Education (NJDOE) student assistance counselor certification. He was a member and Chair of the New Jersey Professional Counselor Examiners Committee (the state licensing board) for 10 years and a former President of the American Association of State Counseling Boards (AASCB), New Jersey Counseling Association, and New Jersey Mental Health Counselors Association. With Dr. Ed Stroh and Nancy Marie Bride, he lobbied for licensure in New Jersey for 20 years and coauthored the licensure bill that was finally passed in 1993.

Dr. Mascari is considered the "father" of *20/20: The Future of Counseling*, a collaborative initiative between AASCB and ACA that resulted in the common definition of counseling. He was among the founders of the New Jersey Council on Divorce and Family Mediation, and he coauthored the seminal work *Family Mediation: An Idea Whose Time Has Come*. He has appeared on numerous radio and television shows, including the *Sally Show*, *Soap Talk*, *48 Hours on Crack Street*, *Straight Talk*, the WNET special *Teens in Turmoil*, and National Public Radio. Dr. Mascari was a NJDOE trainer for Intervention and Referral Service and continues to host trainings at Kean University for New Jersey school districts. More information can be found at https://sites.google.com/a/kean.edu/j-barry-mascari/.

Jennifer Baggerly, PhD, LPC-S, RPT-S, is Professor of Counseling, School of Human Services, University of North Texas at Dallas. She is a former chair of the Board of Directors of the Association of Play Therapy.

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Disaster Mental Health Counseling: Foundations

Chapter 1

Understanding Disaster Mental Health

Jane M. Webber and J. Barry Mascari

Disasters have wreaked havoc in people's lives since earliest times. Hurricanes, fires, and earthquakes are among catastrophic natural disasters that occur throughout the world, and people living in vulnerable geographic areas face the potential of disasters, such as tornadoes and wildfires, as a daily threat. Human-caused disasters (e.g., wars, political conflict, mass violence, and catastrophic accidents) have also deeply affected individuals and communities. The September 11, 2001, terrorist attacks shattered Americans' sense of safety, dramatically changing their world view so that *if you see something, say something* is a continuous civic responsibility. The long-term psychological impact on survivors and families of victims continues even 15 years after the World Trade Center tragedy (Fetchett, 2016). Schools and universities, historically considered places of safety for children, are now targets for shooters, and lock-down drills are standard practice in elementary and secondary schools. Furthermore, the plight of Syria's people during the current civil war has been called the "largest humanitarian crisis since World War II" (Clay, 2017, p. 34). Civil war and persecution have affected more than 20 million refugees and 40 million people internally displaced in Syria, Afghanistan, Iraq, Somalia, and other countries. Social media, electronic communication, and continuous television coverage instantly bring these disasters into people's living rooms.

In times of crisis and disaster, Fred Rogers (2013) reminded us, "If you look for the helpers, you'll know that there's hope" (0:51). Counselors and disaster mental health (DMH) professionals *are* these helpers. The enormity and ubiquity of mass tragedies underscore the need for trained and ready DMH responders in the "era of mass violence" (Mascari, Webber, & Kitzinger, 2015). Although they might not be able to volunteer or deploy to distant sites, all counselors and mental health professionals should be prepared and ready to assist those affected

by mass traumatic events, particularly in their own communities. In this chapter, we describe the organized response to disasters and examine the role of DMH counselors in response to various types of disaster and mass violence events. We follow the development of DMH counseling as a professional specialization as well as advancements in national training, preparedness, and response.

PROTECT, DIRECT, CONNECT

In August 2005, thousands of people huddled in the New Orleans Superdome or were stranded and desperate on the roofs of buildings surrounded by rising floodwaters from levees breached by Hurricane Katrina. Individuals were better able to cope and survive if they could (a) *protect* themselves from danger and trauma in a shelter or a safe place; (b) *direct* their attention to immediate priorities of food, water, and medical needs and restore a sense of hope and meaning; and (c) *connect* to family and friends for support. These three priorities reflect the purposes of DMH and psychological first aid goals and tasks (Crimando, 2009; Myers & Wee, 2005).

Terrorist attacks in France (Paris and Nice), at the Boston Marathon, and the Inland Regional Center in San Bernardino, California have heightened individual and community fear, increasing Islamophobia in the United States and abroad. An atmosphere of dread pervades American daily routines at athletic events, concerts, schools, and universities. With growing numbers of events-turned-violent at the Las Vegas music festival, Orlando nightclub, and the Ariana Grande concert in Manchester, England, "the expectation of psychological trauma and posttraumatic stress disorder is now part of our national consciousness" (Reyes & Elhaida, 2004, p. 399). Disaster, crisis, and trauma counseling skills and response are now an essential part of counselor training and practice (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016).

TYPES OF DISASTERS

How people view disasters and traumatic events influences their reactions. The United Nations defines a disaster as "a serious disruption of the functioning of society, causing widespread human, material, or environmental losses which exceed the ability of affected society to cope using only its own resources" (United Nations International Strategy for Disaster Reduction, 2009, p. 9). The International Federation of Red Cross and Red Crescent Societies (2016) echoed the United Nations' description, adding the qualifier "a sudden calamitous event" (para. 1). A disaster frequently follows a crisis or an *emergency* when "people are unable to meet their basic survival needs, or there are serious and immediate threats to human life and well-being . . . normal procedures are suspended and extraordinary measures are taken in order to avert a disaster" (World Health Organization, 2003, p. 3). Crises are often explained in terms of the Chinese character that is the combination of two characters: danger and opportunity. Thus, a *crisis* is a highly distressful event or time when people are overwhelmed and cannot function with normal coping skills. A crisis might lead to an emergency or a disaster that affects many people. Disasters can be categorized by factors such as demographics, geography, culture, cause, or impact—economic, political, ecological, health, social, technological, or human (Pearce, 2000).

Natural Disasters

Natural disasters are classified by weather (e.g., storm, snow), earth movement such as earthquakes; or biological or ecological impacts such as global warming,

rainforest destruction, or pandemic (Tracy, 2012). These events share similar elements, but the impact of each is unique, and the response depends on past disaster experiences, population, preparation, federal and state support, and resources (Norris, 1992; Pynoos, Steinberg, Schreiber, & Brymer, 2006). Although the impact of disasters is high, their occurrence is low; some geographic areas—for example, a valley may be vulnerable to flash floods, or a plain may be subjected to frequent tornadoes—are at higher risk. For such areas, perceived threat, preparation, and early warning systems for evacuation or taking shelter are key tasks for risk reduction. Disasters are also described as slow-onset or rapid-onset, predictable (e.g., blizzard, hurricane) or without advance notice (e.g., earthquake), and with immediate impact (e.g., deaths by flooding and drowning) or long-term consequences (e.g., chemical or oil contamination, radiation). In Table 1.1, disasters are categorized as natural, human caused, or with human influence.

Mass Violence and Terrorism

Mass violence is an intentional attempt to kill multiple individuals that might stem from extremism or terrorism (Anti-Defamation League, 2016). Terrorists plan to disrupt normalcy by instilling psychological fear, vulnerability, terror, and powerlessness and by maximizing death as well as physical and economic destruction. More mass shootings have occurred in the United States within the past decade than ever. From 1966 to 2012, 90 mass killings were recorded in the United States, composing almost 31% of the world's shootings, and three fourths of the guns

TABLE 1.1
Types of Disasters

Natural Disaster	*Human Caused*	*With Human Influence*
Flood, tsunami	War, military conflict, political takeover, invasion	Pollution, ecosystem impact, deforestation
Earthquake, aftershock	Hostage taking	Dam, levee breech or damage, with flooding
Hurricane, tornado, superstorm, cyclone, typhoon	Terrorist attack	Bridge, road damage
Thunder, rainstorm	Riot, mob, stampede, accidental mass violence	Global warming
Snowstorm, ice storm, blizzard, avalanche, landslide	Aggression, physical attack, shooting, stabbing, torture, homicide, genocide	Radiation leak, nuclear accident, reactor meltdown
Fire, wildfire, forest fire	Assassination	Fire by arson, accidental
Extreme temperature	Bombing, explosion	Mine fire, collapse
Volcanic eruption	Aircraft crash, as a weapon, hijacking	Lack of immunization
Landslide, mud, rock	Contamination; exposure; poisoning of water, food, medicine, air	Hazardous waste
Fallen tree, debris	Nuclear, chemical, biological weapon attack	Gas leak, explosion
Lightning strike, meteorite	Technology, cyberweapon attack	Electrocution
Famine	Chemical, industrial accident, oil spill	Transportation accident with aircraft, bridge, ship, tunnel, train, auto
Dust storm	Large train, ship, road accident	Building, structural collapse; power plant accident
Disease, pestilence, pandemic, epidemic, fatal illness	Mass suicide, suicide pact	Exposure to toxin, toxic pollution
Unexpected or unexplained death, injury		Complex humanitarian emergency
Bridge, road damage		Displacement, relocation, resettlement, migration, asylum, refugee crisis
		Economic decline, collapse

Note. For additional information, see J. Halpern and Tramontin (2007), Mascari and Webber (2010a, 2010b), Substance Abuse and Mental Health Services Administration (2014), Tracy (2012), and Webber and Mascari (2016).

used were legitimately obtained (see Chapter 7 regarding the Pulse shooting in Orlando, and Chapters 14 and 15 regarding school shootings.). As members of emergency management response teams in their organizations and communities, counselors can take proactive steps to assess vulnerability, identify potential perpetrators with the help of the community, and raise awareness of the importance for individuals to be more mindful of their surroundings and to trust "the gift of fear" (De Becker, 1997).

Complex Humanitarian Emergency (CHE)

Disasters also include mass emergencies in which serious political, economic, and social changes deeply affect thousands of people, such as in Syria, Bosnia, Rwanda, or Kosovo. The World Health Organization (2016) defined a *complex humanitarian emergency* (CHE) as follows:

> A humanitarian crisis in a country, region, or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country program. (para. 29)

These social emergencies often reflect the impact of war with massive loss of life from murder, disease, and famine; displaced people in-country (often because of ethnic cleansing); and forced migrations to survive (Klugman, 1999). The exodus from Syria beginning in 2011 and escalating to crisis levels in 2015 and 2016 has forced people to undergo migrations from country to country with major loss of life and property, starvation, extreme suffering, and deprivation (European University Institute Migration Policy Centre, 2016).

A CHE can be categorized by war, refugees, disease, and hunger that require a political, social, and global response. CHEs are typically assessed by the number of (a) war casualties, (b) under-5 mortality, (c) under-5 malnourishment, and (d) displaced people (Keely, Reed, & Waldman, 2001; Moss et al., 2006). CHEs are not natural disasters, although they might follow extreme weather, hunger and famine, epidemics, pandemics, loss of community social services, and threat of danger. A natural disaster could also be used as a trigger for political, social, and economic crises with vulnerable groups, civil unrest, or war leading to a CHE. DMH counselors may deploy to disaster sites, refugee camps, relocation centers, and international advocacy organizations in resettlement areas (see Chapter 6 for DMH ethics in CHEs, Chapter 11 for counseling refugees, and Chapter 12 for international deployment.)

DISASTER MYTHS AND REALITIES

Since 9/11, beliefs about trauma and disaster and their effects on people have changed substantially. Until recently, DMH response was largely informed by personal experience and observation. S. Gold (2009) observed, "The entire field of trauma psychology is based on *theory*. The assertion—or assumption—that catastrophic events can have appreciable adverse impact on psychological functioning is itself a theoretical position" (p. 1). The specialty of DMH counseling has grown rapidly, developing into an evidence-informed body of knowledge and practice through extensive training, publications, and research.

Trauma is not an unusual occurrence, especially after disaster, and most individuals will experience one or more traumatic events over their lifetime (Bonanno, 2004; Briere

& Scott, 2014). Prior to 9/11, many believed that most disaster-affected individuals developed psychopathological reactions and posttraumatic stress disorder (PTSD). The reality is that although “no one who experiences a disaster is untouched by it,” most people affected by disasters are resilient and do not develop PTSD (Centers for Disease Control and Prevention, 2005, para. 3). Many people return to their baseline functioning in a few days or weeks following a disaster. About 8%–12% of people may develop PTSD as a long-term result, and those who had experienced prior trauma or witnessed death or injury have a greater risk for developing PTSD, including first responders and military personnel deployed to war zones (Briere & Scott, 2014). Most postdisaster stressors immediately following a mass disaster are commonly experienced; thus, most individuals exposed to disasters have normal and expected reactions to an abnormal event (DeWolfe, 2000; Weaver, 1995).

In the aftermath of a disaster or mass traumatic event, survivors and witnesses experience a range of reactions that intensify the closer they were to the actual disaster site. Although television and media often catastrophize the psychological condition of survivors, most disaster-affected individuals are resilient and bounce back quickly, emerging from the traumatic event stronger than before the disaster. Although everyone is affected by a disaster, the majority are resilient and work together with neighbors and community members to recover, experiencing posttraumatic growth and a new sense of purpose rather than PTSD (Calhoun & Tedeschi, 2006).

> The vast majority of trauma survivors are neither helpless nor superhuman. Instead, they are regular people who are coping actively and facing their challenges with integrity. Of course, in the midst of the chaos and turmoil, survivors endure tremendous torment, anguish, grief, fear, and rage. In the wake of catastrophe, they may find themselves unable to perform their jobs, concentrate on their studies, or handle the day-to-day tasks of living. They may feel alienated, confused, and overwhelmed. At the same time, most survivors are immediately demonstrating resilience by their initiative, fortitude, compassion, and sense of hope. (Echterling & Stewart, 2010, p. 83)

DISASTER RECOVERY

Disaster recovery is composed of “an array of actions taken by individuals, community groups, local, state or federal agencies and other organizations to restore and rebuild physical, psychological, social, environmental and economic well-being of a community, region, state or nation” (Federal Emergency Management Agency [FEMA], n.d.-a, p. 6). The first individuals to respond are law enforcement personnel, firefighters, emergency medical workers, as well as active military and National Guard/Reserve personnel who secure the disaster area and make it safe. Second responders are American Red Cross local volunteers, DMH specialists, and others who provide psychological first aid, especially in the first 24–48 hours. Local residents typically rush to help in any way possible, especially when the magnitude of a disaster is overwhelming and those affected are injured and suffering. Neighbor-helping-neighbor describes the human capacity to help. For example, the film *Boatlift* (Rosenstein & Velleu, 2011) documented how volunteers with local boats rescued nearly a half million people from Manhattan on September 11 in less than 9 hours. The video is testimony to community resilience by ordinary people rising to serve in extraordinary times of crisis: “average people—they stepped up when they needed to” (Rosenstein & Velleu, 2011, 9:43–9:48). This volunteer effort was the largest sea evacuation in history.

All-Hazards Disaster Preparation

Disaster recovery requires a variety of actions coordinated across agencies and governmental levels to help rebuild affected areas. Critically important in minimizing the impact of a future disaster is the process of *all-hazards preparation*, the most comprehensive planning model for disasters. All-hazards risk analysis begins with identifying potential disasters likely to affect the area and then preparing to respond to each type of disaster. Some planning actions cut across many potential disasters, such as capacity preparedness, evacuation procedures, notification, and sheltering. Other actions are *hazard specific* and *phase specific*. DMH responses are also *scalable* and can be increased or reduced depending on the needs of survivors, the type and cause of the disaster, and the availability of resources (Crimando, 2009).

Phases of Disaster Recovery

In addition to predisaster planning, disaster recovery is organized in five phases, as shown in Figure 1.1.

Phase 1. The *impact phase* begins when the disaster strikes, although the length of this phase varies from 1 day to several days according to the degree of advanced planning in the preparation or threat stage before the disaster occurs. Hurricanes might be tracked for a few days so people can prepare or evacuate, but earthquakes and human-caused disasters occur with little or no warning. Individuals have a range of posttraumatic reactions from shock, panic, and being overwhelmed and confused to maintaining control. In some disasters, the impact phase is extended—for example, extensive flooding from the levee breaches in New Orleans or from hurricanes in Florida.

FIGURE 1.1
Phases of Disaster Recovery

Note. Reprinted from *Training Manual for Human Service Workers in Major Disasters* (2nd ed., p. 5), by L. M. Zunin and D. Myers, 2000, DHHS Publication No. ADM 90-538). Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Reprinted with permission.