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CHAPTER 22

Natural Disasters and First Responder Mental Health

SCOTT L. TRACY

CHAPTER OVERVIEW

This chapter focuses on the counseling speciality of disaster mental health. Topics include a discussion of the science behind various natural disasters and the psychological effects experienced by the survivors. Also discussed are the stages of disaster recovery and counselor actions within each phase. Additionally, this chapter describes the unique lived experiences of first responders and ways that professional counselors can intervene to support the unique behavioral health needs of rescue workers. Finally, the counselor's role in the COVID-19 pandemic is discussed.

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LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Describe the scientific processes associated with natural disasters;
2. Understand how categories of natural disasters have differing mental health implications for those affected;
3. Describe the stages of disaster recovery and counselor therapeutic actions for each stage;
4. Discuss the effects of the novel coronavirus pandemic on professional counseling;
5. List counseling techniques that can be implemented during a global pandemic response;
6. Differentiate between posttraumatic and cumulative stress reactions in first responders; and,
7. Discuss the unique psychological experiences of first responders and ways counselors can meet their behavioral health needs.

INTRODUCTION

Natural disasters can strike anywhere and at any time. Individuals, over their lifetimes, can expect to be affected by some sort of catastrophic event of nature. In fact, 2020 may be the most disastrous ever recorded in modern history. As of late 2020, the global pandemic created by the novel coronavirus took the lives of over 1.8 million people worldwide and over 348,000 in the United States alone ([Johns Hopkins Corona Virus Research Center, 2020](#)). Other pandemic end-of-year statistics are staggering. Worldwide, 84.1 million people contracted the highly infectious disease, with nearly one-quarter of those in the United States, which has experienced the highest death rate of any country by far. The economic impacts of shutdown and quarantine have devastated families and small businesses. Like most disasters, improvised populations and minorities suffered the greatest economic effects, which included unemployment, poor access to healthcare treatment, and higher infection rates. Nearly 14.4 million Americans became unemployed during the pandemic, matching levels not seen since the Great Depression ([U.S. Bureau of Labor Statistics, 2020](#)). It is estimated that one-third of the nation's small restaurants and entertainment venues may close permanently. The psychosocial effects are far reaching, and counselors have been at the frontline seeing record numbers of cases of traumatic stress created by the pandemic.

The pandemic only has added to the already occurring massive hurricanes, paralyzing blizzards, killer tornado outbreaks, and earthquakes that have wreaked havoc on every continent. There is general consensus among earth scientists that the effects of global warming may be responsible for the intensity of severe weather outbreaks that Earth has recently experienced (see Chapter 24, "A Confluence of Crises: Migration, Anthropogenic Climate Change, Mass Casualties, War, and Civil Unrest" for additional discussion regarding the effects of anthropogenic climate change). The scientific basis for climate change is well-established and natural disasters are on the rise ([Tarvydas et al., 2017, 2018](#); [Teahan et al., 2017](#)). No one is immune and disadvantaged populations are most vulnerable. Professional counselors, more than ever before, have been called to duty to help survivors deal with the emotional consequences of disaster. In addition to providing service to the civilian population, counselors also are enlisted to help the emergency service clinicians who are on the front line of disaster response. These emergency clinicians (e.g., paramedics, fire fighters, and police officers) experience a deeply deleterious psychological toll as a result of their rescue efforts. The purpose of this chapter is to identify the nature of natural disasters and their impact on both civilian populations and emergency service clinicians. More importantly, this chapter aims to review the considerations of, actions by, and interventions for mental health professionals who are called to service during disaster events. These goals are realized through the discussions in the following sections: Types of Natural Disasters, Disaster Response System, and Counseling Implications. These main sections are followed by a summary of the chapter and an online list of relevant resources for students, clinicians, and

summary of the chapter and an online list of relevant resources for students, clinicians, and instructors.

TYPES OF NATURAL DISASTERS

A *natural disaster* is defined as a catastrophic event of nature that creates a significant and often long-lasting change to the environment. Natural disasters can be categorized into several classes and are named by the etiological event (see [Table 22.1](#)). These categories include weather- and climate-related, earth movement-related, and biological/ecological-related disasters. It is important to note that this chapter does not directly discuss man-made disasters such as war, environmental pollution, and economic collapse, which also induce similar psychological sequelae, but warrant independent discussion separate from events of nature; the consequences of these man-made disasters are discussed in various chapters of this book.

Table 22.1
Disaster Events by Cause

Weather related	Hurricane, flood, tornadoes, severe thunderstorms, drought
Earth movement related	Earthquakes, tsunamis, volcanic eruptions
Biological/ecological related	Pandemic/disease, global warming, ecosystem destruction

It is important for counselors to understand the category types and likely events of natural disasters, so that they can better debrief both civilian and emergency service populations as they recover from horrific events. Disasters tend to have a regional probability of occurrence. For instance, towns located near a tectonic plate boundary may experience earthquakes, the American plains is known as “Tornado Alley” because of the preponderance of those storms in that region, and any ocean coast region may at some time see the effects of a tropical cyclone. Counselors need to become better informed about the regional disaster probability patterns of their practice area, so that they are able to respond better in times of crisis ([Levers, 2020](#)). The three categories of natural disaster are discussed in the remaining parts of this section: Weather-Related Disasters, Earth Movement-Related Disasters, and Biological/Ecological Disasters.

Weather-Related Disasters

Weather-related disasters are the most common types of catastrophic events. Hardly a week passes without breaking news of a hurricane, flood, blizzard, or tornado outbreak somewhere in America. Weather-related events are the product of a perpetual battle between warm air masses originating in the tropics, cold air masses stubbornly in place at the Earth’s poles, and the collision between the two as a result of the planet’s upper-level wind pattern, known as the jet stream. The bumping of these air masses at their boundaries creates instability in the atmosphere and becomes the breeding ground for storm systems.

Atmospheric storms can occur in various types. The most common type of atmospheric storm, and the leading cause of death from weather-related phenomena, is a thunderstorm. Thunderstorms originate from cells, or columns of rising warm air and sinking cold air. Lightning, hail, and heavy rain become the by-products of the storm’s energy release. Cells that rise high into the atmosphere are termed super cell thunderstorms and can spawn tornadoes.

The single leading cause of weather-related deaths is from lightning strikes. However, flash flooding and wind damage can take human life and create significant structural damage to a region.

Tornadoes have been the scourge of the American Plains and the deep South throughout recorded history. These regions are prone to tornadoes because of their close proximity to the warm and cold air battle zones. Tornadoes develop most often in the spring and fall and frequently occur in outbreaks that can terrorize several states. Thanks to advanced atmospheric imagery, such as Doppler radar, severe thunderstorm and tornado warning

atmospheric imagery, such as Doppler radar, severe thunderstorm and tornado warning systems have improved dramatically over the last two decades. As early as the 1960s, communities often received no warning of an incoming storm, and loss of life was enormous. However, with innovations in weather radar imagery and climate diagnostics, communities now can get warnings of severe storms as they form and then track the direction and intensity of their courses. The average person can expect to receive about a 12-minute window of warning before the arrival of a storm; however, outbreak regions can be identified days ahead of time. The problem is that people in the watch area need to monitor the weather forecast. Smartphones, for example, provide a great warning system mechanism; however, many folks in tornado alley cannot afford this type of technology. An overriding theme in natural disasters is that impoverished populations suffer the greatest impact. The poorest socioeconomic groups do not have the money to purchase warning technology, nor can they afford reinforced housing that is more resistant to damage from natural disasters. In essence, lives can be saved provided that people can afford it, which speaks to inequity issues in society, as much as it does weather and technology.

Despite better warning systems, since 2000, the *National Weather Service* has reported nearly 1,300 deaths from tornadoes in the United States, with 400 communities destroyed. In the spring of 2011, 505 people died in three states during two outbreaks. These atmospheric storms strike quickly and with devastating consequences. A family can lose their home and life possessions in minutes. Children and older adults present the highest risk for loss of life. Individuals who live in impoverished areas face the greatest economic impact, often because they live in unreinforced housing such as mobile trailer parks that offer little protection from storms. Twisters have a selective nature to their destruction. One home may be destroyed, whereas others on the same street are left untouched. Loss of life and injury reports have been reduced dramatically over the last 20 years, but the emotional effects of losing valuable possessions and the anxiety of starting life over, after the devastation, remain potent.

The largest type of atmospheric storm is a tropical cyclone, or a hurricane. Many American folktales surround these enormous storms. The *National Oceanic and Atmospheric Administration* ranks hurricanes as first among the disaster categories that can affect an entire region. Hurricane Katrina, which occurred in 2005, is listed as the single greatest natural disaster ever to affect the United States. Many other great hurricanes have made landfall on America's shore: Camille, Andrew, and the monster unnamed storm that destroyed Galveston, Texas, in 1900 are among these historic cyclones. Most disturbing is the frequency in the development of intense hurricanes. In addition to the global pandemic, 2020 will be recorded as the year with the most active tropical cyclones in Earth's history.

Hurricanes not only cause loss of life, but the massive flooding from a storm surge can submerge large areas of coastal land for months. A storm surge is the sudden rise of the ocean level that accompanies the approaching eye wall or center of the storm. The storm surge causes the greatest loss of life in hurricanes. Torrential rains and devastating winds can destroy the infrastructure of a region, shutting down power plants, water treatment facilities, and hospitals and making roads impassable. Once emergency personnel evacuate a region before the arrival of a hurricane, they often are unable to get back into the damaged area because of these infrastructure disruptions. This was the case in Hurricane Katrina, causing a several-day delay in the arrival of water, food, and medical supplies into the Gulf Coast region after landfall. Not only can the infrastructure of a region be affected, but the entire ecological environment can be altered after a great storm. The disappearance of marshes, beaches, and wildlife often occur and can disrupt the tropical ecosystem for decades. In many cases, the ecosystem is related to the economy. Beach towns are dependent upon the tourism industry. If the beach disappears, so do the tourists, thus further depleting the region's recovery resources. Not only could storm survivors lose their home to the disaster, but they may lose their jobs as well.

No part of America is free from the threat of flooding. Even the desert regions of the Southwest have seen devastation and loss of life from flash flooding. Flooding can occur from three sources. The first type occurs from prolonged rainfall over a region. The ground becomes saturated, and rainfall runoff fills lakes, streams, and rivers, which then rise over their banks. Along rivers, the area near the banks is called the flood plain.

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The second origination of flooding occurs from snowpack melting and ice jamming. As the winter snowpack melts in the northern latitudes, mountain downslope movement of water can overtake a region's watershed, which acts as a natural drainage system. Damming can occur from debris and ice in the runoff streams and create rapid water rises along these streams and their tributaries. The heavy runoff can affect areas hundreds of miles from the actual melting ice and snow. Finally, flash flooding can develop quickly in an area that experiences heavy rainfall in a short time. Many factors predict flash flooding such as the ground saturation, runoff stream condition, terrain, and the amount of rainfall. Generally, rainfall amounts greater than 4 inches per hour can cause a flash flooding event. This type of torrential rain can occur in the late stages of a thunderstorm. Some regions may experience all three types of flooding. The city of Johnstown, Pennsylvania, was destroyed twice in the span of a century by a prolonged rainfall that caused a dam to break and a flash flood event from slow-moving thunderstorms.

Winter storms also constitute large scale disasters because of their ability to disable a region's infrastructure. Storms that produce heavy snowfall and ice may shut down roadways and snap trees and power lines, interrupting transit and turning off electrical supply for days at a time. The loss of power forces many citizens to endure cold, unheated homes. Again, the greatest impact typically is felt among impoverished populations and older adults. Under winter storm conditions, people often attempt to heat their homes using portable heaters that can create fires and cause dangerous levels of carbon monoxide gas to build in their homes. Initially, primary roadways such as interstate highways close. Secondary roads may remain snow-covered for days, preventing an entire population from having access to primary roads. Winter storms also slow rescue workers in their ability to respond to emergency situations.

Winter storms are typically a national event. During winter weather outbreaks in 2010 and 2011, which were particularly harsh, one-third of the nation was affected by four separate blizzard occurrences. The bitter cold that typically follows a winter storm may have a further blistering impact on a region's ability to cope with snow removal and rescue those trapped by the storm. Those living in substandard housing, who are homeless, and who are older adults are at most risk during winter emergencies.

Earth Movement-Related Disasters

The Earth's interior is a dynamic system. Earthquakes, tsunamis, and volcanoes are the products of this dynamic system. The surface of our planet sits on top of a layer known in geology as the crust. The Earth's crust is divided into two types, identified as either oceanic or continental. These layers are named because of the rocks that compose them. The oceanic rock, which contains the Earth's oceans, is lighter than the continental rock and tends to dive, or subduct, under the continents and near shorelines. The movement of these large plates of rock against one another is fueled by large convection currents of magma and heat originating from the Earth's interior. The battle between these large plates is mostly a stalemate but breaks or cracks can occur near the fringe areas of continental and oceanic plates. This entire process, known as *plate tectonics*, produces earth movements. Earthquakes, tsunamis, and volcanic eruptions occur because of these movements and have produced some of the greatest catastrophes in Earth's history. An earthquake occurs when a shift or break happens along a boundary or fault line. The San Andreas Fault in Southern California is one of the most famous of these fault lines. Large metropolitan centers have been built on or near many of the Earth's fault lines and subduction zones. The recipe for disaster has been made. Structural collapse and fires from broken gas lines represent the greatest land threat during an earthquake. This decade alone has seen massive death tolls in the hundreds of thousands from quakes in Haiti, Chile, China, and Japan.

When earthquakes occur in the ocean basin, large sea waves known as tsunamis can be formed. Twice in a 10-year span, the world watched in horror as these giant waves devastated the Indian Ocean basin (2004) and the Japanese coast (2011). These waves inundate coastal regions with giant, fast-moving walls of water. The height and speed of these waves act as a battering ram, destroying everything in their path. The water itself can be

propelled miles inland, causing rapid flooding. There is no prewarning of an earthquake; however, because tsunamis occur after an earthquake, some advanced notice is possible, provided that people have access to the warning system. This lack of warning-system accessibility explained the massive loss of life in the Indian Ocean occurrence.

The intensity, or magnitude, of an earthquake is measured on a scale known as the *Richter scale*. The scale measures from 1 to 10. Earthquakes over a rating of seven are major, and those of nine or greater are catastrophic. There is a direct correlation between the magnitude of a quake and the damage it creates. It is important to note that a quake measured at five or six on the Richter scale can be devastating if it is centered in a populated area that lacks reinforced structures. Poorer sections of a region experience the greatest impact and loss of life because of this. As with weather-related disasters, impoverished populations suffer the greatest in an earth movement catastrophe.

As the rocks shift and return to a stalemate after an earthquake, smaller tremor activity, known as aftershocks, can occur. Many people initially have survived an earthquake, only to be trapped in a damaged building that finally collapses during one of these aftershocks. Aftershocks pose a significant threat to emergency responders during disaster rescue operations. These smaller quakes also provide a great mechanism for secondary traumatization among the survivors of a disaster.

Volcanoes are areas on the Earth where magma rises from deep under the crust and emerges onto the surface. Volcanoes can be contained in large mountains, such as Mount Saint Helens in Washington, or as flatter, more dome-shaped structures, such as the Hawaiian Islands. The large mountain volcanoes present a great risk for becoming a natural disaster. The city of Pompeii, Italy, was destroyed by the eruption of Mt. Vesuvius in 79 AD and has become one of the most famous volcanic eruptions in history. There was, however, another volcanic eruption that occurred in 1833 that caused a disaster of global proportion. The explosive eruption of Krakatoa sent a large ash cloud high into the Earth's atmosphere that was absorbed into global wind patterns. This large debris cloud reflected warming sunlight back into space, sending the entire planet into a mini ice age. Disease, severe weather outbreaks, and extreme cold weather wreaked havoc on our planet for several years. The eruption of this volcano was so large that the explosion was heard hundreds of miles away.

The scale of an Earth movement disaster can occur over very large areas. Travel into the region would be difficult at best. Roads, bridges, and highway systems would be destroyed. Multiple triage and crisis counseling centers would need to be established and maintained for extended time, while rescue and recovery operation continue and aftershocks subside.

Biological/Ecological Disasters

Every year our planet is threatened with a potential natural disaster of biblical proportion. This event is one of the largest health threats to any individual and the overall greatest threat to our species. It is a viral pandemic. The most common of these viruses is influenza, more commonly known as the flu. Over recorded history, the flu has taken more lives than all of Earth's wars combined. Prior to the advent of flu vaccines, major outbreaks became common and would shut down schools, businesses, and entire communities. For example, the 1917 to 1918 Spanish Flu Pandemic coincided with World War I (WWI) and actually took more lives than the war itself. Although the flu strain itself is generally not fatal, the secondary effects of dehydration, respiratory failure, and secondary infection can be lethal. Young children, older adults, and individuals with chronic illness are the most vulnerable. The *Centers for Disease Control and Prevention* (CDC) in Atlanta, Georgia, monitors influenza patterns and issues flu forecasts, much in the way that the *National Weather Service* predicts weather. The CDC maintains a stockpile of vaccines for the known strains of influenza and other contagious diseases and has an extensive infectious disease research unit that continuously develops new vaccines.

Epidemics occur when a viral strain affects a region. Pandemics occur when a strain spreads worldwide. Pandemics are much more serious and involve outbreaks that are global in nature. The great Bubonic Plague, also known as the "Black Plague," of the Middle Ages (c 1300 AD) caused an estimated 100 million deaths. This Black Plague may have reduced the

(c.1300 AD) caused an estimated 100 million deaths. This Black Plague may have reduced the planet's population by 50%. Humanity was on the verge of extinction. The novel (meaning new strain) coronavirus or COVID-19 is a current example of a pandemic. COVID is especially dangerous, because there was no existing vaccine and the disease attacked the respiratory system causing death by lung and heart failure. It is important for all individuals to receive an annual flu vaccination along with any other immunizations recommended by the CDC; this is especially imperative for counselors, because they work in close contact with others. Frequent hand washing and the use of antibacterial and antiviral soap are important in helping to prevent the spread of disease. During pandemics, social distancing and wearing a mask are proven interventions to mitigate the spread of disease and should be incorporated into a professional counselor's practice.

Collateral Effects of Disasters

The types of disasters mentioned previously can lead to a secondary disaster. For example, broken sewage lines in earthquakes and stagnant water in flooded areas become the breeding ground for germs. Poor hygiene among displaced survivors can cause various disease processes. Emergency medical personnel may require universal or other special precautions for counselors interacting in a disaster area. These precautions almost always are enforced in the morgue and medical treatment areas and include gowns, masks, and medical gloves. Counselors usually are briefed by healthcare clinicians on the greatest disease risk and the ways to minimize contact prior to going into these areas. With the onset of COVID and expanded CDC guidelines counselors need to become more acutely aware of disease prevention and how to incorporate those techniques in individual and group settings. [Table 22.2](#) offers suggested CDC guidelines.

Table 22.2
Centers for Disease Control and Prevention Guidelines

During High-Risk Breakout Episodes	Telehealth Services Only Unless Event Is Crisis
During low to medium breakout episodes or for crisis intervention	1. Telehealth services for high-risk clients; 2. Mask wearing by staff and clients; 3. Plastic barriers in contact areas; 4. Closed or socially distanced waiting room that maintains 6 feet of separation; 5. Temperature and symptom checks for staff and clients prior to entering office; 6. Frequent hand washing; 7. Use of sanitizer solution on hands of staff and clients; and, 8. Daily deep cleaning of facility.

Ecological disasters can involve the food or life cycles of a region. The functions of ecosystems are based upon a natural balance of animals that prey upon one another and plant life that supports the animals and environment in which they live. Oil spills, such as the one that affected the Gulf Coast in 2011, or the 2019 Keystone Pipeline spill in North Dakota, destroy both animal and plant life by making the ecosystem uninhabitable for both. Humans may not notice the immediate effects of an ecosystem disaster; however, mental health professionals should be aware of the delayed emergence of ecosystem disasters and expect to engage in long-term counseling services in an affected region. Changes in the life cycle may take years to become permanent. As an example, previously rich fishing waters may become spoiled as the plant and animal life adapts to the ecosystem disaster. In human terms, an ecosystem disaster can knock a wealthy tourist town into a poverty-ridden ghost town. In most cases, ecosystem disasters are anything but natural and are created by man's need to

conduct industrial manufacturing and pillage the natural resources of Earth's land and waters.

Our water is particularly vulnerable to an ecosystem disaster. Most people would think of an ocean oil spill as the most vivid type of ecosystem disaster, but we need only consider that 99% of Earth's water is unusable for human consumption. Most of our water is either filled with salt, as in the oceans; buried deep underground; or frozen in the polar ice caps. Humans exist on only 1% of the total water composition of Earth. Our fresh water supply is depleting, and if the trend is not reversed, this could have a serious impact on the time that humans have on this planet.

DISASTER RESPONSE SYSTEM

The disaster response system originated during post World War II America, as a way to prepare the American public for a response to nuclear attack. The war proved to be particularly devastating to large, underresourced civilian population centers in Europe and Asia. Known initially as *civil defense*, this government agency planned responses to large-scale disaster. The focus of civil defense surrounded what to do after a disaster strike and not on ways to mitigate or prevent a major emergency event. As the cold war ended, civil defense expanded its role and became a much broader government agency, now known as the Federal Emergency Management Agency, or FEMA. FEMA coordinates local, state, and federal responses to disasters of all types. Training, research, and prevention are core tenets of FEMA's role in the American government. A major focus of disaster response involves managing the psyche of the affected population and coordinating the needs of emergency clinicians called to duty in rescue and recovery operations. Current literature in the counseling arena describes phases of behavior and symptom patterns that affect individuals exposed to a natural disaster. Counseling interventions can be initiated to help individuals recover from devastating events. The study of the psychological effects of disaster and intervention strategies is known as disaster mental health (DMH) and is recognized by FEMA as a core response to any horrific event. This section elaborates upon the disaster response system by discussing the following relevant issues: The Psychological Effects of Disaster, Interventions, and Working With Emergency Clinicians.

The Psychological Effects of Disaster

Traumatic experiences from horrific disasters go beyond the human boundaries of age, culture, gender, or religion. The question is not "Can it happen?" but rather, "When will it happen?" Entire populations affected by a disaster can experience an intense release of emotions as a result of sudden, sad, and catastrophic events. Release of these emotions can cause various stress reactions. Medical literature has described these stress reactions as having an impact on both the physical and emotional well-being of an individual. Additional evidence also points toward the negative effects of frequent ongoing stressors, called "cumulative stress," in the weeks and months that follow a disaster. Traumatic experiences from natural disasters can be defined as occurring in two distinct phases, known as primary and secondary (or ongoing) traumatization. This section reviews relevant aspects of primary and secondary traumatization along with identifying the phases of disaster in psychological terms.

Primary Traumatization

Posttraumatic stress disorder (PTSD) is the most studied of the stress reactions and represents the most common result of primary, or initial, traumatization by a catastrophic event (Everly, 1995). Detailed discussion of PTSD has been offered in previous chapters of this book, but it is worthy of revisiting specific details, because of the prevalence of PTSD among disaster victims.

In 1920, Sigmund Freud (1920/1956) published his book *Beyond the Pleasure Principle*, in which he addressed the topic of trauma. The framework for traumatic response as described by Freud continues to influence the development of the diagnostic criteria for PTSD found in

by PTSD continues to influence the development of the diagnostic criteria for PTSD found in the ever evolving *Diagnostic and Statistical Manual of Mental Disorders*, now in its Fifth Edition (5th ed.; *DSM-5*; [American Psychiatric Association, 2013](#)). PTSD is now recognized as a multidimensional behavioral health disorder with complex symptomology ([APA, 2013](#)).

The lived experience of a natural disaster can cause immediate psychological distress, but the psychological consequences generally are transient ([McFarlane, 1987](#)). According to McFarlane, "In the early months, somatic complaints, PTSD and travel anxiety are frequently described. In the long term, however, depressive symptoms emerge. Many individuals with early difficulties rapidly improve while a few develop substantial long-term psychiatric problems" (p. 365). McFarlane suggested that early intervention and education on both the social and psychological impact of disaster may help to predict those who are at high risk for long-term problems. Numerous studies ([Dyregrov, 1989](#); [Hodgkinson & Stewart, 1991](#); [Mitchell & Bray, 1990](#); [Schnyder, 1997](#)) concluded that prevention programs may also help to limit the high-risk group. Many surveys and studies, which ask recipients about their opinions surrounding the effectiveness of mental health services during disaster responses, have reported favorable findings ([Robinson & Mitchell, 1993](#)). For example, a 1997 study in Australia found that police and fire brigade workers rated professional mental health services as 95% effective, peer support services as 93% effective, and debriefing/defusing as 91% effective in helping them to cope with disaster response ([Robinson, 1997](#)). In that same study, 95% of respondents ($n = 755$, at a 60% response rate) supported the perceived importance of continuing counseling services for an extended period of time after a disaster. Knowledge about recovery from psychological trauma is growing. One aspect of recovery involves the importance of talking about one's experiences ([van der Kolk & McFarlane, 1996](#)). This belief infers that humans need to express their thoughts in some way. However, it has been suggested that people resist acknowledging, validating, and deliberating on those aspects of our existence that are emotionally difficult to comprehend ([Tarvydas et al., 2017, 2018](#)). [Herman \(1992\)](#) has asserted that, over time, an individual experiences waves of acknowledgment, followed by periods of denial of their experienced event. Herman has argued that the episodic nature of trauma requires continuous support for those exposed to it. Herman's beliefs have been integrated into contemporary treatment models.

Long-term outcomes after trauma are influenced by the nature of the posttrauma environment ([Raphael & Wilson, 1993](#)). Repeated traumatization, such as aftershocks following an earthquake, adds an enduring traumatic stress response that is thought to synergize subsequent traumatic events ([Levers, 2012, 2020](#)). This means that lesser traumatic events can cause greater stress responses. As the individual experiences more and more traumatic events, as often occurs in the post-disaster recovery phase, the ability to cope becomes compromised. Raphael and Wilson also recommend long-term support for those who experience disaster firsthand. Populations need continued system-based support services in helping them to deal with the emotions and cognitive distortions provoked by exposure to stressful events. Some observers see the role of mental health professionals as providers of vocabulary ([Gist & Lubin, 1999](#)). Counselors are able to offer labels for what individuals think and feel; in this way, mental health workers also can help survivors to normalize their emotional reactions.

Other factors that have an impact on the psychological response to disaster include the degree to which an individual perceives that events are uncontrollable versus preventable. [Gist and Lubin \(1999\)](#) suggest that individuals experience a faster return to normalcy when uncontrollable natural events such as a flash flood or hurricane strike occur. When horrible events occur that are man-made and perceived as preventable, psychological responses linger ([Tomko, 2012](#); [Tracy, 2006](#)). [Baum \(1987\)](#) argued that victims of technological disasters are at greater risk for developing stress reactions because technology systems are assumed to be controllable; recent examples of this would be the nuclear radiation leaks in Russia and Japan and the Gulf of Mexico BP Oil Spill. Likewise, incompetence and failure of sociopolitical systems and political leaders in a disaster can increase the risk for stress reactions and psychological disorders. [Tracy \(2006\)](#) detailed the failures of FEMA during Hurricane Katrina recovery operations that resulted in inadequate medical and basic needs supplies for both storm survivors and rescue workers. This leadership failure resulted in deleterious

psychological effects and hastened PTSD among first responders.

Secondary Traumatization

Jankoski (2002) conducted research that focused on the cost of caring; she stated that the "individuals who care for others often undergo a pain as a consequence of their exposure to others' traumatic material" (p. 11). Many other studies also have supported this claim of secondary or vicarious traumatization of emergency workers like emergency medical technicians, fire fighters, and law enforcement (Dyregrov & Mitchell, 1992; McCann & Pearlman, 1990; Raphael et al., 1984). This vicarious traumatization has occurred in emergency personnel after working with individuals who had undergone traumatic events. Likewise, relatives of survivors coming into a region to help loved ones clean up, utility workers, insurance adjusters, and members of the news media all can be victims of secondary traumatization.

Figley (1998) described a process called compassion fatigue in which traumatic symptoms can develop in individuals who are "empathetically engaged" with others who have experienced traumatic events. Figley listed two factors that have a causal relationship to compassion fatigue: "First, is that an exposure to another's traumatic experiences must occur; and second is an empathetic engagement with that individual must take place" (Figley, 1998, p. 7). The construct

of compassion fatigue contends that trauma stress reactions are contagious and create effects in those individuals who work with psychological trauma victims. [Dyregrov and Mitchell \(1992\)](#) said that "the same traumatic stress symptoms that affect victims of psychological trauma also impact the professionals who work with them. These symptoms include sleep disturbances, flashbacks, nightmares, irritability, anxiety, and depression" (p. 51). Vicarious traumatization continues to be a concern for professionals during the recovery phase of a disaster.

Phases of Disaster in Psychological Terms

The sociological and psychological patterns of recovery occur in five specific stages ([Farberow & Gordon, 1981](#)). These patterns of behavior should dictate the types of interventions counselors use in helping individuals and communities to recover from a disaster. These five stages are:

- **Initial impact phase:** Patterns in the first phase include shock, fear, and extreme anxiety.
- **Heroic phase:** This phase can last up to 1 week after the event and may occur in some cases before the initial impact phase. Disaster survivors reach out to one another in an attempt to save life and property and often involve extreme risk-taking or heroism involving altruistic actions.
- **Honeymoon phase:** This phase may last from 2 weeks to 2 months. Survivors, and the community as a whole, develop a synergy from the outpouring of support and services that stream into a disaster area. A mood of optimism is prevalent and fueled by promises of relief from the government and service agencies.
- **Disillusionment phase:** Lasting from 2 months to a year or more, this phase is characterized by resentment, a sense of loss, and the development of an existential vacuum as government and relief agencies leave the region. The survivors often feel alone and abandoned, which may reactivate previous psychological trauma. This phase is often termed the "second disaster." Counselors need to be aware of the development of disillusionment and begin interventions that address traumatization and take care to provide reassurance.
- **Reconstruction phase:** Communities and individuals may remain in this phase for several years post disaster. A pattern of rebuilding and moving forward is prevalent as survivors achieve control of their reactions and personal problems related to the disaster.

These phases are labile and meant to identify general behavior patterns. It is important to note that individual responses vary and are based on many factors such as the health of the person's coping mechanisms, the presence of a support system, physical health, and other comorbid factors. It is useful to understand the behavioral patterns in order to establish an appropriate intervention strategy.

Interventions

Current interventions in DMH are based on a developmental three-stage model ([UNODRR, 2009](#)). Each stage in the model represents a different counseling intervention that matches victim behaviors along a temporal continuum of recovery. The model also uses a triage scheme, which helps to sort out individuals who are at high risk for the development of acute stress disorder (ASD) and PTSD while providing support to those who appear to be recovering adequately. The three stages of this model (see [Table 22.3](#)) are acute support, intermediate support, and ongoing treatment. Although specific timelines are given for each stage, it is important to understand the many variables that occur with each type of disaster and to know that no two disasters are ever alike. These variables are called temporal issues and must be considered by clinicians as they plan interventions. The three-stage model should be used as a guide rather than a dogmatic protocol. Hurricane Katrina is an example of the developmental nature of disasters. Many Gulf Coast residents were relieved as the outer edge of the hurricane passed, leaving their homes unharmed, only to be traumatized as the man-made levees failed, flooding their homes. Individuals who were recovering

the man-made levees failed, flooding their homes. Individuals who were recovering adequately, and perhaps were euphoric initially, were suddenly acute victims of a natural disaster (Rapheal & Wilson, 1993).

Table 22.3
Support Stages of Disaster Mental Health

Acute stage	1 week	Provide psychological first aid to survivors and perform triage.
Intermediate support	1 week to 1 month	Promote anxiety management and reduce stress. Perform triage and referral for ongoing support.
Ongoing support	1 month to 1 year or more	Provide diagnostic and long-term behavioral health services.

Table 22.4
Eight Steps of Psychological First Aid

Step 1	Make contact with survivors;
Step 2	Provide physical and emotional safety;
Step 3	Stabilize survivors' emotions through active listening, validation, and supportive statements;
Step 4	Gather information about survivors' immediate needs;
Step 5	Offer practical help to meet needs;
Step 6	Connect survivors with family, friends, and support systems such as the ARC;
Step 7	Provide psycho-educational information about stress reactions and reduction; and,
Step 8	Link survivors to collaborative services such as FEMA or a CMHA.

FEMA, Federal Emergency Management Agency.

As a general procedural rule, behavior health specialists need to be aware of the setting they are entering and knowledgeable about the specific leadership, organizations, and policies already in place by the emergency management agencies. Many hazards are present near disaster areas, and hazards such as downed power lines, disease, flooding, threat of structure collapse, and fire may linger for weeks, post impact. Behavioral health clinicians always should follow the directions of the emergency management system that are in place. Depending on the scale of the disaster, the general command chain, known as the incident command system, follows a linear local, state, and FEMA structure. Large-scale and terrorist threats also may fall under the jurisdiction of military personnel. Order from chaos is the primary goal of emergency response organizations, as they begin the rescue operation phase of a disaster. Counselors need to understand that behavioral health issues may not be at the forefront of FEMA goals. It is important for counselors to support the incident command system as well as the leaders, who are experiencing a tremendous amount of rescue-work stress.

Stage 1: Acute Support

Acute support is the first stage and takes place immediately after the mass disaster. This treatment phase may last for up to 1 week. The counselor's goals in this initial stage are to establish contact with survivors, provide direct care, identify individuals who are at high risk for future psychological problems, and arrange for behavioral health follow-up. Many times, this type of intervention plan constitutes psychological first aid (PFA; Brymer et al., 2006). PFA focuses on managing the initial needs of survivors by providing support and resources to begin the recovery process and diminish acute stress reactions and posttraumatic stress. PFA often occurs within the disaster area, at shelters that have been established in churches, schools, or community centers. PFA promotes calm, connectedness, and hope through eight core counselor actions.

The eight steps of PFA are listed in [Table 22.4](#).

PFA is a beginning tool that counselors can employ for use in a mass disaster. The primary result of PFA is establishing the linkages with other support systems that aid in the recovery process. Please see [Box 22.1](#) for a clinical vignette in which to apply the PFA.

BOX 22.1

Clinical Vignette: Night Twister

Jorge is a 47-year-old Hispanic male, whom you meet at an evacuation shelter. Jorge is a single father who shares custody with his ex-wife in caring for their 13-year-old son, Jayna. Jorge's home was destroyed in the middle of the night by a large, destructive tornado. Jorge tells you, "I feel like I am in a dream" and verbalizes his fear that he will never recover all that is lost. Jorge is unable to make contact with his ex-wife and Jayna. He also discovered that the store where he is employed has been destroyed. Jorge repeats that he had no warning and doesn't understand why his house was destroyed while others were untouched.

Conceptualization Questions:

1. What is Jorge's stage of disaster recovery?
2. What is Jorge's most immediate PFA needs?
3. Why does Jorge present as high risk for PTSD, and what can be done to reduce the effects of his traumatic stress?
4. What sociocultural issues need to be considered as counseling interventions progress into future stages of recovery?

Stage 2: Intermediate Support

Intermediate support is the second stage and takes place from 1 week to 1 month, post impact. The primary focus of treatment during this stage is to promote anxiety management and reduce stress, which may preclude an ASD. This is accomplished by the development of a therapeutic relationship using traditional client-centered theory and integrating cognitive-behavioral techniques to train survivors in anxiety management. Specific triage for ASD should occur and referrals made to behavioral health clinicians for intensive care when derealization, depersonalization, or flashbacks are present. There are five core treatment principles in the intermediate stage, and these are identified as follows:

1. Develop a strong working alliance with the survivor;
2. Collaborate with the client in the development of goals;
3. Provide empathy, friendship, and support;
4. Provide positive regard and acceptance; and,
5. Project an attitude of authenticity and genuineness.

Attention to the sociocultural dynamics of the survivors is critical during this stage and is best supported by the five steps just listed. Issues of privilege and dominance often emerge in survivors during this stage. The healer must be aware of their own personal beliefs and biases in order to support a trusting, collaborative therapeutic relationship.

Stage 3: Ongoing Treatment

The final stage typically occurs between 1 and 3 months but can last for years after the disaster impact. This stage focuses on individuals identified in stage 2 and provides more specific diagnostic and long-term behavioral health services. Specific goals in this stage are to offer a differential diagnosis and modify treatment based upon the clinical presentation. These diagnoses often involve anxiety, mood, and substance abuse disorders. Treatment often is carried out in a traditional mental health environment.

It is important to note that most individuals exposed to a natural disaster recover on their own and do not experience lasting psychological effects. Counselors always should focus on

helping the survivors achieve safety and meet basic needs before providing other services. Professionals should make an effort to identify themselves as helpers and what their roles are in the disaster. It is important to help survivors gain accurate information about what is going on around them; this can be accomplished by providing practical and useful psychoeducation. Finally, helpers need to take care of themselves and know their limits. A wounded healer is of little use in DMH operations.

Working With Emergency Clinicians

It has been recognized for many years that emergency medical service (EMS) workers encounter psychologically stressful situations in the course of their jobs, especially those involving disaster and major emergency responses (Substance Use and Mental Health Services Administration [SAMHSA, 2018]). The recent COVID pandemic has brought the world's emergency response systems to the breaking point, and the psychological health of our first responders with it. In his groundbreaking work on stress reactions among EMS personnel, Mitchell (1981) listed events that are likely to cause stress reactions in EMS responders. These events include emergencies involving the death of a coworker in the line of duty; death of a child; gruesome accidents; exposure to domestic violence; and natural disasters with widespread damage, injury, and death. Other scenarios, such as exposure to suicide and homicide crime scenes, terrorist attacks, and failed procedures by rescuers also have been attributed to causing stress reactions in emergency medical clinicians (Mitchell & Everly, 1996).

Medical literature has described these stress reactions as having an impact on both the physical and emotional well-being of rescue workers (Lawn et al., 2020;). In a 2002 study, conducted by McSwain (2003), nearly one-third of all EMS workers left their jobs within 3 years of hire for other occupations. The study also discovered that their workman's compensation insurance claims were three times higher than the average healthcare professional and that job dissatisfaction among emergency workers remained high. Some empirical evidence suggested that the negative effects of frequent ongoing stressors, also referred to as "cumulative stress," are possible reasons for attrition, illness, injury, and job dissatisfaction among EMS personnel (Mitchell & Bray, 1990). On average, natural disasters such as earthquakes, hurricanes, or tornadoes happen somewhere on the planet each day. What these horrific natural events have in common is the ability to affect many people at the same time but in different ways. Disaster workers can be both directly and indirectly affected by their work in these events. Lundin and Bodegård (1993) reported that the impact of the disaster on emergency workers is dependent upon several factors. First, the impact involves the harshness of the environment of the rescue operation. The harshness can be defined as the weather conditions, travel distance of the rescue teams, and the number of victims. Another aspect is the demography of the victims whom the disaster workers are trying to aid. Lundin and Bodegård suggest additional examples of this, including whether the victims have the same language and ethnic, religious, or cultural backgrounds; have the same interests; or are members of a shared occupational group, such as plant or office workers. Finally, McFarlane (1987) notes that "personal factors of the rescue workers such as maturity, level of education, amount of emergency service training, and earlier experiences in disaster response strongly influence the reactions of disaster workers" (p. 367).

EMS personnel deal with the sociocultural consequences of disaster at interpersonal levels. Not only do they experience the loss of life and physical disability of disaster victims, but the financial, interpersonal, and spiritual losses within the survivors (Raphael et al., 1984). As such, vicarious traumatization continues to be a concern for the rescue worker.

Previous Counseling Interventions for Emergency Personnel

A process to treat and prevent stress reactions, called critical incident stress debriefing (CISD), was introduced to emergency personnel by Mitchell in 1983. CISD became a widely accepted protocol for use by emergency service agencies such as law enforcement, fire departments, paramedical and rescue teams, and emergency department staff (Wilson, 1995). CISD evolved over time into a more comprehensive process involving a multicomponent work-

CISD evolved over time into a more comprehensive process involving a multicomponent work-based systems approach to helping EMS workers deal effectively with the traumatic and highly stressful components of their work. This evolved process was titled critical incident stress management (CISM; [Mitchell & Everly, 1997](#)). CISM was adopted in 2000 by the National Transportation and Highway Safety Administration ([NTHSA, 2002](#)) as the part of the national curriculum for emergency medical technicians and paramedics that deals with the stress reactions and the well-being of the EMS clinician. NTHSA, the federal agency that regulates EMS training in America, has made attempts at addressing PTSD and burnout among emergency health workers.

This process of CISM involves a team approach based upon a partnership of mental health professionals and a peer support group. The team helps the affected individual express their feelings toward a particular event or situation that had a strong emotional effect for the individual ([Mitchell & Bray, 1990](#)). CISM engages in an open discussion that relies on group support for helping participants overcome the stress brought about by a particular event ([Mitchell & Everly, 1997](#)).

The five core components of CISM are:

1. Early intervention treatments for EMS clinicians exposed to critical incidents;
2. Provision of psychosocial support to rescuers in need;
3. An opportunity for expression of thoughts and feelings;
4. Crisis education; and,
5. Assistance in the development of coping mechanisms.

[Mitchell and Bray \(1990\)](#) advise "that of all these components should be administered with cultural understanding and sensitivity" (p. 116). Furthermore, he describes that a disruption in one of these components can exacerbate stress reactions. Also, PTSD can create negative effects on the way caregivers perform their duty.

CISM programs consistently yield very positive comments in surveys and studies ([Everly et al., 2000](#)). Even studies that cited evidence of the lack of efficacy of CISM still reported high perceived helpfulness of the debriefing process by participants ([Hyttén & Hasle, 1989](#); [Kenardy et al., 1996](#); [Rogers, 1996](#)). The American College of Emergency Physicians ([ACEP, 2000](#)) indicates that "CISM involves a partnership between mental health professionals and a peer support group of emergency workers. This partnership allows participants to express their feelings toward a particular situation that had a strong emotional effect and should be used as the mainstay for EMS provider wellness" (p. 62).

Although CISM has been identified as a process for the management of critical incident stress, it was not until recently that additional focus was placed on cumulative stress and its effects on EMS workers. CISM commonly is used in day-to-day impact incidents, but not for day-to-day low-impact incidents. Cumulative stress continues to be a significant problem for emergency workers, and we are seeing this play out during the COVID pandemic; unfortunately, it typically goes unaddressed. Better ways to support emergency workers from the long-term psychological effects of their job and a clearer understanding of the subculture of rescue work are needed.

The Culture of the Rescue Worker and Current Counseling Approaches

Paramedics, police officers, fire fighters, and other emergency workers know that they are the first to respond to horrific events on a daily basis. The reality of encountering extremely physically and emotionally traumatic situations, especially those involving disasters and major emergency responses, is an accepted part of the profession ([Mitchell, 1981](#); [Rapheal, 1977](#); [Teahan et al., 2017](#)). As a result, the first responders to medical emergencies and traumatic injury experience an intense, yet controlled release of emotions because of these catastrophic events. This unique experience helps to define the subculture of the emergency worker.

[Mitchell and Bray \(1990\)](#) outlined personality characteristics common to emergency service clinicians. Labeled as rescue personality traits, EMS personnel tend to be detail-oriented, set high performance standards, and be very dedicated. Additionally, rescuers are quick decision-

high performance standards, and be very dedicated. Additionally, rescuers are quick decision makers and are action-oriented (see Table 22.5). Understanding the rescue personality is an important part of gaining entry into the subculture of emergency service clinicians.

Working in emergency service professions exposes an individual to significant suffering and pain. The types of pain being experienced by emergency workers in COVID response efforts are historic in context. Many EMS workers themselves had contracted and died from the COVID-19. Worldwide, rescuers have witnessed record call volumes, worked in cumbersome personal protective equipment that often was inadequate and in short supply, and held the hands of countless dying clients. First responders have experienced overwhelming complex emotions that include anxiety, depression, and mental and physical fatigue. Counseling interventions should focus on helping rescuers to understand their emotions and use that insight to help the victims who have called for their care (Tracy, 2006). EMS personnel need counseling models, which help them frame and control their emotions, rather than compiling a symptom inventory checklist of their physical and emotional reactions. Existential rather than cognitive and behavioral approaches may be advantageous for this specialized counseling population, especially when dealing with the complexity of emotions during COVID. Existential theory (ET) orientations provide a viable therapeutic system, because they help the emergency worker to verbalize, converse, question, and debate the horrific and stressful experiences they encounter. There are four key therapeutic issues in existential psychology: the search for meaning from life experiences, exploring feelings of isolation, developing an understanding of freedom, and the acceptance of death. EMS clinicians are faced with many of these issues at once. Focused listening and Socratic dialogue are the main techniques as the counselor listens for themes in the client's talk that reflect struggles with meaning and identity (Day, 2007). It is important to focus on the responder's need to make sense of the suffering that they have witnessed. Psychoeducation on self-care techniques should be incorporated into every session and may include healthy diet tips, exercise, sleep, hygiene, recreation activities, escape time, and meditation and mindfulness techniques. Frequent follow-up is important in reinforcing the self-care behaviors.

Table 22.5
General Personality Traits of Emergency Service Clinicians

Thinking patterns:	Behavioral patterns:
Detail oriented	Action oriented
Obsessive	Quick decision-makers
Easily bored	Risk takers
Highly dedicated	Need to be in control
Need to be needed	High need for stimulation

The main objective is to help the emergency workers restructure attitudes about themselves and their chaotic environment. This self-awareness and awareness of the environment can lead to positive new attitudes about the work. The ultimate outcome would be to help rescuers not become trapped by past decisions, events, or patterns of behavior. It also allows workers to, in a safe and nonjudgmental environment, openly express their frustrations over system and leadership failures. First responders can share the many transgressions they have witnessed, especially against those citizens that are disadvantaged. Using the ET approaches would focus emergency workers on the importance of lifesaving work and help the rescuer define the meaning of their existence.

Mental health professionals need to work with families of emergency workers as well. Counseling and psychoeducational services should focus on assisting family members to gain insight into the stresses of emergency work and on helping their loved ones to employ effective coping strategies for the management of job-related stress. Most importantly, frequent referral and follow-up of EMS workers exposed to cumulative stress must occur.

Working with EMS personnel in essence is a counseling specialty. Training on cumulative stress and stress management, in general, must be an ongoing process during therapy sessions with rescue workers. Professional counselors should be aware of the specific

stressors unique to rescue work and tailor counseling interventions to meet the needs of this special population. Finally, counseling theory grounded in ET can be a useful approach in helping EMS and their families make meaning out of human suffering (Box 22.2).

BOX 22.2

Clinical Vignette: Too Much and Not Enough

Madeline is a 32-year-old female and 8-year career paramedic who presents for counseling at the suggestion of her supervisor. Madeline has worked 12 days in a row during the pandemic state of emergency and has responded to nearly 60 emergency calls during that time. She reports difficulty falling asleep yet feels fatigued. Madeline states her appetite is poor and she can't concentrate at work. Madeline begins weeping in session and states the amount of death she has seen is too much for her to bear. She openly expresses anger on first responders not having enough PPE equipment. She states, "We knew the virus was coming but we were unprepared." Madeline now questions her desire to remain as a paramedic and states "What difference do I really make?"

Conceptualization Questions:

1. What are Madeline's existential issues and how can they be addressed in counseling?
2. What type(s) of stress reaction is Madeline experiencing?
3. How did system and leadership failure affect Madeline's ability to cope with the stress of disaster response?

COUNSELING IMPLICATIONS

DMH has many implications for counselors and really should be viewed as a counseling subspecialty. Mental health professionals, perhaps more so now than ever before, are likely to be called to duty to help populations affected by disaster. Global warming and the world-wide pandemic have forever changed humanity. Political system failures have worsened the effects of disasters, causing existential crisis in citizens and rescuers alike. It is important for professional counselors to understand the nature of the disaster and how to work with emergency service clinicians and the surviving population. The skills of triage and assessment are important counseling tools in disaster areas. Flexibility and adaptability are important. The work environment of a counselor changes during disasters. The tranquil office is moved to a school, church, or noisy community center. The office may become mobile and move from street to street as the rescue and recovery efforts progress. The COVID pandemic has necessitated that counselors provide telehealth services. In a disaster, counselors must be able to adapt their intervention approaches to meet the needs of the population as well as the demands of the environment, as dictated by the catastrophe. A thorough knowledge of the psychological effects of disaster is needed by all counselors. Counselors routinely should practice the skills of PFA. Professional counselors also should be aware of their changing role as the phases of disaster recovery progress.

Oftentimes, counselors themselves are victims—a tornado does not skip over a home, because there is a healer inside. Therefore, it is important to recognize that healers may be experiencing the same psychological effects as the population of a region. Counselor self-awareness is extremely important as the chaos of a disaster encompasses the counselor's environment. Response protocols usually dictate that counselors from other communities be used for psychological response efforts, but, as stated earlier in this chapter, infrastructure damage may delay the arrival of out-of-town helpers. In the event of regional disasters, many towns are affected, and the arrival of counselors is dependent upon their ability to gain entrance into the area from other parts of the country. This process may take many days to organize. These factors place counselors at high risk for secondary traumatization and other stress reactions. Counselor awareness and supervision are essential for clinicians functioning in a disaster area. Whenever possible, one experienced clinical supervisor should be identified to provide only supervision services. This supervisor should not participate in any

other duties in the disaster response and should concentrate all of their efforts on helping the healers.

CONCLUSION

No one is immune to a natural disaster. Counselors can expect to be called to service several times during their career to help populations cope with the psychological consequences of a disaster. Counselors themselves often become a survivor of these events. It is important for healers to review disaster scenarios with emergency management agencies ahead of time.

Counselors need to learn and practice their roles in a disaster and to work as part of the emergency services team. All professional counselors should be aware of the stages of disaster response and be competent clinicians of PFA and triage. Counselors need to be aware of the cultural nature of disasters. The poor, older adults, and young children are at greatest risk for the development of psychological trauma from a disaster. Rescue personnel need immediate and long-term attention to help them deal with the psychological cost of caring. Specialized training and continuing education on DMH is a mandate for our profession and continues to emerge as our dynamic planet changes as a result of global warming. The question is not will we be called to service, but when.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

American Counseling Association (<https://www.counseling.org/knowledge-center/mental-health-resources/trauma-disaster>)
5999 Stevenson Avenue, Alexandria, VA 22304
800-347-6647

American Psychiatric Association (<https://www.psychiatry.org/psychiatrists/practice/professional-interests/disaster-and-trauma>)
1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209
703-907-7300

American Psychological Association Disaster Response Network
(<https://www.apa.org/practice/programs/dmhi>)
750 First St. NE, Washington DC, 20002
800-374-2721

American Red Cross (www.redcross.org)
2025 E Street NW, Washington, DC 20006
202-303-5000

Centers for Disease Control and Prevention (<http://emergency.cdc.gov>)
1600 Clifton Road, Atlanta, GA 30333
800-232-4636

Federal Emergency Management Agency (<http://www.fema.gov/hazards/index.shtm>)

500 C Street, Washington, DC, 20472

U.S. Department of Education (www.ed.gov/admins/lead/safety/training/responding/crisis)
Crisis Response: Creating Safe Schools
400 Maryland Avenue, Washington, DC, 20024
1-800-USA-LEARN

U.S. Department of Health and Human Services, Office of Minority Affairs. (n.d.). *Cultural competency curriculum for disaster preparedness and crisis response*. Retrieved from <https://cccdpcr.thinkculturalhealth.hhs.gov/>

U.S. National Response Team (www.nrt.org)
800-424-8802

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CHAPTER 23

Genocide, War, and Political Violence

KIRRILY PELLIS AND CHASTE UWIHOREYE

CHAPTER OVERVIEW

The distress of populations affected by genocide, war, and the specific phenomenon often referred to as “ethnic cleansing” and political violence is typically viewed through the lens of trauma and posttraumatic stress disorder (PTSD) (the word “war” is used in the rest of this chapter to refer specifically to “ethnic cleansing”). However, there have been increasing critiques of the assumed universal applicability of the trauma paradigm, from psychologists and psychiatrists, as well as anthropologists and sociologists, engaged with individuals and societies affected by mass violence. This chapter reviews how the specific characteristics of genocide, war, and political violence pose challenges to biomedical and Western psychological framings of trauma. It argues the need for greater attention to cultural context, intersecting structural oppressions, and social justice and considers how narrative- and arts-based tools, underpinned by principles drawn from multicultural and decolonial approaches, may assist in this endeavor.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Explore the causes, manifestations, and consequences of mental distress for populations affected by genocide, war, and political violence;
2. Appraise critiques of biomedical and Western psychological framings of trauma, with a focus on the neglect of cultural specificity and structural oppressions, including colonialism and social justice;
3. Examine alternative approaches to working with populations affected by genocide, war, and political violence (in the country of origin and in exile), underpinned by principles drawn from multicultural and decolonial approaches to counseling; and,
4. Consider how the adoption and adaptation of narrative- and arts-based tools, within counseling practice, may aid greater sensitivity to cultural and power dynamics and foster meaning-making, empowerment, and calls for social justice.

INTRODUCTION AND CONTEXT

The evolution of trauma as a psychological concept is intimately connected with the shifting nature of warfare during the 20th century. The term “*shell shock*” was introduced to explain the trauma exhibited by soldiers following the first World War. Shell shock was understood as being due to soldiers’ inner vulnerabilities being brought to the surface. This was challenged by research emanating from later conflicts, specifically Vietnam and the pioneering work of psychiatrist [Robert Lifton \(1973\)](#), which, along with research and advocacy from the movement to end violence against women, formed the basis for the diagnosis of PTSD and its inclusion within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* in 1980. In more recent years, the fallout from conflicts, and specifically genocide, war, and political violence, have continued to advance and challenge understandings of trauma, PTSD, and therapeutic approaches.

Counselors, social workers, psychologists, and psychiatrists engaging with individuals and societies affected by mass and political violence have become increasingly critical of attempts to apply narrow biomedical or biopsychological framings of trauma, particularly as found within the *DSM*, to diverse sociocultural contexts around the globe ([Boothby et al., 2006](#); [Bracken, 2002](#); [Jones, 2004](#); [Summerfield, 1999, 2001, 2002](#)). This is not to deny that trauma has biological and psychological influences and manifestations, as explored elsewhere in this volume. However, this chapter suggests that there has been an overemphasis on intrapsychic functioning that is divorced from a consideration of “historical patterns of power, international politics and local patterns and languages of suffering” ([Khan, 2017](#), p. 96). Drawing on scholarship from the fields of sociology and anthropology, as well as critical psychology, this chapter reviews how the specific characteristics and legacies of genocide, war, and political violence pose challenges to biomedical and Western psychological framings of trauma. It argues the need for greater attention to cultural context, intersecting structural oppressions, and social justice and considers how narrative- and arts-based tools, underpinned by principles drawn from multicultural and decolonial approaches, may assist counselors in working with survivors, whether in the country of origin, or with refugee and asylum-seeking populations in exile.

The chapter begins by exploring causes, manifestations, and consequences of mental distress for populations affected by genocide, war, and political violence before moving to sections focused on contextualizing trauma and meaning-making, structural oppressions and epistemic justice, and the politics of trauma. These major sections are followed by a summary conclusion of the chapter and a helpful, online list of resources for instructors, students, and clinicians.

MASS VIOLENCE AND MENTAL DISTRESS

This section provides a brief overview of how specific forms of mass violence, namely

This section provides a brief overview of how specific forms of mass violence, namely genocide, war, and political violence, are defined, along with illustrative examples, before turning to the effects on the lives of those who survive.

Genocide

Genocide is not a new phenomenon. From the campaign of Athens against Melos, through the crusades of the Knights Templar and Mongol conquests, to the decimation of the indigenous peoples of the Americas and Australia, the deliberate destruction of groups of people *because of who they are* is a constant refrain of human history (Chalk & Jonassohn, 1990; Levene, 2000). However, genocide as a concept was coined by a Polish lawyer, Raphaël Lemkin, in response to the systematic murder of six million Jews during the 1941 to 1945 Holocaust. The United Nations [UN] (1948) *Convention on the Prevention and Punishment of the Crime of Genocide* defines “genocide”:

as any of a number of acts committed with the intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such:

1. Killing members of the group;
2. Causing serious bodily or mental harm to members of the group;
3. Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
4. Imposing measures intended to prevent births within the group;
5. Forcibly transferring children of the group to another group. (UN, “Article 2,” p. 1)

The term remains contested (M. Shaw, 2015). Some argue that it is too restrictive, by focusing on certain groups while not recognizing others, such as political groups (Hinton, 2002), whereas, others argue that the definition needs to evolve to address more recent acts of mass violence (Shaw, 2015). Consequently, there is disagreement over which events constitute genocide. There have been successful international prosecutions of genocide related to the 1994 Genocide Against the Tutsi (Rwanda) (see Box 23.1) and the 1995 Srebrenica genocide, where more than 8,000 Bosnian Muslim (Bosniak) men and boys were killed by Bosnian Serb forces in a designated U.N. safe area. Indictments for genocide also have been brought against members of the Khmer Rouge, who between 1975 and 1979 killed around two million political opponents, ethnic minorities, professionals, and intellectuals in Cambodia. The International Criminal Court has charged former Sudanese President Al Bashir with genocide, war crimes, and crimes against humanity in relation to the targeting of non-Arab civilians in Darfur (see Bloxham and Moses [2010] for a good overview of genocide across time and place). Box 23.1 offers a brief contextual discussion of the Rwandan genocide, in order to illustrate the need for culturally specific approaches in helping people to heal.

BOX 23.1

Tips From the Field

1994 Genocide Against the Tutsi: Cultural Approaches to Healing

The 1994 Genocide Against the Tutsi saw over one million, mainly Tutsi, systematically murdered in 100 days by an extremist, Hutu-led government (des Forges, 1999). This violence was the culmination of successive waves of violence, fueled by colonial divisionism by first German and later Belgian authorities. The colonial authorities reconstituted the social groups of Hutu, Tutsi, and Twa as ethnic groups, initially privileging the Tutsi monarchy, before power was handed to the Hutu majority with independence in 1962 (Prunier, 1995). Sexual violence was used systematically during the genocide, leading to a high HIV/AIDS prevalence rate among survivors, as well as children born of rape. An estimated 400,000 children were orphaned (Human Rights Watch [HRW], 2003). Thus, as Sinalo (2018, p. 31) observed, the genocide can be viewed as “a much more complex,

chronic form of trauma" encompassing the structural violence of colonialism, neo-colonialism, authoritarianism, and patriarchy resulting in "the destruction of identity—that continues today."

Mental health infrastructure, resources, and personnel, both "traditional" and "modern," were destroyed during the genocide (Mukamana et al., 2019). Numerous surveys have been conducted to estimate the prevalence of PTSD and other mental disorders (Dyregrov et al., 2000; Munyandamutsa et al., 2012). However, the appropriateness and effectiveness of such "deficit-focused approaches" based on Western trauma paradigms have been questioned (Sinalo, 2018, p. 191). While manifestations of mental distress have been labelled as trauma and attempts have been made to find concepts within the Kinyarwanda language (e.g., *Ihahamuka* is translated literally as breathless with fear and often is used synonymously with trauma [Taylor, 2017]). Rwandan psychologist Chaste Uwihoreye explains that this does not reflect the complexities of people's experiences, understandings, or processes of meaning-making (Denborough & Uwihoreye, 2019). Uwihoreye notes that this views the mental distress as coming from within a person and is thus unaligned with Rwandan cultural worldviews, which frame mental distress as arising from interactions and events (Denborough & Uwihoreye, 2019).

Uwihoreye is pioneering an alternative approach, one which is deeply embedded in the Rwandan cultural context and informed by arts-based and narrative therapeutic approaches. For instance, Uwihoreye uses proverbs as a way to connect with individuals, to express stories, and to listen. In Rwanda, proverbs are "often used to express what a person has seen, heard, and experienced at the level of emotions, feelings, and states of mind, as well as to indicate to someone that they have been understood" (Bagilishya, 2000, p. 342). Proverbs can be used to elicit "a mode of expression used to recognize, confirm and participate in what the other is living on an emotional level" (Bagilishya, 2000, p. 342). Uwihoreye uses proverbs to describe a problem and separate it from an individual, for example: *ibuye ryagaragaye ntiba rikishe isuka* (meaning when you identify a stone in your field, this stone will never damage your hoe) and to acknowledge that the person is the expert of their pain. Arts-based methods are also used, such as drawing the pain and in identifying support networks.

Ethnic Cleansing

"Ethnic cleansing" is a form of war or mass violence and is a contested term, defined by the United Nations (1994) as "a purposeful policy designed by one ethnic or religious group to remove by violent and terror-inspiring means the civilian population of another ethnic or religious group from certain geographic areas" (p. 130). Critics have argued that it is an attempt to water down the Genocide Convention, which places the obligation on the international community to intervene in order to prevent its occurrence (Shaw, 2015). For example, there is considerable disagreement about the 1992 to 1995 "Bosnian War." Legally, the only part of the conflict deemed to be genocide is the 1995 Srebrenica massacre, whereas other cases before the UN-established International Criminal Tribunal for Yugoslavia have been ruled as ethnic cleansing, war crimes, and crimes against humanity rather than genocide. It was argued that it was not possible to demonstrate the "intention to destroy," despite massacres, systematic rape, the establishment of concentration camps, forced displacement, and the destruction of cultural heritage (Lieberman, 2010). A more recent case of ethnic cleansing is the expulsion of over 900,000 Rohingya Muslims into Bangladesh from Myanmar since 2017, following the destruction of villages and the rape of women and girls (Human Rights Watch, 2017).

Political Violence

Political violence does not have a legal definition and is a very broad term encompassing: "a heterogeneous repertoire of actions oriented at inflicting physical, psychological, and symbolic damage to individuals and/or property with the intention of influencing various

audiences for "affecting or resisting political, social, and/or cultural change" (Bosi & Malthaner, 2015, p. 440). Actions include "attacks on property, bodily assaults, the planting of explosive devices, shooting attacks, kidnappings, hostage taking and the seizure of aircraft or ships, high profile assassinations, public self-immolation" as well as torture, forced disappearances, sexual slavery, or mass killings (Bosi & Malthaner, 2015, p. 440). Political violence can be enacted by state actors (e.g., government, police, or army), those working on behalf of the state (paramilitaries), or non-state actors. As Bosi and Malthaner (2015, p. 440) note, depending on the context, the actors involved, and who is speaking, "these radical forms of contentious politics may be called either terrorism or resistance." This is not to say that each label is equally valid in all cases, but rather to attend to the politicized nature of knowledge construction about events, experiences, and motivations.

Examples of political violence include the following: the tactics undertaken by the British and other colonial powers in subjugating populations (e.g., the brutal suppression of the Mau Mau uprising in Kenya in the 1950s); murder, extreme political repression, and/or disappearances of political opponents during dictatorships, such as under Mugabe in Zimbabwe (1987–2017) and Pinochet in Chile (1973–1990); apartheid in South Africa (1948–early 1990s); and, most recently, the police violence toward *Black Lives Matters* protesters in the United States (2020).

Legacies of Mass Violence

The psychological trauma paradigm, and specifically PTSD, has become the dominant lens through which the impact upon individuals of extreme violence of genocide, war, and political violence is viewed, not only by mental health professionals, but also by the media and more widely in popular, everyday usage, particularly within the Global North (Fassin & Rechtman, 2009). The symptomology of PTSD, as set out in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) is explored in-depth elsewhere in this volume (Chapters 1 and 2). In brief, PTSD is diagnosed when an individual (or a close relative or friend) directly experiences or witnesses actual or threatened death, serious injury, or sexual violence and experiences symptoms under four headings: re-experiencing the event, avoidance of reminders of the event, negative cognition and mood, and hyperarousal.

Notwithstanding the important insights that this framework has yielded in understanding and treating the impact of trauma on individuals, sociologists and anthropologists, along with mental health clinicians who have worked with survivors of mass violence, have suggested that the trauma paradigm fails to capture the experiences, perspectives, and legacies of survivors in a number of areas critical for the healing and re-building of lives (Boothby et al., 2006; Bracken, 2002; D. E. Hinton & Hinton, 2015; Jones, 2004; Khan, 2017; Summerfield, 1999, 2001, 2002).

First, genocide, war, and political violence are collective experiences, with individuals targeted because of their identity as a member of a group or collective. The social fabric is ripped apart, with the bonds between individual and community severed, thus suggesting a need to engage with the collective context and sociocultural processes of meaning-making.

Second, devastation is wrought not only on the psychological dimension of life, but also upon the physical (e.g., bodily injuries, malnutrition); material (e.g., destruction of homes and infrastructure); social (e.g., destruction or dislocation of familial and friendship networks and social institutions); and spiritual (A. L. Hinton, 2002, p. 12). "Trauma" is therefore ongoing, not just as a psychological construct, but also one firmly embedded in daily lives, relationships, and environments. Rather than an event or series of events, trauma is embedded in historical and contemporary structures of oppression. To facilitate processes of destruction, one "group" often constructs itself as superior and subjugates "the other" as inferior, the outsider, dangerous, and impure. For example, Nazi propaganda blamed the Jews for the economic depression in Germany and construed them as subhuman, in contrast to the pure Aryan race; the Nazis viewed the Jews as threatening to overrun the country. Likewise, during the early 1990s in Rwanda, Tutsi were portrayed as dishonest, as a threat to the country, and as cockroaches that needed to be exterminated. Repeated discrimination,

country, and as cockroaches that needed to be exterminated. Repeated discrimination, dehumanization, and disempowerment can be compounded in the present, through asylum systems and nonreflexive psychological interventions.

Third, genocide and mass violence are inherently political acts, not just in their enactment, but in how they are responded to and remembered. Engaging with questions of politics, justice, and agency is therefore central when working with survivors of mass violence. This includes questions of whose knowledge and voices get heard and who is silenced. As [Khan \(2017, p. 100\)](#) questions: "How do people want to repair their own worlds compared with experts who speak on their behalf?" In the following sections we unpack each of these critiques in turn.

CONTEXTUALIZING TRAUMA AND MEANING-MAKING

Considerable debate has raged over the extent to which PTSD is a universal response to trauma. Critics have pointed to the specificity of the historical, cultural, and political contexts which have informed the diagnostic foundations of PTSD, namely calls for restitution for U.S. veterans who fought in Vietnam (1965–1975) (see [Fassin & Rechtman, 2009](#); [Young, 1995](#)). In contrast, proponents have argued that the biological basis of symptoms, such as reexperiencing and arousal, suggest that PTSD does exist universally ([Dyregrov et al., 2002](#); [Marsella et al., 1996](#)). In a review of studies, [Hinton and Lewis-Fernández \(2011\)](#) found substantial evidence of cross-cultural validity of the PTSD criteria (*DSM-IV*), but in a number of areas central to diagnosis, including avoidance/numbing, local interpretations of symptomatology, and the prevalence of somatic symptoms, more empirical research was required along with the need for re-working of criteria to increase cross-cultural applicability. While *DSM-5* has attempted a greater engagement with culture, with an appendix that includes cultural idioms of distress and cultural explanations of distress or perceived cases ([Khan, 2017](#)), cross-cultural applicability has not been developed, fully, in relation to PTSD.

While some symptoms at least may be found universally, the meanings given to the symptoms are shaped by a host of other factors, including history, culture, religion, politics, and personal life experiences ([Bracken, 2002](#); [Jones, 2004](#); [Patel, 2003](#); [Summerfield, 1999, 2004](#)). This creates what [Kleinman \(1977\)](#) terms the "category fallacy." For example, nightmares are designated as a symptom of PTSD, yet it depends whether a given society regards nightmares as significant or problematic as to whether they may be reported ([Bracken, 2002](#)). Moreover, the ways in which the symptoms are interpreted may vary according to local ways of understanding and meaning-making. While in the Global North, in general, "medicalized ways of seeing have displaced religion as the source of everyday explanations for the vicissitudes of life and the vocabulary of distress," while in other societies, religious or cultural beliefs remain influential, with greater emphasis on the interconnections among mind, body, and spirit ([Summerfield, 2004, p. 233](#)).

A growing number of studies have sought not only to explore the cross-cultural validity of PTSD, but to examine the relationship with localized cultural idioms of distress ([D. E. Hinton & Good, 2015a](#); [Kirmayer et al., 2007](#)). Idioms of distress are a "way of talking, or other forms of behavior shared with other people from the same culture (i.e., ethnicity, religion, community) used to express, communicate or comment on distress" ([Kirmayer & Gómez-Carrillo, 2019, p. 8](#)). For example, research conducted in Peru, following the political violence of the Shining Path (1980s–1990s), where 70,000 indigenous Andeans were killed by the guerilla movement and Peruvian military, found that while 25% of this population group exhibited PTSD symptoms, this did not fully capture expressions of distress and suffering. Instead, this suffering was better encapsulated by Quechua terms such as *pinsamientuwan* (roughly translated as worrying thoughts, worries), *ñakary* (suffering, especially collective suffering), and *llaki* (sorrow, sadness) ([Pedersen et al., 2010](#)). Therefore, any intervention requires an understanding of local knowledge and processes of meaning-making, as well as the recognition that suffering is often "both an interiorized and collective experience" ([Khan, 2017, p. 23](#); [Wilkinson & Kleinman, 2016](#)).

Similarly, [Wessells and Monteiro \(2000\)](#) document a case of an Angolan orphanage, where the children exhibited typical clinical symptoms of trauma including nightmares, bedwetting,

and concentration problems. The children believed a spirit was haunting the building, and so the Christian Children's Fund (CCF), now named ChildFund International, called on a local healer to perform a ritual for spiritual purification. Subsequently, the trauma symptoms diminished and the relationship between the children and adults improved. Consequently, Wessells and Monteiro (2000) argue that by developing a hybrid program that combines perspectives across cultural systems, a more holistic and context-specific understanding of healthy child development was gained ensuring the success of the project.

Clinical understandings of trauma and PTSD need to be contextualized socially and culturally, with the symptomology found in the *DSM-5* being only a "subset of symptoms associated with such syndromes" (D. E. Hinton & Good, 2015a, p. 14). Culture both shapes how traumatic events are understood and experienced and offers approaches to meaning-making and healing, particularly through cultural forms (as illustrated in Box 23.1), ritual practices, and religious traditions. While with any form of therapeutic work, it is important to ask critical questions about efficacy and not romanticize traditions that may reinforce unequal power relations or stigma (Wessells & Monteiro, 2000), there is increasing recognition of the importance of contextualizing psychiatry and psychology in ways that account for the interrelationships among the brain, lived experience, and the sociocultural world (Kirmayer et al., 2017).

STRUCTURAL OPPRESSIONS: PAST AND PRESENT

A second critique of the Western biomedical model of trauma and PTSD concerns how the traumatic event is conceptualized. The diagnosis of PTSD is unusual in that it is one of the few disorders in the *DSM-5* which specifies a cause, not just symptomology (Khan, 2017). Yet this cause is an extreme event, such as witnessing mass killings or experiencing sexual violence, which does not consider the "everyday" aspects of trauma (Sinalo, 2018). "Everyday," here, is meant in the sense of the routinized, "insidious" structural "conditions that enabled the traumatic abuse such as political oppression, racism or economic domination" to occur in the first place and which might compound distress in the aftermath of the event, including when engaging with health systems or psychological interventions (Craps, 2013, p. 24). Returning to the case study of Quechua-speaking communities in Peru, research has documented how idioms of distress are not only related to recent direct violence, but also to the structural and symbolic violence of poverty, racism, and inequality embedded in colonialism and enduring into the present, accompanied by concerns about modernity and globalization (Pedersen et al., 2010). Idioms of distress such as *ñakary* and *llaki* encapsulate suffering past, present, and anticipated, which have evolved over time to account for new meanings and attributions (Pedersen et al., 2010). Therefore, the concerns and priorities of survivors may not necessarily be "inwards, to their mental processes, but outwards to their devastated social world" (Summerfield, 1999, p. 1454).

Psychiatrist Jones (2004, p. 245) concluded from research in Bosnia-Herzegovina that children's lasting well-being did not correlate solely with the amount or length of violence to which the children had been exposed or with the ratings on PTSD scales. Instead, what mattered was "how personally disruptive the event had been: What had happened to their family and friends and the landscape in which they lived?" Consequently, she argues that "the main psychic injury of war is the disruption of those ties, the destruction of identity through the destruction of our social world" (Jones, 1995, p. 510). Continuity of the activities of daily life, such as going to school, can be influential in promoting well-being. In Sierra Leone, following the brutal civil war, Coulter (2009, p. 180) observed that while individuals did not forget what had happened to them and their families, "healing was conceived in terms of being able to procure a livelihood—to go to school, to trade, to get a job, to make a living—so that life could go on."

For those who remain in the countries where the atrocities were perpetrated, challenges are presented not only with the destruction of the physical and social landscape but also with living alongside those who perpetrated such atrocities (Pells, 2011). Das (2000) develops the notion of "poisonous knowledge" to describe this interaction between past and present. Das (2000, p. 208) argues that if it were "one's way of being with others" that "was brutally

(2000, p. 208) argues that if it were "one's way of being-with-others" that "was brutally injured, then the past enters the present not necessarily as traumatic memory but as poisonous knowledge." Past events are not "present to consciousness as past events" but instead have come "to be incorporated through an individual's thoughts and actions into the temporal structure of relationships" (Das, 2000, p. 220). Past events are therefore ongoing, embedded in the structures and relations of daily life.

In contrast to the previous discussion, according to Patel (2003), those living in a new country may experience multiple losses, including:

the loss of home, of homeland; the loss of health, of role, language and culture; the loss and separation from family, friends, compatriots; the loss of identity, dignity, purpose and opportunity in life. The loss of hope ...: the hope of justice, the hope of recognition, the hope of safety and protection, and the hope of a life without fear. (Patel, 2003, p. 18)

Mental distress can be compounded by ongoing structural oppressions. Patel (2003, p. 18) describes the effects of a combination of a "harsh (legal) asylum system, racism, detention, poverty, homelessness or very poor housing, difficulties in accessing health services, isolation and continued uncertainty"; such mental distress is reported by refugees as being "worse than the torture I suffered before." This leads to what Kleinman (2015, p. xiv) terms "the terrible irony of social suffering" as "those institutions created to cope with violence and its aftermath are also responsible for contributing to its intensification and bad outcome.

Moreover, the trauma discourse can medicalize and pathologize emotional and behavioral responses, which might be relatively common, given the circumstances (Jones, 2004; Wessells, 2006). For example, the desire for revenge toward killers has been reinterpreted as a sign of poor mental health (Summerfield, 2002). While it might not be considered as a "positive" emotion, it is understandable when individuals have lost family members during mass violence. In the UK, health workers are required to report individuals who are perceived to be vulnerable to radicalization under the counterterrorism "Prevent" policy. Terrorism is constructed as an irrational act, and thus falls under the remit of mental health services, resulting in "an individual's cognitive distortions, rather than their political demands, [and these] became the locus of intervention" disproportionately affecting individuals perceived to have been racialized as Muslim and impeding access to healthcare due to fears surrounding "Prevent" (Younis & Jadhav, 2020, p. 621).

In summary, structural inequities along political, economic, social, and cultural lines, at both the global and local level, drive and exacerbate mental distress (Khan, 2017; Wilkinson & Kleinman, 2016). This has led to calls to "decolonize" trauma counseling (Goodman, 2015); to adopt more expansive understandings of both "distress" and "healing," beyond a focus on the individual and the event; and to recognize and address external, ongoing sources of distress and how these are rooted in historical and current systemic oppressions, including transgenerational trauma. This requires engaging with considerations of politics and power, to which we now turn.

THE POLITICS OF TRAUMA

Genocide, war, and political violence are all political acts, and so working with survivors necessitates engaging with political questions, both within one's own work, as well as within a broader context. PTSD has been argued to function as a "political metaphor" (Fassin & Rechtman, 2009; Khan, 2017, p. 46), prescribing certain ways of being and acting, designating whom the legitimate victims are and reproducing relations of power, whether between counselor and survivor or in the realm of international political economy. This raises questions about how to address inequities and power relations in therapeutic work as well as in addressing the root causes of trauma in systemic social and political injustices (Martín-Baró, 1994).

Fassin and Rechtman (2009, p. xi) argue that "trauma has become a major signifier of our age" that is used politically to support certain claims, legitimate some forms of action, and undermine others. For example, "We are not mad, we are betrayed" was the response of a Bosnian refugee to researchers from a mental health project pilot (Summerfield, 2002, p.

Summerfield, 2002, p. 1106). The refugee resented the "problem" being presented as a matter of individual illness rather than a collective, moral, and political issue. Although psychological interventions can assist survivors in coping with traumatic experiences, they rarely address the root of human rights violations and injustices and can become a smokescreen for a lack of political engagement (Summerfield, 2002). While neutrality is a key tenet of humanitarian intervention (an arena in which psychiatry and mental health has assumed an increased prominence), Jones (1998) argues that this can have adverse psychological and political consequences. This refers both to the individual therapist working on the ground as well as to organizations, donor agencies, and governmental departments in which the psychosocial approach is the selected mode of intervention.

The dangers of failing to consider politics and the balance of power within societies are exhibited in Argenti-Pillen's (2003) study of the "Cinnamon Garden culture." The "Cinnamon Garden culture" refers to the central Colombo location of many of the Sri Lankan mental health nongovernmental organizations (NGOs). Sri Lankan psychosocial workers translated trauma discourse into Sinhalese, finding equivalent concepts such as fear, terror, and violence. However, the psychosocial workers were part of the Colombo elite resulting in a "discursive distance" from the communities with whom they worked. Additionally, concepts were aligned with Orthodox Buddhism rather than the heterogeneous practices of Sinhalese Buddhist villagers (Argenti-Pillen, 2003, p. 204). Consequently, Argenti-Pillen argues that the introduction of foreign concepts and their application exacerbated preexisting inequalities in Sri Lankan society. Therefore, with any intervention, professionals need to take the utmost care in first understanding local power dynamics and socially inscribed divisions, according to gender, race, class, religion, sexual orientation, and so on. Such issues relate to the politics of knowledge production, that is, whose knowledge counts and whose voice gets heard.

As noted previously, experiential knowledge and local ways of meaning-making may be discounted in favor of biomedical or biopsychological frameworks (Breslau, 2004; Patel, 2003). This can be fundamentally disempowering and may reproduce the power dynamics at play during the traumatic incident(s) in which survivors have limited or no control. Moreover, it constitutes a form of epistemic injustice. Fricker (2007, p. 44) defines "epistemic injustice" as occurring when "the subject is wronged in her capacity as a knower" which is "wronged therefore in a capacity essential to human value."

Alternative approaches have sought to create space for survivors to testify to their experiences and make demands for truth and justice. During the Guatemalan civil war (1960–1996), indigenous Mayan people were massacred by the army and paramilitaries. Following exhumations at Plan de Sánchez, in 1994, issues of truth, memory, and justice took tangible forms through community support groups, which involved truth-telling processes, in addition to the initiation of prosecutions of local military commissioners by NGOs. Sanford (2003, p. 242) argues that through combining "community recovery, the reintegration of agency, and a political project for seeking redress through the accretion of truth" it was possible to break "the binary that counterpoises justice and healing." By adapting the testimonial model from the individual to the community dimension, it can be possible for communities to challenge "structures of violence and lateral impunity" through the interaction between the local and national level (pp. 240–242). Similarly, in Rwanda, Sinalo (2018) documents the importance of creating space for genocide survivors to give testimonies and to participate in shaping public discourses. At the same time, testimony or public expression of past pain is not culturally acceptable in all societies. Again, care should be taken to understand sociocultural dynamics.

S. Shaw (2005) writes of the antipathy toward the Sierra Leonean Truth and Reconciliation Commission as "speaking of the violence—especially in public—was (and is) still viewed as encouraging its return, calling it forth when it is still very close and might at any moment erupt again ... social forgetting is a refusal to reproduce the violence by talking about it publicly" (p. 9). Similarly, for those seeking asylum or for those who are refugees, the search for justice can be an important part of recovering a sense of agency and identity. As with the previous examples, this is a very individual choice. Whereas for some, speaking out is an important part of challenging injustices past and present, for others, addressing immediate needs such as housing and food, as well as concerns for personal security, may be paramount.

Therapists can play an important role in supporting clients to connect with solidarity groups and in advocating for access to other services, such as housing, legal representation, education, and other health services (Patel, 2008).

Decolonizing trauma counseling therefore necessitates political literacy on the part of counselors, not only to understand the sociopolitical issues facing the individuals with whom they are working, but also to take an active role in the decolonization process (Goodman, 2015). This could include reviewing the policies and practices within institutions and organizations at a local, national, and international level to understand how policies may give rise to or accentuate trauma that has a disproportionate impact on certain marginalized groups and how resources

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are distributed (Goodman, 2015). Moreover, clinicians need to be reflexive of their own personal histories, assumptions, and practices in order not to sustain injustice and power inequalities within their own work (Jones, 1998; Martín-Baró, 1994).

TRAUMA-INFORMED PRACTICE AND IMPLICATIONS FOR COUNSELING

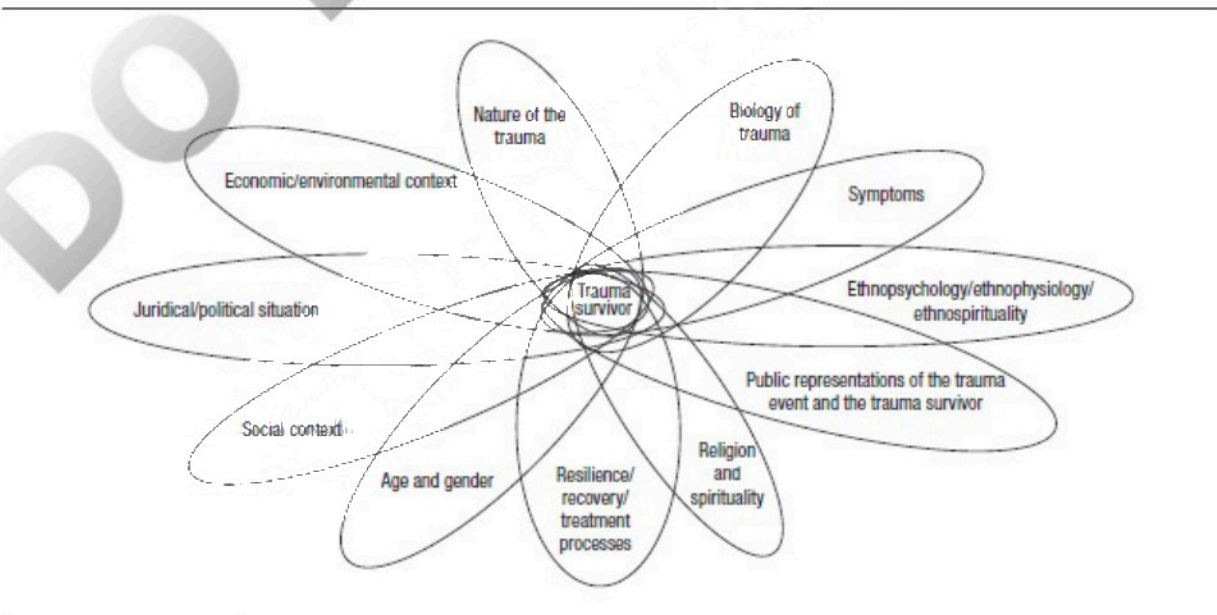
This section considers trauma-informed practice with survivors of genocide, war, and political violence, bearing in mind the critiques explored throughout this chapter. We begin by outlining frameworks, which have sought to bridge cultural and critical psychology, neuroscience, social sciences, and anthropology, and by identifying implications for integrating cultural and contextual factors into counseling practice, before turning to specific psychological tools within narrative- and arts-based approaches. Specialist training and supervision should be sought before working with trauma survivors. Well-meaning but ill-informed interventions can cause serious damage.

Cultural Humility and Social Justice

Bringing together psychological and anthropological perspectives, D. E. Hinton and Good (2015b) propose a holistic framework for working with trauma survivors of mass violence. Their framework is illustrated in Figure 23.1 and is composed of 11 dimensions for assessing trauma survivors.

The **trauma survivor** is positioned at the center, indicating the need for a person-centered approach, but one which is holistic and contextualized. The **nature of the trauma** experienced is crucial in understanding the impact and possible responses; for instance, the nature of the event (e.g., killing of family members, sexual violence), the symptoms induced, whether it was experienced as an individual, a group, intergenerationally, the type of loss (e.g., social, cultural, economic), and whether it was one-off, episodic, or chronic.

Figure 23.1
Eleven Dimensions for Assessing Trauma Survivors



Source: Reproduced with permission from Hinton, D. E., & Good, B. (Eds.). (2015a). *Culture and PTSD: Trauma in global and historical perspective* (p. 51). University of Pennsylvania.

In understanding the impact on the individual, it is important to account for the **biology of trauma**, given the profound impact on the nervous and endocrine system (these issues are

detailed in the chapters in the first section of this textbook) and that current stresses like poverty can compound symptoms. **Symptoms** include both those within the *DSM* as well as a much broader “traumatic symptom pool,” which varies across cultures (D. E. Hinton & Good, 2015b, p. 59). Symptoms need to be interpreted in the local context, which can create “feedback loops,” shaping which symptoms of trauma are more prevalent in any given context. **Age and gender**, which intersect with other inequalities such as race, class, sexual orientation, and so on, increase vulnerabilities to experiencing certain types of trauma (e.g., sexual violence among women); they also shape how trauma may have an impact on the individual and influence pathways to healing, such as barriers to seeking healthcare following sexual violence due to stigma.

Attending to the local context requires knowledge of ethnopsychology, ethnophysiology and ethnospirituality, which focus on how both the trauma and resultant symptoms are interpreted and experienced, including both idioms of distress and how these intersect with globally circulating discourses and approaches to trauma and PTSD. **Religion or spirituality** may be central here, and religious practices can provide remedies, in relation to complex bereavement, mourning, and rituals for the death of others. **Public representation of the trauma event** also has an impact on a survivor’s sense of self and identity. For instance, if survivors are seen as weak or stigmatized because of their distress, this can construct and shape the ways in which survivors see themselves. Memorialization, commemoration practices, and the relationship between individual and collective memories may create opportunities for re-traumatization (e.g., if survivors are excluded or their narratives not heard) or for healing (D. E. Hinton & Hinton, 2015).

Approaches to therapeutic practices often are founded on a deficit approach, that is, what the individual is lacking or cannot do, rather than on strengths and sources of **resilience**, whether individual or collective in the **recovery or treatment process**. Interest has grown in the possibility of posttraumatic growth, whereby individuals may not only return to previous levels of functioning but may obtain new insights and strengths and participating in collective social action can play an important role (Goodman, 2015; Sinalo, 2018).

Processes of healing also may be shaped by a series of (or lack of) resources. First, **social context**: relationships and networks might have been disrupted due to death, displacement, or exile. Trauma can continue to reverberate through social structures and interactions, including intergenerationally, such as with increased rates of domestic violence and alcohol and drug abuse (D. E. Hinton & Good, 2015b, p. 84). Second, **economic-environmental context**: such as personal and familial safety, and access to housing, safe water, and food, without which traumatic symptoms such as anxiety may intensify. Impoverished groups typically have less access to healthcare and are more likely to suffer from physical and mental ill-health. Third, **juridical/political situation**: demands for redress and justice are often intertwined with survivors’ journeys toward healing. Support is needed where survivors are called upon to testify and where justice mechanisms, such as trials, do not necessarily address local perceptions and realities, leading to resentment and revictimization.

Taken together, these perspectives enable counselors to consider the multiple factors that shape both trauma and the responses of survivors to their experiences, bridging the mind-body-world and the individual and collective. D. E. Hinton and Good (2015b) argue that this prevents any assessment from being decontextualized or abstracted and enables the counselor to identify key processes or areas for possible intervention. In the rest of the section, we turn to looking at additional considerations for trauma-informed practice.

Creating a Safe Environment

It is widely acknowledged that supporting trauma survivors practically and emotionally to feel safe and secure during counseling is of utmost importance. Depending on individual circumstances, it may be helpful to explore with survivors the possibility of finding a “safe place” that they can visit when dynamics in or out of therapy feel unsafe or overwhelming. This place can be a real or imagined place or space. The feelings, sounds, smells, and sensations associated with it need to be connected with and linked to a trigger word so that the person can self-soothe by going to this safe place; alternatively, the therapist can support or facilitate the survivor’s connection with the safe place. Other grounding and self-soothing

or facilitate the survivor's connection with the safe place. Other grounding and self-soothing techniques should be in place, as well as buffering and building on the survivor's coping strategies and resources.

Attending to Power Dynamics and Reflexivity

Creating safety within therapeutic work extends beyond the cultural competence of the counselor, to adopting a systemic approach that considers the safety of systems, institutions, and clinical settings, while attending to power dynamics (Maercker et al., 2019). The therapeutic work itself may be reminiscent of aspects of the torture experience; for example, being alone in a closed room with a person who is positioned as a powerful/authoritative figure asking personal questions. Moreover, counselors could be perceived as representing various roles, including that of being a rescuer or savior to that of being an oppressor or persecutor. If the therapist is positioned as a rescuer, this might place the survivor in a position of victim or passive recipient. These issues around power are important to discuss in clinical supervision, as this type of work can provoke powerful transference and countertransference reactions.

Working With Interpreters

Interpreters may be required to ensure good communication and the creation of a safe space (Leanza et al., 2014; Tribe & Raval, 2003). Key issues worth considering include: (a) allowing additional session time, including the time to meet and build rapport with the interpreter; (b) examining roles and expectations; (c) discussing any observed nuances such as body language, gestures, and tone of voice (with reference to cultural knowledge); and (d) offering time to provide a debriefing experience for the interpreter.

The selection of an interpreter is a critical decision. Some people feel uncomfortable speaking with someone from their own community because of fears of confidentiality and/or of being judged, and this can be a barrier for openness. Other people may have specific preferences for interpreters with whom they would feel more comfortable, and these should be discussed. Unfortunately, many services are limited by a lack of resources, and therefore, choice is not an option. Also, there is often reliance on nonprofessional interpreters, which might affect the quality of the communication and raise confidentiality concerns (Maercker et al., 2019).

Impact of the Work

Healthcare professionals report profound psychological effects of the therapeutic work with refugee and asylum-seeking people (Rees et al., 2007). Counselors may experience changes in the way they perceive the world; may have feelings of anger, anxiety, and depression; and may encounter intrusive images (vicarious trauma), an overwhelming sense of responsibility, or even survivor guilt, depending on their own personal histories and contexts in which they are working (Sabin-Farrell & Turpin, 2003). Self-awareness and self-care are crucial, even more so when working in a post-conflict area with restricted resources and limited support networks.

Therapist's Position

Remaining "neutral" when working with refugee and asylum-seeking people is impossible, given the sociopolitical context (Tribe & Raval, 2003). In taking a nonneutral stance, the therapist clearly is opposing the atrocities experienced by the survivor. The survivor's experiences should be actively listened to and validated, and care needs to be taken to address the person as a whole individual and not to define the person by their traumatic experience and/or their immigration status. Providing a space in which the survivor can be held emotionally is crucial, one where the person is recognized, and their experiences are acknowledged. Additionally, it is essential to foster alternative ways to express (verbal and nonverbal) or name some of the unbearable experiences. This can support the survivor in meaning-making and serve to break the "conspiracy of silence" (Danieli, 1998) that often is experienced by survivors.

Psychological Approaches and Tools

In this section we consider narrative and arts-based tools for working with trauma survivors. While there are numerous tools available for counselors, we suggest that these approaches facilitate greater sensitivity to cultural context, encourage the decolonization of knowledge production, and have the potential to address social justice (though this is a work in progress and should not be assumed). This is by no means an inclusive summary; however, it is hoped that some of the breadth of options demonstrates the wide range of approaches available, to be creatively used and interwoven into existing multimodal therapies.

Selected therapies are discussed briefly in the following subsections: narrative therapy, tree of life technique, cultural genograms and life storybooks, testimonial psychotherapy, creative therapies, and bereavement work. A careful assessment and formulation is needed to ascertain the appropriateness of the type and time of these interventions, in order to ensure that the therapist is not adhering to a one-size-fits-all approach.

Narrative Therapy

Narrative therapy involves helping survivors to deconstruct and challenge their dominant stories and to create more empowering life narratives (White, 2000). Survivors' lives may seem full of problem-saturated stories and negative dominant discourses, such as of being "bad, damaged, and hopeless," which they then may internalize and thus self-stigmatize. Therefore, externalizing the problem, that is, seeing the problem as separate from the person, might support survivors to see that they are not the problem; the problem is the problem (White, 2004). Additionally, survivors can be supported in identifying unique outcomes or exceptions, which thicken the survivors' less told stories and may assist them in reconnecting with their strengths, skills, and values, as well as in providing an opportunity for them to reauthor their stories (Beaudoin, 2005). Narrative therapy acknowledges the connectedness of peoples' lives and builds on people's skills and sense of agency. Narrative therapy takes the stance that people always respond to trauma, and that these responses say something about what the person values or was preserving and protecting. For example, this can be supported through questions such as the following: What is this pain you feel a testimony to? What is it you hold precious that has been violated? What kind of life have you been fighting and struggling for?

Tree of Life Technique

This is a narrative therapy tool that originally was developed by Ncazelo Ncube, a Zimbabwean psychologist, for children who had been orphaned by HIV/AIDS. Since its origin, the tool has been extended to working with numerous age groups and in wide-reaching areas, including with those who have experienced trauma and loss. The Tree of Life enables people to strengthen their relationships with their own history, their culture, and the significant people in their lives.

In this technique, a tree is used as a metaphor to promote survivors' discussion about:

- The roots (origin of family name, country of birth, stories and songs from the past, and ancestors)
- The ground (everyday activities and the situation at present)
- The trunk (strengths, resiliencies, and skills)
- The branches (hopes, wishes, goals, and dreams)
- The leaves (people or pets—real, imagined—who have been important to the person)
- The fruits (the gifts people have been given, including both material and essential gifts of life such as love and kindness)

Often, these representations are in pictorial form, and people can express their ideas in whichever way they choose, including the use of objects, pictures, and paint. When the Tree of Life is done as a group, people can display all of their trees together, and in doing so, they can create a forest of trees, a community. This can support people in feeling part of

something and listened to; then the group may choose to reflect and comment on what they have been struck by when reading other people's trees. The group then discusses the storms and dangers faced by trees; they can use this as a metaphor for thinking of ways of weathering through the storm and remembering the roots, leaves, and so forth. This process is usually completed with a certificate and ceremony.

The Tree of Life has been extended to work with different groups. For example, the principles of the tool were applied to the metaphor of a football pitch and were used with former child soldiers (Denborough, 2008). This technique has encouraged people to draw on their strengths, resiliencies, and narratives of the past, as well as to be part of a wider community. Another adaptation is the Kite of Life, which focuses on moving participants from intergenerational conflict to intergenerational alliance (Denborough, 2010).

Cultural Genograms and Life Storybooks

Cultural genograms have similar aims as those of the Tree of Life technique. A genogram is a pictorial representation of a family tree that goes beyond the factual detail by attending to themes, relational dynamics, and psychological factors while attending to cultural considerations (McGoldrick et al., 1999; Rigazio-DiGilio et al., 2005). The genogram is a way for the counselor to support the survivor in telling their life story. For example, when talking about overcoming hardship, the counselor may look at the genogram and inquire what hardships the survivor's grandmother or cousin may have experienced, or what the person thinks an aunt or husband might have thought of the hardship the survivor faced. This can be a sensitive way to explore other areas of difference such as spirituality, religion, cultural rituals, and race. Genograms can be complemented by other tools such as ecomaps, life storybooks, or timelines. These documents are a construction or reconstruction of an individual's life and involve the integration of internal processes with relationships and values within the family, as well as community within the cultural context (Cook-Cottone & Beck, 2007).

Testimonial Psychotherapy

It is important to support survivors in having their voices heard and encouraging them to feel that their voices are worth hearing; this ultimately can assist survivors with journeys of personal, as well as social action and change. One way that incorporates this stance, as well as embracing the storytelling culture of some communities, is through testimonial psychotherapy (Akinyela, 2005; Schwartz & Melzak, 2005). This therapy places justice as the therapeutic entry point (Agger et al., 2009). Testimonials allow the retelling of events to a therapist, who documents the narrative, and, through an interactive process of reviewing it with the survivor, produces a written testimony that acknowledges the experiences and provides vital documentation for political or personal purposes, transforming private pain into political or spiritual dignity (Agger & Jensen, 1990).

The testimonial process enables the victim to gain some distance from the event and to focus on different aspects of the story, such as on survival (Lustig et al., 2004). This can lead to essential and powerful meaning-making discoveries. Lustig et al. (2004) state the following:

Testimonial therapy emphasizes an individual's personal resources by creating a written document for socio-political purposes, thereby engendering a sense of agency, and counteracting innate feelings of powerlessness and inferiority. Moreover, participants' control over the creation of the document, as well as their right to disseminate it, or keep it to themselves, contrasts sharply with the lack of influence over original events described in the testimony. (p. 34)

Creative Therapies

Creative therapies are based on the premise that art is healing and uses innovative means when working with people, including visual art, creative writing (including poetry), music, narradrama (Dunne, 2000), sociodrama (Kellerman, 2007), and dance/movement therapy (Gray, 2001; Harris, 2007). Using different media may be helpful in expressing the traumatic

(Gray, 2001; Harris, 2007). Using different media may be helpful in expressing the traumatic experiences while attending to multiple sensory processes, which is especially relevant as trauma can impair nonverbal domains of the body (van der Kolk, 1994). Additionally, using creative means can provide a contrary experience to that associated with trauma, thus facilitating distance, desensitization, processing of trauma memories (Kozłowska & Hanney, 2001), enhancing one's sense of control and authorship, stimulating the imagination, and facilitating the mind-body connection (Malchiodi, 2008). Furthermore, different ways of expressing oneself may resonate with those from communities where dance and music are culturally important means of storytelling.

Using creative means can facilitate connection. For example, in addition to verbally creating a safe place, the clinician and client may create a safe box, whereby the outside of the box can signify comforting and safe images, and the inside of the box can be used for objects and pictures that represent difficult feelings. Additionally, people can be encouraged to act, write a song or poem, dance, make a movement, or draw their life as a journey; others may find using dolls, puppets, and masks as powerful symbols for unexpressed feelings, and others may find writing a book about their experiences to be cathartic (Malchiodi, 2008).

Bereavement Work

Many survivors who have experienced mass violence and torture also have experienced multiple losses and bereavements (D. E. Hinton & Good, 2015b). Survivors may be uncertain of a family member's whereabouts or burial site, including the events leading to the killings. Bereavement work can be valuable, using a culturally appropriate medium and bearing in mind that ideas, beliefs, and rituals associated with death and the afterlife vary (Honwana, 1999). Useful techniques may include:

- writing a letter to the lost one/ones
- creating a memory box
- creating a remembrance mural or piece of artwork
- carrying out cultural or religious rituals or ceremonies
- discussing the stories, legacies, values, memories, and lessons that the person living can carry with them throughout life

Experiences of multiple losses must be taken into account throughout the therapeutic work, as the ending of therapy might be representative of these earlier losses and/or abandonment.

CONCLUSION

The existential horror of genocide, war, and political violence, and its enduring legacies for survivors, has been explored throughout this chapter. The extreme nature of the violence that has been experienced by individuals presents several challenges for clinicians above and beyond the usual therapeutic considerations. In addressing these challenges, we have advocated for the adoption of a broader framework than the purely psychological, illustrating how insights from sociology and anthropology can strengthen therapeutic work. This includes understanding sociocultural processes of meaning-making and systemic oppression, which shape idioms of distress and calls for justice. In practice, this requires a holistic framework, which addresses the needs of the individual, addressing the sociocultural, political, and environmental context, while