Professional Psychology: Research and Practice
1995, Vol. 26, No. 6, 550-557

0735-7028/95/$3.00

The American Psychological Association–California Psychological Association Disaster Response Project: Lessons From the Past, Guidelines for the Future

David M. Aguilera
Santa Clara, California

Lynn A. Planchon
California School of Professional Psychology, Fresno

The American Psychological Association–California Psychological Association Disaster Response Project provided valuable lessons about disaster response at the local and state levels. The authors offer guidelines from the experiences of pioneers of organized disaster response and from published accounts on how to set up disaster response networks, the necessary training to become a disaster response volunteer, and how to maintain a disaster response team (e.g., tools needed, psychologists' roles, cultural diversity, and interprofessional camaraderie). Also described are the following: interventions for stress responses from victims, helpers, and children; special problems of social disasters; implications of media presence; and psychologists' roles in educating the public and government agencies about disaster response. Finally, the future of disaster response in the mental health profession is discussed.

On October 17, 1989, just as the cameras began to roll for baseball's World Series game at Candlestick Park, the Loma Prieta earthquake shook the San Francisco Bay area, causing widespread damage, ending lives, and sending thousands into a state of panic. The moment had arrived for crisis intervention and for the creation of a long-term disaster response plan. The California Psychological Association (CPA) responded with vigor, and during the next 3 days, over 350 psychologists and other mental health professionals were given disaster training in crisis intervention and management of posttraumatic stress responses (Buie, 1989). Then CPA President Durand Jacobs activated a task force to draw each of CPA's 22 chapters into a proactive, grassroots disaster response network.

Previous CPA Trauma Response Committees had responded to incidents such as the 1988 Stockton schoolyard massacre (California State Psychological Association Trauma Response Committee, 1989), but mobilization of resources had focused on immediate interventions by a few experts. For the Loma Prieta disaster, CPA's offer of pro bono disaster relief during the emergency phase appeared to have a catalytic effect in stimulating mental health planning among large-scale agencies. For example, the American Red Cross (ARC), which had previously focused on the food, clothing, and shelter needs of disaster victims, was now involved in unprecedented conjoint mental health planning with public agencies, such as State and County Mental Health and Office of Emergency Services, and with the private sector, represented by CPA. A sense of trust, mutual respect, and even camaraderie began to grow among the designated representatives of these agencies.

Meanwhile, it appeared that a national zeitgeist was ripening toward integration of psychological services into more sophisticated state, regional, and national plans for disaster response (G. A. Jacobs, 1995). This zeitgeist was evident in March 1990 when the elected officers of State and Provincial Psychological Associations (SPPAs) from across the nation gathered at the American Psychological Association (APA) Practice Directorate's Annual Leadership Conference in Washington, DC. At their business meeting, the assembled SPPA representatives voted unanimously to send a resolution to the APA's Board of Directors calling for a grant-in-aid to CPA for developing and field-testing a prototype for disaster response. That grant-in-aid, approved at the June 1990 meeting of the APA Board of Directors, funded the APA–CPA Disaster Response Project and provided the impetus for a groundswell of activity involving hundreds of California psychologists and thousands of disaster victims over the next several years.

DAVID M. AGUILERA received his PhD from United States International University in 1980. He is currently a clinical psychologist in independent practice in Santa Clara and is employed at Tri-City Children & Youth Mental Health Service in Fremont, California. He chaired the American Psychological Association (APA)–California Psychological Association (CPA) Disaster Response Project Subcommittee on Educational Materials, was founding chair of the CPA Public Interest Division within which resides the CPA Disaster Response Committee, and was founding chair of the Santa Clara County Psychological Association Trauma Response Committee.

LYNN A. PLANCHON received her MS from San Jose State University in 1993. She is currently a doctoral student in clinical psychology at the California School of Professional Psychology, Fresno. Her major academic interest is in the area of human–companion animal relationships, pet loss, and human bereavement.

WE WISH TO THANK Durand Jacobs, prime mover in the APA–CPA Disaster Response Project, for his consultation on this article. The work described herein was accomplished by many esteemed colleagues in California and throughout the United States and Canada. Their extraordinary contributions and valor are gratefully recognized.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to David M. Aguilera, 900 Lafayette Street, Suite 605, Santa Clara, California 95050-4967.

In October 1991, the CPA presented an Interim Project Report (D. F. Jacobs, 1991) to the APA Council of Representatives. At that time, planning was proceeding toward a nationwide network of psychologists specially trained to provide pro bono services when disaster strikes. The 1991 interim report made specific recommendations to SPPAs on building their disaster response capabilities. The concerted efforts of SPPAs and dedicated psychologists across the country combined to form the APA Disaster Response Network (DRN) and made it possible for APA to present this gift to the nation at the 100th Annual Convention of the APA in August 1992. The DRN is housed within the APA Practice Directorate, is responsible for organizing the state coordinators for disaster response, and uses a newsletter as its mode of communication. Currently, there are an estimated 2,000 DRN psychologists in the United States and 200–300 DRN psychologists in Canada. Disaster response has been heralded as a public interest activity that fulfills the ethical mandate for psychologists to promote human welfare. Disaster response is indeed one of the most visible public services of the CPA and the APA.

Creating a Statewide Organization: The California Experience

Based upon organizational experiences in California, several recommendations by D. F. Jacobs (1991) for state psychological associations building a disaster response capability are summarized below:

1. It is important to appoint a qualified chair who can devote the considerable time and energy needed to establish and maintain liaisons with state and local ARC and Department of Mental Health (DMH) representatives. The chair should remain in close telephone contact with local association chapter or regional disaster committee chairs, aid in recruitment of psychologist volunteers, participate in community planning meetings, and otherwise direct and support local disaster committee efforts.

2. State association leaders can serve as role models and catalytic agents in activities. Disaster response activities would remain a highly visible agenda item at board meetings, for example, through the creation of a mission statement to guide the activities of the state committee. The state association's role is to network with state-level agencies, to assist in maintaining continuity of disaster chairs, and to keep the system as simple and self-sustaining as possible. The government affairs committee might also keep legislative representatives informed about this pro bono activity of psychologists to assist constituents in their districts. The media can be provided with names of local psychologists who have received specialized disaster training, who provide pro bono services to their community, and who are available to comment when disaster strikes.

3. The general membership needs to be kept informed of disaster response activities (e.g., through newsletters with articles related to traumatic stress and call outs) and of the applicability of training to daily practice issues. In association central offices, a lending library could be established for membership use with disaster-related materials such as an annotated bibliography of references, free brochures available from the Emergency Services Branch of the National Institute of Mental Health and from APA, and educational materials for distribution to direct and indirect victims immediately following a disaster.

4. The core emphasis on building disaster response capability is grassroots networking among local psychologists, other mental health professionals, and agencies such as the local ARC chapter. Contacts can be made with community mental health organizations interested in providing disaster mental health services, county clinicians and designated disaster administrators, and emergency services personnel; for example, these groups could be included in a local disaster drill. Without grassroots networking, volunteers will not be available when needed.

5. Because the Red Cross does not respond to all disasters, contact should be initiated with the state, provincial, and regional branches of the DMH. Discuss with these agencies the availability of trained volunteers to provide emergency mental health services. At this time, many states' disaster preparedness plans do not recognize or include the means for dealing with the psychological impact of disaster, and state associations may wish to consult with governmental groups about such inclusion.

6. Although the primary commitment is to provide emergency support to local Red Cross chapters and to mental health agencies, Red Cross trained psychologists should be encouraged to liaison with other professional associations and community groups of interest. There is a critical need for translators and for volunteers with sensitivity to their community's culture. In particular, participating psychologists could seek to establish channels of communication with ethnic groups in the community, perhaps through "gate keepers" or other trusted intermediaries. Additionally, psychologists of diverse ethnic backgrounds should be sought for participation in disaster response activities.

7. State associations should restrict participation in disaster response activities to licensed psychologists who agree to follow their professional association's ethical code and the disaster response protocol. Basic information on participating members would include name, address, office and home telephone numbers, languages spoken, notations on disaster-related experience, and special populations served. Updated participant listings would be kept on hand to overcome communication breakdowns during a disaster and, with permission, would also be distributed to Red Cross and mental health officials.

Current California Perspectives

Current CPA Disaster Response Committee Chair Denruth Lougeay views herself as a planner–developer who has an organizational role. She describes her committee as transitioning from a visionary and action oriented focus to a more closely structured and regulated organization. While the committee has evolved, it has adhered to the belief that disaster response organizations should remain as horizontal and grassroots oriented as possible. It is not advisable to create an organization that has a vertical hierarchy because the local disaster committee may view this as an unwanted imposition of structure, which may result in rejection of such structure. Also, an overarching structure may not fit with local needs. Local psycholo-

gists may best know the needs of their particular geographic and cultural milieu.

The state DRN chair is also responsible for keeping psychologists motivated. However, one of the difficulties with this task is the limited budget of most disaster response committees. Meetings held to connect the disaster response chairs are expensive because of travel. Lougeay will begin an experiment in teleconferencing this year and is considering holding a meeting of the chairs at the 1996 CPA convention. In another attempt to bring together psychologists with mutual interests, the current organizational structure includes two California disaster response coordinators under the chair. Lougeay views her role as both a disseminator of information, providing disaster information updates to local chairs, and a consultant in case of disaster.

Preplanning With Existing Organizations

Dusty Bowencamp, ARC Disaster Health Services supervisor, has served a central role within the ARC in forming the relationship with psychologists in California. According to Bowencamp, the importance of preparing for an unexpected disaster was graphically demonstrated in the April 1995 Oklahoma City bombing. Disaster workers there were met initially by an extremely limited number of appropriately trained mental health professionals, by well-meaning but inexperienced community members attempting to deal with grieving families (without supervision), and by a continued reluctance to create resources for victims following the exodus of trained personnel.

Preplanning for disaster is multifaceted according to Linda Fain, disaster assistance coordinator for the California DMH. Such preparation means listing mental health volunteers who can provide either immediate response or long-term interventions after the initial disaster workers have gone. Preplanning is also the process of identifying emergency response resources and creating memorandums of understanding (MOUs) with organizations such as the local ARC chapter, the local Community Mental Health Services, and other professional and caretaking organizations, delineating the roles of each organization. Included in preplanning would be designing programs around disaster grants such as a 60-day or 9-month Federal Emergency Management Agency (FEMA) grant. Further attention can be paid to the use of mental health volunteers from the private sector for part-time or hourly assistance, because many such independent clinicians are unable to take leave of their practices for extended time periods.

The Disaster Mental Health Services' manual (American Red Cross, 1991) has sections on cooperative agreements with other organizations, including detailed questions to be addressed when establishing such agreements. An MOU has been written between some county operated Community Mental Health Services and California Red Cross chapters. Such MOUs provide a starting point for interagency preplanning as well as an ongoing process by which to update disaster preparations. A list of primary organizations involved in disaster response is described in Kalayjian (in press).

Disaster Response Training

Good training is essential for disaster response. The Red Cross course, "Disaster Mental Health I," (D. F. Jacobs, 1991) is 1½ days in length and is a prerequisite for membership on an ARC crisis team. ARC course trainers must have completed special course work by the Red Cross; hence, training remains a bottleneck in some cases. It is also necessary for psychologists to continue with further certification, specifically in debriefing techniques and in crisis intervention with children. Also, field experience is necessary to maintain skills and interest between large-scale disasters. Examples of how psychologists may obtain field experience include responding to call outs by the local Red Cross chapter to assist victims of single-family home fires or by going on ride-alongs with members of the police and fire departments. The latter method builds rapport and helps these departments place trust in psychologists during crisis situations.

To begin working in disaster response in their communities, psychologists can work with the Red Cross (e.g., as with the California Project) or can volunteer to work with community mental health centers. These centers often continue psychological interventions for quite some time after the disaster incident. Psychologists must understand that when they volunteer to work with the Red Cross or a community mental health center, they are making an important commitment. However, disaster response is not limited to working with the Red Cross or a community mental health center, as there are various types of disasters or critical incidents in the community each day. Psychologists have options, and they do not necessarily have to work on the disaster site itself. For example, they could educate the community about disaster preparedness.

The interests of psychologists must be developed, but how does one go about getting psychologists involved? Ideally, disaster response involvement would begin very early in predoctoral training. This involvement would include pro bono work and would not mean simply seeing clients—it would include getting involved in the community. Benefits to psychologists include the opportunity to experience cultural diversity, to become far sharper observers of the human condition through immersion, and to develop expertise in this area of professional practice. There are three kinds of applied predoctoral training—field experience, practicum, and internship—and the commitment to pro bono activity would begin early in psychologists' careers. The Red Cross has established a policy whereby students can be brought onto a disaster site and function within the range of their capabilities, provided that they are under the direct supervision of a disaster-trained, licensed psychologist. To date, graduate students have been involved in various disasters across the country, including a South Dakota plane crash and the Oakland, California firestorm.

Maintaining a Disaster Response Team

Tools of Disaster Response

When psychologists are called to a disaster site, they bring with them an emergency responder kit as described in the ARC course work. Some counties have created extensive disaster response manuals for mental health professionals that include

items such as a mental health disaster plan, disaster facts, emergency callback policy, clinical issues, a field manual, and ways to deal with children's reactions to a disaster (San Diego County Mental Health Services, 1989).

Educational handouts are extremely important and can be given "to the media, schools, parents, industry, and to targeted sub-populations of victims and helpers" (D. F. Jacobs, 1991, p. 6). Psychologists should have educational handouts to give to the public both before and during a disaster. Such materials help people become better prepared for disasters, educate people on what to expect, and reassure them that there is psychological help available for the survivors of a traumatic event. These various handouts can facilitate understanding of the issues and potential responses of the individuals for whom the handouts were designed (e.g., possible issues encountered by children, older people, rescue workers, volunteers, etc.). It is also prudent to have these handouts available in several languages, according to the needs of the community.

Psychologists' Roles in Disaster Response

Psychologists' roles in disaster mental health are multifaceted and include that of clinician, preventive mental health consultant, and mental health educator, to name a few. Although the first commitment is to provide emergency support to local Red Cross chapters and agencies, psychologists are encouraged to participate in disaster drills and critiques and to network with other local community organizations by informing them of the availability of trained mental health volunteers (Aguilera & Broenen, 1992).

How do the roles of psychologists using crisis intervention skills in the field differ from the skills of psychologists in the consulting room? It is not unusual for most of the patients that psychologists see in their regular practices to be victims of early trauma (e.g., physical, sexual, or psychological abuse). These patients could be seen as dealing with chronic posttraumatic stress disorder. However, the skills of emotional support and disaster counseling are entirely different from psychotherapeutic skills. During disasters, psychologists are dealing with a range of individuals across the spectrum of mental health and most frequently with "normal" individuals.

As opposed to office consultations, in disaster counseling it is important to remember that the average length of contact with a crisis victim is less than 10 min. Psychologists can be very helpful in a short amount of time by reaching out to the person, making themselves available in a very informal and casual manner, and simply talking with the person. This process is very different from eliciting an in-depth interview from a patient. To accomplish such work ably, psychologists need to be trained in crisis intervention techniques, which is an educational benefit of disaster response work.

When disaster strikes and psychologists enter an ARC shelter or service center, they first locate the site manager and inform her or him about their crisis intervention skills and qualifications for disaster response. The psychologists are then assigned to a particular area in which their expertise can be used. It should be remembered that psychologists are subordinate to the Red Cross or agency structure in which they are operating.

Once inside the shelter, it is important for psychologists to build rapport with the volunteers and employees. Make contact by spending break time or by having lunch or dinner with them. Psychologists also have to be sensitive to the fact that some workers will be fearful that if they exhibit problems they are having or certain responses to the crisis situation that they will be evaluated in a negative manner by their superiors. Psychologists may correct this unfounded concern and be sources of comfort and support by providing debriefing for Red Cross volunteers as well as for their mental health colleagues (Aguilera & Broenen, 1992).

Regarding legal issues, generally, mental health professionals who function under the direct auspices of the ARC or a public agency mental health department are covered by the liability insurance carried by these agencies (American Red Cross, 1991; D. F. Jacobs, 1991). With respect to mental health hospitalization procedures, ARC policies state that paid or volunteer staff cannot perform such procedures. However, this policy does not prevent psychologists from identifying the need for commitment and contacting the appropriate local authorities (G. A. Jacobs, 1992).

Experiences of Psychologists on Crisis Intervention Teams

Some psychologists prefer to have a description of disaster work before engaging in this work; such a description is a sufficient topic in itself (Aguilera, 1992). However, no such description will be adequate because of the changing needs of the moment in the midst of disaster response. Indeed, the most important characteristics of a responding psychologist may be resourcefulness and role flexibility. In reporting to a disaster site, a first responder may encounter a rapid influx of traumatized victims in a seemingly chaotic shelter but the next day find the shelter almost vacant except for a few fatigued staff. Alternately, responders to a FEMA disaster relief center may discover long lines of seemingly passive individuals but upon evoking a discussion would likely find contained anger and frustration. Still another possibility is not being called out for the disaster at all, which can occur because of organizational or other issues. The latter scenario is often the most disturbing to mental health professionals who have channeled their own disaster-related anxiety into thoughts of fulfilling a caretaker role.

Disaster response may self-select psychologists who find such work exciting and personally rewarding. Providing an immediate response to a crisis situation is an ennobling challenge that can draw on the very fiber of the helper's being. Personality issues aside, many psychologists appear to be drawn to disaster work for the satisfaction of providing assistance to others who are in a moment of great need. There is a camaraderie among disaster responders who, at the end of the day, look to kindred spirits with a deep feeling of a shared, challenging experience. After a day in the trenches, it is not unusual for responders to fully realize how well their ARC training has prepared them, or, even more frequently, how well the disaster system works.

Cultural Diversity and Disaster Response

An important area of training in disaster response is with people from different cultures. Although translators are cer-

tainly effective for bridging the language barrier, psychologists need to be sensitive to cultural differences before a disaster. "When professionals intervene among ethnic and minority populations, it is essential that they consult professionals from those groups or, at least, community leaders, if they themselves are not a member of that community or culture" (Hobfoll et al., 1991, p. 854). Psychologists will need to establish communication with "gate keepers" of different ethnic groups (e.g., African American, Hispanic, etc.) within and around their communities. "Through these trusted intermediaries, psychologists may serve in a consultative or direct fashion when extending services to persons whose cultural backgrounds and language may be different from their own" (D. F. Jacobs, 1991, p. 3). Psychologists could also conduct training with mental health professionals from diverse cultures. It makes good sense to recognize that very often a great number of ethnically diverse communities are affected by disasters. As shown in many previous studies, counseling of ethnic minority patients may be enhanced by an awareness of the dynamics of cultural mistrust (Coleman, Wampold, & Casali, 1995), and this may be particularly true for social disasters involving racial tensions.

Interdisciplinary Collaboration

William O'Callahan has been a leader and founder of much of the ARC disaster response work in California. One of his main goals as volunteer coordinator for the ARC San Francisco Bay area is to make the ARC disaster response network as broad and interdisciplinary as possible. Although each profession is encouraged to recognize its unique abilities, therapist volunteers are selected who can look beyond guild issues and focus on serving the community. O'Callahan looks for therapists who are compatible despite being in competition with fellow volunteers in their work lives.

Most organizing of therapist volunteers has emphasized linkages with the various local and statewide professional associations and with volunteers having similar duties at the disaster site. However, at the recent ARC Oklahoma City bombing operation, an experimental step was taken to assign the various mental health professions to specific teams with different tasks. Licensed psychiatric nurses, social workers, and marriage and family counselors were assigned as escorts to be with families (e.g., when the family procured dental records). Psychologists and psychiatrists were assigned to the Death Notification Team, functioning alongside a medical examiner and a clergy member. Initial reports indicated that such differentiation appropriately emphasized the specific skills of the various professions (D. Bowencamp, personal communication, May 23, 1995).

Disaster Stress Responses

Dealing with Victim Stress

The first large-scale use of volunteers trained through the ARC Crisis Intervention course occurred at the Oakland Hills firestorm of 1991. As has been common in subsequent disasters, most crisis contacts occurred in the midst of frantic activity at the disaster site or shelter, lasted 1 to 10 min, and entailed mainly ventilation, brief support, and notification of immediate resources (Aguilera, 1992). Also as seen subsequently, on-site psychologists were asked by Red Cross media personnel to speak with the television crews; this gave psychologists an opportunity both to reach additional victims who may have fled the area and to educate the community at large.

Educational materials for victims, emergency personnel, and disaster volunteers are another method for dealing with disaster stress. Such materials usually convey a description of posttraumatic stress responses, behaviors that may serve to heighten denial of stress, expressive methods to process stress and grief responses, and specific local resources for immediate and ongoing mental health needs. The Educational Materials Subcommittee of the APA–CPA Project surveyed CPA disaster chairpeople and a wide variety of disaster response coordinators throughout the state to garner a comprehensive portfolio of such materials. The same materials have been used in various disasters throughout the nation, such as in Hurricane Andrew, and also have been shared with APA and the ARC local chapters. Educational materials were sorted by disaster type (e.g., earthquakes, fires), population served (e.g., emergency workers, older persons), and culture–ethnicity. Translated materials were also gathered and continue to be in particular demand in order to respond to the specific needs of local populations.

Children's Responses

Working with children in the context of disaster requires specialized knowledge. Children and adolescents have differing responses to disaster depending on characteristics such as the following: gender and age; type of disaster; family and community contexts; and degree of exposure to life threat, injury, and loss (Vogel & Vernberg, 1993). Knowledge of developmental differences as well as the social context of children is crucial to both prevention and intervention (Hobfoll et al., 1991). As such, specific methods and educational materials have been developed for children, parents, and educators (Alameda County Mental Health Services, 1990; American Psychological Association, 1991; Pitcher & Poland, 1992; Vogel & Vernberg, 1993). Identification of local mental health professionals with child services experience and a knowledge of the sociocultural community context of children is recommended in planning for disaster.

Helper Stress

Helpers are indirect victims of disaster, and debriefings are one of the main methods for dealing with helper stress. Although formats vary, the main components of formal debriefings usually entail the following: introducing the boundaries of the process; eliciting detailed descriptions of the participant's experience of the incident; helping to ventilate feelings attached to these experiences; eliciting information about symptoms and describing likely stress responses; and aiding reentry, including alerting the helpers about resources for further mental health assistance (Mitchell, 1983).

From the experiences of California disaster responders, formal debriefings of volunteers were often scheduled on short no-

tice and performed by the mental health volunteers who were readily available. Using a model that remains in place to date, those psychologist volunteers who were unable to respond to the disaster immediately were activated for debriefings, not only of Red Cross volunteers, but also of members of their own Red Cross crisis intervention team (Aguilera, 1992).

Although the effects of disaster on the mental health of worker–volunteers have been previously noted (Dunning, 1990), only recently has a specific enlargement of the issues affecting mental health personnel been described (D. F. Jacobs, 1994). Anecdotal accounts of psychologists' attitudinal and behavioral changes following disaster work have described a sense of invulnerability, rapid pacing of speech and activity, increased sense of self-importance in one's mission, impulsivity affecting judgment, anger if the responder feels underused or poorly used, reluctance in returning to the routine of life, and a disappointment in the seemingly slow pace of others such as family members.

Families of disaster mental health workers are likely to experience some of the effects of general disaster work such as concern for the mental status of an exhausted or stressed partner, worries about physical safety, and uncertainty about when a partner would return home (Wooley, 1991). Debriefing of mental health workers and providing support for their families need to be an accepted part of disaster mental health routine (D. F. Jacobs, 1994). As with the direct victims, educational materials for disaster workers and their families are available and should be routinely used.

A Unique Type of Victim and Helper Stress: Social Disasters

Social disasters refer to civil and political unrest that threaten the social structure of a given population. The 1995 Oklahoma City bombing of a federal building brought to the fore the effects of unexpected social disaster on individuals and a community. Acute shock reactions were witnessed at a much higher degree, grief reactions were more dramatic and extreme, there was more initial anger, somatic symptoms such as strokes and headaches were more pronounced, and posttraumatic stress symptoms usually seen weeks or months after the initial incident were apparent before the initial responders had left the incident site (D. Bowencamp, personal communication, May 23, 1995). Social disasters may create the appearance of a random act of violence akin to a mistaken drive-by shooting, a perception that may leave people unprepared and without psychological defenses or explanation for these incidents.

Disaster responders in California have also had recent experiences with social disasters such as the 1992 Los Angeles civil unrest. Although many accounts in the literature deal with natural disaster, mental health volunteers need to attend to the unique aspects of civil or political disturbances as noted by Robert Scott (1992), chair of the Los Angeles County Psychological Association Disaster Response Program. Possible unique aspects include a high level of personal threat that is due to a lack of positive community feeling for the disaster workers. Disaster agencies may not be seen as neutral and may even be targets for attack. Because of concerns about personal safety, there may be decreased availability of disaster responders, increased numbers of volunteers having flashbacks to wartime experiences, and heightened stress for families of disaster volunteers because of the threat to workers. There may be an absence of humor to diffuse tension and a lack of closure on the event with a sense of imminent recurrence of the disaster. Not unusual would be repeated witnessing of the actual event by millions of people through the media.

Disasters and the Media

An important issue to consider in any disaster is the assignment of a person or persons to talk to the media, as the media will have an inevitable presence following any large-scale incident. Unfortunately, some mental health professionals in this situation may lose judgment or accuracy, because media interviews can be anxiety-provoking as well as intoxicating; hence, media interviews can produce statements that would not ordinarily be made. Such effects may also relate to the novice or inexperienced mental health responder who unexpectedly finds her- or himself under the glare of television lights and who exaggerates situations or in other ways loses a professional stance, such as in giving unauthorized statements regarding victims.

Given that the public has limited knowledge of what psychologists do and diverse feelings about psychology as a profession (Benjamin, 1986; Wood, Jones, & Benjamin, 1986), psychologists who are interviewed by the media have a powerful opportunity to facilitate the public's understanding of psychology and the role of psychologists. The media can be used to disseminate important information, such as expected psychological responses to the disaster and agencies that are providing services (Gist & Stolz, 1982). However, excessive exposure to psychological information in the media may produce an adverse image of psychologists as was the case in Israel during the Persian Gulf War in 1991. "It is therefore imperative that professional training for working with the media emphasizes explicitly the damage of psychological overexposure and the necessity of controlling and regulating interaction with the media" (Raviv & Weiner, 1995, p. 93).

The media should not be allowed to enter a shelter or a service center because that is a serious breach of privacy of the individuals in the shelter. Managers of such shelters are charged with maintaining privacy, and any requests by the media should be cleared through them. The broader issue of interviewing those who have survived or the families of victims may well be a double-edged sword. Depending on the context, media presence can be an unwanted intrusion on a defenseless victim or an opportunity to ventilate and receive social acknowledgment and support through a voluntary interview.

Educating Government and the Public

Many government bureaucracies may be more accustomed to concerns about property damage and may not have disaster plans regarding mental health issues. As noted previously, psychologists need to take an active role in alerting newspapers and the various related branches of government (e.g., Office of Emergency Services, Department of Forestry, parks depart-

ment, etc.) to the availability of disaster mental health resources. Hobfoll et al. (1991) found that "the watchword for both professional intervention and public policy after the Persian Gulf War and other traumatic events facing communities is *outreach*" (p. 853). Much needs to be done in terms of outreach, and psychologists, like other mental health professionals, have unfortunately fallen short in this endeavor. Before a disaster occurs, psychologists need to let the community know that they are trained in disaster response and are available. This is a form of soft marketing that is extremely important for a priori disaster planning.

Peggy Dudder and Carl London, CPA legislative advocates, educate legislators and the public about psychologists' involvement in disaster response. After receiving newspaper clippings from local psychologists, these advocates send the clippings to the legislators in that geographic region to apprise them of what psychologists are doing on a pro bono basis for the legislator's constituency. The legislative advocates have also notified legislators, through specific letters and other materials, about the pro bono contribution of psychologists to the legislator's constituents following a local disaster.

Future Directions in Disaster Response

Preplanning and organizational development is a continuing process. Changing staff and the shifting of roles within organizations require a routine assessment of disaster capabilities. For interagency coordination, regular disaster drills provide an avenue to upgrade capabilities as well as to generate excitement for disaster response work. Identification of resources is the first step toward creating an active network of public and private sector mental health volunteers.

As mentioned previously, training through large agencies such as the ARC can bottleneck. In addition to the basic ARC training for mental health professionals, certification through nationally recognized disaster experts is highly desirable. Debriefing skills can also be enhanced beyond basic levels of competency through advanced certification in critical incident stress debriefings (CISD).

Electronic technology may open a variety of strategies to deal with disasters. Communication could be enhanced (a) through portable cellular equipment including telephone, fax, and memo; and (b) through linkages to centralized data sources by modem. The availability of educational materials, for example, has been largely through next-day delivery services and has yet to use computer bulletin boards. Electronic linkages will enhance the use of disaster consultants who may be geographically removed from the incident site. Research or other data relevant to specific disasters would become immediately available.

Regarding the future of professional psychologists, disaster response activities fulfill the highest aspirations of ethical standards toward the public welfare. It is a pro bono activity for many, but is also a legitimate activity of professional practice when dealing with crises and disasters affecting employees and companies. Disaster response enhances the image of psychology and mental health in general (e.g., by changing the inaccurate image of an exclusively guild-oriented profession in the eyes of legislators). The individual clinician may enhance skills that help him or her more easily recognize the symptoms of posttraumatic stress in clinical practice. There is also the satisfaction of contributing to society in a manner akin to the reasons for which many of us were attracted to the profession. The role of graduate students in disaster response is particularly welcomed, not only for the skills gained, but also for the training of a cadre of professionals who have experienced the relevance of immediate disaster response in the alleviation of human suffering. Disaster response work is likely to become a tradition within the mental health professions.

References

Aguilera, D. M. (1992, March). *From Loma Prieta to the East Bay firestorm: An evolutionary perspective.* Paper presented at the convention of the California State Psychological Association, La Jolla, CA.

Aguilera, D. M., & Broenen, R. (1992, August). *Experiences of psychologist volunteers on Red Cross Crisis Intervention Teams.* Paper presented at the 100th Annual Convention of the American Psychological Association, Washington, DC.

Alameda County Mental Health Services. (1990). *How to help children after a disaster: A guidebook for teachers.* Oakland, CA: Author.

American Psychological Association. (1991). *Helping kids cope: A guide to helping children cope with the stress of war* [Brochure]. Washington, DC: Author.

American Red Cross. (1991). *Disaster services regulations and procedures (ARC 3050M).* Washington, DC: Author.

Benjamin, L. T., Jr. (1986). Why don't they understand us?: A history of psychology's public image. *American Psychologist, 41,* 941–946.

Buie, J. (1989, December). Clinicians leap to aid of quake's survivors. *APA Monitor,* p. 20.

California State Psychological Association Trauma Response Committee. (1989, February). The Stockton schoolyard massacre. *California Psychologist, 23*(1), 1.

Coleman, H. L. K., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European-American counselors: A meta-analysis. *Journal of Counseling Psychology, 42,* 55–64.

Dunning, C. (1990). Mental health sequelae in disaster workers: Prevention and intervention. *International Journal of Mental Health, 19*(2), 91–103.

Gist, R., & Stolz, S. B. (1982). Mental health promotion and the media: Community response to the Kansas City hotel disaster. *American Psychologist, 37,* 1136–1139.

Hobfoll, S. E., Spielberger, C. D., Breznitz, S., Figley, C., Folkman, S., Lepper-Green, B., Meichenbaum, D., Milgram, N. A., Sandler, I., Sarason, I., & van der Kolk, B. (1991). War-related stress: Addressing the stress of war and other traumatic events. *American Psychologist, 46,* 848–855.

Jacobs, D. F. (1991). *Interim report: APA–CPA Disaster Response Project.* Unpublished manuscript.

Jacobs, D. F. (1993, August). *Storm of no name: The role of psychologists in disaster.* Paper presented at the 101st Annual Convention of the American Psychological Association, Toronto, Canada.

Jacobs, D. F. (1994, August). *Impact of providing disaster services on mental health volunteers.* Paper presented at the 102nd Annual Convention of the American Psychological Association, Los Angeles, CA.

Jacobs, G. A. (1992, August). *Legal/ethical issues in disaster mental health.* Paper presented at the 100th Annual Convention of the American Psychological Association, Washington, DC.

Jacobs, G. A. (1995). The development of a national plan for disaster mental health. *Professional Psychology: Research and Practice, 26,* 543–549.

Kalayjian, A. S. (in press). *Disaster and mass trauma: Global perspectives on post disaster mental health management.* Long Branch, NJ: Vista.

Mitchell, J. J. (1983). When disaster strikes: The critical incident stress debriefing process. *Journal of Emergency Medical Services, 8,* 36–39.

Pitcher, G. D., & Poland, S. (1992). Crisis intervention in the schools. New York: Guilford Press.

Raviv, A., & Weiner, I. (1995). Why don't they like us? Psychologists' public image in Israel during the Persian Gulf War. *Professional Psychology: Research and Practice, 26,* 88–94.

San Diego County Mental Health Services. (1989). *Disaster: A manual for public mental health professionals.* San Diego, CA: Author.

Scott, R. T. (1992, August). *The great human earthquake: Reflections on crisis intervention during the April '92 L. A. civil unrest.* Paper presented at the 100th Annual Convention of the American Psychological Association, Washington, DC.

Vogel, J. M., & Vernberg, E. M. (1993). Task force report part 1: Children's psychological responses to disasters. *Journal of Clinical Child Psychology, 22,* 464–484.

Wood, W., Jones, M., & Benjamin, L. T., Jr. (1986). Surveying psychology's public image. *American Psychologist, 41,* 947–953.

Wooley, M. J. (1991). *Response to the Cantara spill.* Unpublished manuscript.

Received June 7, 1995
Revision received July 5, 1995
Accepted July 5, 1995 ■