

# **Crisis Intervention After Major Disasters**

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In this article the author presents a brief description of acute stress disorders and describes some early intervention strategies for working with traumatized adults and children in the immediate aftermath of a major disaster. It was written in response to the December 1999 floods that devastated much of Venezuela, killed 50,000 people and left 500,000 homeless and psychologically traumatized. The content of the article was originally presented in a lecture format for professionals and lay people who went out to work with the survivors in the shelters. It was then written in English, translated into Spanish, distributed to counselors in the shelters in Caracas, and sent out on the Internet to mental health professionals across the country. Though it was written for mental health professionals working with victims of the Venezuelan floods, it was written with non-technical language and will hopefully be useful to other mental health professionals, working with survivors of a wide range of major disasters.

## **WHAT IS A PSYCHOLOGICAL CRISIS?**

A psychological crisis comes about when a traumatic event overloads a person's capacity to cope in his or her usual fashion. Psychological crises cannot reliably be predicted based on the events that precede them. An event that precipitates a psychological crisis for one person is not necessarily going to precipitate a crisis for another person. Nonetheless, some events commonly precipitate psychological crisis reactions. These include war, physical assaults, torture, rape, automobile accidents, intense personal losses, and natural catastrophes such as earthquake, fire and flood. Events like these will often induce a psychiatric disorder that we call an ACUTE STRESS DISORDER. The Acute Stress Disorder is characterized by feelings of intense fear, helplessness and horror. There may also be an emotional numbing, a lack of emotional responsiveness, a feeling of detachment, reduced awareness of surroundings, a sense of unreality or amnesia. People suffering an Acute Stress Disorder may feel anxious, excitable, agitated, distressed, despairing, irritable, or hopeless. They may re-experience the event in recurring dreams, flashbacks, or persistent memories of the trauma. The person may avoid people, places and objects that may re-awaken memories of the traumatic event. They may have difficulty concentrating and may have difficulty functioning in their usual way at home and at work. They may also suffer survivor guilt or guilt for not providing enough help to others. Some people may become aggressive or self destructive, disregard self-care, become confused or behave in a bizarre fashion.

When dealt with quickly, the symptoms of Acute Stress Disorder will typically diminish or disappear entirely within 30 days. In some cases, particularly when untreated, Acute Stress Disorder may persist. If its duration is from one to three months we call it an ACUTE POSTTRAUMATIC STRESS DISORDER. When the symptoms last more than three months, we call it a CHRONIC POSTTRAUMATIC STRESS DIORDER. (The above diagnostic information is derived from the DSM-IV, 1994) It is not uncommon for untreated Posttraumatic Stress Disorder symptoms to persist for many years and become serious constraints on a person's life. It is also important to remember that when a person struggles with a severe stress reaction, it is likely that the family or any other people around the patient will also be affected by the symptoms of the patient's Post Traumatic Stress Disorder.

### **WORKING WITH ACUTE AND POST TRAUMATIC STRESS DISORDERED PATIENTS**

Counselors working with Acute and Posttraumatic Stress Disordered patients may assist them in the management of the post-traumatic event tasks (informing others, making calls, rescheduling the person's daily routine), and providing a safe place to talk about either the event, the person's symptoms, or whatever else is foremost on the patient's mind. Though it is sometimes initially painful to talk about the traumatic event, people often report a sense of relief and a reduction of symptoms after they have been able to talk about the event. They can see the situation more clearly after putting the pieces of the problem out on the table and looking at them, along with a counselor. While adults may talk with a therapist, a child suffering an acute stress reaction is likely to talk about it in the child's non-verbal language of play as well as in the verbally spoken metaphors of the stories they tell from their imagination. So with children, we are more likely to conduct a play therapy session (more about this later). In many circumstances, as mentioned above, the sudden behavior change of the traumatized person affects the whole family. When this happens it is often helpful for the whole family to meet with a therapist who can help them address the difficult issues and improve communication between family members.

A traumatic event is one in which a person's coping mechanisms are overwhelmed by the intensity of the situation. In treating Acute Stress Disorder and Post Traumatic Stress Disorder we want to recover the event, break it down into smaller pieces, understand it, master it, digest it and make it all more intelligible. There are, however, some circumstances in which the person is uninterested in or unable to speak of the specific traumatic event. In these circumstances the person is encouraged to speak about whatever is uppermost in his or her mind and in these circumstances the symptoms sometimes diminish nonetheless.

### **COUNSELORS WORKING WITH VICTIMS OF NATURAL DISASTERS**

In natural disasters such as earthquakes, catastrophic fires and floods it is important for counselors to remember that everyone is affected by the crisis, including the counselors themselves. As such, there are several useful principles to keep in mind:

#### **1) COUNSELORS NEED TO TAKE CARE OF THEMSELVES AND EACH OTHER – PHYSICALLY AND EMOTIONALLY.**

It is easy for counselors to become overwhelmed and emotionally drained by this kind of work. They need to take breaks, eat properly, and rest when they become tired. A traumatized and overwhelmed therapist is not able to be as helpful to the people that need him or her. Experienced psychologists and psychiatrists who have never worked in crisis before are often quite surprised to discover how exhausted they feel after doing crisis counseling for only three or four hours.

## **2) COUNSELORS NEED TO REMEMBER TO THINK CLEARLY.**

It is easy to lose perspective and become confused in a crisis. Counselors should try to slow down, make a checklist of priorities to address with each case, and discuss their clinical decisions with their colleagues.

## **3) COUNSELORS NEED TO SET PRIORITIES.**

In a crisis people often lose their ability to evaluate what is important from what is not. With each case it will be helpful for the counselor to have a checklist for guiding him or her through the work. It might include information such as: name of patient, age, address, family members, physical illness or injury, time of last meal, etc. Safety, medical concerns, sleep, food, and shelter must be either attended to or considered before any psychological treatment can begin. People cannot overcome their fear until the real danger has been removed. Many people are delirious, anxious or depressed because of medical problems. Others are agitated due to lack of sleep. If a person hasn't eaten for a while they may be depressed, agitated, or have difficulty thinking. It is dangerous to treat these kinds of problems as simply psychological problems. Sometimes a patient needs a meal, a rest, some first aid or some medication more urgently than anything else.

## **4) COUNSELORS NEED TO WORK COLLABORATIVELY AND SEEK SUPERVISION FROM ONE ANOTHER.**

Crisis work is best performed in a site where intense interdisciplinary interaction between colleagues is possible. Such an environment gives counselors the opportunity for mutual supervision and consultation with medical doctors, nurses, psychiatrists, psychologists, social workers and others involved. It is easy for counselors to become overwhelmed with the intensity of the problems and find their thinking clouded. Consultation becomes essential for conscientious crisis intervention.

## **5) WORKING WITH PATIENTS IN CRISIS IS NOT THE SAME AS SEEING PATIENTS IN A PRIVATE PRACTICE OR A CLINIC SETTING.**

Your crisis intervention "office" may be a large room with many other people in it doing all sorts of different things or it may not be in a building at all. Confidentiality may be seriously compromised by the nature of the emergency and the need for support from others. Office hours in a crisis have nothing to do with the clock. The counselor meets with people when they are in need. Sessions last as long as the needs and resources allow them to last.

## **6) COUNSELORS WORKING IN A CRISIS NEED TO BE LIGHT ON THEIR FEET.**

Crisis counselors need to leave the private practice model behind and even leave the clinic model behind. They need to look at the situation for what it is and be as creative and innovative as they can. They need to improvise with space, time, materials and resources. They need to collaborate closely with others. They need to assess their task and choose goals appropriate to the circumstances and the situation. They need to be forgiving of others and themselves when they lose their composure. And, if at all possible, they need to maintain their sense of humor.

### **CRISIS INTERVENTION**

The crisis intervention setting is different from a clinic setting. The counselor may be in a school or a church, in a field or under a tree. And just as the crisis intervention setting is different from a clinic, so too are the problems the crisis counselor deals with. The problems include the kinds of symptoms described above in the section describing ACUTE STRESS DISORDER. During the crisis the goal of treatment is not characterological change, or insight into the childhood origin of the patient's problems. If such insights occur, that is obviously very good but that is not the goal in the initial contact in the field.

The goal of crisis intervention is to help the patient to COPE with the trauma.

The goal is to help the patient ADJUST to the new situation.

The goal is to RETURN THE PATIENT TO THE PREVIOUS LEVEL OF FUNCTIONING.

These goals are met by inviting the patient to talk about his or her experiences, get some perspective on the event, sort out the associated feelings, and problem solve about how to deal with his or her problems.

### **FIRST CONTACT**

In the first contact it will be useful to get a little bit of information like the person's name, medical condition, social support system, etc. but the crisis patient should not be subjected to a lengthy intake evaluation. The counselor should try to set the patient at ease, clarify the task and invite the patient to talk. A good crisis counselor is a good listener but the crisis counselor is often more active than a psychotherapist who sees patients on an on-going basis. The crisis counselor clarifies, reassures, educates, offers advice about practical matters that the patient needs to deal with, and refers patients to appropriate agencies and programs. The counselor needs to be very mindful of the patient's medical condition, seek medical consultations about any concerns they may have and refer patients for medication consultations whenever anxiety, depression, agitation or sleeplessness are at levels that severely impair functioning or make the crisis intervention impossible.

### **LONG AND SHORT TERM GOALS**

In the midst of a crisis, people lose perspective. They are flooded with thoughts and feelings. They have difficulty setting priorities and as a result they tend to get very concerned about things they can't deal with and tend to avoid or ignore the more immediate concerns of the moment that they can deal with. For this reason it is often useful to help the patient to organize his or her thoughts into two sets of goals - a set of short-term goals and a set of long term goals. SHORT TERM GOALS include calming

down, trying to come to terms with their intense fear, talking about what has just happened to them, getting shelter for the night, having something to eat, etc. LONG TERM GOALS include getting into a long-term therapy, looking for a job, finding permanent housing, etc. The crisis counselor needs to be very ACTIVE and DIRECTIVE in helping the patient sort out these two types of goals and then in attending, in a very practical way, to achieving the short term goals and making a plan to attend to the long term goals.

### **MAKING A PLAN**

People in crisis have trouble concentrating, thinking straight, using good judgment, and setting priorities. It is often helpful for the therapist to take notes while talking to the patient to keep track of all the information and to have a list of topics to remind the counselor to cover during the interview. At the end of the session it is often very useful to actually WRITE UP A PLAN for the patient to follow and send the patient away with the plan in their hand. It is best to prepare the plan with the patient's collaboration, to write the plan in legible penmanship, to number each of the points and to format it so that it is easy to read. It may say things like:

- 1) If I get upset I will talk to a counselor.
- 2) I will call my Uncle to see if he can help me out during the next two weeks.
- 3) I will talk to my doctor about replacing my usual medication for my asthma.
- 4) I will put my name on the list for low rent housing.
- 5) I will go to the agency to look for work

### **TELLING THE STORY**

People develop the symptoms of an Acute Stress Disorder because they have been exposed to a traumatic situation that overwhelmed their ability to cope with the situation in their usual way. Consequently, their symptoms serve to cover or hide the overwhelming and unmetabolized experiences. Crisis intervention is intended to 1) help the patient tell his or her story, 2) get some distance on the event to help understand what had happened, 3) hang words on the experience and 4) return the patient to his or her previous level of functioning. As the patient tells the story of the traumatic experience he or she may cry, laugh, yell, whisper, fall silent for a while, recall another seemingly unrelated loss, or become preoccupied with some feature of the story that seems insignificant. The therapist should listen patiently and keep the patient returning to his or her story.

### **COMMON THEMES IN THE STORIES OF TRAUMA**

In the process of hanging words on the experiences of trauma we find several recurring clinical pictures (this list is by no means inclusive):

- 1) Those who are overwhelmed by emotion and have difficulty speaking.
- 2) Those who don't convey any emotion at all while telling a story of horror.
- 3) Those who feel guilty for surviving the disaster while other died or were hurt.
- 4) Those who feel that they either caused the calamity in some way or feel they should have done something differently to save someone.

1) When people are overwhelmed with emotions, counselors should help them calm down by taking them to a quiet place, offering a cup of water, allowing them to emote for awhile and then trying to help them speak about what they are experiencing. Sitting with the patient in silence or letting him or her cry for a while is very helpful but eventually it will be important to help him or her try to speak about the unspeakable.

2) For patients who are emotionally numb the counselor can point out the usual feelings that most people might have in such circumstances and wonder with the patient what feelings might be hidden from view. BUT it is also important to remember that if a person is emotionally numb, it is to ward off the overwhelming affect. It is important that the counselor respects the patient's defenses and gives him or her time to let the feelings about the experience come to the surface. Crisis counselors have recognized for many years the way that some victims of trauma may appear to be doing well in the first days following the crisis and then completely fall apart a week or two later, when they are in the safety of another context.

3) Though it is irrational, it is also very common to encounter people feeling guilty for surviving a tragedy that others did not. The crisis counselor needs to monitor suicidality in these patients and help them to mourn their losses by inviting them to talk about the people and things they have lost. It is sometimes useful to ask the person if his or her deceased loved one would have wanted the patient to suffer or be happy with the rest of his or her life. It is rather simplistic but sometimes shifts the focus from the survival guilt to the mourning that resides beneath it.

4) For those who feel that they may have, in some way, caused the flood or earthquake or feel they could have done something to save their family, it is important to help them recognize the power of the opponent they were up against, acknowledge the fear and confusion of the moment, and, again, help them to mourn their losses. After the person has told his/her story it is often good for the patient to tell the story again and again and again and again. Patients won't need to be told to do this but they can be invited to feel free to tell the story repeatedly without feeling that they are boring people with the same story. Counselor can expect that with each telling the details of the story may be further elaborated and the pent up affect further released.

### **TERMINATION**

Crisis counseling is, by its nature, very brief. Many interventions take place entirely in one session. It is important to conduct the session as a single session treatment. If the counselor sees the patient again, that is fine but it is helpful to regard each session as an intervention unto itself. The crisis intervention should end with a concrete plan for the patient to follow. The plan should be written and given to the patient. If the patient is a child the plan should be given to the adult in charge or placed in a chart for the child's on-going care. The counselor should make any and all referrals that might be necessary and, then, the patient and therapist need to say their good-byes. The therapist needn't worry about being too neutral. It is okay in crisis counseling for the counselor to express sadness and anger about the tragedy the patient has met, to offer advice and to wish the patient good luck. Though physical contact is avoided in psychotherapy, hugs are not

uncommon in the midst of catastrophic events. A reassuring touch or a hug can sometimes make all the difference in the world. While counselors need not be phobic about touching a patient in these circumstances, it is important to remember that the crisis patient is often feeling like an exposed nerve and too much physical affection can sometimes be confusing. The question will be, Is this reassuring touch for the patient or does the counselor need it. If the counselor needs it, it should be solicited from another colleague, not the patient.

### **CHILDREN**

Most of what was said above applies to children as well. The big difference, however, is that when children tell their story they will tend to speak more in the language of play and the metaphors of their imagination. As such it will be helpful to meet children who have suffered traumatic experiences with a pocket full of crayons and a pad of paper and/or a pile of toys or puppets. With the paper and crayons children can DRAW A PICTURE and TELL A STORY that will reflect their concerns in metaphor. The invitation is for them to draw whatever they want and tell a story about it. To help the counselor understand the metaphor it is useful to invite the child to talk about the picture. The counselor should not ask, "What is it?" but rather "What can you tell me about this?" "What happened before this scene that we see here in this picture?" "What is going to happen next?" It is often useful to write the story down as the child dictates it to the counselor. Afterward the counselor can read the story back to the child and the story can be elaborated. In this way, the counselor and the child have the opportunity of entering into a dialogue about the monster or the war or the big animal or whatever other metaphor might be used to speak of their concerns about their traumatic experience. Drawing a picture and telling a story is also a useful technique when children experience flashbacks of the trauma or are awakened by nightmares of the trauma. When they can draw their dream and tell a story about it they can often get some distance on it and manage it a little better as well. When children wake up at night frightened from a terrible nightmare, it does no good to deny the existence of the monster that they just saw! Instead, ask them to show you what they saw by describing it, acting it out, drawing a picture of it or telling a story about it. Often no interpretation of the material is necessary. The counselor should just let the children express themselves and elaborate their stories while the counselor remains curious and empathizes with the affect. If children have some difficulty getting started the counselor can invite the child to draw a picture of the traumatic event, the house before and after the flood, the trees before and after the fire, the building during the earthquake, etc. TOYS and PUPPETS provide the same opportunity to express the child's deepest concerns in the metaphors of play.

### **CONNECTIONS, DISCONNECTIONS AND RE-CONNECTIONS**

We all know ourselves and find pleasure in our world through the connections we have to the people, places and things in our lives. When those connections are cut due to fire, flood or earthquake, children and adults become frightened not only by the event they just suffered but also by the disconnection from everything that once was their world. In such circumstances it is important to try to reconstruct the world by hanging on to whatever has survived – including objects and memories. When working with children, it is often useful to invite them to draw a picture and tell their story while the counselor

takes dictation. Afterward the child can draw pictures of his or her home before and after the disaster, draw pictures of the people he or she lost, draw pictures of how he or she used to feel and draw pictures of what the feelings are now. The stories they dictate can be read back to them and they can add additional stories and pictures in time. These pictures and stories can all be stapled together into a BOOK, which may, for the rest of their lives, be the only thing remaining of all that they lost.

Children need to feel at home where they are. If possible, define their sleeping space, put their possessions in a bag, and offer some sort of consistency. Reassure them of your efforts to do your best to help them but don't offer promises you can't keep. Be honest. Help them to feel at home in their temporary shelters. They will often enjoy having something like a toy that they can hang onto and use to maintain some sense of security during an otherwise chaotic time. If possible it could be comforting to build some sort of schedule into the routine at the shelter. It might be useful to invite the children to sit together and have stories read to them. Children might also find some comfort in taking turns talking about their experiences of the trauma in a group context – but this should be monitored closely, as some children might be overwhelmed further in such an activity.

If possible the children should have access to paper, crayons, pencils, toys, puppets, children's books and safe places to play. The crisis counselors should expect upsets emerging seemingly out of thin air. The reason for this is that as children begin to feel safe, they will allow their memories and feelings to come to the surface and suddenly they may just begin crying. Other times a word, or an activity, or a person will serve as a trigger and suddenly the memories and feelings will come rushing in. Children may have symptoms of insomnia, eating problems, aggressive behavior, withdrawal, bizarre behavior, etc. It is best to initially look at all of this as an expression of the trauma but, in fact, some of it might be pre-existing behavior simply re-emerging within the context of the emergency shelter.

In this regard, it is also important to remember that adults and children, affected by crises include people with the full range of diagnoses – depressives, obsessive compulsives, psychotics, addicts, mentally retarded people, borderline patients, etc. And in a crisis, counselors will see all of them. People will often fall apart in a crisis and look much worse than they usually do but after a suitable crisis intervention they will be able to cope with the situation, adjust to the new reality, and return to their previous level of functioning.

Finally – and this is worth repeating! – crisis counselors need to pace themselves in their work to avoid getting overwhelmed. If they do get overwhelmed they will need a crisis intervention themselves. This is not a joke. In fact, crisis counseling for emergency workers is becoming increasingly common. Though there is no shame in a crisis counselor needing a crisis intervention, whenever possible, we should try to avoid the possibility of the crisis counselor getting overwhelmed. The crisis counselor needs to pace him or herself, eat properly, rest properly, consult with colleagues on cases, and debrief (speak with a colleague or supervisor) about particularly stressful or upsetting cases.

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