

Crisis Intervention With Survivors of Natural Disaster: Lessons From Hurricane Andrew

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Crisis intervention has typically been conceptualized as seeking a return of clients to a state of equilibrium. Our work with Hurricane Andrew survivors in south Florida, as part of the Disaster Mental Health Services team of the American Red Cross, has led us to appreciate the importance of several further considerations. In our work, we developed a proactive approach, attempting to recognize and extend clients' preexisting strengths. We offer a number of pragmatic interventions, focusing particularly on children's issues and we draw attention to sensitive multicultural issues.

On August 24, 1992, Hurricane Andrew created a world dominated by a profound sense of loss for approximately 200,000 people who were left homeless in south Florida. As volunteers with the Disaster Mental Health Services team through the local chapter of the American Red Cross (ARC), one of our primary tasks was to restore some sense of control and dignity to the victims of this disaster. They had experienced not only physical loss but also emotional and social losses. Yet perhaps most salient was the loss of the sense that the world is usually a safe, secure, and predictable place (see also Janoff-Bulman, 1992).

As members of the Disaster Mental Health Services team, our efforts began as providing practical aid and support. Quickly, however, our approach to this task evolved toward a model of attempting to empower the hurricane's victims. We received ARC training as mental health workers 3 days after the disaster, and within hours after training we found ourselves providing counseling services. We were the only two mental health workers in our emergency relief center during the first weeks, and logistical difficulties limited communication with other mental health team members. In an attempt to deal with the demands of the situation, we built upon the ARC crisis response model to help survivors in the acute phase of crisis. In this article we describe our impressions of the mental health aspect of the relief effort. We believe these impressions have implications for disaster counseling more generally.

We want to point out two limitations in our discussion. First, although counselors in the relief effort served both the ARC staff members and disaster survivors, this article deals strictly with the latter (for discussion of issues facing disaster relief providers, see Armstrong, O'Callahan, & Marmar, 1991; Duckworth, 1991; Paton, 1989, 1990; Paton & Kelso, 1991; Summers & Cowan, 1991). Second, this article is an impressionistic account of our experiences in the field. We have mostly relied on anecdotal evidence, but we do not have systematic data to support these impressions.

THE CRISIS SETTING

The ARC Emergency Relief Center in Perrine, Florida, was one of many service centers; at one point, at least 16 ARC assistance facilities were in operation. It served a population of predominantly lower socioeconomic-status disaster victims. The clients' diverse ethnic identities included African Americans, Cuban Americans, Mexican Americans, Puerto Ricans, Central Americans, and people from the Caribbean nations. In the initial aftermath of Hurricane Andrew, it

was not uncommon for lines of more than 500 people to wait for many hours to receive an appointment to obtain disaster relief. For many, long lines were a daily experience in the attempt to gain help from agencies such as the Federal Emergency Management Agency, the Post Office, and military kitchens. The magnitude of the natural disaster, and the sometimes rigidly bureaucratic nature of the relief effort, tended to reinforce the powerlessness of the victims and undermine their sense of efficacy.

Questioning the Limitations of Crisis Intervention

The crisis state has been studied for more than 50 years, beginning with Lindemann (1944). Several theories of the crisis state and models for crisis intervention with adults, have been proposed (Aguilera & Messick, 1974; Baldwin, 1979; Caplan, 1964, 1970; Jacobson, Strickler, & Morley, 1968). Although it has been argued that crisis intervention has no unified theoretical model (Smith, 1977), there is general agreement that crisis interventions are the preferred approach to treating disaster survivors (Frederick, 1977; Heffron, 1975; Kim, 1975; Schulberg, 1974; Taylor, Ross, & Quarantelli, 1976; Tuckman, 1973; Zarle, Hartsough, & Ottinger, 1974).

Although the crisis state has been variously defined, some consistent themes emerge from the models. Underlying all definitions is the acknowledgment that extremely stressful events can evoke a state of disequilibrium, characterized by disorganization of thought and behavior. A foundation of crisis theory is that, generally, disasters do not result in serious mental illness or severe psychiatric impairment for large segments of the affected populations. Most theories postulate a stage of numbness, shock, or denial immediately following the traumatic event. There is general acceptance of the idea that social support plays an important role in ameliorating the effects of the stressful stimulus (Caplan, 1976). All models recognize a potential for return to the equilibrium state, and some place an emphasis on the opportunity the crisis state provides for positive growth to occur—that is, beyond precrisis functioning (Baldwin, 1979). But this is not to say that adaptive resolution invariably occurs. Most models also acknowledge the possibility that maladaptive coping responses may leave the person at less effective functioning levels than the precrisis status. The crisis period is recognized by all of the models as a critical period to subsequent recovery.

The underlying goal of crisis intervention has historically been to restore the victim's functioning to predisaster levels (Aguilera & Messick, 1974; Janosik, 1984). Janosik (p. 14) added that "A more ambitious goal is to improve pre-crisis levels of functioning" (p. 14).

We regard this as more than an "ambitious goal." Our experience suggests that holding this goal is in fact a very important aspect of effective crisis intervention. We say this because we believe that proactive, culturally sensitive, and empowering interventions were effective in restoring and improving functioning in the clients we served.

What does this mean in more concrete terms? Many approaches to crisis intervention have centered on offering support and mobilizing existing support networks. Other emphases are on reducing cognitive distortions about the situation and providing material information (Baldwin, 1979; Janosik, 1984). In contrast, there has been less therapeutic emphasis on activating the clients' potential or on extending previous areas of strength. One exception is Horowitz, Stinson, and Field's (1991) emphasis on engaging the person's own adaptive processes in whatever way possible. Our interventions were similarly based on the belief that enhancing clients' perceived power would not only restore predisaster functioning but improve it.

This focus took several forms. Foremost, we took a proactive rather than reactive role (see also Phifer, 1990). Rather than wait inside for clients to make their way through the processing gauntlet, we spent time with the center's clients while they waited outside in line or inside for their appointments. This approach gave us an opportunity to make initial contact and provide basic emotional support and teaching, without using terms that may have had negative connotations, such as *therapy* or *mental health patient* (see Baren, 1976). Even the small act of offering ice water to those in line became symbolic of a broader sense of caring. Moreover, the upbeat approach we took appeared to be contagious (see also Ursano & Fullerton, 1990), helping to restore the clients' sense of dignity and personhood. Many clients declared that these positive experiences in line were the first times they had laughed since the onslaught of the hurricane.

The waiting-in-line period was used for other purposes as well. We held both formal classes and informal group discussions of coping and parenting as the clients waited to be seen. In these sessions we provided information about typical reactions of others to the disaster. Additionally, we included suggestions that individuals could use in their recovery and in their response to others. We believed that this knowledge would mitigate against fear and anxiety, offer people concrete coping options, and increase the likelihood that the people would seek further contact with the mental health team.

Another procedural difference between typical crisis intervention and our approach was more subtle. Both in in-line and in more formalized therapy, we used substantially more touching than ordinarily would be expected in a clinical setting. Holding hands, offering a hug, cuddling small children—all seemed to help restore a sense of self-worth and modeled appropriate actions to others.

It seemed to us that our proactive stance helped the adult clients' self-referral for counseling and the referral of their children. In total, at least 150 families a day were seen at the emerging relief center for one of its various operations, with the two counselors combined conducting as many as 40 individual sessions daily. We saw mostly individual clients—children, adolescents, or adults. It was not often possible to see entire families, because their members were engaged in different rebuilding activities. Besides individual sessions, we saw approximately three families and conducted two other group sessions daily. The length of the individual clients' sessions varied greatly, from about 20 minutes to well over 1 hour, depending on the individual's immediate needs. Most of the clients were seen only on a single-session basis. But a number returned to the center to show their appreciation or for a follow-up session. Although no systematic

evidence was collected regarding improvement, in most clients we observed clear behavioral signs of improvement following treatment.

We were present at the center from 9 to 13 hours daily for the first 3 weeks of the operation, and we remained involved in counseling activities on a part-time basis throughout the life of the center—slightly longer than 2 months. This article addresses crisis intervention performed within the 6-week crisis period (as defined by Janosik, 1984). Although our focus is on this early period, several clients reported that the nature of our interaction with them made them more likely to consider joining counseling groups at school or to enter long-term therapy when the local agencies had reestablished themselves.

Benefits to the Counselor From the Crisis Setting

The frantic pace of the work and the limited resources available would appear at first glance to work to disempower the counselor. The acute stage of crisis leaves most people very receptive, however, perhaps even optimally receptive, to new options and the possibility of developing new skills (Janosik, 1984). Furthermore, a counselor's brief interventions can be especially powerful and can often have a long-term influence in such circumstances (Baldwin, 1979; Pynoos & Nader, 1988; Rapoport, 1962). This period can also be an optimal learning one for the counselor, who is often forced by necessity to be more pragmatic and eclectic than usual.

Crisis counseling is extremely demanding and intense. This pressure has surprising payoffs, however. Because of the large number of clients seen in a given week and the intensity of the work, the counselor has the opportunity to recognize elements of effective treatment that might be more difficult to perceive in longer term counseling because of the slower pace of events. The pace of our work in the center made salient to us issues that we believe are near-universal, and it helped us to discover techniques that seemed to provide substantial relief to many of the storm's victims.

Furthermore, the nature of the stressor—a natural disaster rather than a personal crisis or a work conflict—enabled the clients to express their emotions easily. Our experience in this respect was consistent with Janoff-Bulman's (1992) conceptual analysis. That is, clients seemed to experience a shattered sense of the world as a meaningful place, yet their sense of people as basically benevolent seemed fairly intact. Relatively free from the shame and self-blame that often accompanies victimization from violent acts, our clients seemed particularly open to sharing their psychological experience of the disaster. We frequently received immediate feedback from clients about the impact and usefulness of the sessions. Indeed, at least partially as a result of their experiences at the center, several of our clients returned to volunteer themselves.

EMERGENT ISSUES AND OUR THERAPEUTIC RESPONSES

As just indicated, the experience of crisis intervention made a number of therapeutic issues salient to us. These issues in turn led us to the use of several techniques that we believe were particularly effective in this context. In this section, we describe some of those issues and intervention techniques. Among adults, one of the major issues was the overall sense of helplessness experienced (Brown & Ziefert, 1988; Seligman, 1975; see also Carver, Scheier, & Pozo, 1992). Our therapeutic response was to focus on the adults' preexisting strengths and how they might be extended and embellished. Among children, the issues and our therapeutic responses were more diverse. We consider

these two groups separately in the following two sections. We then discuss several issues influenced by cultural differences.

Issues and Therapeutic Responses Among Adults

Our clients' reactions to Hurricane Andrew were similar to those noted in previous natural disasters. For example, J. R. Freedy (personal communication, September 8, 1992), who studied the effects of Hurricane Hugo (e.g., Freedy, 1993; Freedy, Shaw, Jarrell, & Masters, 1992), reported that anxiety, sadness, numbness, and anger were common during the immediate aftermath of Hurricane Hugo. Many adult victims of Hurricane Andrew were similarly overwhelmed by a sense of loss (Baldwin, 1979; see also Cohen, 1987); by perceptions of a lack of control (cf. Burger, Van-Staden, & Nieuwoudt, 1989; Phifer, 1990; Simpson-Housley, Lipinski, & Trithardt, 1978); and by a general sense of disorientation and negative affect (Janoff-Bulman, 1992; see also Phifer & Norris, 1989; Weinrich, Hardin, & Johnson, 1990). But these experiences sometimes create an enhanced capacity to learn new coping behaviors and problem-solving skills (Baldwin, 1979). Indeed, learning that occurs during a crisis state often tends to last, and coping behaviors adopted during the crisis tend to be repeated during stressful situations in the future (Schwartz, 1971). Thus, this crisis also presented an opportunity to create adaptive patterns for the future—patterns that may not have been there before. As Rapoport (1962, p. 30) put it, "A little help, rationally directed and purposefully focused at a strategic time, is more effective than more extensive help given at a period of less emotional accessibility."

A sense of loss from a disaster such as this can come in many forms. Not surprisingly, many clients were mourning the sudden disappearance of a predictable and safe place to live. There were also broader losses. Many clients were lacking the fundamental necessities for survival. Particularly during the first week, it was difficult to acquire basic nutrition. Some were living in condemned buildings. To sleep, family members would crowd into the only room in their house that had a serviceable roof. Most area residents were without electricity for weeks. Some were reduced to using fire hydrants as water sources. Many clients had also lost their means of employment, what little savings they may have had, and their hopes for the immediate future. In addition, they were grieving over the destruction of possessions that had mainly sentimental value, such as photographs and gifts.

Clients' perception of self-efficacy are important, but they cannot be addressed until their basic needs have been met (Janosik, 1984). For example, the confused and disoriented mother of two who had been sleeping fitfully in her car for several days could not be expected to make decisions until a safe and secure abode was arranged for her. When the minimal needs of the clients were met—food, water, and shelter—then the clients made maximum use of their potential to benefit (at least in the short term) from single-session interventions.

As individual counselors, the two of us are grounded in dissimilar theoretical orientations, and we differed in our conceptualizations of clients' problems. One of us held a cognitive-behavioral and brief solution-focused perspective; the other worked from developmental and psychodynamic orientations. Our immediate-term results, based on the clients' self-reports and behavioral changes, seemed to be similar. Both developed comparable therapeutic alliances, although one of us typically spent much longer doing so than the other (as much as half the session, compared with only 1 or 2 minutes). The longer procedure was intended to allow clients to express their affect and experiences, both during and after the hurricane. That counselor then encouraged clients to describe positive coping experiences from the

past, and the therapeutic focus thereafter remained on the person's strengths and potential for recovery and renewal. The other counselor spent less time allowing clients to dwell on negative experiences, instead focusing them rather quickly on the immediate future and engaging in short-term goal setting. Both of us frequently drew on the clients' perceived strengths, and both of us used stress-reduction exercises that the clients could then use themselves daily, such as guided imagery and techniques for muscle-group relaxation. The result, we believe, with both approaches to intervention, was to remind clients of their capabilities and reawaken in them a sense of their own power to overcome.

Increasing the adults' sense of mastery can also occur outside the therapeutic relationship. Many clients claimed that their values had changed (at least temporarily) as a result of events taking place in their neighborhoods. Neighbors mostly pulled together, helping to provide food, offering shelter, and repairing roofs. They had found a common bond in pain and misfortune. In addition, the clients reported that they had begun to appreciate the fundamentals of life, family, and community responsibility, and to realize the transitory nature of material goods and personal possessions. Similarly, in one survey of survivors of Hurricane Hugo, an overwhelming majority of respondents reported that the disaster had led to more cooperation among neighbors, that their family had been brought closer together, and that they had made new friends (J. R. Freedy, personal communication, September 8, 1992).

Issues and Therapeutic Responses Among Children

Treating a large number of children gave us a great deal of exposure to their concerns and provided a substantial knowledge base from which we could develop interventions. In this section, we indicate some issues that emerged from our work with these young disaster survivors, and we then suggest techniques that seemed to provide positive outcomes for a high percentage of our clients, at least in the immediate term.

Problems that emerged. Children as well as adults experienced a sense of overwhelming loss as a result of the storm. This sense manifested itself in a wide range of forms. Many of the children expressed awareness that their encounter with the hurricane was life threatening. Sometimes they focused on the death of animals, usually birds, that they had seen after the storm. Other concerns included losing favorite toys, losing a best friend who had moved away because of the storm, and losing a sense of the predictability of the future. For instance, in the first few weeks after the storm, no one knew which school, if any, the children would be attending. The sense of a safe, secure, and predictable world had been undermined. This varied sense of loss was observed in the children's anxieties, repetitive play themes, increased dependency, and regressive behaviors.

Most children seen in the relief center evidenced regression regardless of their age (14 months to 17 years). Although some children displayed extreme behaviors, such as bed wetting and thumb sucking, more commonly children and adolescents were simply more dependent and less self-sufficient than in predisaster functioning, as indicated both by self-reports and by parental reports.

The children's anxieties about the storm seemed to be increased by the shattering of their illusion of parental control. After the initial stress of the storm, many children found their parents unable to provide them with the necessities of living that had previously been furnished automatically. Many children experienced their parents screaming, crying, and being out of control, as never before. Some children were forced into parentlike roles by events of the storm. For

example, children sometimes held walls and doors against the force of the wind while their parents were frozen in shock. The loss of confidence in their parents' ability to control events in the world left children feeling vulnerable to the cruelties and dangers of life, when previously they were buffered by parental assurances of protection.

Naturally enough, the anxieties of child victims of disaster were often dominated by hurricane-specific content (see Dollinger, O'Donnell, & Stanley, 1984; Ponton, Bryant, & DiClemente, 1991). Children reported fears and nightmares about hurricanes, rain, and wind, as well as "normal" developmental fears, such as fear of the dark. Additionally, many children feared the (often quite realistic) possibility of looters harming them.

Sometimes the anxiety derived from hurricane-related experiences that were unanticipated by the counselor. Consider this example: An 8-year-old South American girl was overcome with grief following the hurricane. Her parents believed she was saddened primarily over the loss of her toys. Puppet play revealed that the child was preoccupied with the fact that her best friend was moving back to South America. Focusing on working through the storm experience or the loss of home and toys was simply not appropriate for this child until her primary issue had been dealt with.

Although hurricane-specific fears dominated the anxiety experienced by many children, this experience was by no means universal. One of the most noteworthy insights that emerged from this experience was that many stimuli unrelated to the storm also produced substantial anxiety in these children—a phenomenon that has gone virtually unmentioned in recent discussions of responses to trauma. In a systematic study of a sample of 56 children (Shelby, 1994), mothers reported that their children were fully as fearful of stimuli unrelated to Hurricane Andrew as they were of storm-related stimuli. This finding is consistent with data from other studies. Pynoos and Nader (1988) noted seemingly unrelated fears among children who had witnessed the sexual assaults of their mothers. Milgram and Milgram (1976) found high levels of anxiety unrelated to self-reported situation-specific stress. Although Sullivan, Saylor, and Foster (1991) reported that children became more afraid of the "big bad wolf" after Hurricane Hugo, most people appear to have interpreted this as strictly symbolic—that is, fear of the big wind. Our experiences, however, suggest that this is not the case. For example, children in our center reported on various occasions having increased fears of "Fred-die Kruger," "Jason," and even the devil. Indeed, many of the children we saw had as much fear of the non-storm-related stimuli as they had concerning the hurricane itself.

The implication of this situation is that the counselor needs to be wary before arriving at conclusions concerning the nature of the child's fears. In a number of cases we treated, the root of the children's fright was abuse. When uncovered, abuse then should become the central concern of the counselor. The abuse may be a result of increased pressure in response to the demands of the disaster or the abuse may have been ongoing.

Another issue that emerged from our experience concerns repetitive disaster themes in children's play. Such play has commonly been considered problematic (Joyner, 1991; Rigamer, 1986). We believe, however, that play such as acting out the hurricane, acting out death scenes, and acting out the morning after the storm generally represent natural attempts at resolution. We consider that this type of play is a problem *only when the child fails to progress through the entire event*. For example, the child may repeatedly act out the destruction of the storm, but rather than moving on to the rebuilding efforts and experiencing a sense of relief and accomplishment at the end of the play, the child may remain stuck in the most anxiety-producing moment.

If the destruction is followed by positive resolution and moving forward, such play, even if it occurs with great frequency, should probably be considered adaptive (Saylor, Powell, & Swenson, 1992).

Another issue that emerged concerned relations between children and parents who would not ordinarily be regarded as abusive. We frequently observed in the families seen in the center a combination of decreased parental attentiveness and unreasonable parental expectations about their now overly needy children. We observed that many parents either had difficulty recognizing that their children's unusual behaviors were grief related (see also Raphael, 1982) or had difficulty recognizing the effect of the disaster on the children (see also Rigamer, 1986). The result was that the child's problem usually went unacknowledged and, indeed, was often met with punishment.

Intervention tactics. Although the value of verbalizing the traumatic incident has long been recognized (Baldwin, 1979), children's limited verbal capacities make the traumatic experience difficult to convey verbally. Because the natural mode of communication for children is play (Axline, 1947; Landreth, 1991), the child's attempt to deal with disaster is reflected in the need to engage in "playing-it-out" instead of "talking-it-out" (Axline, 1947; Van Ornum & Mor-dock, 1983). Although the recurrence of disaster themes in children's play is a noted symptom of child disaster survivors (see Vogel & Vernberg, 1993), use of these themes in play can also constitute a tactic for an appropriate crisis intervention.

Children need to accept the events that have occurred, make sense of these events, regain a sense of mastery and control, and resume age-appropriate roles and activities (Vogel & Vernberg, 1993). Effecting all this change will probably take more than one session. But we consider the critical role of crisis intervention therapy to be helping the child regain a sense of mastery and control. The feared situation must somehow be brought into the child's egocentric construal of the world in a way that frees the child from responsibility for the disaster and provides a regained sense of power.

It may seem counterintuitive to say that stimuli that are realistically beyond the child's control should be construed (by the child) as within the child's control. Yet much empirical evidence implies that unrealistic estimations of ability are quite adaptive for young children and occur normally (Bjorkland & Green, 1992). Children's overestimations of their abilities and their power buffer them from the disappointments of failure and leave them more able to pursue future tasks. It follows that children who regain a sense of empowerment early in their recoveries from the experience of a disaster are likely to be better equipped to devote the necessary energy to understand and accept the disastrous event, and they may more easily resume age-appropriate activities.

What we have come to regard as an important technique used in the center involved having the child draw the feared stimuli, which forces the overwhelming abstract fear into a more manageable and delimited concrete form. The child was then encouraged to express feelings such as anger and sadness in response to the drawing. We believe that the next step is crucial. The child was allowed to *defeat* the picture—by talking to it, yelling at it, stamping on it, crumpling it into a ball, throwing it away, or tearing it up. The catharsis and sense of control the children gained from this experience appeared to broaden their perceived sense of power, in addition to dealing with this acute crisis. (See Shelby, 1994a, 1994b, for further discussion of research and application of this technique with this population.)

Consider the following example: A 3-year-old Cuban American boy was brought for counseling by his mother. She reported that he had been fearful and clinging since the day of the storm (a week before). The child was instructed to draw a picture of the hurricane,

and he told it several times "usted es muy malo" ("you are very bad"). The counselor then told him that now he could do whatever he wanted to do to the hurricane he had drawn. He smiled and promptly wadded the picture and ran across the building to throw it away. He repeated the exercise several times, with increasingly positive affect. He finally announced that he was finished and smiled brightly. His mother, who believed a miracle had taken place, said that this was the first time he had smiled or left her side since before the disaster.

An occurrence that was relatively common in our experience was that children who were in the midst of giving an account of their fears would get "stuck" at the most frightening moment of the event. We found that an effective technique in such cases was encouraging children to complete their play with positive endings. For example, a 10-year-old boy was referred because of repeated nightmares concerning the threatening presence of Jason, the character from the *Friday the 13th* movies. In the center, he was clinging to his father, reluctant to speak to anyone other than his father, and despondent. His nightmares had begun after the storm. He woke up each time as Jason was perceived as reaching through the window, threatening the boy's life. The child was instructed to add a happy ending to his nightmare. The aim of the intervention was to have the child describe the feared situation but to go beyond the nightmare by adding a ending that left him successful and in control. The child left the center smiling, joking with the counselor, and no longer tied to his father's side.

In our work, puppets were often used to reenact the storm, to show how to rebuild and reestablish new lives, and to communicate other less hurricane-specific issues (such as abuse). Consistent with clinical reports of therapy with children in other traumatic situations (Carter, 1987), puppet play seemed to provide a protective cloak through which children could express their distressing feelings.

Another tactic used with some effectiveness in our work was positive reframing. For example, a 9-year-old Puerto Rican girl who had experienced Hurricane Hugo 3 years earlier, as well as Hurricane Andrew, began to cry as it rained outside our center. The counselor determined that the rain itself was the anxiety-provoking stimulus. She then discussed with the child how various life forms benefit from the rain. In play, the child acted out scenes in which animals even prayed for rain. Providing this option of positive reframing expanded the child's repertoire of existing coping mechanisms and permitted her to accommodate better to the experience of rain as an event in life.

For some young children, the most appropriate intervention in individual therapy is simply supplying the emotional needs that some parents are ill equipped to handle. When children who were identified as the products of a harsh parenting style were asked, "Do you want me to hold you?" all of them ($n = 19$) responded positively. When provided esteem-oriented assurances (e.g., "You are a good boy," or "You are a smart girl") and assurances of safety, the children evidenced striking behavioral signs of comfort, relief, and positive affect. Ideally, parents would be involved in this process and encouraged to provide for the needs of their children. But this work was not always possible for a variety of reasons. For example, some parents permitted us to see the child only while they saw the caseworkers for their food, clothing, and shelter vouchers. When the parents completed their session with the caseworkers, they were anxious to leave.

To provide interventions appropriate to the child's needs, the counselor must allow the child freedom to reveal his or her areas of concern. If not, the counselor may ill-advisedly direct the child to hurricane-focused therapy, when the source of concern may actually

lie elsewhere. A useful way to prevent this possibly is to instruct the child to "draw what scares you the most." This may lead to a drawing of the hurricane, but it may not.

As noted earlier, crisis intervention work may well reveal abusive conditions in the child's life, and the crisis counselor must be prepared for this possibility. In such cases, the crisis counselor will be called on to explore the child's experience and legitimize the child's feelings. If an abusive situation has been revealed, the counselor should also make the necessary report of abuse, despite the chaotic conditions that prevail at the time.

Multicultural Issues

Our experience makes clear to us the critical importance of cultural sensitivity in disaster counseling. Although cultural diversity may not be as great in all areas of the country as in south Florida, this issue is likely to remain a concern in future natural disasters. Multicultural issues emerge both in individual therapy and in the manner in which the staff provide assistance to their clients.

As an example, we found a significant degree of religious conceptualization of hurricane-related incidents among our clients. The hurricane itself was often referred to as the "work of the devil" or even as the devil himself. These clients were frequently willing to offer Biblically based reasons for the hurricane (e.g., "since nature was bending its knee to the Lord, the end of the world was nigh"). A number of clients believed that God had caused or allowed the hurricane as a punishment. As a result, they attempted to determine which behaviors to change to avoid future calamities. The attribution of meaning to natural disasters is not unusual (see also Janoff-Bulman, 1992; Ursano & Fullerton, 1990). But these religion-based construals of the situation may present a dilemma to the counselor. Although not challenging deeply held client beliefs, the therapist serves survivors better allowing them to process feelings of guilt and responsibility.

Another issue was that a number of parents in the population we served described values systems that emphasized harsh physical punishment and deemphasized nurturing behaviors. As these parents explained to us, harsh punishment promotes discipline, and avoidance of nurturing prevents "spoiling." We suspect that when these practices were combined with the increased needs of children following the storm, the result was the emergence of patterns of abuse and neglect. That is, the children needed reassurance of safety during this period and demanded it through actions such as crying and increased dependency. These parents' value system directs them to respond adversely to these particular actions, and they are less inclined to meet the child's needs than are other parents. Even if they were willing to provide additional nurturing, the demands on their time and energy were excessive during the initial postdisaster phase. Thus, we observed some parents responding to the increased activity of the child with harsh punishment, leaving the child even more needy and fearful.

Intervention in this cycle is necessary, but it must be handled delicately. The overwhelming demands of the situation and the values of the parents must both be met with empathy. Most of these parents were themselves parented in a similar way. Helping the parents remember their own childhood needs for nurturing, and their fear and anger when punished at these times, may help the parents become more receptive to alternative parenting styles. We found it helpful to educate parents about both children's responses to disaster and normal developmental patterns. Ideally, cognitive restructuring begins through such activities so that the parent leaves the crisis intervention not only with sensitivity to crisis reactions in the child but also with

increased self-awareness and new expectations for child-parent interactions. Admittedly, this is a lot to expect from such a brief intervention.

Social support networks appeared stronger and more elaborate, and were generally regarded as more important, among African American and Hispanic groups than among non-Hispanic White persons. Generally, the existence of these networks led to assistance of several types in the lives of persons affected by the storm. Whereas traditional crisis intervention focuses on individual or immediate family interventions, we believe that counselors should use extended-family networks, particularly for those clients who evaluate these networks as important.

A final issue concerns cultural sensitivity in management of relief operations. In our center, ethnocentric assumptions made by the predominantly middle-class Anglo-American staff served to increase distress among many minority-group clients. For example, instructions were usually given only in English in our center, despite the fact that large numbers of clients spoke only Spanish. As a result, clients failed to receive needed information and felt a loss of dignity and power. Thus, a necessary subsidiary role played by the counselors was to serve as a bridge between the Red Cross staff and clients by communicating desires of both groups and searching for change through compromise.

CONCLUSION

Although many of our observations are consistent with the literature on crisis intervention, we believe that our experience offers practical suggestions for clinical work in this area. We point particularly to the importance of counselors assuming a proactive role, noting and extending clients' strengths, pushing the client beyond being "stuck" in the most threatening aspect of the experience, recognizing that clients may have non-hurricane-specific as well as hurricane-specific fears, and being sensitive to multicultural issues.

Although we are relying largely on our own clinical observations, we believe that our interventions were effective in the immediate term for several reasons. The proactive stance we took made the opportunity for interventions more accessible to disaster survivors who might not have taken advantage of mental health services otherwise. The generally upbeat attitude we displayed and the use of physical contact appear to have lessened clients' potential resistance to engaging in therapy and resistance to work within therapy. Despite our differing therapeutic modalities, our attempt to form therapeutic alliances, to emphasize the client's preexisting skills, and when possible to extend those skills, seemed to promote positive change in adults. Through play, children were encouraged to express their traumatic experiences, which helped to restore a sense of mastery and power. Finally, the multicultural sensitivities of the counselors quite likely aided in the clients' openness to our therapeutic interventions.

Although Hurricane Andrew was one of the most costly natural disasters in American history, and the effects will be felt for a number of years, we hope it will also be a unique catalyst for change. We believe that disasters can provide an opportunity for counselors to make maximum their impact on clients and provide an opportunity for clients to grow rather than settle for stability.

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