PSYCHOLOGISTS' PERCEIVED INFLUENCES OF EARLY STRATEGIES ON THE PSYCHOSOCIAL RESPONSE TO THOSE AFFECTED BY DISASTER

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Abstract

Currently some confusion exists as to how health professionals should best respond to the psychological needs of those affected by disasters. Some have argued that early psychological intervention is essential and others have argued that early formal psychological interventions have no useful role in post trauma response. This study highlights the importance of considering both counselling and non-counselling factors as potentially influencing the psychosocial response of disaster victims. Although posttraumatic stress disorder (PTSD) is not the only mental disorder that can develop as a result of exposure to disasters, it is probably the most frequent and debilitating psychological disorder associated with traumatic stress. In this exploratory-descriptive study the researcher aimed to explore and describe psychologists' perceived influences of early strategies on the psychosocial response to those affected by disaster. The researcher used non-probability snowball sampling to access participants. The sample consisted of 5 participants. Semi structured interviews were conducted. Content analysis was used to analyse the data obtained from interviews. Results that emerged from the data suggest that there are many factors that influence the psychosocial response to those affected by disasters. These factors include the screening process, needs of survivors, the method of choice for treatment, the timing of intervention, pharmacology, the South African context, training and planning. The study makes a contribution to the growing knowledge of early strategies in response to those affected by disasters.

Key words: Posttraumatic stress disorder (PTSD), traumatic stress, early strategies, psychosocial response, disasters.

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CHAPTER 1 INTRODUCTION

1. Orientation and motivation for the study

Although psychological reactions are common after exposure to traumatic events, it is widely accepted that traumatic stress symptoms will reduce over time (Galea, Ahern & Resnick, 2003; Litz, 2004). However, there are those who are at risk for developing chronic mental health problems. Posttraumatic stress disorder is most associated with exposure to traumatic events however traumatic experience can lead to the development of many other health problems. Currently there is a lack of cohesion and clarity internationally and in South Africa about how best to respond to the needs of those exposed to a disaster (Litz, 2004; Bisson, Brayne & Ochberg, 2007; van Wyk & Edwards, 2006). A number of factors have led to this confusion, including: (a) paucity of scientifically validated research; (b) the elements of disasters that make the psychosocial response different from the normal consultation room setting; (c) conflicting arguments around issues of modality and timing; (d) the influence of non- clinical considerations; (e) contextual and cultural factors that are unique and specific to the South African context.

Examples of treatment guidelines that are available and have been developed using a strong methodology include guidelines from The United Kingdoms National Institute for Clinical and Health Excellence (NICE) and the National Collaborating Centre for Mental Health, (2005). The general trend indicated in these guidelines is towards flexibility and nor doing too much initially. It is important that an evidence-based approach is adapted to South African cultural and contextual conditions and used by psychologists to inform the psychosocial response to those affected by disasters. An investigation of the literature of psychological sequelae after exposure to

traumatic events and current early intervention strategies provides the theoretical background to the practical experience of South African psychologists working in the post-disaster context. Their perception of concerns and difficulties regarding both counselling and non-counselling factors are elaborated and documented and compared with recommendations from the literature.

2. Aim of the study

The aim of this study was to explore and describe the perceptions of psychologists regarding the influence of early strategies on the psychosocial response to those affected by disasters. Ultimately the current methodology emulates an expert consensus model and allows for the perception of knowledgeable participants to inform such “best practice” recommendations. This study thus addresses both counselling and non-counselling factors as potentially influencing the psychosocial response of disaster victims.

3. Chapter delineation

Chapter 2 reviews the literature on psychological sequelae after a disaster and describes the variety of symptoms that may be experienced as a result of exposure to a traumatic event. As the majority of disasters are life-threatening situations it is understandable that research has focussed on Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) (Gray, Litz, & Olsen, 2004). However, traumatic experience can lead to the development of other psychiatric disorders and other non-psychiatric issues that account for the mental health impact of trauma (Kessler et al., 1995). In this chapter explanatory frameworks for post-disaster responses are discussed, stress is explained as a general response to stressors and compared to

PTSD as a specific type of stress. The development of posttraumatic stress disorder is focussed on as a guiding framework for focussing on the needs of disaster victims. Psychological models of traumatic stress are outlined later in the chapter offering a theoretical orientation to the aetiology of posttraumatic stress disorder (PTSD).

Chapter 3 describes the professional care provided immediately or soon after trauma and is otherwise referred to as *early intervention.* The first section discusses the origins and utility of psychological debriefing models (including Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM)). Some of the arguments highlight difficulties in the early intervention field. Current international trends in early intervention strategies are presented. Psychological first aid (PFA) is the focus of intervention, as it is an approach recommended by many practice guidelines. Early intervention in the South African context is discussed and finally an orientation to early intervention strategies for children and adolescents is offered.

Chapter 4 discusses the issues surrounding the confusion regarding how best to respond to those in psychological need after disasters. One of the reasons is the methodological pitfalls and ethical dilemmas inherent in this type of research. Therefore, rigorous clinical trails are rare and the ecological validity of intervention studies is very low. Furthermore, the elements of disasters make the psychosocial strategy response to those in need different from the normal consultation room setting. Non-clinical factors which may influence post-trauma treatment are considered as well as problems in the South African context and the need for research that addresses these issues.

Chapter 5 describes the method used to gain some understanding of the practice of South African psychologists who work with those who have been affected by

disasters. It describes the procedure used to gather and analyse data from South African psychologists regarding the perceived influence of early strategies on the psychosocial response to those affected by disasters.

Chapter 6 presents a synthesis of the analysis conducted independently by the researcher, her supervisor and the assistant coder using the method described in the previous chapter. This procedure produced six overarching themes around which various sub-themes were clustered. The chapter discusses each of these themes, sub-themes and categories that emerged from the open-ended questions presented in the interviews.

Chapter 7 concludes by explicitly addressing the research question, noting the limitations of the study as well as recommending future research directions.

CHAPTER 2 PSYCHOLOGICAL SEQUELAE AFTER A DISASTER

This chapter reviews the literature on psychological sequelae after a disaster and describes the variety of symptoms that may be experienced as a result of exposure to a traumatic event. Although there is little doubt that these stress responses are commonplace after a traumatic experience, most individuals will heal psychologically, socially and morally over time (Galea, Ahern & Resnick, 2003; Litz, 2004). However, there are those who are at risk for developing chronic mental health problems. As the majority of disasters are life-threatening situations it is understandable that research has focussed on Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) (Gray, Litz, & Olsen, 2004). However, traumatic experience can lead to the development of other psychiatric disorders and other non-psychiatric issues that account for the mental health impact of trauma (Kessler et al., 1995). In this chapter explanatory frameworks for post-disaster responses are discussed, stress is explained as a general response to stressors and compared to PTSD as a specific type of stress, as well as an explanatory framework for non-PTSD symptom pictures. Psychological models of traumatic stress are outlined later in the chapter offering a theoretical orientation to posttraumatic stress disorder (PTSD).

1. Defining “disaster”

The classification of a traumatic event as a disaster is not always straightforward and the distinction between individual traumatic experiences and disasters is not clearly defined (Quarantelli, 1995). The use of a single definition can be limiting, for example, a commercial airplane crash is nearly always considered a disaster whereas

light airplane crashes which may result in the death of many people seldom are. In the literature, for the most part, disaster definitions include the loss of life. However, some of the best-documented and important disasters in the past 20 years did not involve loss of life such as the Three Mile Island nuclear reactor accident (Davidson & Baum, 1986).

1.1. Definition of "disaster" in the South African context

South Africa's history has created a culture of violence (South African Police Service, 1997).These conditions have resulted in high levels of psychological trauma that have affected large numbers of people. South Africa faces problems of widespread poverty, endemic communicable diseases and a poorly developed infrastructure. In general, mental health and other resources needed to deal with the consequences of disasters and continuous trauma are inadequate to deal with the demands (Stewart, 2005). In addition to crime, unemployment and HIV/AIDS have contributed to the social problems of the communities and thus affected the ability of individuals to cope with and recover from accidents and natural and man- made disasters (Tshwane Metropolitan Municipality, 2006).

Disasters in South Africa would include natural disasters (for example large scale firestorms, floods and tornadoes). Man-made disasters would include mining incidents and aircraft, train, taxi and bus accidents. South Africa's most recent disaster was of a socio-political nature when xenophobic violence erupted in May 2008. Cape Town Disaster Management had accommodated 10000 people after asylum seekers had been forced from their homes. Hundreds more were seeking shelter at police stations. South African Police reported that 43 people lost their lives after two weeks of violence (South African Press Association, 2008).

Some other examples of disasters in South Africa include firestorms that raged for days that resulted in many deaths and left thousands of people homeless in January 2000 and 2004. Train accidents occurred in October 2003 and November 2007 where many people on board as well as people standing on the platform were killed. Mining accidents occurred in November 2007 where 3200 miners were trapped underground. In January 2009, 167 miners were trapped underground in Blyvoor No. 5 mine near Carltonville. In April 2001, 43 people were killed in a soccer stampede in Ellis Park stadium in Johannesburg. In December 2001, a truck accident clamed the lives of 48 people (Timeline of South African Disasters, n.d.).

For the purposes of this study a disaster is defined as follows: *A disaster is any unexpected event that influences a large number of people who may potentially be affected psychologically and in need of psychosocial assistance.* According to this definition "victims" of a disaster include those that escape death, those who are injured, family members of survivors and the deceased and those who have witnessed a catastrophic event. This would mean that something like a school based accident (for example, the Triomph taxi accident in 2007) where members of the community (including many of the fellow students and teachers) were thought to be in need of psychosocial assistance would be described as a "disaster". The researcher acknowledges that this is a fairly broad definition, but also contends that many of the factors of interest mentioned in the problem statement (see chapter 4) are still present within the broad definition of disasters that is used to operationalise the phenomenon under study.

Disasters (even in the broad manner defined above) are unpredictable and uncontrollable and result in terror, frailty and vulnerability to those exposed to them.

"Trauma" is derived from a Latin root meaning "wound". Unlike pain, wounds involve injury and bodily harm. This implies that they produce scars that may take a long time to heal. "Injury" is derived from a word meaning "wrong" and "heal" comes from a word meaning "whole". When dealing with trauma we are dealing with a psychological sense of being broken, through an injustice of an event a person's wholeness has been shattered (Walser & Hayes, 1998). In a diagnostic sense we may understand the word "trauma" differently, but the essence of the semantic aetiology remains.

2. Epidemiology

On average, people are remarkably resilient and most individuals will heal psychologically, socially and morally over time (Galea, Ahern & Resnick, 2003; Litz, 2004). However, epidemiological studies in the United States show that between 8% and 9% are at risk for chronic mental health problems as a result of exposure to traumatic events (Breslau, Kessler, Chilcoat, Schultz, Davis & Andreski, 1998; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Green, Lindy and Grace (1992) found a 59% lifetime rate of PTSD among survivors 14 years after the flooding caused by the collapse of the dam in Buffalo Creek, West Virginia but in general rates of posttraumatic stress disorder after disasters vary between 13% and 95% (Armenian, Morikawa, & Melkonian, 2000) A variety of reasons (including differences between measures used) are usually offered for this large range, but a full discussion of this argument lies outside of the scope of the current study. The researcher was unable to find South African statistics related to general mental health problems as a result of exposure to traumatic events. However, a household survey was conducted in South Africa between 2002 and 2004 to assess the lifetime prevalence of psychiatric

disorders (Stein, Seedat, Herman, Moolmal, Heeringa, Kessler & Williams, 2008). This study showed a lifetime prevalence of posttraumatic stress disorder (PTSD) in South Africa to be 2.3 %.

The majority of disasters are life- threatening situations and thus understandably mental health researchers have focussed on disorders such as posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) in which the primary characteristics are exposure to life threatening situations and resultant anxiety and fear (Gray et al., 2004).

3. Post-trauma reactions

3.1. Acute Stress Disorder

People that are recently exposed to a traumatic experience demonstrate a wide variety of anxiety symptoms in the initial weeks after exposure and there is little doubt that these symptoms are commonplace after a traumatic experience. The majority of these stress responses are transient and people generally adapt naturally to their experience over the course of a few months (Bryant & Harvey, 2000). The DSM 1V-TR (American Psychological Association (APA), 2000) stipulated that PTSD could only be diagnosed at least one month after the trauma. In 1994, the DSM 1V introduced the Acute Stress Disorder (ASD) diagnostic category to describe people distressed by a traumatic event who could not be readily described in existing diagnostic categories, with the emphasis on the very severe reaction experienced within the first month after the trauma (McNally, Bryant, & Ehlers, 2003). The introduction of this diagnosis was to fill the diagnostic gap that existed in the initial month following trauma.

The primary difference between the criteria for ASD and PTSD is the time frame and the emphasis on dissociative reactions to the trauma in the case of ASD. According to the DSM-1V-TR (APA, 2000) Criterion B refers to the following dissociative symptoms of which the individual must have at least three: a subjective sense of numbing, detachment, or absence of emotional responsiveness; a reduction of awareness of his or her surroundings; derealization; depersonalization; or dissociative amnesia. Criterion C refers to the individual persistently re-experiencing the traumatic event. Criterion D refers to a marked display of avoidance of stimuli that may arouse recollections of the trauma. Criterion E is that the individual has marked symptoms of anxiety or increased arousal. Criterion F refers to evidence of significant distress or impairment. Criterion G refers to the time frame of the disturbance which must last for a minimum of two days and a maximum of four weeks after the traumatic event, after which time a diagnosis of PTSD becomes more applicable. Criterion H refers to the exclusion of symptoms that are due to the physiological effects of a substance or a general medical condition, and are better accounted for by Brief Psychotic Disorder, and are not merely an exacerbation of a pre-existing mental disorder.

3.2. Posttraumatic Stress Disorder

While a whole range of symptoms are possible after a disaster, posttraumatic stress disorder (PTSD) is the most frequent and debilitating psychological disorder that occurs after traumatic events and disasters (Galea, Nandi & Vlahov, 2005). Fortunately, many people who have been exposed to a traumatic event recover over time however there are those that ultimately develop symptoms of PTSD which if left untreated can develop into a chronic condition.

Although it is recognized that PTSD is not the only mental disorder that can develop as a result of exposure to disasters, it is generally believed that chronic PTSD is more difficult to treat than more acute clinical presentations. Characteristic of PTSD is the feature of marked avoidance of reminders of the disaster and thus those who are most distressed may avoid contact with mental health clinicians. As a result some people with chronic PTSD become incapacitated with severe and intolerable symptoms.

Posttraumatic Stress Disorder (PTSD) was introduced into the nosologic classification in psychiatry in 1980 and thus marked the beginning of contemporary research of the response of victims after being exposed to a severely traumatic event (Blake & Sonnenberg, 1998). Classifying a disaster as a traumatic event is not always straight forward as there is no clarity in the distinction between individual traumatic experiences and disasters. Disasters are mass traumatic events affecting large segments of the population and include natural and technological disasters. However, if we look at the diagnostic criteria for posttraumatic stress disorder, it becomes clear that disasters do constitute the kinds of events that may lead to posttraumatic stress disorder on an individual level.

3.2.1. Diagnostic criteria for posttraumatic stress disorder according to the DSM-1V-TR

In the DSM-1V-TR (APA, 2000) criterion A1 is exposure to a traumatic event. This includes witnessing the event, being involved in the event or hearing of the event. Criterion A2 is a subjective assessment of the criterion whereby the individual experiences helplessness or horror at the trauma (Galea et al., 2005). According to the DSM-IV traumatic events are bracketed from other stressful experiences in that these

catastrophic events are etiologically linked to a specific syndrome, namely posttraumatic stress disorder. The criteria to be met in diagnosis of posttraumatic stress disorder are defined by their connection to the past traumatic event. Symptoms central to posttraumatic stress disorder, that were not present prior to the event and distinctly connected to the event include *re-experiencing* of the event, *avoidance* of stimuli and intrusive thoughts connected to the event, *numbing* of responsiveness and symptoms of *increased arousal* (Breslau et al., 1998). Criterion B captures the re-experience element and responses in symptoms like distressful dreams, dissociative flashbacks and psychological and/or physiological distress at exposure of internal or external cues of the event. Criterion C refers to persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness. Criterion D refers to persistent symptoms of increased arousal such as hypervigilance, exaggerated startle response irritability and difficulty concentrating. These responses, by definition occur when the immediate stressor or traumatic event is over and persist beyond the physical presence of the stressor (Foa, Keane, & Friedman, 2000).

Criterion E refers to the duration of the disturbance which is more than one month. Post traumatic stress disorder also cannot be diagnosed immediately after a disaster. Part of the reason why an immediate diagnosis is not made is because of the high rates of spontaneous “remission” of traumatic stress symptoms. Criterion F refers to clinically significant distress or impairment in important areas of functioning that manifest as a result of the disorder.

It is important to remember that although many people have symptoms of traumatic stress immediately after a traumatic experience, the development of posttraumatic stress disorder after a traumatic experience is not inevitable (Litz, 2004).

3.3. Non-PTSD symptom pictures

Posttraumatic stress disorder is not the only resultant pathology, depression, anxiety disorders, substance misuse and adjustment disorders are also common. Along with these psychiatric disorders there are other non-psychiatric issues that cause distress such as finances, lack of information, housing and breakdown of relationships (Kessler et al., 1995

Common diagnostic sequelae to disasters include major depressive disorder (MDD), personality disorders, specific phobias, panic disorder and disorders of extreme stress not otherwise specified (DESNOS) (Foa et al., 2000). Other psychological symptoms include fatigue, sadness, poor concentration, dysphoria, guilt and feelings of helplessness and heightened arousal and anxiety. For most victims these symptoms diminish in intensity with time and form an integral part of the normal stress response. However, when these symptoms become excessive in frequency, magnitude or duration they can be considered pathological (Deahl & Bisson, 1995).

3.3.1. Complicated Grief

In addition to the threat of personal safety disasters often involve the unexpected death of a close friend or family member. However, pathological grief reactions stemming from traumatic events relative to grief reactions to deaths owing to natural causes cannot be differentiated (Gray et al., 2004). Neglecting the unique psychosocial consequences of bereavement by focussing only on acute stress disorder can result in sustained and unaddressed pathological grief (Gray et al., 2004). The formal label of this proposed disorder has changed from Traumatic Grief to

Complicated Grief (CG) in recognition that sustained pathological grief reactions can occur following deaths resulting from natural causes (Gray et al., 2004). The distinction between complicated grief and un-complicated grief is primarily the presence of unremitting and incapacitating distress that interferes markedly with social and occupational functioning for several months or years following the loss.

Complicated grief can be distinguished from Major Depressive Disorder (MDD), Adjustment Disorder and PTSD. An exclusive focus on the criteria for MDD, Adjustment Disorder and PTSD following bereavement experiences would result in distressed individuals going unidentified and untreated. Although a diagnosis of Adjustment Disorder would imply that the individual was experiencing marked distress following the death of a loved one, the lack of specificity fails to provide direction for treatment planning.

3.3.2. Trauma-Related Guilt

If the traumatic event led to another's death or serious injury, survivors may feel guilt about his or her life being spared or about not providing enough help or protection to others. These individuals often perceive themselves to have greater responsibility for the consequences of the disaster than is warranted (DSM-IV-TR, APA, 2000). Kubany (1998) states that in the light of the severity and pervasiveness of guilt among trauma survivors it should be considered to be a key feature of PTSD (presently guilt has an associated feature status in the DSM-IV-TR) and is proposed to be a key feature when the DSM-V is introduced. Guilt and guilt-related beliefs play an important causal role in the perpetuation and maintenance of posttraumatic stress, low self-esteem and depression.

Kubany and Manke (1995) define guilt as an unpleasant feeling accompanied by a belief (or beliefs) that one should have thought, felt or acted differently. Four cognitive dimensions of guilt were identified which include (1) perceived responsibility for causing a negative outcome, (2) perceived lack of justification for actions taken, (3) perceived wrongdoing or violation of values, and (4) beliefs about pre-outcome knowledge which in social psychology is termed “hindsight bias”.

3.3.3. Anger and aggression

The activation of anger has been recognized as a feature of clinical disorders that result from experiencing disasters. Chemtob and Novaco (1998) presented their own theoretical orientation which is a regulatory deficits model and describe types of anger regulation. In conjunction with trauma, anger is intrusive and is part of a dyscontrol syndrome involving heightened arousal as a survival response to severe threat. Maladjustment occurs when the person fails to regulate responses in accordance with situational realities and intense anger is activated in the absence of genuine survival threat. Associative reminders can provoke cognitive processing into “survival mode” which includes activation of anger structures and as part of that shift there is substantial loss of self-monitoring. In “survival mode” a person responds to context-inappropriate cognitive distortions that tend to confirm the presence of a threat and lead to the activation of anger and aggression (Chemtob & Novaco, 1998). Day to day functioning occurs with a high degree of self-protectiveness and reactivity, thus being stuck in this mode, the individuals thinking becomes polarized and dichotomous (good-bad; friend-enemy).

3.3.4 Dissociative behaviour

Dissociative reactions are believed to be significant in posttraumatic adjustment. Van der Kolk and van der Hart (1989) argue that dissociative responses following trauma lead to psychopathology because they impede the accessing and processing of memories and emotions associated with the traumatic experience. Thus the process of integration and resolution of the experience will be inhibited resulting in PTSD (Koopman, Claasen, Cardena & Spiegel, 1995). The emphasis on dissociation and its pivotal role in acute trauma response has been criticized on the grounds of insufficient evidence to support this idea (Bryant & Harvey, 2000; Keane, Kaufman & Kimble, 2000; Marshall, Spitzer & Liebowitz, 2000).

Dissociative behaviour is thought to be a defining underlying dynamic for PTSD, borderline personality disorder, acute stress disorder and somatization disorder. Terms commonly used to describe dissociative experiences include depersonalization, which refers to a wide range of experiences in which one feels a subjective sense of numbing and detachment from current actions, perceptions and emotions; derealization refers to the experience that one's surroundings are not quite real; dissociative amnesia refers to a partial or complete loss of memory of current experiences or actions. Problems with identity or the self as related to these experiences are included with most descriptions of dissociation.

Wagner and Linehan (1998) assert that the primary function of dissociative phenomena is to regulate the exposure to cues related to the traumatic experience. Dissociative experiences that occur at the time of the trauma may function to regulate exposure to aspects of the trauma as it is occurring and dissociation after the trauma may function to regulate exposure to cues associated with the trauma. In addition, a secondary function of dissociative phenomena is the regulation of the exposure to cues to negative affect. Foa & Hearst-Ikeda (1996) have similarly conceptualized

dissociative behaviour as an avoidance of emotions. According to Green and Lindy (1994) symptoms may include depersonalization, derealization, a subjective sense of numbing or detachment, dissociative amnensia and a reduction in awareness, anxiety and arousal and intrusive re-experiencing of the event. Cardea and Spiegel (1993) highlighted other responses such as time distortion, alterations in cognitions and somatic sensations.

3.3.5 Substance abuse

There is a high prevalence of alcoholism in long-term posttraumatic stress survivors. Alcohol dependence and withdrawal produces its own stress reaction which exacerbates symptoms creating its own vicious cycle (Jacobson, Southwick & Kosten, 2001). Jacobson et al., (2001) state that alcohol performs an agitation lowering function in the weeks and months following a disaster. It inoculates against severe anxiety states and lowers physiological reactivity. The experiential avoidance approach to understanding trauma highlights the impact of an unwillingness to experience certain negatively evaluated cognitions, emotions and physiological states. Alcohol and substance abuse serves as a dysfunctional attempt to eliminate these primary thoughts and emotions (Walser & Hayes, 1998).

3.3.6 Less common/peripheral traumatic sequelae

The above section highlights the more prevalent symptoms that individuals may experience post-disaster. There are however some patients that may require more unique approaches due to the uniqueness of their histories or experiences. It is argued that there is a delayed variant of PTSD in which individuals exposed to a traumatic event do not exhibit PTSD symptoms until months or years afterwards. The

immediate precipitant may be a situation that resembles the trauma in a significant way. For example, a childhood abuse survivor who experiences a disaster and may relive the original traumatic experience (van der Kolk, 2002). These problems serve as an important factor in a predisposition to the development of PTSD in response to subsequent traumatic stressors like disasters as well as a poor prognosis in the capacity to recover from a traumatic event.

Co-morbidity between PTSD and borderline personality disorder is not uncommon in sexually abused adolescents and children. Studies have indicated that 60-80% of females diagnosed with borderline personality report a history of childhood sexual abuse (Herman, Perry & van der Kolk, 1989). Herman and van der Kolk (1987) have suggested that borderline personality disorder may present as severe and chronic PTSD manifestations. The World Health Organisation includes a diagnostic category in the ICD-10 of enduring personality change that result mainly from exposure to “catastrophic stressors”. The DSM-1V-TR does not include a diagnostic category reflecting personality changes induced by trauma (Yehuda, 1998). Goodwin (1985) recommends that a diagnosis of a personality disorder should be deferred until PTSD symptoms have been resolved.

The above section highlights the more prevalent symptoms that individuals may experience post-disaster. Due to the scope of these symptoms it becomes difficult to pin down a single aetiological approach with their concomitant explanatory frameworks. Although the above general symptom pictures have been identified, it is also acknowledged that individuals unique histories and experiences may lead to symptoms not mentioned here. Furthermore, symptom profiles give us an understanding of what a person will present with. For the researcher’s purpose (to

evaluate the influence of a variety of strategies) it also becomes important to ask how or why? In answering these kinds of questions it becomes important to look at explanatory frameworks.

4. Explanatory frameworks for post-disaster responses

4.1 Stress as a general response to stressors.

Much of the more generalized responses to disasters may be due to a regular stress response. The Stimulus-Event Model of Holmes (1979) supports the definition that stress is a result of the events that are likely to produce feelings of tension and fear.

Selye (1974) highlighted the reactions and responses (physiological and psychological) of individuals exposed to stressful situations, such as heart rate, blood pressure and respiration. Stress therefore is described as a non-specific response of the body to any demand made upon it. For example, investigations by Anisman (2001) of recently traumatized victims after a disaster reveal the presence of heightened cortisol levels which coincide with agitation, anger and hypervigilance. Usually these elevated responses settle back down over weeks or months as the body automatically returns to homeostatic balance with regard to cortisol and other stress hormones.

At the time of disaster stress hormones are responsible for the shutdown of any function that is superfluous to immediate survival including digestion, sleepiness, sexual appetite and hunger. In preparation for the fight or flight response blood pressure rises, the heart beats faster, breathing quickens, vessels in the stomach are constricted, perspiration increases to regulate increasing body temperature. Along with the infusion of norepinephrine, endorphins are released. This accounts for the increased pain thresholds found in those in extreme alarm states (Naparstek, 2006).

The most widely used definition of stress defines it as a process that incorporates the two definitions described above. This view highlights the fact that individuals respond or perceive an event in different ways and is understood as a transaction between the person and the environment. The appraisal/transactional model of Lazarus and Folkman (1984) is the most widely used process model. In this model person-environment transactions tax or exceed the resources of the individual. Stress is thus the relationship between demands and the ability to deal with them. It is neither an environmental stimulus, a characteristic of the person nor a response. Ongoing interaction between the person and the environment is reciprocal, with each influencing and in turn being influenced.

Lazarus (1975) defined two types of appraisal, namely primary and secondary appraisal. When an individual makes a primary evaluation the situation can be appraised in four possible ways: (a) irrelevant; (b) benign and positive (c) harmful and threatening (d) harmful and challenging. Secondary evaluations determine what resources and coping strategies the individual has at their disposal. This model focuses on homeostasis and assumes that psychological distress would decrease once balance and stability is resumed. The form of treatment implicit in this theory is crisis intervention.

Tertiary appraisal was defined by Antonovsky (1979) which is an extension of the Stress-Coping-Appraisal Model. It is a developing time modulated, goal-orientated, dynamic and motivated process. People generally try to avoid tertiary appraisal as they would have to admit that the world is not as safe as it seemed, that they are vulnerable and that some things do not comply with supposed rules of justice.

4.2 Explanatory framework for non-PTSD symptom pictures

Due to the wide variety of symptoms and clinical syndromes that can be precipitated by a disaster, it becomes difficult to use a single aetiological approach. A possible solution to this situation is to look at common factors that would be applicable over a wide variety of aetiologies. Or framed differently, an explanatory framework against which to understand the efficacy of a variety of strategies would need to focus on fairly general needs of victims that are thought to be important. "Importance" here can refer to immediate needs (subjective) as well as preventative (i.e. not necessarily an identified need by a survivor, but one that may be important in the development of chronic pathology). This common factors approach helps to frame the research question in a fairly atheoretical sense and is expressly chosen due to the diversity of potential problems that individuals may experience post disaster. This does not preclude that certain theoretical themes may arise from the data analysis but the researcher wishes to depart from a fairly theoretical approach as far as non-posttraumatic symptoms are concerned.

The post-trauma environment has an important influence on recovery. The person feels the need to be treated sensitively and respectfully. This implies that all emergency personnel and other role players potentially may influence this need. This might serve as a buffer against the development of chronic pathology (Litz, Gray, Bryant, & Alder 2002). In the immediate aftermath of a disaster, survivors need to follow their natural inclination regarding who they talk to, and how much they disclose. Professionals should take the lead from survivors in terms of what they want and what they perceive their needs to be (Foa et al., 2000).

Survivors have very immediate identified needs in their efforts to adjust to the traumatic event. These needs depend on the nature of the trauma as well as the extent

of possible physical injuries and the extent of other losses they are experiencing (for example, the loss of a loved one or the loss of housing). Survivors may feel the need for comfort, reassurance and the establishment of safety in order to protect them from further threat or distress (McNally, Bryant, & Ehlers, 2003). In the immediate post-disaster context survivors may feel the need for affiliation. For example, survivors may have been separated from loved ones, relatives and friends, assistance thus takes the form of facilitating the reunion of affected individuals. Survivors may feel the need for practical help in overcoming fatigue and exhaustion, practical help in this instance could be the provision of a blanket and pillow in order to rest in a safe space until medical personnel arrive (Stewart, 2005). Many survivors need information regarding aspects of the traumatic event, as well as information about common responses to trauma and reassurance that symptoms of posttraumatic stress disorder in the aftermath of disaster are normal (McNally et al., 2003). In the immediate context, (i.e. 0-48 hours) any one-size-fits-all strategy is infeasible as it is too early and too intrusive (Edwards, 2005). Survivors may have many competing needs as well as a diminished capacity to absorb new information (Litz, 2008). A period of watchful waiting for approximately four weeks after the event is recommended as initial distress and impairment during this period is not considered abnormal, and the majority of survivors heal naturally relying on their existing coping strategies and social support systems (National Institute of Clinical Excellence, 2005). There is no specific way of identifying survivors at risk for developing chronic pathology. However, assessment and monitoring is important in the early identification of potential problems. Emotional reactions such as distress and fear should be seen as adaptive signals rather than symptoms of pathology and change can often be fostered through comfort and reassurance (McNally et al., 2003). There are few published

randomized trials of interventions initiated in the first 14 days following a disaster (Foa et al., 2000). However, in the acute interval (a few weeks after the event) there is good evidence that cognitive therapy and exposure therapy can be confidently prescribed to survivors that are still impaired and distressed (Litz, 2008).

Survivors might need to be linked to systems of support and sources of help which will be ongoing. Facilitation of social support for those who do not have access to support systems may promote recovery from trauma (Wessely, 2005). In addition, survivors might need practical help, advice and support to cope with additional burdens as a result of the disaster (McNally et al., 2003). This study explores counselling and non-counselling strategies' influence on the psychosocial adjustment of those affected by disasters by keeping the above needs in mind.

4.3. PTSD as a specific type of stress

The acute and chronic responses to stress associated with most psychiatric disorders are distinct from the stress response system in PTSD. PTSD is a particular type of stress response in which biological systems are progressively sensitized (Yehuda, 1998).This conclusion has been facilitated by the biologic findings of the Hypothalamic-Pituitary-Adrenal (HPA) axis which has informed stress research by insisting that more than one type of stress response exists (Yehuda, 1998).

Recent findings related to the biology of trauma and PTSD has been one of the most significant developments in the field of traumatology. Neuroimaging findings (Rauch, 1998) suggest that many biological alterations in PTSD are not present in trauma victims without PTSD. Studies of alterations in the hypothalamic-pituitary-adrenal axis (Yehuda, 1998) in trauma exposed individuals with and without PTSD

suggest that the biological implications of PTSD are not simply the result of normal processes of adaptation to stress.

An event becomes a strongly formed memory, a traumatic memory, when emotions are high and stress hormones are triggered which act on the amygdala – and the memory is stored or consolidated. A combination of high sympathetic activation and low activation of the hypothalamic-pituitary- adrenal axis (HPA) during stress may enhance memory consolidation (Yehuda, McFarlane & Shalev, 1998). Animal studies have shown that an increase in circulating epinephrine immediately after aversive exposure leads to an increase in avoidance behaviour (McGaugh, 1998). Research suggests that the pathogenic effect of traumatization may be mediated by functional changes in the brain's capacity to respond to further stress and by enhanced learning and consolidation of traumatic memories (McFarlane, 1988; Resnick, Yehuda & Pitman et al., 1995).

Given the dose-response (high levels of cortisol were usually considered proof that stress has occurred) relationship with cortisol and stress (Selye, 1956) it was anticipated that trauma severity would be associated with increased levels of cortisol. However, Boscarino (1996) demonstrated a negative correlation between trauma severity and cortisol levels. In a group of almost 2500 Vietnam veterans in which PTSD was prevalent low cortisol levels were recorded. In addition there were alterations at many levels of the HPA axis that are the reverse of the corresponding alterations in chronic stress responses.

Table 1 compares HPA axis alterations in PTSD with those described as part of the classic stress response. The way in which the HPA is altered in those with PTSD appears to be exactly opposite of that which occurs as part of the classic stress response.

Table 1 *Differences between HPA axis alterations in posttraumatic stress disorder (PTSD) and chronic stress/depression.*

Posttraumatic Stress Disorder	**Chronic stress/depression**
Decreased levels of cortisol	Increased levels of cortisol
Increased glucocorticoid receptor sensitivity	Decreased glucocorticoid receptor responsiveness
Stronger negative feedback inhibition	Erosion of negative feedback
HPA system becomes progressively more sensitized	System becomes progressively more desensitized

(Yehuda, 1998)

The difference between the classic stress response and PTSD as described in the above section is not comprehensive. However, it serves to highlight PTSD as a distinct diagnostic category. In the general question around what strategies might be useful to alleviate distress / prevent posttraumatic stress disorder from developing, it therefore becomes important to understand the nature of the disorder. A description of the nature and aetiology will form the theoretical background against which the findings of this study could partly be understood.

4.4. Psychological models of traumatic stress

The researcher was unable to find a comprehensive model of the aetiology of posttraumatic stress disorder. Various models place significance on different aetiological factors, thus in order to gain a comprehensive and clear understanding of

the aetiology this description is essentially an extrapolation of the various models reviewed in the literature. Also evident in the literature review is that other researchers have had similar difficulties with regard to explicit research on the aetiology of the disorder (Mckeever & Huff, 2003; Rubin, Berntsen & Klint Johansen, 2008; Elwood, Hahn, Olatunji & Williams, 2007).

In the last decade cognitive behavioural therapy (CBT) has received the most attention and empirical evidence supporting its efficacy in the treatment of victims exposed to traumatic events (Foa & Rothbaum, 1999; Foa et al., 2000).Because of the clear efficacy of CBT it is also generally accepted as an explanatory framework for the nature and aetiology of posttraumatic stress disorder. This section briefly highlights some of the more well known CBT approaches used to understand and treat the disorder. It will be ended off by a summary of the needs of the disaster victims in relation to the prevention of posttraumatic stress disorder.

The DSM-1V-TR (APA, 2000) states that in order for posttraumatic stress disorder to be diagnosed an individual must have been exposed to a traumatic event during which horror, fear and helplessness is experienced. It is essentially a stimulus-response model. The event is the stimulus and criteria B, C and D the response (Rubin et al., 2008). However, as mentioned previously, not everybody exposed to a traumatic event displays symptoms of traumatic stress disorder, and of those who do only a few will develop posttraumatic stress disorder. The realization that the development of posttraumatic stress disorder was not a normative response led to research regarding risk and vulnerability factors (McNally, 2001). Diathesis-stress models suggest that traumatic events serve as a primary precipitating factor but also that pre-existing individual differences in psychological vulnerabilities contribute to the development of posttraumatic stress disorder (McKeever & Huff, 2003).

The mnemonic model of posttraumatic stress disorder asserts that the current memory of a negative event and not the event itself determines symptoms. For this reason, the authors of the mnemonic model propose that the "event" be removed from its aetiological status in the DSM-1V and replaced with "the memory of the event" (Rubin et al., 2008). The memory remains in "active memory" because of an informational overload of the individual's cognitive system and thus cannot be integrated into autobiographical memory. This leads to the intrusive re-experiencing of the event which characterizes posttraumatic stress disorder. According to Ehlers and Clark (2000) much of the aetiology of posttraumatic stress disorder is thought to centre around the fact that traumatic memory does not incorporate into autobiographical memory in the normal way.

4.4.1 Ehlers and Clark's Cognitive Model

Ehlers and Clark (2000) assert that the basis of the development of autobiographical memory is the incorporation and integration of new life experiences into an individuals existing fundamental schemas. In the aftermath of a traumatic event, the individual has to incorporate the experience (for example, "I am going to die") into existing fundamental schemas. When extreme experiences occur, individuals are unable to assimilate this information with existing schemas not only because it is unfamiliar, but also because the implications are emotionally painful. In normal situations individuals remain calm and can organize the sequence of events in memory. Subsequently they are able to recall the events voluntarily and in temporal order. Ehlers and Clark (2000) call this "conceptual processing". During intense emotional arousal sensory impressions are not organized in a meaningful way, thus

features of the trauma are re-evoked involuntarily in response to associative cues often in a disorganized and fragmented manner.

Intrusive re-experiencing is often alien to a person's pre-morbid experience of themselves and subsequently results in a sense of dyscontrol (for example, "I am normal/okay"/ "I am coping" vs "I am going crazy"/ "I am not coping") resulting in fear and confusion. Ehlers and Clark (2000) call this "data-driven processing". Negative appraisals of the trauma sequelae result from the misinterpretation of common initial PTSD symptoms (such as flashbacks), and are not seen as a normal part of the recovery process, but rather that they indicate a threat to their physical or mental well being. These appraisals produce negative emotions (e.g. anxiety, anger or depression) which encourage dysfunctional coping strategies such as avoidance and emotional numbing and in turn enhance PTSD symptoms (Ehlers & Clark, 2000). The task of integrating new incompatible pieces of information may oscillate between letting the information in and feeling overwhelming emotions and blocking the information and feeling numb is described as "emotional processing" (Ehlers & Clark, 2000; Foa & Kosak, 1986).

The experience of dissociation when focussing on memories of the traumatic event has been strongly associated with traumatic events (Cardena & Spiegel, 1993). Dissociation is characterized by an experiential disconnection from the self and/or the environment (Cardena, Maldonado, Hart & Spiegel, 2000). However, a chronic state of numbness indicates behavioural, cognitive and emotional avoidance which is a dysfunctional attempt to cope with painful emotional states which in turn are associated with negative and dysfunctional beliefs and attitudes. They are considered dysfunctional because they increase the frequency of intrusions and prevent the disconfirmation of inaccurate beliefs (for example, "The world is unsafe and

unpredictable"). These dysfunctional beliefs support a continued sense of threat in which there are selective attention to threat cues and increased vigilance (for example, "If I do not take extra precaution, my life will be in danger", "I can't make plans for the future because the next awful thing is going to happen"). The attempted avoidance increases the individual's overall levels of anxiety and arousal symptoms (hyperarousal). When schema discrepant events occur individuals must reconcile the event with their beliefs about themselves and the world. In order for these schemas to be repaired, beliefs must be altered and accommodated so as to incorporate this new information. The way in which schemas are repaired is to "complete" the processing of traumatic material (Horowitz, 1986). This is only possible by exposure to the trauma memory by some form of reliving the traumatic event or by exposure to anxiety provoking cues, thereby allowing for the elaboration and contextualization of the trauma memory into the individual's history and life experiences (Foa et al, 2000; Ehlers & Clark, 2000). When events have been integrated, individuals can describe and explain their significance for the overall meaning of their life.

4.4.2 Emotional Processing Theory

Foa and colleagues have proposed similar theories to those of Ehlers and Clark (2000) that may help to understand the aetiology and treatments that promote recovery from posttraumatic stress disorder (Foa & Kosak, 1986; Foa, 1997; Foa & Cahill, 2002). While Ehlers and Clark emphasize cognitive factors Foa's theories place more emphasis on behavioural factors in the aetiology and maintenance of PTSD. According to Foa and Kosak's Emotional Processing Theory (1986) the development of PTSD after a traumatic event is a result of the disruption in normal emotional processing of the event.

Three conditions are proposed that promote successful treatment of PTSD namely: (a) emotional engagement with the feared stimuli, (b) habituation of the feared responses represented in the fear structure, and (c) modification of the erroneous cognitions embedded in the structure. Individuals with PTSD can be distinguished from those without PTSD and non-traumatized victims by two erroneous cognitions. Firstly, that the world is a dangerous place and secondly, that the self is completely incompetent (Foa, 1997).

4.4.3 Emotional Engagement Hypothesis

Foa's (1997) Emotional Engagement Hypothesis suggests that good recovery from PTSD has been associated with high emotional engagement resulting in a peak in symptoms after a traumatic event. Low emotional engagement resulting in a delayed peak in PTSD symptoms should therefore be associated with poor recovery later on. The experience of dissociation when focussing on memories of the traumatic event is common in posttraumatic stress disorder and indicates the absence of emotional engagement and increased severity of posttraumatic stress disorder symptoms (McFarlane, Golier & Yehuda, 2002). Foa's (1997) hypothesis suggests that emotional engagement is required for a natural recovery as well as for treatment for PTSD. It therefore seems logical that the continued presence of extreme low engagement (dissociation) would be related to increased severity of PTSD symptoms (McFarlane, et al., 2002).

4.4.4 Habituation Hypothesis

The Habituation Hypothesis (Foa & Cahill, 2002) posits that although emotional engagement appears to be necessary for recovery, by itself may not be sufficient. A

second important process is habituation, defined as a gradual reduction across successive exposure sessions of the amount of fear elicited by the traumatic memory.

As an example of the habituation hypothesis, Jaycox, Foa & Morral (1997) found three different patterns of response as measured by subjective units of distress (SUDS) during imaginal exposure for PTSD. Patients in the first cluster showed high levels of anxiety initially followed by a gradual decline over the next five sessions. Patients in the second cluster also showed high levels of anxiety initially, but showed little decline in the anxiety levels in subsequent sessions. Patients in the third cluster showed little anxiety initially and no decrease in anxiety over subsequent sessions (low initial engagement without subsequent habituation). There was significant improvement in the patients who showed both emotional engagement and habituation compared to those that showed engagement without habituation, or those who showed neither engagement nor habituation. The emotional engagement hypothesis and the habituation hypothesis are thus supported by the results of this study.

If we consider the above information we can extrapolate a variety of needs that may be experienced by those affected by disasters. This will be presented towards the end of the chapter. In the South African context it is important to consider the influence of culture on the experience of PTSD. The extrapolation in the South African context would not be complete without considering the potential influence of culture on the aetiology and experience of PTSD.

4.5 The cultural expression of PTSD

Marsella and Christopher (2004) highlight cultural sensitivity in understanding and treatment delivery for those affected by disasters. It has been argued that PTSD is a Western and culture specific disorder (Summerfield, 2004). The pathologising of

human experience leads to certain groups of people being more traumatized by the diagnosis than by the traumatic event. However, Van Rooyen and Nqweni (2010) propose a model that acknowledges PTSD as a universal diagnosis, while seriously considering how culture may influence the expression thereof. The authors contend that merely highlighting cultural sensitivity on the one hand, and attacking the diagnosis of PTSD as inappropriate on the other hand, is avoiding central issues. Thus the proposed model takes both sides into account in a manner that shows that universality and cultural uniqueness are not mutually exclusive (Van Rooyen & Nqweni, 2010). The model highlights universal elements such as memory consolidation and schema disruption and the relationship between exposure and recovery that are similar to the Western models presented in the previous section. It further highlights that these universal elements may express differently due to cultural influences. Although PTSD may have a universal core, it becomes important to recognise that the disorder may not present in the same way in the South African context. Cultural sensitivity is important as far as the needs of survivors are concerned.

5. Reducing the risks of the development of PTSD

In the sense of preventing the traumatic memory from being formed the easiest solution is to prevent actual exposure to traumatic material. In an ideal world this would mean that a focus for intervention would be the prevention of the actual disaster. This is outside the scope of the current enquiry- however we can still say that to protect a person from being exposed to traumatic material is important. Practically this means that to remove the person from the scene of disaster as soon as possible constitutes an early intervention strategy that would meet a psychological need.

Dysfunctional behavioural and cognitive coping strategies such as avoidance and numbing, prevents memory elaboration which hinders the reassessment of negative appraisals and subsequently exacerbates symptoms. When the trauma memory is elaborated the individual has the opportunity to modify problematic appraisals that maintain a sense of current threat. Elaboration and engagement with the trauma memory allows for the integration into autobiographical memory in place of active memory thus reducing intrusive re-experiencing. Practically this means that if a person experiences a disaster, “protecting” them from all anxiety provoking material could paradoxically be maintaining avoidance of the trauma memory and thus inhibit engagement with the trauma memory which is needed for elaboration and integration.

The misinterpretation of symptoms of posttraumatic stress disorder in the post-disaster context may lead to negative appraisals such as “I am going mad”. Normalization rather pathologising the experience of posttraumatic stress symptoms by means of psycho-information can act as an important buffer against negative appraisals. This provides the survivor a means to making sense of symptoms experienced and reassurance that they are to be expected and may be considered part of the healing process (Edwards, 2005). In this regard the quality of other peoples’ reactions in the aftermath of trauma is important. Appropriate social support facilitates the normalisation of symptoms. Other people are often uncertain about how they should respond to a trauma victim and may avoid talking about the event in order not to distress the person. This may be interpreted as “nobody cares about me” and may exacerbate symptoms (for example, social withdrawal and estrangement). In addition, by not being able to talk about the experience, the opportunity to gain feedback that might challenge negative appraisals about the meaning of the event is reduced (Ehlers & Clark, 2000). Appropriate social support that fosters normalization

and provides a sensitive challenge to dysfunctional beliefs is therefore also an important need for most disaster victims.

The survivor needs to maintain a sense of autonomy and human dignity. This can mitigate the thought process of “mental defeat” thereby influencing subsequent appraisals (Ehlers & Clark, 2000, p. 331). A perceived loss of all autonomy, accompanied by the sense of not being human any longer can precipitate negative appraisals such as “my life will never be the same again” or “I am worthless”. Allowing a person to get back into their normal routine as soon as possible (in order for them to experience themselves as autonomous) is therefore also important. The needs highlighted here focus on prevention but do not supersede other needs mentioned earlier in the chapter.

6. Summary

In this chapter psychological models of PTSD were discussed with a focus on Ehlers and Clark’s Cognitive Model (2000) and theories that focus more on behavioural factors such as Foa and Kosak’s Emotional Processing Theory (1986) and Foa’s Emotional Engagement Hypothesis (1997). Many of the biological findings of PTSD focus on similar constructs as the findings from psychological studies and there seems to be consensus about the role of contextless fear triggered by salient memories.

The wide variety of anxiety symptoms that survivors may experience after exposure to a traumatic event were discussed (Foa et al., 2000). Many of these symptoms are transient, and people generally adapt naturally (National Institute of Clinical Excellence, 2005). However, there are those who may develop chronic pathology of which PTSD is the most frequent and debilitating. Potential general

needs of survivors as well as more specific needs relating to the prevention of PTSD are listed below (Litz et al., 2002; Foa et al., 2000; McNally et al., 2003; Edwards, 2005).

- A one-size-fits-all strategy is infeasible
- Attending to survivors immediate subjective needs
- Survivors need to be treated sensitively and respectfully
- Comfort, reassurance and the establishment of safety
- The need for affiliation
- Practical help
- Accurate information regarding the event
- Psycho-education (for both victims and support systems) aimed at creating understanding ad normalisation
- Respecting the survivors' choice as to whether they want intervention or not
- Assessment and monitoring
- Protection from unnecessary exposure to traumatic material (e.g. vicarious traumatisaton
- Safe exposure to anxiety provoking material in the weeks following the disaster

In the context of the needs of those affected by disaster the question thus arises as to how and when can people be assisted in the aftermath of a disaster to reduce the risk for developing posttraumatic stress disorder while remaining sensitive to immediate needs. Apart from the general considerations mentioned in this chapter, the early intervention literature also forms a relevant background to interpret the potential findings of this study. Chapter 3 considers the early intervention strategies that have been considered accountable in the research.

CHAPTER 3 EARLY INTERVENTION

This chapter describes the professional care provided immediately or soon after trauma and is otherwise referred to as *early intervention.* The origins and utility of psychological debriefing models (including Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM)) are discussed. Some of the arguments highlight difficulties in the early intervention field. Current international trends in early intervention strategies are presented. Psychological first aid (PFA) is focussed on which is an approach recommended by many practice guidelines (United Kingdoms National Institute for Clinical and Health Excellence (NICE); National Collaborating Centre for Mental Health, 2005). Early intervention in the South African context is discussed and finally an orientation to early intervention strategies for children and adolescents is presented.

1. Psychological debriefing (PD)

The term “debriefing” has long been associated with early psychological intervention, with emphasis on prevention and a way in which to identify individuals at risk for developing chronic posttraumatic reactions. “Psychological debriefing” (PD), is appropriate in the context of institutions such as police, fire fighters and ambulance services where it is an extension of the institutional culture rather than a form of counselling (Litz et al., 2002). However, the term has become synonymous with early psychological intervention following trauma. Forms of debriefing have become well recognised and widely practised (Bisson, McFarlane, & Rose, 2000).

1.1 Historical origins of debriefing

The modality of debriefing is historically rooted in the attempt to address stress and not trauma. “Historical group debriefing” was developed by the U.S. military historian S.L.A. Marshall and was first used in combat to address battle fatigue and to obtain a history of combat episodes in World War 11. This model enabled soldiers to describe their experiences and different perceptions in a group setting. The objective was to provide some shared sense of meaning in an informal and unstructured environment where no interpretations were made (Litz et al., 2002).

The narrative tradition of debriefing developed by S.L.A. Marshall is linked to the belief that in just one debriefing session for victims some of the feelings could be evoked and expressed, and subsequently long term adjustment would improve and the risk of developing PTSD would be reduced. In its original context, soldiers had little understanding of the pattern of events on the battle ground. Subsequently, in a group setting the process of debriefing allowed them to gain a realistic narrative or verbal representation of their combat experience and an opportunity to organize their emotional reactions to the event (McFarlane, 2000). The process of debriefing might have been appropriate in its’ original context, but this does not seem to be true for civilians.

1.2 Critical Incident Stress debriefing (CISD)

The prototype of debriefing interventions is Critical Incident Stress Debriefing (CISD), which has been in use for 20 years. Group therapy is a paradigm employed in this model. Mitchell and Everly (1995, p. 271) describe CISD as a seven phase “structured group meeting or discussion” in which affected individuals are given the opportunity to share their thoughts and emotions with other members of the group

supported by the fact that they are not alone in their reactions. This seven phase model includes (1) an introductory first phase which aims to establish safety, containment and ground rules within the group, focussing for example on confidentiality; (2) the second phase includes establishing the facts of the traumatic event and expression of emotions related to the event as well as acknowledging and validating the emotions as appropriate therefore normalising the participants' feelings; (3) the third phase is to elicit the thoughts that the participants had during the traumatic event, this "thought phase" represents a transitional phase from the cognitive domain to the affective domain; (4) next is the reaction phase considered to be emotionally the most powerful phase. Here such questions as "What was the most difficult aspect about the situation for you personally?" are asked. This phase is intended to last between 10 and 40 minutes; (5) the fifth phase is a transitional one in which the cognitive, emotional, physical and behavioural symptoms are discussed; (6) the following phase entails a cognitive psycho-educational component and informs the participants what symptoms they can expect to experience. For example, information is given on diet, exercise, rest and the benefit of talking to one's family and friends. At this stage the participants are tentatively encouraged to explore the possibility of anything meaningful or positive that emerged from the traumatic situation; (7) during the seventh and final phase of re-entry, issues are clarified, questions answered, encouragement offered, reassurance given, and closure facilitated. Further aims are to identify individuals who might benefit from more formalised psychotherapy. The entire process of CISD is intended to take place within 24 and 72 hours after the traumatic incident and entails a group session lasting approximately 90 minutes – depending on group size and participation.

Debriefings are not counselling sessions but rather discussions aimed at putting the traumatic event into perspective. They provide the individual with a framework to understand their thoughts and feelings. The emphasis is placed on normalisation (i.e. it is a normal reaction to an abnormal experience) and pathologising individual reactions is avoided. Although Michell and Everly (1995) acknowledge that the process has both psychological and educational qualities, it should not be considered as a form of psychotherapy. Originally CISD was designed for emergency services personnel and not a stand alone or individual intervention but a comprehensive intervention system (Turnbull, Busuttil & Pitman, 1997). Unfortunately the term CISD was used widely to refer to the specific group intervention as well as the comprehensive package. This was later rectified with the term Critical Incident Stress Management (CISM) (Everly & Mitchell, 1999).

1.3 Critical Incident Stress Management (CISM)

CISM is a comprehensive, systematic and multi-component approach to the management of traumatic stress in personal and work settings. It contains multiple interventions that can be drawn on as the crisis unfolds, before, during and after the traumatic event. The interventions fall into 3 main categories namely: (1) interventions for the individual; (2) interventions for groups; and (3) interventions for the environment, which includes support for families, organisational support and community support. Everly and Mitchell (1999) state that although CISM was originally developed for emergency services personnel, the program is inherently flexible and can be modified, thus applicable to any organisation or constituent group. CISM interventions are designed for implementation during the acute crisis phase, specifically on-scene, in-the-field support.

1.4 Critique of psychological debriefing

The events of 9-11 assumed a huge demand for brief psychological intervention from professionals. However, there was uncertainty amongst many professionals on what interventions were recommended based on scientific evidence (Litz, 2004). Early interventions have only recently been subjected to rigorous clinical research. However, survivors of trauma appreciate supportive care and palliative assistance in the face of disaster even if it does not improve their recovery (Litz, et al., 2002).

Based on results of various controlled clinical trials there is no empirical support for Critical Incident Stress Debriefing (CISD) or Critical Incident Stress Management (CISM) and therefore not recommended for victims of trauma (National Institute of Mental Health, 2002). There is no scientific evidence that the immediacy of psychological debriefing decreases the opportunity for maladaptive and disruptive cognitive and behavioural patterns to become established (Kaplan et al., 2001; Naparstek, 2006). In a summary of results of randomized controlled trails in the Cochrane Review (Rose et al., 2001) the notion that debriefing could be harmful was illuminated. It was claimed that rather than being beneficial, it could increase the risk of chronic posttraumatic stress disorder (Bisson et al., 2000; Rose et al., 2001). In two of these with MVA survivors and women who had miscarried there was no evidence that debriefing was better than no debriefing; in one with burn survivors, debriefing was associated with a worse outcome and the longer the debriefing session was the worse the outcome. Chemtob, Thomas, Law & Cremiter (1997) conducted a study of debriefing of those affected by a hurricane. It is the only study in which there was any evidence of benefit and in this study the debriefing took place six months later and not immediately afterwards.

Neria, Solomon and Ginzberg (2000) argue that any group- based brief format for victims of trauma without pre- and/or post intervention might be potentially harmful. The goal of creating a sense of safety and stability may be undermined by eliciting emotional expression in the context of a once-off crisis intervention session. Group composition in CISD settings is often not homogenous. Individuals have unique perceptions of the event, thus some may be more distressed than others. Therefore there is a risk of vicarious trauma by being exposed to the traumatic narratives of others. Also intense re-exposure of emotions experienced by others in CISD can re-traumatize some individuals without allowing time for habituation. Even though emotional expression has a central place in current psychological treatments and is central to the emotional processing theory, the eliciting of strong emotions seems inappropriate in the immediate post-disaster context (Foa et al., 2000).

Stuhlmiller and Dunning (2002) hypothesize that debriefing has evolved in a medical model and therefore the process of debriefing may encourage pathological outcomes. The authors call for a critical rethink about psychological debriefing which is derived from a pathogenic framework and thus overshadow positive outcomes and undermine self-reliance and self-resilience. In addition, the difference in what is defined as a critical incident is problematic as well as the assumption of adverse effects, failure to separate normal stress and traumatic stress psychologically and the difference in terms of their biochemical phenomena.

There is no scientific evidence that the immediacy of psychological debriefing decreases the opportunity for maladaptive and disruptive cognitive and behavioural patterns to become established (Kaplan, Iancu, & Bodner, 2001). According to Michell and Everly (1995) it is possible that early intervention after a disaster disrupts

defences and coping strategies whereas providing late intervention can provide psychological aid when these mechanisms are stronger

Understanding debriefing and its potentially harmful nature is important in the current study due to debriefing's perceived widespread use in combination with misconceptions about its efficacy in preventing posttraumatic stress disorder. In looking at the perceived efficacy of early intervention strategies we therefore cannot leave out the possible impact of inappropriate debriefing sessions.

2. Current international trends in early intervention strategies

The danger in the early intervention field is the assumption that most people adjust to extreme traumatic stressors on their own. This belief may deny those in need of help in overcoming their sense of helplessness and other overwhelming emotions that might result in psychopathology (Raphael, Meldrum & McFarlane, 1995). On the other hand to prescribe formal secondary prevention services to everyone exposed to trauma is inappropriate (Litz & Gray, 2004; Raphael et al., 1995).

In response to the disappointing research results for psychological debriefing, it is not recommended that professionals use debriefing for those exposed to trauma (Academy of Cognitive Therapy, 2005; National Institute for Mental Health, 2002). However, survivors of trauma appreciate supportive care and palliative assistance (from any source or professional) in the face of disaster even if it does not improve their recovery (Litz et al., 2002). Although there is an understandable humanitarian desire to help those confronted with distress and unimaginable pain in the wake of a disaster, well intentioned but ineffective interventions have been developed and implemented due to their intuitive appeal. It is necessary for beneficial interventions

to be developed and to subject these interventions to rigorous empirical scrutiny even in the early intervention context (Raphael & Wilson, 2000; Gray et al., 2004).

The emphasis in early intervention is placed on the importance of attending to survivors' individual needs in a non-prescriptive and flexible way. To assess their own safety, learn what to expect in terms of future reactions and marshal the resources needed (McNally et al., 2003). Bisson et al., (2007) encourages an approach that takes into account individuals' natural resilience built on psychological triage and proper stratified care. Individuals that are affected are to be provided, in an empathetic manner with practical, pragmatic psychological support. In addition, the importance of provisions made for individuals to obtain appropriate early support based on an accurate and current assessment of need. Individuals that experience continued symptoms for a month or more can benefit from psychological intervention.

Litz (2008) made the recommendation that early interventions built on CBT principles need to be developed in order to accommodate the unique challenges posed by victims of disasters. There are enormous differences within the trauma types and contexts and a one-size fits all strategy falls short. In order to facilitate symptom reduction and enhance functioning in the early intervention arena some of the key mediators to positive outcomes include promoting agency, hope, acceptance, meaning-making, bolstering personal and social resources and fostering a strategic approach to future trauma-related challenges.

Macy, Behar, Paulson, Delman, Schmid and Smith (2004) describe a comprehensive approach called "post-traumatic stress management" (PTSM). The emphasis is on involvement of all role-players in a process of assessment and planning of a broad range of interventions aimed at the needs of all those affected. Liaison with community leaders is deemed essential as they will play a major role in

giving constructive direction to community members. Macy et al., (2004) highlight the following:

> Rather than focussing primarily on disturbing or negative elements of the traumatic event, great care is taken to build a sense of safety and stability at the beginning of group sessions. Attention is focussed on phenomena that elicit the expression of, and that promote, the resiliency of the group members and of the community as a whole (p. 221).

The National Institute for Clinical Excellence (NICE) (2005) published evidence based guidelines for the management of PTSD. The guideline suggests practical, emotional and social support in the immediate aftermath of a traumatic incident. Key priorities for implementation in the initial response to trauma include: (1)"For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice when delivering services"; (2) "Where symptoms are mild and have been present for less than four weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD), should be considered. A follow up contact should be arranged within one month".

The guideline states that both health and social services play a role in the organisation of appropriate social and psychological support for those affected by disasters. The psychosocial aspect of the disaster plan should contain the provision for immediate practical help, support for affected communities and those caring for survivors, the provision of mental health care providers and evidence-based assessment and treatment strategies. In addition, roles and responsibilities of all health care workers should be clear and agreed upon in advance.

Early intervention is a challenge for researchers, decision makers and care providers as rigorous clinical trails in the disaster arena are rare (Gray et al., 2004). Thus there is a need for effective care that realistically matches available resources (Litz, 2008). Individualised considerations in terms of a one-size-fits-all approach are difficult, therefore there is a need for an approach that is not harmful (like debriefing potentially may be) and addresses major issues. The focus at the early phase is rather on reducing emotional intensity and on practical adjustment (Litz et al., 2002). The Academy of Cognitive Therapy (2005) included the recommendations that helpers are advised not to include psychological interventions at the early phase after trauma.

Current best practice treatment manuals seem to lean towards not doing anything in the face of the controversy around early intervention strategies. In the immediate aftermath of a disaster (i.e. 0-48 hours) psychological interventions are not recommended (Academy of Cognitive Therapy, 2005). Mild symptoms are seen as part of a normal traumatic stress response and should normally dissipate over a period of four weeks. During this time a “watchful waiting” period is recommended. A follow up contact is recommended (National Institute for Clinical Excellence, 2005). The single most important indicator of subsequent risk for PTSD appears to be the severity or number of post traumatic stress symptoms from about one to two weeks after the event onwards (McNally et al., 2003). To date there are few randomized controlled trials of intervention carried out in the first fourteen days following disaster thus, the optimal time for introducing interventions remains to be answered. According to McNally et al., (2003) certain elements of CBT are more effective than supportive counselling or no intervention within the first month. However, any intervention that is carried out within a month of the event is probably coinciding with

normal recovery processes, and the intervention should interfere as little as possible with these processes (McNally et al., 2003).

As has been mentioned before, it seems to be inhumane not to offer any kind of support after a disaster. The stringent application of the "evidence-based" principle in formal treatment manuals does highlight the need for monitoring (in which an understanding of risk factors and screening does become important). The argument here is that it is important in the disaster context to be able to predict who may be at risk for later adjustment problems. Because of these difficulties, the use of psychological first aid (PFA) is recommended by intervention specialists (Litz & Gray, 2004; McNally et al., 2003; Bisson, 2007) and many practice guidelines advocate this approach (National Institute of Mental Health, 2002).

3. Psychological First Aid (PFA)

Psychological First Aid (PFA) is often used in the crisis intervention context and is designed to reduce acute stress reactions experienced by individuals in the immediate aftermath of a traumatic event in order to facilitate short and long term functioning. Litz (2008) describes PFA as a flexible conversational approach that provides information, comfort, support, connectedness, and fosters coping in the immediate aftermath of a disaster. Although PFA strategies are informed by the consensus of experts and available evidence, it needs further empirical validation (Boscarino, Adams, & Figly, 2005; Everly & Flynn, 2006; Jones, Roberts & Greenberg, 2003).

The essence of PFA is that a specific precipitant exists and that the victim is clearly distressed. . The responses that facilitate such recovery are deliverable by non-professionals (i.e. not just counselling/therapy professionals, but also firemen, paramedics, law enforcement officers etc.).

PFA meets four basic standards: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in field settings; (3) appropriate for developmental levels across the lifespan; (4) culturally informed and delivered in a flexible manner. PFA acknowledges that disaster survivors experience a broad range of early responses that may be normal. As such it tries to do as little as possible while still providing some relevant assistance. It also often includes psycho-educational elements aimed at normalizing responses after a disaster (National Child Traumatic Stress Network and National Centre for PTSD, 2006).

3.1. Basic objectives of Psychological First Aid

The core actions of psychological first aid (PFA) constitute the basic objectives of providing assistance within days or weeks following an event. The amount of time spent on each core action should be based on the survivor's specific needs and concerns. The core actions are as follows: (1) Contact and engagement: To establish a human connection in a compassionate and non-intrusive way; (2) Safety and Comfort: To enhance immediate and ongoing safety and the provision of physical and emotional comfort; (3) Stabilization: Calm and orientate emotionally overwhelmed or distraught survivors; (4) Information gathering: current needs and concerns: Help survivors to specify what their immediate needs are and gather information as appropriate. (5) Practical assistance: Offer practical assistance and information. (6) Linkage with collaborative services: Connect survivors to possible social support networks; (7) Information on coping: Support adaptive coping thereby empowering survivors; (8) Provide information that may help survivors cope effectively with the psychological impact of disasters (National Child Traumatic Stress Network and National Centre for PTSD, 2006).

4. Current South African trends

South Africa's history has created a culture of violence. These conditions have resulted in high levels of psychological trauma that have affected large numbers of people. South Africa faces problems of widespread poverty, endemic communicable diseases and a poorly developed infrastructure. In general, mental health and other resources needed to deal with the consequences of disasters and continuous trauma are inadequate to deal with the demands. Long-term outcomes after exposure to a traumatic event are largely influenced by the nature of the post-trauma environment. The impact of a disaster and subsequent traumatic stress responses may be exacerbated by repeated and enduring traumatisation (Raphael & Wilson, 1993).

In South Africa, survivors and communities have many needs in the aftermath of traumatic events. Prevention of the symptoms of traumatic stress is only one of them. There are many different targets of early psychological intervention. After responding to assist victims at the site of a train disaster and at local hospitals, Stewart (2005) identified that the needs of those affected were foremost for "a safe space within a terrifying moment" (p. 8). Furthermore it is reported that pragmatic considerations (e.g. handing out tissues, requesting bed pans from nurses, gentle smiles) were more appropriate in this instance than complex models of intervention.

Van Wyk and Edwards (2006) challenged many assumptions held by South African therapists offering crisis intervention for victims of traumatic events. It was assumed that it was important to offer psychological debriefing as a means of preventing the development of future mental health problems. However, in the light of research findings procedures for crisis intervention were re-evaluated. Although it has been advised not to include psychological interventions in the early phase, van Wyk

& Edwards (2006) highlight the fact that it is not easy to determine where practical support ends and psychological intervention begins.

Edwards, Sakasa and van Wyk (2005) highlight the resourcefulness and resilience that characterize most affected people as well as the importance of acknowledging the wide range of individual responses to traumatic events. Van Wyk and Edwards (2006) describe the work done at a trauma clinic as “trauma support” rather than “trauma debriefing” or “trauma counselling”. Trauma support is a three-stage process, with the focus on assessment and early identification of those affected where intervention is needed. The procedure is neither predefined nor prescribed, and is in line with Gist and Woodhall’s (1999, p. 217) emphasis ensuring that interventions “supplement and reinforce resilient responses of individuals and organizations” and do not encourage strategies that may reinforce vulnerability and reliance, but rather emphasize autonomy.

South African political violence has been transmutated into random criminal violence over the years (Hajiyiannis & Robertson, 1999; Straker & Moosa, 1994). The Wits Trauma Model was developed out of an empirical multiple case study approach derived within the South African context. It has been found to be useful dealing with diverse cultures, age groups and across a wide range of traumas. It is acknowledged that trauma impacts on both internal and external psychological functioning and thus proposes a treatment approach which addresses these processes as well as intervention which is structured and problem-oriented. Furthermore it is deemed to be a time limited and cost effective approach which is appropriate considering the enormous demand for such services in South Africa. (Hajiyannis & Robertson, 1999).

The principles of trauma intervention internationally and in South Africa are being carefully evaluated as a result of “controversial” debriefing interventions. Ober,

Peeters, Archer, & Kelly, (2000) argue that communities must be supported to build culturally appropriate debriefing models, including those that apply in acute situations of trauma which are superimposed on chronic traumatization.

According to Silove's (2000) adaptational framework most individuals and their communities adapt to trauma without professional assistance, which implies that recovery is fostered by natural social, biological and cultural mechanisms. Although Silove's adaptational framework does not specifically refer to the South African context, the importance of adaptation to the cultural environment and sensitivity to cultural issues in trauma response is emphasised and therefore relevant. Early intervention linked to the adaptive domains could include the following:

1. Safety/security: In order to reduce distress early interventions must ensure safety.
2. Attachment domain: Providing information and supporting the search for family members. In the case of loss or death the appropriate rituals for grief and farewell should be supported.
3. Justice domains: Addressing core justice issues and acknowledging the individuals human rights is critical. In addition, the suffering that the individual has endured should be recognized without creating unrealistic expectations for immediate relief.
4. Identity and role: Valued identities should be recognized and supported as well as the roles adopted by those affected by traumatic events.
5. Existential meaning: Early interventions may include re-establishing contact with spiritual and religious leaders.

In South Africa the idea of an intensive single session could be valuable was influenced by Straker and Moosa's (1994) work. The value of providing an opportunity to talk and express feelings for those traumatised by political oppression and brutality was highlighted. Although a single session was not specifically recommended it was observed that many of those affected by trauma, because of various unstable social conditions, found it difficult to attend more than once.

An example of the flexibility of a "trauma debriefing" intervention in the South African context is described by Peeke, Moletsane, Tshivhula and Keel (1998) following an armed robbery in a financial institution which took place on a Saturday morning. All employees had been held hostage at gunpoint while the robbers forced them to open the safe. Although no-one was injured, employees returned to work on the Monday reportedly afraid and felt unsafe in their work environment. Three group debriefing sessions were decided upon by the human resources manager who had been trained in crisis intervention. During the first session several of the women were in extreme distress "cried and ran in and out of the session" (p. 24). The group was then divided into two, those who were in distress and those who appeared to be coping. Help was elicited from those who appeared to be coping better to support those who were clearly in distress. Issues of generalised fear towards black people, which developed into animosity towards black colleagues, along with feelings of resentment of the attention given to those affected were addressed by the counsellor in a pragmatic and sensitive manner.

A recent study was conducted in South Africa by Van Rooyen and Sandison (2008). This study employed similar methodology in a similar population to the current study. Findings from this study indicated that non-counselling factors also potentially influenced the perceived psychosocial adjustment after disasters. This

multiple case study focussed on three disasters that resulted in loss of life. Two of the three disasters under study indicated early strategies that were potentially harmful (if compared to current literature), but in some cases the influence of other non-counselling factors were sometimes seen as more beneficial than early counselling would have been. Various factors influenced the efficacy of the psychological intervention and were either perceived as helpful or unhelpful by the therapists involved. Factors perceived as helpful included: (1) homogenous manageable groups; (2) personal characteristics of therapist (adequate training, previous experience working with trauma, flexibility and the value of being adaptive); (3) victims offered a variety of choices in terms of how best to process their trauma (e.g. talking to a minister, participating in mentor groups or being on their own); (4) psycho-education; (5) the therapist being available as a consultant; (6) a trauma response team with a common approach; (7) a pre-set plan which acts as a buffer to harmful practices.

Factors perceived as unhelpful included: (1) no screening of those exposed to trauma; (2) political motivation and pressure by organization for intervention to take place; (3) large unmanageable groups (sharing traumatic memories results in vicarious trauma for those individuals who were not directly exposed); (4) a variety of professionals converging on the scene without a unified approach to what constitutes effective early intervention; (5) eliciting powerful emotions.

Furthermore, findings from this study indicated that extra treatment factors also influenced the efficacy of early interventions during disasters. These factors included logistical considerations, cultural factors, pressure from management and political organizations, therapeutic methodologies as well as appropriate training and exposure of psychologists and other mental health professionals. The current study is essentially an extension of this initial/pilot study.

Although the focus of this chapter so far has been on early intervention for adults, children are also exposed to a wide range of traumatic life experiences (Chemtob & Taylor, 2002). However, there is a paucity of research that addresses early mental health interventions for children (Cohen, 2004). The next section provides an orientation to current trends in early intervention for adolescents and children.

5. Early intervention for children and adolescents

Children seldom present themselves for mental health treatment and they are almost always dependent on parents or caregivers to recognize that a mental health problem exists. The younger the child is the more the dependency is likely to be.

Based on current research cognitive behavioural therapy (CBT) has the strongest efficacy for traumatised children with PTSD symptoms although the "active ingredient" in terms of the specific cognitive behavioural component is unknown (Cohen, Berlinger, & March, 2000 p.128). Children may develop a wide range of psychological difficulties such as other anxiety symptoms, depression and substance abuse. Few studies have addressed the efficacy of CBT in the treatment of non-PTSD symptomology.

Although the potential harm of psychological debriefing for adults in the immediate aftermath of disasters is well documented, there is no information regarding whether these same risks are present for children (Cohen, 2004). However, an intervention such as psychological debriefing which is typically provided in a group setting exposes children to the reactions of adults and other children. Children may not be a homogenous group with regard to their experiences. Thus exposure to trauma related stories may increase physiological arousal and change a child's

cognitive understanding of the event as more threatening than as originally perceived (Cohen, 2004). Futhermore, eliciting PTSD symptoms may be particularly difficult as almost half of the diagnostic criteria are dependent on the child's ability to accurately report their internal emotional state (Cohen, 2004).

Psychological first aid (PFA) is a recommended evidence informed approach for assisting children, adults and families in the immediate aftermath of disaster (National Centre for PTSD and National Child Traumatic Stress Network, 2006). The emphasis is on clarifying the facts, normalising symptomology and teaching problem solving techniques. Furthermore, such interventions can serve as a screening function to identify children at risk. The reactions of the parents and parental support of the child following a traumatic event are potentially powerful influences. Thus, all recommended treatment approaches incorporate psycho-education. The psycho-educational components of CBT as well as in psychological first aid (PFA) are important for educating parents, teachers and caregivers in monitoring the child's symptomology (Cohen et al., 2000).

6. Conclusion

Disasters are very often chaotic situations and organising an effective set of interventions is difficult in the midst of enormous confusion. At the level of psychologists responding to those in need, there is nearly always a sense of urgency to be helpful, compassionate and competent to delivering assistance. Some current international trends highlight the need for rigorous empirical scrutiny of beneficial intervention strategies and the need for common core methodologies and measures. In contrast, other trends highlight a flexible approach and recommend that a one-size fits all strategy falls short (Litz, 2008). This implies that intervention strategies must be

flexible enough to deal with the unique individual needs of those affected by the disaster in order to facilitate psychological health and ultimate well-being. Looking at posttraumatic stress disorder considerations and other kinds of symptoms the general trend is towards flexibility and not doing too much initially. Many practice guidelines recommend psychological first aid (PFA) in the early intervention context for children, adults and families, as the approach addresses many of the difficulties as described above (Litz, 2008; Bisson et al., 2007; Bisson, 2008; National Institute for Clinical Excellence (NICE), 2005).

Chapter 4 describes some of the reasons surrounding the confusion about how to best respond to those exposed to disasters. Including some of the methodological and ethical problems related to empirically validated research as well as the elements of disasters which by virtue of their cause are often characterized by chaos and disorganization.

CHAPTER 4 RESEARCH PROBLEM

Early intervention goals for individuals exposed to traumatic events are unanimous and clear amongst scientists, practitioners, advocates and policy makers (Bisson, 2008). These include: the prevention of post traumatic mental health problems and impairments in functioning to those most vulnerable by providing evidence-based interventions and strategies. In the immediate post trauma context, policy and decision makers are often confused by the experts as there seems to be more agreement “about what not to do than what to do” (Litz, 2008, p.504.). Because of the relative vagueness of appropriate early intervention, care providers are advised to be flexible, accepting and respectful of unique human responses to trauma rather than being prescriptive (Litz, 2008).

This chapter discusses possible reasons for the confusion surrounding the question of how best to respond to those in psychological need after disasters. One of the reasons is the methodological pitfalls and ethical dilemmas inherent in this type of research. Therefore, rigorous clinical trails are rare and the ecological validity of intervention studies is very low. Furthermore, the elements of disasters make the psychosocial strategy response to those in need different from the normal consultation room setting (Baum, Solomon, & Ursano, 1993). Non-clinical factors, which may influence post-trauma treatment are considered as well as problems in the South African context and the need for research that addresses these issues.

1. Confusion surrounding Critical Incident Stress Debriefing (CISD)

As previously mentioned in Chapter 3, the mainstay of early intervention has been Critical Incident Stress Debriefing (CISD), intended for professionals who have been exposed to trauma indirectly, such as personnel in the emergency medical and fire departments. However, in practice CISD is often provided to those with direct exposure. The debate around CISD has a multitude of arguments levelled on both sides of the spectrum, but considering the evidence, is not an appropriate intervention for those most in need (Bisson & Deahl, 1994; Bisson, Brayne & Ochberg, 2007; Mayou, Ehlers & Hobbs, 2000; Hobbs, Mayou & Harrison,1996; Litz, Gray, Bryant & Alder, 2002; Rose, Bisson & Wessley, 2001). The argument around CISD is only one of the problem areas in the disaster response field. The main problems related to the present study are highlighted in the next section.

2. Confusion within the early trauma intervention field

The first and major concern within the early trauma intervention field is about what to do. Authors like Litz (2004) and Bisson et al. (2007) describe the nature of the problem as confusion about how to best respond to those exposed to a disaster. Thus it seems that intervention options consist of ineffective treatments (i.e. debriefing) or waiting for the development of chronic pathology before the implementation of valid treatments.

The originators of CISD have argued that early psychological intervention after traumatic events is an essential aspect of a comprehensive continuum of care (Everly & Mitchell, 1999). But others have argued that formal early psychological interventions have no useful role in post-trauma response and emphasise the importance of good social support as the key to the prevention of psychopathology

(Wessely, 2005). The reason for the confusion is that there is a lack of evidence to support the efficacy of various early interventions and there exists a need for externally valid research (Bisson & Deahl, 1994; Deahl, Gillham & Thomas, 1994; McFarlane, 1988; Litz et al.2002; Rose, Brewin, Andrews & Kirk, 1999). Litz (2004) includes difficulties such as inconsistencies in intervention, timing, duration, trauma type, recipients and facilitator training. Yehuda (2002) highlights the issue of bridging the gap between empirical treatment literature and real-life clinical practice. She questions the trend towards clinical practice that does not always represent early intervention literature. It seems that this inconsistency either calls "for clinicians to change their practices to those described in the literature or for researchers to contribute studies to the literature that match treatment techniques that clinicians are using" (Yehuda, 2002, pp. ix-x). Further, she states that an expert consensus guideline and findings generated on the basis of empirical evidence present an interesting synthesis. For example, the Expert Consensus Guidelines (Expert Consensus Panels for PTSD, 1999) and the treatment guidelines of the International Society for Traumatic Stress Studies (Foa, Keane & Friedman, 2000).

Michell and Everly (1998) argue whether the findings from studies on critical incident stress debriefing are really so authoritative and are highly critical of the methodologies used. They point out that if debriefing is going to fail it is usually a result of how the debriefing is conducted or to the methodologies used to conduct debriefing According to Everly Jr., and Flynn (2006) the Cochrane investigations "are in no way consistent with the principles, nor the practice, of crisis intervention in community or mass disaster settings" (p.181). Thus they assert that conclusions based upon the Cochrane Review that early psychological intervention (especially debriefing) is ineffectual and may be harmful may not be warranted. Irving and Long

(2001) state that although not enough convincing arguments about the benefits of debriefing have been provided, this “is not the same as demonstrating that it does not work” (p. 313).

Rothbaum and Foa (1993) state that it is important to note, from a clinical point of view that most trauma survivors who show symptoms of distress in the early aftermath of a traumatic event develop prolonged stress disorders. Thus, the impact phase of trauma offers “a window of opportunity” (Jehuda, 2000, p. 158) during which those at risk of developing chronic stress disorders can be identified and treated therefore making the difference between recovery and life-long illness. Furthermore, the choice between treatment and no treatment should be replaced by the notion of “depth of treatment” (Jehuda, 2000, p. 160).

Gray et al., (2004) state that the scarcity of empirically validated research cannot be attributed to lack of innovation or effort, but rather due to the barriers and complications to conducting rigorous investigations in a chaotic post-disaster environment. However, the challenges associated with controlled clinical trails are not necessarily insurmountable and the future of early intervention will be determined by a collective capacity by researchers to overcome the obstacles that are inherent after disasters (Gray et al., 2004). On review of the literature, one of the most consistent statements pertains to insufficient research, particularly randomized controlled trials. The complexity of dealing with individual experiences to traumatic events is evident by the limited research and clinical data available. Part of the problem with clarifying the situation is that this type of research is fraught with ethical dilemmas and methodological pitfalls and as such is difficult to implement.

2.1. Methodological pitfalls and ethical dilemmas

One such research problem is that disasters are by definition usually unpredictable and studies are usually retrospective Timing is often critical in researching traumatic events. However, disasters strike without warning and the logistical implications of conducting timely assessment (e.g. getting to the geographical area of the disaster to conduct a field-based study) are problematic (Baum, Solomon and Ursano 1993). One of the major challenges to conducting methodically sound early intervention research is access to and continued contact with trauma victims. Understandably, victims are acutely distressed and may be unwilling or unable to discuss their emotional state. In addition, individuals affected might have left the scene of the disaster which would result in a sample not always being representative (Raphael & Wilson, 1993). King, Vogt and King (2004) state that there are special methodological issues that threaten the validity of trauma research. There are a variety of complex interconnected factors that moderate recovery including temperament, developmental stage and individual differences in psychological and physiological make up, gender, culture and social context (Breslau et al., 1998; Kessler et al., 1995; Shalev, 1999; True, Rice, Elsen et al., 1993). There are certain risks and resilience factors that influence the response of individuals after a traumatic event and random assignment to groups according to experiential (e.g. early childhood abuse), personal (e.g. hardiness) or environmental (large network of support structures) attributes cannot be done. In addition to the above factors the importance of the quality of the environment in terms of how friends, family and society responds to the individual who has been exposed to trauma and the professional care provided immediately and soon after trauma can create or attenuate the risk of enduring problems.

Litz et al. (2002) highlight a number of ethical issues pertaining to the immediate post-trauma treatment environment that need to be addressed. There is lack of consensus among trauma researchers in terms of the informed consent process immediately after a traumatic event. Informed consent is an obvious mandatory prerequisite in a clinical trail however, in the immediate aftermath of a traumatic event affected individuals may too overwhelmed or distraught to fully process information regarding risks and benefits of the study or how they are required to participate. The APA (2000) states that within the first 2 days after a traumatic event a diagnosis of acute stress disorder may not be given. The reason being most individuals, including those who recover spontaneously, experience pronounced emotional stress during the immediate aftermath of a traumatic event. As a result, higher levels of epinephrine and cortisol are circulated which impairs information-processing capacities. Therefore, it is argued that a period of time is necessary for victims to process emotions and cognitions related to the traumatic event. It is essential for the initial shock to diminish until they are fully able to understand the informed consent process (Litz et al., 2002; Litz & Gray, 2004).

Few of the clinical studies include appropriate control groups. Freedman (1987) speaks of the concept “clinical equipoise”. This refers to the unethical assignment of participants to a group where the treatment is inferior. Therefore, would it be ethical to expose randomly assigned victims of trauma to placebo groups? Litz, (2004) argues that the use of placebo groups in this instance can be condoned as no validated effective treatment exists for early psychological intervention for those affected by trauma.

Meaningful research is impossible without the collaboration between researchers and others involved in assisting trauma victims. To address this problem, Litz (2004)

proposed a probability survey of mental health professionals across the USA questioning what they know and what they might need to learn if they were to be used as a resource responding to the psychological needs of a person that has had a traumatic experience. The current study employs a similar methodology.

From a purely humane perspective, some kind of psychosocial response in the aftermath of a disaster seems appropriate. The debate around traumatic experiences as far as psychological intervention goes is carried by varied opinions, but in essence the multifaceted argument often revolves around issues of *modality* and *timing* (Litz, 2004).

3. Elements of disasters

Generally, one of the most prominent problems associated with disaster research is the lack of agreement about what constitutes a disaster. There is wide variation in the nature and severity in the types of disasters studied and a lack of systematic classification of various components of a disaster (Litz, 2004). Much of the previous paragraph is true of general treatment considerations for early intervention after any traumatic experience. But a second major consideration is that disasters in and of themselves offer elements that make the psychosocial strategy in response to the needs of victims different from the normal consultation room based setting (the post-disaster setting involves many people and is normally characterized by disorganization, and survivors display an array of emotive and behavioural responses). One important element is the variety of professionals that are usually involved with alleviating psychosocial responses after trauma. Some of these professionals have advanced training in acute trauma intervention and some have advanced degrees in the allied health professions such as social workers,

psychologists and psychiatrists and are usually directly involved with alleviating psychological distress. Other first and early responders that are called on to assist in a time of tragedy have various training backgrounds and roles but they might often influence psychosocial responses after a traumatic experience (for example, a fire-fighter who addresses a survivors need for the experience of a safe environment by being taken to one). Even though there is great variability in training background, roles and philosophy at various stages in the chain of response, all professionals, in the aftermath of a disaster have a collective investment in facilitating psychosocial recovery of those affected (Litz, 2004). This study assumes that these non-counselling kinds of experiences may also facilitate/hamper recovery within the disaster context and that is why the "strategies" in the title and aim are framed around what people may need during and soon after a disaster experience rather than just focussing on effective counselling *per se*. Because of the involvement of a variety of role-players in disaster response, it becomes important to ask "who can do what?" to promote healthy psychosocial responses.

4. Non-clinical considerations

Thirdly, the recovery of disaster victims is multifaceted because of the complex interaction between the individual and the environment (Raphael & Wilson, 2000). While the above statement may be true of any psychosocial adjustment, post-trauma treatment may possibly be more influenced by non-clinical considerations. For example, in the United Kingdom debriefing is compulsory for employees exposed to traumatic events so that the employer avoids legal liability. Everly and Mitchell (1999) argued that employers have a commitment to implement psychological service to employees, and failure to do so could constitute negligence. On the other hand,

McNally, Bryant and Ehlers (2003) argue that not everyone exposed to traumatic events either wants or needs professional help. Apart from possible legal implications of non-treatment, there is also often a knee-jerk reaction from politicians, the media and the community to do something toward the psychosocial recovery of victims. This may mean that service providers may be "pressured" into providing services even when they are not indicated. Although the exact nature of all these kinds of environmental influences cannot always be clearly differentiated, this study contends that such influences may influence the psychosocial recovery of victims (for example, the potential psychosocial effect on a disaster victim of having to recount their traumatic memory to an array of television cameras).

5. South African context

Fourthly, while some valuable research has appeared about the experience of traumatic stress in the South African context (van Wyk & Edwards, 2006; Peeke, Moletsane,Tshivhula & Keel, 1998; Edwards, Sakasa & van Wyk, 2005; Leibowitz-Levy, 2005; Straker, 1994; Eagle, 2004), the researcher could find no published work on disaster responses from a purely psychosocial perspective in the South African context. The researcher contends that given this situation an open ended exploration of the phenomena was accountable. Furthermore, there remains a need for research that takes the unique contextual factors of disasters into account, especially into how these contextual factors may find expression in the South African situation. This study addresses these issues in a methodologically appropriate manner (to be explored more fully later in the methodology section). This approach also allowed for contextual factors (such as those alluded to in chapter 3) that are unique and specific to the South African context to emerge. There is growing recognition that individuals from many

different cultures and societies respond to traumatic experiences in a universal way. However, there remains a need for systematic research in order to determine the extent to which psychological treatment that have proven efficacy in Western Societies are effectively been implemented in a developing country such as South Africa (Foa, et al., 2000).

6. Conclusion

This chapter has identified problem areas regarding our knowledge base of effective early intervention strategies for those affected by disasters. It outlined some of the reasons for the confusion amongst professionals as to how best to help those affected by disaster, one of the reasons is that research is fraught with ethical dilemmas and methodological pitfalls and thus difficult to implement. In addition, those called upon to respond to disasters have varying training and roles. However, each may influence psychosocial responses. Little is known about the treatment of trauma in Third World countries as most of the research on the topic has been conducted in Western industrialized countries. Within the above context of somewhat conflicting research results with regard to what may be necessary and sufficient as an intervention strategy this study serves to highlight psychologist's present perspectives on what might be useful when responding to the psychological needs of people after a disaster.

Chapter 5 describes the method used to gain some understanding of the perceptions of psychologists regarding the influence of early intervention strategies on the psychosocial response to those affected by disasters.

CHAPTER 5 RESEARCH METHODOLOGY

The present chapter describes the method used to gain some understanding of the practice of South African psychologists who work with those who have been affected by disasters. It describes the procedure used to gather and analyse data from South African psychologists regarding the perceived influences of early strategies on the psychosocial response to those affected by disasters.

1. Research aim

The overall aim of this study is to explore and describe psychologist's perceived influences of early strategies on the psychosocial response to those affected by disasters.

2. Research methodology

2.1.Research design

The study proposes a qualitative and exploratory design. It was conducted from a descriptive interpretive paradigm as the emphasis is on the meaning of the data collected, rather than quantitatively considered (TerreBlanche & Durrheim, 1999). The motivation for an exploratory descriptive design is that it serves to broaden the understanding of a certain topic (Grinnell & Williams, 1990). The exploratory descriptive design for this study allowed for an open-endedness that is appropriate seeing that the "strategies" (in the aim) are in essence a relative unknown. As the researcher wished to look at more than narrowly defined counselling strategies *per se*, the open-endedness provided by a qualitative exploratory design is preferred. The use of this methodology is appropriate so as to understand the psychologist's subjective

experiences of the psychological needs and influence of early strategies for those who have been exposed to traumatic events. It is be possible to apply the findings to broader populations, but may generate further research in other settings.

The exploratory nature of the design is appropriate in the context of the lack of research in the South African disaster context and the general lack of cohesion in the international arena. A qualitative design allowed for open ended questions and allowed for questions that had not been asked, which would be difficult to achieve with another design.

The researcher acknowledges that ultimately recommendations (within a broad psychological perspective) would like to be made on how to appropriately respond to disaster victims. In this sense the current methodology allowed for the perceptions of knowledgeable respondents to inform such "best practice" considerations. This kind of methodology therefore emulates an expert consensus model and allows for a greater variety and scope of efficacy information to be gathered than is the case with more traditional efficacy or intervention outcome research models. There are some limitations to this approach which are noted in Chapter 7.

2.2 Research procedure

2.2.1. Participants and sampling method

Purposeful, non-probability snowball sampling was used for this study. The researcher contacted psychologists who have been involved in offering services in group disasters. The researcher's supervisor is involved in a network of psychologists who have been involved in trauma counselling after group disasters. Thus the supervisor assisted with access to contact telephone numbers as well as e-mail addresses for the sample. There is no method to guarantee that each element of the

participants will be equally presented since the sample only included those participants who are willing to participate in the study (Fink & Kosekoff, 1988). The inclusion criteria for participants was that they have acted to respond to the psychological needs of those affected by disaster as defined by this study (this would also include removal from normal place of practice). The researcher wished her respondents to be able to comment on more than counselling strategies (See Chapter 4) rather than just those that are relevant in the face-to-face consultation with a client in the confined safety of the psychologist's practice and this is why the researcher included the removal from normal place of practice criterion.

The results of this study are therefore be pertinent to the sample and cannot be generalized in the sense that it may not necessarily reflect accurately the perceptions of all psychologists involved in disasters. It allowed the researcher to gain an in-depth understanding as opposed to generalizable findings. However, because of the expertise of the respondents (as psychologists) their views on the influence of strategies may still be useful in the sense that these views may still accountably inform practice. Sampling was continued until data saturation was achieved. The researcher sampled five respondents.

Once informed consent (Appendix A) was obtained, the respondent was requested to complete a biographical questionnaire to gather information regarding the respondent's registration category, his/her experience dealing with people affected by trauma and the period of time he/she has been registered with the HPCSA. This information was primarily used to describe the sample (rather than for content analysis purposes). The respondents name and mailing address was requested in order to provide feedback of the study's outcome.

2.3. Data gathering and analysis

Semi-structured interviews were conducted on an individual basis so as to give some structure to the interviews, while allowing for participants to express their perceptions freely. The questions for the interview served as a guideline and as such were deviated from when it was found that certain pertinent issues which arose were not being adequately addressed. One interview was conducted telephonically as the participant was outside the boundaries of the Nelson Mandela Metropolitan area (the network of psychologists that was used is a national one).

Both telephonic and face-to-face interviews were voice recorded by means of a digital recording device. This had been tested and the system worked. The researcher was therefore able to focus on the interview and not be distracted by taking notes. The data was transcribed verbatim and analysed by the researcher and an independent coder using content analysis. Content analysis refers to the analytical classification process that a researcher follows in order to organize data into relevant themes and categories. This process of content analysis consists of open coding where raw data is organised into recurrent themes and concepts that may be then used to analyse the data (Babbie, 2004; Neuman, 2006). The researcher identified and categorized the participant's responses according to different themes and categories. Both the researcher and independent coder negotiated the different themes and categories so as to avoid bias from the researcher. The content analysis process followed Tesch's (1990) Model of Content Analysis, which is an eight-step model to categorise the data meaningfully.

As with all research, it is important to establish the accuracy of the information or its internal validity. The researcher employed Guba's Model of Trustworthiness (De Vos, Strydom, Fouche & Delport, 2002) to ensure objectivity and to counter research

bias throughout the qualitative data analysis process. Questions are posed to the researcher regarding credibility, transferability, dependability and conformity of the results of the qualitative data (i.e., internal and external validity, reliability and objectivity) (Marshall & Rossman, 1995). The “truth value” of the research, i.e. applicability, consistency and neutrality is determined by the responses to the questions (De Vos et al., 2002).

3. Ethical considerations

Participants were fully briefed about details of the research project prior to the commencement of the interview. Participation was on a voluntary basis and participants were free to withdraw from the project at any time. Confidentiality of the participants was guaranteed and they will remain anonymous. Research participants signed an informed consent form after explanation of the aims of the research and their rights as research participants before the interviews took place. In the case of telephonic interviews a covering letter (Appendix B) describing details of the project and an informed consent form were e-mailed to participants and interviews did not commence until signed consent forms were received by the researcher. The participants are not considered to be a vulnerable population (by virtue of their training they would be well aware of their rights as research respondents) and the study will not cause harm to the participants (non maleficence). Participants were given the opportunity to ask questions about the study before and at the end of the interviews.

This chapter described the methods used to gain an understanding of psychologists’ perceptions of the influences of early strategies on the psychosocial

response to those affected by disasters. Chapter 6 presents a synthesis of the results using these methods.

CHAPTER 6 RESULTS AND DISCUSSION

1. Introduction

This chapter presents a synthesised analysis of the data collected by the researcher using the methods described in Chapter 5. In doing so, it addresses directly and indirectly the research questions posed to respondents during the interview process. The overall aim of the study was to explore and describe psychologists' perceived influence of early strategies on the psychosocial response to those affected by disasters.

2. Description of the sample

Semi-structured interviews were conducted among three clinical psychologists and two counselling psychologists. The participants in the sample were all white, and included three females and two males. All psychologists in the sample had experience of being called away from their usual place of practice to respond to the psychological needs of those affected by disaster. The average time registered with the Health Professions Council of South Africa (HPCSA) was 13.8 years, ranging from four years to thirty eight years. The average percentage of trauma related work load was 47.4%, ranging from of 2% to 90+%. Four of the interviews were face-to-face interviews, whilst one interview was conducted telephonically. The interviews were all conducted in English and lasted approximately 4 hours in total, with individual interviews ranging from half an hour to one hour.

The different types of disasters that participants in this study had been called out to assist those in psychological need included natural and man made disasters. One participant had responded to South African returnees who had been directly involved

in the Tsunami and the earthquake in Haiti. These survivors had been injured or had lost family members as a result of the disasters. Other participants were called out to assist at man- made disasters such as mock exercises simulating aircraft accidents, drownings and motor accidents.

Criminal acts of violence such as armed robberies, rape and gang related shootings were other types of disasters that participants were called out to in order to assist those in need. Although at face value, acts of violence do not look like disasters, they are included in this study. A disaster (see Chapter 2) for the purposes of this study was defined as any unexpected event that influences a large number of people who may potentially be affected psychologically and in need of psychosocial assistance. Thus criminal acts of violence as a disaster type, is included.

The sample was heterogeneous in terms of professional training and experience in the post-disaster context. The ethnicity of the participants was homogenous as all the participants were white. This factor may influence the generalizability of the study and is noted in the limitations section in Chapter 7.

3. Analysis of the data

After careful review of the participants' responses, themes, sub-themes and categories emerged from the data. It must be noted that because the themes are so interwoven and interconnected, some overlap between themes is inevitable. Some of the themes were virtually identical to specified areas of questioning. The first open-ended question was designed as an introductory question (What kinds of experiences have you been called out to in order to assist survivors in psychological need?). Therefore the function was to elicit information regarding the participants' kinds of experiences that they had been called out to in order to assist those in need after a

disaster. The second open-ended question ("Was any kind of screening done to help with treatment decisions? How did this work?") was a direct aim question focussing on the kind of screening done to help with treatment decisions. The fifth and sixth questions respectively are also direct aim questions, ("What are the psychological needs of people in a disaster context and how can those needs be met?" "What treatment strategy/formulation did you use in a counselling situation? How well did you perceive this to work?)

Other themes emerged from the data as a result of the participant's responses to questions posed by the researcher in a more open format (based on the question guide) during the interviews. On reflection of the interviewing process the researcher feels that the use of semi-structured interviews was appropriate. The researcher was thus given the flexibility to deviate from the question guide at times, which facilitated the conversational flow and the exploration of pertinent issues which emerged. Key themes characterising the data will now be presented.

4. Key themes characterising the data

The results of the literature review and the analysis of the data collected from the interviews produced six broad themes:

4.1 A cluster of issues related to the *screening process*.

4.2 A group of issues surrounding the *needs* of those affected by disaster

4.3 The theme related to the *method of choice for treatment*

4.4 Issues characterizing the *South African context*

4.5 The theme regarding *planning* of professionals and non-professionals

4.6 Issues related to disaster response *training*

Within these overarching themes, certain sub themes and categories were identified as the basis for making sense of the data. The qualitative findings for the open-ended questions will now be presented and discussed.

4.1 Screening

The sub-themes and categories related to *screening* that emerged from the data are presented in Table 2 below. Reference was made to pressure from corporations/media, psychologist as consultant, non-professionals in the screening process, groups versus individual counselling, screening of children and adolescents and monitoring.

TABLE 2 *Screening theme, sub-themes and categories*

Theme	**Sub-Themes**	**Categories**
4.1 Screening	4.1.1 Pressure from the media/corporations	(a) Motivation for psychological intervention (b) PRO function (c) Perception of the media
	4.1.2 Psychologist as consultant	(a) Co-operation and assistance (b) Facilitate dissemination of knowledge
	4.1.3 Non-professionals in the screening process	(a) Relying on non-professionals (b) To be adequately informed
	4.1.4 Groups versus individual Counselling	(a) Vicarious traumatisation (b) Benefit of groups
	4.1.5 Screening of children	(a) Guidance to teachers

	and adolescents	(b) Symptomatic children (c) Asymptomatic children
	4.1.6 Monitoring	(a) Difficulty maintaining contact (b) Internet (c) Avoidance behaviours

Screening or psychological triage refers to the decision making process in which highly symptomatic or individuals at risk can be identified. Those who could be identified as vulnerable to further mental health problems include individuals: (a) with pre-existing psychiatric problems or substance abuse problems; (b) who are bereaved; (c) who are injured; (d) who have been intensely exposed to the disaster through proximity or duration of exposure (Marcus, 2000).

These sub-themes will now be discussed in greater detail. Participants' verbatim quotations will be validated against the relevant scientific literature where relevant.

4.1.1 Pressure from corporations/media

All participants perceived screening to be an important part of the disaster response. Furthermore, without exception all participants acknowledged that not everybody exposed to a traumatic event neither wants nor needs psychological intervention. Individuals should be given the choice as to whether they want counselling or not. However, all participants felt that the motivation for psychological intervention was not always in the best interests of the survivors. Rather, political pressure, media driven reactions on the part of various corporations (in terms of "wanting to be seen doing the right thing" and "wanting to get coverage in the

media") influenced the screening process. One participant was pressured by to see every individual in a group setting. Pressure seemed to mean that screening was skipped which resulted in heterogeneous groups. The participant perceived the urgency on the part of management "to be more of a PRO (Public Relations Officer) function" than a strategy that would benefit those affected. The same participant mentioned another instance where appropriate screening was done. According to this participant "this worked". It seems that in the absence of pressure, the psychologist as consultant was able to screen those affected by means of facilitating the dissemination of knowledge and skills. Another participant expressed the eagerness of management in having people seen to as positive (in situations motivated by genuine concern), however, she/he said "…not everybody wants somebody to talk to. People have their natural ways of dealing with a crisis".

A third participant said that "Trauma counselling is perceived [by the media] to be mandatory and that if you don't have trauma counselling then you will never recover" He/she added that the volunteer industry is supported and upheld in this way.

The literature supports the responses that emerged. It is suggested that not everybody wants or needs psychological intervention after a traumatic event (McNally et al., 2003). According to Foa et al. (2000) the survivor needs to follow their natural inclination regarding their choice of who they talk to and how much they disclose. Furthermore, Ehlers and Clark (2000) state that a survivor needs to maintain a sense of autonomy, the loss of which can precipitate negative appraisals of the situation. According to Litz, (2008) there is no highly specific way for identifying survivors at risk for having difficulty adjusting on their own, in addition, in an ideal world we would be able to follow up on anyone who needed additional care.

Therefore it is important “to prepare to plant helpful seeds rather than assume follow up is possible” (Litz, 2008 p. 503).

It appears that non-clinical considerations such as pressure from the media, corporations and politicians had a potential negative influence on the psychosocial response to survivors. The sense of urgency for “treatment” was motivated by possible coverage in the media and the need to be seen doing the “right” thing. However, it is questionable as to whose needs were being met when survivors were urged by management to participate in mandatory “psychological briefing”. It is clear from the relevant literature and the participants’ responses that the subjective needs of those affected were not always considered. Forced treatment without screening may lead to vicariously forming a traumatic memory.

4.1.2 Psychologist as consultant

One participant described his/her positive experience regarding the screening process that took place in a school context. He/she explained that firstly, there was opportunity beforehand to plan the “whole process”. Secondly, there was co-operation and assistance from other role-players regarding the way in which the plan would be executed. This participant explained that the psychologist is “better as a consultant”, as “there are not enough hands to [screen] everybody”. The participant related the benefit of acting as a consultant in which he/she spent more time with the headmaster, teachers and parents than he did with the children who were affected
He/she was therefore able to facilitate the dissemination of information and psycho-education among other role players involved including the headmaster, teachers and the minister. The children were then addressed at an assembly which served to “communicate some information to them, but not an overload”. The effect of this kind

of screening process had a positive influence on the responses of survivors. The dissemination of psycho-information enabled survivors to understand and accept symptoms that they may be experiencing shortly after the traumatic event, as well as knowledge regarding possible traumatic stress symptoms that may manifest later. This screening process allowed survivors to make an informed choice as to whether they needed further intervention Screening was described by this participant as follows:

> *Screening does not necessarily have to be a formal procedure (as in a symptom checklist) but can be done by giving information to those affected so that they can subjectively decide whether they wanted [sic] or needed [sic] to talk to somebody. Giving people a variety of opportunities a choice that they might choose what they needed, follow up screening was then done on an individual basis. In some cases a formal follow up can be decided upon by the child, parents or a combination. Education/information provides a healthy position to actually decide whether a follow up was needed or not*

Another participant described similarly described the role of the psychologist as “not the hands on screening and treating…it is much more managing the situation, training, supervising and advising”. According to Seedat, Duncan and Lazarus, (2001) consultation refers to the range of activities that a psychologist undertakes in making their skills and knowledge available to early responders. A consultative relationship implies a co-operative partnership between psychologist and other role players in the aftermath of disasters.

The researcher thus concludes that co-operation between psychologist as consultant and other role players has a positive potential influence on the psychosocial

response to survivors. The dissemination of skills and knowledge by the psychologist facilitates a coherent and similar framework in which the needs of those affected can appropriately addressed.

4.1.3 Non-professionals in the screening process

One participant explained that “if you are dealing with the immediate affect of say 100 or 200 people you can’t really screen all of them”. In this instance management or anyone closely involved can identify those most directly affected. Then they can be assessed individually “at least what the impact had been, and are they going to need follow up or not”. He/she related the impossibility “for professional assistance to reach everybody” and that “one has to rely on non professionals and sometimes train figures in the community to be able to do the assessments [screening]”. He/she added that “there are screening instruments that are very simple and easy to administer…with good reliability… so it can be done by people that are not professionally qualified but certainly they need to be informed”. Another participant mentioned that he/she was rarely involved in the screening process, the reason being that “the companies all go through their own internal processes of deciding what is necessary and then call me out”.

All participants agreed that simple screening and monitoring functions can be done by professionals and non-professionals alike (for example, lay counsellors, ministers’ and medical personnel). By addressing risk factors and “knowing how to identify someone who needs psychological assistance could potentially have a great influence [on a positive psychological response after a disaster]”. It was emphasized that people who are not directly involved, such as management could perform an important role in this regard.

It appears that non-professionals play a potentially valuable role in assisting those in need in the post-disaster context. However, although a professional qualification is not always required, responders need to be adequately informed. The role of a psychologist as a consultant plays a valuable part in this regard.

4.1.4 Screening for group composition

Four participants expressed their concern about groups made up of members that have different experiences of the incident. The participants perceived the telling and re-telling of the trauma narrative in a group setting to be inappropriate. One participant said that this approach enhances the risk of the re-experience component as well as “exposing someone to maybe something they maybe haven’t seen”. Similarly, another participant said that vicarious traumatization and “re-traumatizing people” is a risk factor in a group. A third participant said that “you cannot shield the group from exposure to an irrational reaction or traumatic reaction of others”. In addition, a large group is more difficult to contain emotionally than a small group. A large group in one instance was the result of time constraints and the psychologists were therefore unable to do “psychological triage” (screening).

However, one of these participants acknowledged that if groups are “homogenous” in terms of their experience of the event, if re-telling of the trauma narrative is avoided and the focus is on normalization and psycho-education a group setting can be beneficial. The participants were aware of the potential damage that could be done in group situations. However, one participant stated that:

> *Even though CISD is shown to be harmful, in the reality of our South African context it might be more practical. However, to manage the range of responses*

in a group setting is highly specialized. The need to sensitively protect some members from the experience of others a person needs to be not only highly qualified, I think they need to be highly trained within that reaction.

Participants were in agreement that in certain instances the group setting may be beneficial particularly in terms of imparting accurate information regarding facts surrounding the traumatic event. One participant described the group setting as an opportunity to share their "collective responses" in order to "weave a collective truth of what had happened [accurate information regarding the traumatic event]". However, the participant added that "there was no screening done, but in retrospect it would have been better for those directly involved". Another participant expressed the belief that a group provides social support and members draw on the strength and resilience of one another. This is supported by the literature which suggests that the group setting is not to encourage emotional processing, but rather to respond to the acute need of sharing their experience (Foa, 2001). As discussed in Chapter 3, research has revealed the potential harm of Critical Incident Stress Debriefing (CISD) (Bisson et al., 2000; Rose et al., 2001) thus the indiscriminate use of single-session debriefing is not recommended (NCCMH, 2005).

Groups may be more practical in the South African context as they are a potentially effective and efficient way of disseminating information to many people in one place. In addition groups may facilitate social support and a sense of community cohesiveness. However, to mitigate the potentially harmful effects inherent in a group setting the following conditions need to be met: (a) the facilitator of these groups needs to be highly trained; (b) members of the group need to be homogenous in their

experience of the traumatic event; (c) telling and retelling of the trauma narrative in a group is to be avoided; and (d) the eliciting of negative emotions is contra-indicated. The screening for group composition is a different kind of screening compared to screening for “at risk” individuals. At risk individuals are those who are vulnerable to chronic traumatic stress symptoms as result of their prior history. Screening for group composition refers to screening for homogeneity (as mentioned above).

4.1.5 Screening of children and adolescents

One participant described the screening process in a school context as follows: “After giving guidance to the teachers and educating them on basics to look out for certain symptomology in the children in class, one was then able to contact the parents”. He/she explained that after a week or two after the event a core group of children were presenting with PTSD symptomology such as “not being able to sleep, not wanting to go to school, scared to walk in the park”. These children were then seen on an individual basis. Children not displaying symptoms were seen in a group in their specific grades. This participant believes that school counsellors serve an important function in the screening process as “children have a direct link” to them. He/she added that because of the stronger bond younger children have to their parents, it is important that the parents are educated in terms of symptomology to look out for.

It seems that in the school context the psychologist plays a valuable role as a consultant. The psychologist was able to disseminate knowledge and in so doing was able to assist teachers and parents to identify certain traumatic stress symptoms. The co-operation of parents, teachers and school counsellors in the screening and monitoring functions in identifying children at risk was perceived as a positive

influence on the psychosocial response. It therefore allowed the psychologist to see at risk children on an individual basis for further assessment or to initiate treatment.

4.1.6 Monitoring

All respondents acknowledged that monitoring is an important function. “They need to be seen after the event, as well as different times after the event…Every time there’s a significant life event it seems as if it’s attached to the [original traumatic] event”. Another participant described the difficulty for psychologists in private practice to maintain contact with survivors who may benefit from treatment. He/she explained that schools, companies or government departments are reluctant to disclose contact information. “Follow ups should be formalized (for example, a short consent form). Contacting those at risk after the event is a necessary function and should be sanctioned”. Similarly another participant said that following up private individuals after a traumatic event is not easy. As an example, (this was second hand knowledge, the participant was not involved in this incident), he/she spoke of the London tube bombing where an effective system was implemented by a service that was made available to those affected on the internet. The service was essentially assessment and repeat assessment after a certain period of time. He/she explained that those that do suffer with long term problems experience shame, inadequacy and a disintegrating self esteem/ self concept. They “don’t want to show their faces [and] don’t want to admit it [their symptomology]”. Thus this service is appropriate as it is used anonymously. Furthermore, the internet is a potential way in which the effects of trauma can be dealt with on a “much larger stage and will be much more easily accessible.”

Contacting those at risk after a traumatic event, for various reasons is not easy. Furthermore, at risk survivors are unlikely to seek help because of the numbing and avoidance behaviours that characterize posttraumatic stress symptoms. As discussed previously in Chapter 3, people are remarkably resilient and on average most people will heal naturally over time (Galea, et al., 2003). However, there are those that are at risk for developing chronic mental health problems (Breslau et al., 1998; Kessler et al., 1995). Symptomatic individuals may be at risk of developing chronic pathology, one of which is posttraumatic stress disorder which is debilitating and difficult to treat (Gray et al., 2004).

Considering the logistical and ethical difficulties in maintaining contact with survivors, initial assessment and screening in the immediate post-disaster context is valuable. Psychologists as consultants can facilitate the dissemination of psycho-education. In this way affected individuals have relevant knowledge regarding self-monitoring of symptoms in the acute phase and later. The ability of survivors to self-monitor symptoms assists them in the decision of when to seek help as well as preventing secondary anxiety regarding possible symptoms that may or may not manifest. Empowering affected individuals in this way has a potential positive influence on post-disaster outcomes.

4.2 Psychological needs

The following sub-themes and categories that emerged from the data relating to the *needs* of those affected by disasters are represented below in Table 3. Reference is made to immediate issues, pragmatic considerations and the post-trauma environment.

Table 3 *Sub-themes and categories related to the needs of survivors*

Theme	**Sub-theme**	**Categories**
Needs	Immediate issues	(a)Physical safety (b)Psychological safety (c)Children (d)Normalization
	Pragmatic considerations	(a)Practical safety guidelines (b)Attending to subjective practical needs
	Accurate information	(a)Information regarding the event (b)Psycho-information (c)Normalization
	Post-trauma environment	(a)Difficulty in interacting with other professionals (b)Survivors' experience of the event (c)Social support

The sub-themes and categories that emerged from the data will now be discussed in greater detail.

4.2.1 Immediate issues

One participant said that there are no "standards of needs". The focus of care should be on the immediate issues and the ability to assess what those needs are. Furthermore, "There is immediately a need to restore resources, which are material, emotional, social and medical… You can't say which ones come first"

However, he/she acknowledged that generally *safety* is the first basic need the second is to locate their social support, family members and people close to them.

Participants were united in identifying both physical safety and psychological safety (reducing distress, comforting, basic empathy and support) as a priority. One participant suggested that providing safety can change the persons' perception of the event.

However, in the South African context of crime (housebreaking at gunpoint, rape, armed robberies) one participant said "you cannot assure someone's safety".

With reference to the need of safety for children he/she added "Barbed wire, cameras, huge burglar bars…..what message is this giving the child". This is supported by the literature which states that children's perception and understanding of events are influenced by the reactions (parental safety-related distress) of adults around them (social referencing) (Cohen, 2004).

4.2.2 Pragmatic considerations

According to Stewart (2005) pragmatic considerations are sometimes more appropriate than complex models of intervention. One participant described that in some instances *practical needs* were subjectively more important than psychological needs. Similarly another participant described a specific incident in which "nobody was interested [in trauma counselling, rather their needs were] how to restore their house and how to restore their boat so that they could go fishing again…the practical issues". Another participant focussed on dissemination of information regarding practical safety guidelines. For example, "don't walk alone, parents must fetch them and take them to school".

4.2.3 Accurate information

All participants identified the need for *accurate information* for survivors as well as friends and family/community members. This includes information regarding the event (if requested), psycho-information and available resources. One participant recommended that *psycho-information* in the form of a pamphlet would be useful. He/she describes it as "something that you can pop in someone's hand" at a time when their capacity to respond to verbal information is limited. *Normalizing* post-trauma reactions is deemed important by all participants. An acceptance of symptoms they are experiencing, and psycho-information in terms of symptomology that may present at a later date.

4.2.4 Post-trauma environment

Another participant expressed the difficulty sometimes in interacting with medical professionals. He/she was concerned that the survivor might be "out of [physical] danger in fifteen minutes, but a week or two weeks down the line they might still have a great level of morbidity because of the psychological issues". He/she added that early responders need to have an understanding of how their response may "have a lasting effect on the person". According to Litz et al. (2002) the post-trauma environment has an important influence on recovery thus first responders such as medical personnel and other role players need to be mindful of the survivors' need to be treated sensitively and respectfully. As discussed previously in Chapter 3, attending to immediate subjective needs of survivors' influences their experience of the event. This may serve as a buffer against the development of chronic pathology (Litz et al., 2002). Professionals should take the lead from survivors in terms of what their needs and wishes are and actions should be based on these specific concerns

(Foa et al., 2000; National Child Traumatic Stress Network and National Centre for PTSD, 2006).

All participants highlighted the survivors' need for social support. Support may be facilitated by means of homogenous group settings in which people can draw on the support of others. One participant emphasised that "[support] is a generally human need" and recommends the holistic handling of trauma by involving everybody including family members and friends. Attending to survivors with the above needs in mind is considered by participants to have a potential positive influence on psychosocial recovery.

4.3 Method of choice for treatment

The sub-themes and categories that emerged from this question are presented in Table 4. Reference was made to the influence of CISD, psychological first aid, cognitive behavioural therapy, narrative approach with children and the emotional reactions of psychologists.

Table 4 *Method of choice for treatment, sub-themes and categories*

Theme	**Sub-themes**	**Categories**
4.3 Method of choice of Treatment	4.3.1 The influence of CISD	(a) Difficulty slotting in (b) Professional discomfort
	4.3.2 Psychological First Aid	4.3.2.1 Basic empathy and support 4.3.2.2 Normalizing 4.3.2.3 Facilitating social support 4.3.2.4 Psycho-education 4.3.2.5 Need to be flexible

		4.3.2.6 Fostering resilience
	4.3.3 Cognitive Behavioural Therapy	4.3.3.1 TFCBT 4.3.3.2 Age appropriate CBT
	4.3.4 Narrative approach with children	(a) Exposure to trauma narrative (b) Traumatic memory
	4.3.5 Emotional reactions of psychologists	(a) Feeling overwhelmed (b) Feeling inadequate
	4.3.6 Timing	(a) Mitigating a sense of urgency (b) Optimizing recovery (c) Current best practice guidelines
	4.3.7 Pharmacology	(a) Sedatives not recommended (b) Caring rather than placating

The sub-themes related to method of choice for treatment will now be discussed in greater detail.

4.3.1 The influence of Critical Incident Stress Debriefing (CISD)

Two of the participants were not considered regarding their method of choice for treatment in certain situations. There were various reasons for this, one being that the method of treatment was already decided upon by other psychologists connected to a government based organization. In this case it was critical incident stress debriefing (CISD). The participant described the scenario as “difficult to slot into a system that I already knew was possibly not the best way to approach this”. Another participant experienced a similar situation in which CISD was already in progress on his/her

arrival. Even though his/her training had been grounded in CISD, the participant felt that eliciting emotions in the group was counter-therapeutic. He/she expressed the following: "we were taught a wonderful debriefing model you're supposed to go through what they saw, what people smelt, heard…it's not applicable, not applicable to me". Engaging in a treatment modality that was not their usual treatment approach clearly caused professional discomfort.

As discussed in Chapter 3, "psychological debriefing" (designed to prevent the development of later pathology through the ventilation of emotions and reactions following a traumatic event) is not recommended (National Institute of Mental Health, 2002). However, the influence of this approach is clearly evident by its continued use.

Inappropriate debriefing sessions may thus have a negative impact on the psychosocial recovery of survivors. The participants' experience of this strategy corresponds with the international research in this regard.

4.3.2 Psychological first aid (PFA)

Basic empathy and support, normalizing symptoms, psycho-education (in terms of what to expect, when they need help and giving factual information), mobilizing social support and attending to the immediate needs of survivors were considered by all participants to be valuable.

Two of the participants specifically mentioned psychological first aid (PFA) as their method of choice for treatment. One of whom said that PFA is a "system of thinking [that] is very useful although it is not validated scientifically". As mentioned previously in Chapter 3, although PFA strategies are informed by the consensus of experts and available evidence, it needs further empirical validation (Boscarino et al., 2005). He/she had certain reservations in terms of this approach as he/she believes

that PFA “is very much an American model with focus on the individual”. The focus on the individual has been brought into question in the South African context. According to Gist and Lubin (1999) an awareness of societal and environmental factors that contribute towards psychological distress has been acknowledged. It is also acknowledged that interventions need to extend beyond the individual to the treatment of the entire community.

The researcher noted that the basic objectives of PFA were implicit in the method of choice of two of the participants although not labelled as such.

4.3.2.1 Basic empathy and support

All participants spoke of the importance of “containment”, support and the need to reduce acute stress reactions. The comfort offered to survivors is a component of psychological first aid and is encapsulated in the following comments:

“a holding presence”

“a physical presence so they feel that they are not alone”.

“ a purely human connected response- the experience of not being alone, being with somebody who understands”

4.3.2.2 Normalizing symptoms

As mentioned previously (See Chapter 2), Edwards (2005) asserts that normalization rather than pathologizing the experience of posttraumatic stress symptoms by means of psycho-education provides the survivor a means of making sense of the symptoms and offers reassurance. However, one participant indicated that although normalizing initial reactions is a part of PFA, it is also necessary to

communicate to the person that certain risk factors in their history may place them at high risk for chronic mental health problems.

4.3.2.3 Facilitating social support

Another important component of psychological first aid is the facilitation of social support. One participant described the promotion of social support as “the most important factor in the recovery from trauma instead of trying to counsel everybody or debrief everybody…” He/she advises that trauma should be handled holistically including family and friends, everybody should be involved. “Get the staff in groups, share the experience and try to pick up the risk factors”. The main function of the group is “mainly to promote and to optimize the social support amongst themselves”. This participant highlighted how people draw on the support of others and recover. He/she added that “social support transcends culture it’s not culturally bound but a generally human need”. Another participant stated that “People want family and friends around where there’s been death and grief, a loved one to be there and comfort them”. However, a third participant cautioned that “a person finds it difficult to experience emotional and social support if that social supporter doesn’t understand their symptoms of stress”.

The group context may have a positive influence on recovery as it provides a sense of cohesiveness and social support. However, it may have a negative influence when members experience a sense of alienation because of conflicting perceptions of the traumatic event. Thus, as mentioned previously in this chapter, the need for effective screening and being alert to individual differences is important.

4.3.2.4 Psycho-education

Psycho-education and information for victims, family members and others not directly involved was considered by all the participants to be valuable. One participant said that “people that are not directly involved can also be aware of what people are experiencing- what is helpful/useful or not”.

4.3.2.5 The need to be flexible

Two of the participants named an integrative/eclectic approach as their method of choice for treatment. The need to be flexible in order to accommodate the unique needs of those affected is reflected in the following statements:

“I’m using different things, from different places…”

“Each reaction required a different strategy”.

4.3.2.6 Fostering resilience

In a group setting solution focussed therapy was considered to be useful by one participant. Although labelled as a solution focussed approach, focussing on each individual’s capacity to build and enhance their natural resilience is in line with psychological first aid. Similarly another participant highlighted the benefit of “empowering people to help themselves”, which is also one of the core objectives of this approach.

4.3.3 Cognitive behavioural therapy (CBT)

4.3.3.1 Trauma-focussed cognitive behavioural therapy (TFCBT)

One participant described the use of cognitive behavioural techniques “to disarm a hysterical reaction”. The particular techniques employed were not elaborated upon. However, he/she emphasized that the techniques used were “supportive” rather than “confrontative or antagonistic”. Another participant specifically recommended Eye Movement Desensitization and Reprocessing (EMDR) and CBT with prolonged exposure. Trauma –focussed cognitive behavioural therapy (TFCBT) is an intervention that focuses on the trauma using CBT techniques of which exposure therapy and EMDR are commonly used. EMDR is often considered a variant of CBT. It combines components of exposure and cognitive therapy with directed eye movements. Negative aspects induced by the traumatic event are recalled as well as an alternate, desired positive self-representation while visually following back-and-forth hand movements by the therapist (Foa et al., 2000). According to the National Collaborating Centre for Mental Health (2005) EMDR has evidence of efficacy for the treatment of chronic PTSD.

Prolonged exposure requires the individual to vividly imagine the trauma for prolonged periods. The individual provides a detailed narrative of the event including sensory cues and affective responses (Litz, 2004). Effective behaviour exposure therapies should control the duration of emotional exposure and avoid the unstructured processing of painful emotion (Foa, et al., 2000). Randomized controlled trials have produced positive results for multiple session trauma-focussed cognitive behavioural therapy (TBCBT) within one month after the trauma for survivors with acute stress disorder (Bryant et al., 1999). However if an individual’s reaction is

extreme formal intervention can be beneficial when applied earlier (Bisson et al., 2007).

4.3.3.2 Age appropriate Cognitive Behavioural Therapy (CBT)

A third participant highlighted the importance of age appropriate cognitive behavioural interventions where children were involved. These interventions included "participating in rituals (for example, no fighting), keeping diaries, writing in journals and making a book of the family". The importance of age appropriate interventions is supported in the literature which states that, for example, the needs of children in the 3rd to 5th grade relate in part to their emerging conscience and sense of responsibility or guilt about what has occurred. Therefore encouragement of altruistic activities (drawings, making cards and other acts of kindness) for those who have been injured or died aids adaptive coping (American Academy of Child and Adolescent Psychiatry). The loss of developmental skills after exposure to a traumatic event is transient and common. The participant stated that children who were identified as presenting with symptomology such as not eating, avoiding going to school and generalized anxiety were given individual cognitive behavioural therapy. According to the American Academy of Child and Adolescent Psychiatry children may show generalized fear, anger, altered sleeping and eating patterns and regression behaviour after exposure to a traumatic event. Furthermore, the participant said that the length of therapy is usually limited to six sessions because of the lack of psychologists in this department. He/she explained that access to psychologists is difficult because most people can't afford these services. Therefore psycho-educational component of CBT is important because of limited resources and resultant limited contact between psychologist and those affected.

According to Bisson (2008) it is important that clinical decisions and treatment is informed by research evidence. As discussed earlier in Chapter 3, as a result of limited evidence practical social and emotional support should be offered shortly after a traumatic event (NCCMH, 2005). The United Kingdoms National Institute for Clinical and Health Excellence (NICE) recommends a watchful waiting period for affected individuals for up to one month. However formal interventions may be initiated earlier if indicated (Bisson, 2008).

4.3.4 Using a narrative approach with children

According to the literature children have difficulty in accurately reporting his/her internal emotional state (Litz, 2004). In a narrative group, exposure to trauma related stories may increase physiological arousal and alter their cognitive understanding of the event thus rendering it as more threatening as originally perceived. Furthermore, children's perceptions and understanding of events are influenced by the reactions of adults and children around them (social referencing) (Litz, 2004). One participant explained that "when asked how [they] feel they would think…it seems that they didn't quite get it". He/she added that this approach had a negative impact as a result of exposure to details of the event which may or may not be reality based. In order to maintain an accurate understanding of details of the event, the literature suggests that children are encouraged not to go beyond the known facts (American Academy of Child and Adolescent Psychiatry).

Another participant related an incident which he/she perceived to be "potentially harmful". In this case a mental health professional had exposed children to a very emotive experience and "had actually forced the children to re-tell the story". The participant believes that it is within this "highly emotionally charged" context that a

person develops an initial traumatic memory. This is consistent with the literature which suggests that much of the aetiology of posttraumatic stress disorder centres around the fact that traumatic memory does not incorporate into autobiographical memory in the normal way (Ehlers & Clark, 2000) (See Chapter 2).

One participant discussed that for children who remained asymptomatic, addressing them in groups according to their grades is appropriate. However, he/she stated that the size of the groups was important "I don't take a whole lot because they stir each other up a lot".

4.3.5 The emotional reactions of psychologists

Emotional reactions of psychologists included feelings of inadequacy and being overwhelmed by the post-disaster context were described as follows:

> *"I felt a bit lost because I didn't know how to deal with it [an extremely hysterical reaction]. What was helpful was knowing the psychologists who specialized in trauma"*

> *"Trauma responders need to be comfortable (and not overwhelmed) with people who have emotions that are not contained".*

> *"When you going into group situations I find it quite intimidating, especially when you're newly qualified"*

> *"[The need to] placate or numb emotions is sometimes related to the professionals anxiety about this persons experience"*

"[Overwhelming feelings experienced by the therapist] doesn't lead to emotional containment of the patient, it just leads to more anxiety that is suppressed"

The statements above are indicative of the anxiety experienced by some psychologists. Inadequate training and experience may exacerbate these overwhelming feelings and may impact on the ability to treat.

4.3.6 Timing of intervention

One participant perceived "a sense of immediacy" and pressure for psychological intervention on the part of corporations/management as problematic. He/she said that immediate counselling or debriefing is not necessary and led to "doing more harm than it was helpful". He/she added that the role of the psychologist in this regard was "to slow things down" in order to counter the sense of urgency and "maybe to address more practical needs". Another participant similarly related that "symptomology came out much later than the actual trauma", he/she added that you didn't know who was caught up in the movement or who was actually traumatized until a week or two after the incident". A third participant said that early intervention is about optimizing recovery thus "at the earliest indication, if they are not recovering from the trauma, initiate treatment even as early as two or three weeks after the event". However, he/she cautioned that therapy that is initiated too soon after the event if someone doesn't "actually have a disorder" the process of therapy may induce posttraumatic stress symptoms.

As discussed in Chapter 3 as well in the previous section of this chapter, current best practice treatment manuals' highlight that psychological interventions are not

recommended in the immediate aftermath of a disaster (i.e. 0-48 hours) (Academy of Cognitive Therapy, 2005). According to Gray, et al. (2004) it is unclear whether there is an optimal time frame for intervening in the acute phase (after this initial 48 hour period to 30 days). Early interventions that have yielded positive outcomes were implemented an average of ten days or more after trauma occurred (Bryant et al., 1998; Foa et al., 2000).

4.3.7 Pharmacology

One participant believes that physiological reactions do not always require medical intervention in the form of tranquilizers. Furthermore he /she said that general practitioners will immediately prescribe tranquilizers for PTSD and those affected will be given time off from work. He/she describes this practise as “very destructive, particularly in work related trauma” (exacerbating numbing and avoidance respectively). Another participant explained that a victim of an armed robbery may be “awake all night…how can they operate machinery”, alternatively if they are prescribed sedatives “to make them sleep, it makes them drowsy” and may interfere with occupational functioning. Therefore he/she recommended that one needs to “work within expectations”. A third participant perceived that although “sedation after trauma is not necessarily good”, in the case of a hysterical reaction the participant “wondered “whether it [sedatives] was not the best for her”. There have been some studies of pharmacologic interventions but no evidence has been found for preventative effects of sedatives (Pitman et al., 2002). However, symptomatic pharmacology may be considered in the case of severe symptoms (Bisson, 2008). Another participant explained that often the response from professionals is to numb or placate emotions which are more related to the professional’s anxiety than to the

survivor. Caring rather than placating, (“don’t need at all costs to make emotions go away”) is a way in which the anxiety they are experiencing is normalized and helps survivors gain control over their emotions.

Considering the relevant literature and the participants’ responses the researcher suggests that as there is no evidence for the benefit of sedatives for survivors following a traumatic event they should not be routinely prescribed. However, in cases of an extreme reaction symptomatic pharmacology may be considered. Normalization of anxiety has a positive influence on psychosocial recovery as according to Foa (1997) emotional engagement is a requirement in the process of natural healing.

4.3.8 Conclusion

Reflecting on the relevant literature and responses from the participants regarding the question of the method of choice of treatment it appears that in the immediate phase after a traumatic event, psychological first aid strategies (although not always labelled as such) have a positive influence on psychosocial response to survivors. Although research has shown the potential harmful effects of psychological debriefing, the approach is still used by some mental health practitioners. The eliciting of negative emotions is inappropriate at a time when the survivors need is for safety, security and comfort. Reducing distress, which is a core objective of psychological first aid, thus addresses this need. Treatment guidelines recommend that formal intervention such as trauma-focussed cognitive behavioural therapy should only be initiated if symptoms do not resolve after a period of watchful waiting (up to one month). However, in the acute phase, there is evidence that TFCBT (in cases where symptoms are extreme and not subsiding) implemented as early as 2 weeks following

the traumatic event has a positive influence on recovery. The enormity of a disaster may be overwhelming even to experienced mental health professionals (Hall, Ng, & Norwood, 2004). It follows that inadequate training and experience may exacerbate these overwhelming feelings and may impact on the ability to treat. Regarding pharmacologic treatment considerations, no evidence has been found for the preventative effect of sedatives, although they may be considered in the case of extreme symptoms (Pitman et al., 2002).

4.6 The South African context

The sub-themes and related categories that emerged from the data relating to this theme are differences in expressing grief, the language barrier, perception of trauma and being led by the culture. These sub-themes will now be presented in more detail.

4.6.1 Differences in expressing grief

One participant noted how different cultures have different ways of mourning he/she describes the difference in funeral services as follows:

> *The coloured people, they all need to be involved in some kind of ritual even if they weren't directly involved. It is important for them to have a service or a closing ritual at the place where it happened. If white children [lost their lives] black people used to say "why is it over" (not sufficient for the other cultures), whereas with black people it's a very long service.*

4.6.2 Language barrier

Seedat, Duncan, & Lazarus (2001) argue that until multilingualism constitutes an important factor for psychologists in a community context it remains difficult to foster co-operative and meaningful relationships. However, they state that although language is central in all mental health intervention, there is always some level of understanding to be found through personal connection.

One participant believes that the healing process is hindered by the language barrier when people don't speak English or Afrikaans. In his/her experience a "Xhosa speaking psychologist would have been better…..processing in their mother tongue will be better". However, the participant dealt with it by not using complicated language and keeping it simple and straightforward.

4.6.3 Perceptions of trauma

One participant identified differences in the perceptions of the traumatic event in a mixed racial group. He/she explained that "Their life of on going stress and trauma was far worse [than this particular traumatic incident]. Furthermore, individual differences in the perception of traumatic events refer to more than racial or ethnic heritage but also include factors such as age, religion and gender. As an example he/she said that "often in a group men feel they can't cry, men feel that's what women do, they [men] have to be strong in a situation".

4.6.4 "Led by the culture"

One participant believes that "people bond to their own culture". He/she explained that as an outsider "you are led by the culture". Furthermore he/she added that only after "the rituals of that culture have been completed" can you start early intervention

strategies. According to the literature, clinicians and mental health workers from respective cultural groups, or those that work extensively with these groups should be identified and recruited to assist with assessment as they will have insights that an outsider will not. Treatment modalities should be culturally sanctioned. Only by understanding the culture of each community will it be possible to anticipate and recognize the distress and intervene effectively in the community (Marcus, 2000). According to Marsella and Christopher (2004) good intentions are not enough. In order to help the victims of disasters it is essential to understand and respect different cultures. Attempts to help could be misunderstood as interfering or "even political attempts to influence or control" (Marsella & Christopher, 2004, p. 521).

4.6.5 Conclusion

Issues characterizing the South African context that are perceived to influence the psychosocial response to those affected by disaster include differences in expressing grief, the language barrier, perceptions of trauma and being led by the culture. Misunderstandings may be avoided by recognizing, understanding and respecting cultural values and needs.

4.7 Planning

The sub-themes and categories that emerged from this theme are presented below in Table 5. Reference was made to lack of planning, practical issues and the role of the psychologist.

Table 5 *Planning, sub-themes and categories*

Theme	**Sub-theme**	**Categories**
4.7 Planning	4.7.1 Lack of planning	(a) Disorganization (b) Little demand for trauma readiness (c) Disaster response teams (d) Lack of cohesion
	4.7.2 Practical issues	(a) Lack of space (b) Lack of privacy
	4.7.3 Role of the psychologist	(a) Role needs clarification (b) Blurring of therapeutic boundaries (c) Credibility of psychologists' role

These sub-themes will now be presented in more detail.

4.7.1 Lack of planning

Three of the participants expressed that the chaos and disorganization that is inherent in a disaster context was exacerbated by lack of planning or readiness on the part of various corporations/institutions. This notion is supported by the literature which suggests that if communities are unable to respond, or respond in a haphazard manner, people are likely to become increasingly bewildered and helpless. Disorganization leads to increased fear, panic and an inability to function (Hall et al., 2004).

One participant stated that "by law companies have to have an occupational safety program in place and ideally a request for psychologists comes from them. They [companies] don't know how to deal with trauma and there is very little demand for

trauma readiness". According to Hall et al. (2004) a chain of command must be established. Communication is vital for successful functioning as are clearly defined roles for each of the critical responder groups (For example, fire fighters, police and rescue teams). Disaster committees comprised of knowledgeable individuals should be developed and maintained.

Another participant described that part of the problem is that in the "short response time, people you might identify to go with you are often not available on such short notice". To remedy such a situation he /she suggested that an "organization" or a "list of people" should be available on call to respond immediately when a disaster occurs. The participant also expressed concern for the lack of cohesion and not working within a similar framework among mental health practitioners. He/she said "a range of people with variety of approaches and backgrounds working in an isolated manner" contributed towards the disorganization at the site. A third participant described the scene post-disaster as follows:

> *Everyone I've been to prevailed with chaos. It was mad. Mad people crying, mad people sympathizing, everyone working each other up… all the stakeholders come in…and you don't know who's who in the whole thing. Politicians just walking around, prayer groups, a lot of social workers from different organizations*

4.7.2 Practical issues

Four of the participants mentioned that certain practical issues hindered the process of psychological assistance. One of the factors mentioned was the lack of adequate space to see people if needed, as well as the lack of privacy. The venues were described by one psychologist as often being "difficult and awkward".

4.7.3 Role of the psychologist

The general role of the psychologist has been distinguished from the role of the psychologist in the screening process as different categories emerged from the data in respect of these roles. One participant asserted that the role of the psychologist in terms of services rendered in the post-disaster context needs clarification. The participant believes that in some instances psychologists were forced into roles by politicians and the media, whereby they were expected to perform duties that are outside the scope of their responsibility (for example, collecting money for a funeral). In this particular incident psychologists were threatened by politicians on the scene and told “if you don’t do this you’re going to loose your job”.

The blurring of therapeutic boundaries was implicit in another participant’s experience. He/she found himself/herself in an advocacy role when addressing safety issues with management in companies that had repeatedly experienced armed robberies. In addition he/she said that “sometimes they [staff] gripe about the manager” which necessitated a meeting with manager and staff to bring about the changes necessary to improve the quality of life of employees. The role of psychologists in disasters (by virtue of their cause) sometimes involves advocacy on the part of the psychologist which does confuse and blur the boundaries of the traditional roles experienced by psychologists in the normal consulting room context (Pretorius-Heuchert & Ahmed, 2001).

It is perceived that the credibility of the psychologist’s role, integrity or authority is often undermined. This is implicit in the statements made by two participants. One participant mentioned that the role of psychologists’ is an “add on” and largely ignored in the overall process of disaster response. This participant added that “other

professionals may or may not see the value of what a psychologist can offer". Another participant described his/her experience when arriving at the scene of a disaster as "I could have driven off and they wouldn't have even known I was there"

4.7.4 Conclusion

A lack of planning is perceived to have a potential negative influence on the psychosocial response to survivors. Disorganization may result in increased fear and panic, further impairing the survivor's ability to function. In addition, the lack of cohesion and not working within a similar framework contributes towards the disorganization. The need for disaster response teams was identified. Practical issues such as lack of adequate space and privacy to see people if needed were perceived to hinder the process of psychological assistance. The blurring of boundaries of the traditional role of the psychologist is evident as it sometimes involves advocacy in the disaster context.

4.8 Training

The sub-themes and categories that emerged from the data relating to this theme are presented below in Table 6. Reference was made to training for professionals/non-professionals and training of psychologists.

Table 6 *Training theme, sub-themes and categories*

Theme	**Sub-theme**	**Categories**
4.8 Training	4.8.1 Training for professionals/non-professionals	(a) Need for coherent and unified strategies (b) Specialized training (c) Training programs for volunteers (d) Doing more harm than good (e) Accountabilty
	4.8.2 Training of psychologists	(a) Trauma as a sub-specialization

These sub-themes will now be discussed in greater detail.

4.8.1 Training for professionals/non-professionals

The need for coherent and unified early intervention strategies for all mental health practitioners was identified by all participants. The importance of working from a more or less similar framework is implicit in the following statement:

> *All of the cases that involved the community [they] were total chaos. What inhibited the process is that everybody came in at different stages of intervention. Social worker-ritual of throwing something into a fire- community going to the place where the taxi crashed, or they would take the children to the venue.*

Everybody had there own kind of intervention.

One participant said that specifically in a group setting, knowledge of psychological first aid (PFA) is not enough. Registered counsellors, social workers and psychiatrists need to be trained appropriately. He/she is adamant that "managing the range of responses in [the] group setting, I think, becomes highly, highly specialized". He/she added that because medical professionals or firemen are often the first line responders it is important for them to be aware and sensitive to the psychological impact they might have on survivors.

Another participant was concerned about the quality of various training programs specifically people working for NGO's like Lifeline, FAMSA and particularly victim support programmes at a police station. He/she stated that:

> *Trauma counselling and debriefing is very fashionable and there are a lot of people that feel they want to make a contribution, some of them have a very good training program in place, but that is not a guarantee…the standards are not generalized*

However, he/she acknowledged that "it is an impossible hope that professionally qualified individuals will cover all areas". Thus, volunteers in disadvantaged communities are being trained specifically in the area of continuous trauma- with focus on training, awareness and supervision. They act as role models in the community. He/she added that "We really need to look at developing those systems around the community much more than focussing on the individual… focussing on

the individual pathologizes that person. We [psychologists] have to think more ecosystemically as well in that case".

A third participant stated that people need to feel that they are contributing. However, "someone just walking off the street and wanting to help without training would possibly be doing residual harm". He/she added that "if someone is trained about what to look out for we could pretty effectively have people intervene in situations like this". However, "that would be rare and most people who just arrive on the scene don't have training and it's dangerous". All of the participants acknowledged that those who respond to disasters and don't have training could do more harm than good. However, all participants acknowledged that non-professionals who are informed (what to say, what not to say) could play a valuable part in post-disaster response. In addition, parents, friends and family members might help with the practical things such as "refreshments, heating and organizational aspects".

One of these participants explained that people who are not registered with the Health Professionals Council of South Africa (HPCSA) are problematic as there is no accountability and the public have no recourse. However he/she identified the need for qualified people to work in community organizations and is aware that the (HPCSA) is trying to remedy this irregularity by creating a new category like psychological counselling. Furthermore, he/she added that some people who have done voluntary counselling in police stations are now in private practice, unregistered-which is unlawful. One of the other participants was similarly concerned about lay counsellors "in a one-on-one kind of situation".

4.8.2 Training of psychologists

The training of psychologists regarding trauma was called into question by all participants. One participant said “As much as we are specialists in psychology I don’t think everybody always realises how much of a sub-specialization trauma is”. He/she added that “we need to look at our training of psychologists…. there is a difference between trauma counselling and other counselling”. Another participant believes that in some instances psychologists who responded “actually weren’t adequately trained” which resulted in confusion when arriving on the scene. He/she described their reactions as “now what do we do, where we going now, we’ve got a group but what do we do now?” Two of the participants said that they were trained in the old debriefing model within which certain factors are omitted such as specific knowledge in traumatic stress symptoms (such as dissociation). Another participant said that “training isn’t sufficient in terms of trauma… training (in my day) was superficial and didn’t take into account the different cultures”

4.8.3 Conclusion

According to the literature all mental health providers should undergo appropriate disaster relief training. A mental health practitioner without relevant training is described as “useless at best or harmful at worst” (Marcus, 2000). Training of professionals and non-professionals in addressing the needs of those affected by disaster was perceived as an important influence on the psychosocial recovery of survivors. Although motivated by a sense of social responsibility and good intentions responders themselves may feel inadequate and overwhelmed in the post-disaster context of chaos and disorganization. Thus the survivors need for psychological

safety, comfort and support is negatively influenced by the responders' lack of experience and training in this context.

Chapter 6 provided a presentation and discussion of the results obtained. Chapter 7 provides a final conclusion of the study including limitations and recommendations.

CHAPTER 7 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Chapter 7 provides conclusions to the present study. Thereafter the limitations and recommendations are presented.

1. Conclusions

This study is an attempt at exploring and describing psychologists' perceived influences of early strategies on the psychosocial response to those affected by disasters. Many of the issues that were anticipated during the problem statement emerged from the data. Even though mental health professionals and other role players have a collective investment in facilitating the psychosocial recovery of those affected, there are many factors, both counselling and non-counselling that contribute towards the future mental health of disaster survivors. The factors that psychologists' perceived to influence the psychosocial recovery of survivors after disasters include the screening process, the needs of survivors, the method of choice for treatment, the timing of intervention, pharmacology, the South African context, training and planning.

In summary results that emerged from the data suggested that screening and monitoring are considered to be an important function in identifying those who might be at risk for chronic mental health problems. However, it is not always possible for psychologists to screen everybody on an individual basis therefore the psychologists' role as a consultant is more appropriate in this regard. The role of psychologist as consultant implies co-operation from management, institutions, corporations and the media. However, the screening process is often inhibited by the media's impression

that “psychological debriefing” is mandatory. Thus, motivated by “doing the right thing” psychologists are often pressured by politicians and management to see everyone without screening.

Addressing the immediate subjective needs of those affected is perceived to have an important influence on the psychosocial recovery of survivors. All role players need to treat survivors sensitively and respectfully. The post-trauma environment has an important influence on the survivor’s experience of the event (Litz et al., 2002). Physical and psychological safety is perceived to be the most important need, although professionals should take their lead from survivors in terms of what their needs are (National Child traumatic Stress Network and National Centre for PTSD, 2006). Other identified needs included accurate information regarding the event, psycho-education, normalization of symptoms, facilitating social support and practical needs.

The method of choice for treatment included psychological first aid (PFA) and cognitive behavioural therapy (CBT). In the absence of a clear approach/method in some instances some participants rely on a more intuitive/eclectic level. However, the basic objectives of PFA were implicit in these methods of choice although not labelled as such. Some participants perceived that many mental health practitioners still uphold Critical Incidence Stress Debriefing (CISD) as their method of choice. The uncritical implementation of outdated debriefing models was perceived as a potentially harmful influence on psychosocial recovery. The telling and re-telling of the trauma narrative with children in groups is perceived to have a negative influence on psychosocial recovery. It is within this highly emotionally charged context that an initial traumatic memory may be developed.

The timing of intervention is perceived to have an influence on psychosocial recovery. Psychologists' perceived a sense of immediacy for psychological intervention on the part of the media and management. Pressure for psychological intervention is perceived to have a potential negative influence on the psychosocial response to those affected. According to the Academy of Cognitive Therapy (2005) psychological interventions are not recommended in the immediate aftermath of a disaster. However it remains unclear whether there is an optimal time for intervening in the acute phase (Gray et al., 2004).

No evidence has been found for the preventative effects of sedatives (Pitman et al., 2002). However, symptomatic pharmacology may be considered in the case of severe symptoms (Bisson, 2008).

Certain issues characterising the South African context were perceived to have an important influence on the psychosocial response to disaster victims. These included differences in expressing grief, the language barrier, perceptions of trauma and being led by the culture.

Disasters by definition are chaotic and disorganized and confusion in the post-disaster context is exacerbated by professionals and non-professionals who have different training backgrounds, roles and frames of reference. The lack of a coherent and cohesive framework among mental health professionals is perceived to have a potential negative influence on psychosocial recovery. The training of psychologists is perceived to be inadequate. Feelings of being overwhelmed and inadequate may be exacerbated by a lack of specialized disaster relief training and impact on their ability to treat. Other early responders arriving on the scene of a disaster although motivated by a sense of social responsibility and good intentions are perceived to possibly do more harm than good. The quality of various training programs for volunteers was

brought into question as they are not standardized. In addition, people are not registered with the Health Professionals Council of South Africa (HPCSA) therefore there is no accountability and the survivors have no recourse.

Generally the psychosocial aspects of disaster response is perceived to be an under planned and under co-ordinated process. Pre-trauma readiness is perceived to be important, as relevant role players would then be equipped if the need arose. However, the need for pre-trauma readiness has not been well received by most corporations/institutions.

2. Limitations of the study

In Chapter 5 mention was made of the strategies employed to assure the validity and reliability of the research and its conclusions. The current section briefly explores these strategies and the possible limitation of these strategies and factors that could threaten or limit the validity of the research conclusions.

According to Lincoln and Guba (1985) inquiries should be based on trustworthiness and authenticity. Criteria of trustworthiness include that the research should be credible, its findings transferable, dependable and confirmable. In regard to Lincoln and Guba's Model of Trustworthiness (1985), Marshall and Rossman (1995) presented the following questions: (a) How credible are the particular findings of the study? By what criteria can we judge them? (b) How transferable and applicable are these findings to another setting or group of people? (c) How can we be reasonably sure that the findings would be replicated if the study was conducted with the same participants in the same context? (d) How can we be sure that the findings are reflective of the subjects and the enquiry itself, rather than a creation of the researcher's biases or prejudices?

2.1 Generalisability

The results of this study may not be generalisable to other psychologists (as is generally the case with qualitative exploratory research). However, by sampling until data saturation was reached, the researcher aimed to get as comprehensive a picture of the perceptions under study. Possible limitations to the internal representativeness of the sample group, and therefore the internal generalisability of the study include the following:

(a) The ethnicity of the participants was not representative of the South African population as all the participants were white. Psychologists from other ethnic groups may have differing perceptions which may influence the generalisability of this study. It is recognised that differences in perceptions among other ethnic groups might form the focus of future research.

(b) The professional training and experience of the participants in the post-disaster context was heterogeneous. The participants had a broad range of trauma related experience ranging from 2% to 90% of their workload. Thus the generalisability of this study may extend to the overall population of psychologists regardless of trauma related experience.

2.2 Researcher bias

An important threat to the validity of qualitative research conclusions is the selection and/or skewing of data to accord with the researcher's preconceptions (Miles & Huberman, 1994). Qualititative research thus acknowledges the inevitability of some researcher bias but attempts to safeguard its conclusions through a range of techniques (Marshall & Rossman, 1995). As described in Chapter 5, the current study

attempted to limit the skewing effect of the researcher's perspective through the use of *inter alia* the researcher's supervisor and an independent coder during the data capturing and data analysis phase. Nevertheless, the possibility of some insider bias affecting the research outcomes remains a possibility as the researcher may have made some assumptions during the research process.

2.3 Perception research pitfalls

Perception research pitfalls could be a further limitation of this study. The impressions of psychologist's regarding the influence of strategies presents its' own difficulties. However, in the study views may be more objective due to the training of psychologists. In addition the large body of existent literature forms an accountable foundation against which perceptions were reflected. Given the nature and purpose of the study, the limitations of small sample size and perceptions of influence rather than real influence are considered acceptable.

3. Recommendations

3.1 Research

- It is important that early intervention strategies are adapted to South African contextual conditions and used by psychologists to inform the psychosocial response to those affected by disasters. Further research is recommended in this regard.
- For future research it is recommended that the researcher take back results to those studied. Data, analytic categories, interpretations and conclusions may be tested from whom the data was originally collected. According to Lincoln and Guba (1985) if the reconstruction is adequate, credibility is increased.

3.2 Practice

- Given current deficiencies in mental health services in South Africa, it is important to draw on community members and other non-professionals to help assist those in need after a disaster. The development of an appropriate training program in this regard is recommended.
- Due to the variety of professionals and non-professionals who offer their services following a disaster, it is recommended that the psychologist as consultant is part of the overall disaster response plan.
- It is recommended that in order to work from a cohesive and coherent framework all mental health practitioners should have specific disaster response training.
- It is recommended that psychologists who choose to work in the post-disaster context undergo specialized disaster response training.
- On call disaster response teams are recommended.
- There is a need for greater networking between different role players involved in disaster response including management in businesses and corporations, municipalities, hospitals and disaster response organizations.
- It is recommended that traumatic stress societies generate an interest for companies and institutions to adopt pre-trauma readiness programmes as part of disaster response plans.

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Appendix A

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

RESEARCHER'S DETAILS	
Title of the research project	**Psychologist's perceived influence of early strategies on the psychosocial response to those affected by disasters**
Reference number	**HO9HEAPSY022**
Principal investigator	**Nerina Blackburn**
Address	**NMMU** **Department of Psychology** **P.O. Box 77000** **Port Elizabeth**
Postal Code	**6031**
Contact telephone number (private numbers not advisable)	**083 320 7350**

A. DECLARATION BY OR ON BEHALF OF PARTICIPANT		Initial
I, the participant and the undersigned	(full names)	
ID number		
Address (of participant)		

A.1 HEREBY CONFIRM AS FOLLOWS:		Initial
I, the participant, was invited to participate in the above-mentioned research project		
That is being undertaken by	Nerina Blackburn	
of the Department of	Psychology	
of the Nelson Mandela Metropolitan University.		

THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:					Initial
2.1	**Aim:**	The researcher is studying psychologists' perceived influences of early strategies on the psychosocial response to those affected by disasters. The information will be used to gain an understanding of the perceived influences of early strategies on the psychosocial response to those affected by disasters.			
2.2	**Procedures:**	I understand that semi-structured interviews will be conducted on an individual basis that will take approximately one hour. Feedback regarding the study's outcomes will be made available.			
2.3	**Risks:**	I will not remain anonymous to the researcher and supervisors should I request feedback.			
2.4	**Possible benefits:**	As a result of my participation in this study more insight can be gained into the influences of early strategies on the psychosocial response to those affected by disasters.			
2.5	**Confidentiality:**	My identity will not be revealed in any discussion, description or scientific publications by the investigators.			
2.6	**Access to findings:**	A copy of the research will be placed in the library of the Nelson Mandela Metropolitan University. An article may be published in a journal aligned to the profession of psychology. Feedback regarding the findings of the study will be provided to participants on request.			
2.6	**Voluntary participation / refusal / discontinuation:**	My participation is voluntary	YES	NO	
		My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle	TRUE	FALSE	

3. THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:									Initial
Nerina Blackburn									
in	**Afrikaans**		**English**		**Xhosa**		**Other**		
And I am in command of this language.									
I was given the opportunity to ask questions and all these questions were answered satisfactorily.									

4.	No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	

5.	Participation in this study will not result in any additional cost to myself.	

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:		
Signed/confirmed at	on	20

Signature or right thumb print of participant	Signature of witness: Full name of witness:

B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)									
I,	Nerina Blackburn							declare that:	
1.	I have explained the information given in this document to							(name of participant)	
2.	He / she was encouraged and given ample time to ask me any questions;								
3.	This conversation was conducted in	**Afrikaans**		**English**		**Xhosa**		**Other**	
	and no translator was used.								
4.	I have detached Section D and handed it to the participant							YES	NO
Signed/confirmed at				On				20	
Signature of interviewer				Signature of witness: Full name of witness:					

C. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT	
Dear participant Thank you for participation in this study. Should, at any time during the study: - an emergency arise as a result of the research, or - you require any further information with regard to the study	
Kindly contact	Nerina Blackburn
at telephone number	083 320 7350

Appendix B

Biographical information

All information will be treated as strictly confidential.

1. Name:…….....……..

2. Mailing address (street or post box address or e-mail address)

……...

……...

……

3. Date of birth:……

4. Gender:…….

5. Date since first registered with HPCSA:.....

6. Registration category:……

7. Experience dealing with traumatic stress (i.e. % of case load):…….…….

8. Would you like to receive feedback of the results of this study?

Yes….. No…..

Appendix C

Contact person: Nerina Blackburn **December 2009**

Dear Participant

As part of my course work for the Masters degree in Clinical Psychology, I am required to complete a research treatise. The title of my treatise is: “Psychologists’ perceived influences of early strategies on the psychosocial response to those affected by disasters”. The proposed study aims to explore and describe the perceptions of psychologists regarding the influence of early strategies on the psychosocial response to those affected by disasters. With this goal in mind, I wish to approach you for your assistance and participation.

Should you agree to participate in this study you will be requested to complete a consent form and a biographical questionnaire. A semi-structured interview on an individual basis will then take place at your convenience. The interviews will be digitally recorded and will be transcribed verbatim. The data will be analysed by the researcher and an independent coder using content analysis. Confidentiality and anonymity is guaranteed. Participation is on a voluntary basis and you are free to withdraw from the project without any recourse. Should you wish, the researcher will gladly provide general feedback.

Your participation will be valued and truly appreciated. In the event that you should require any additional information, I can be contacted via the following number and email address:

Cellphone: 083 320 7350 or

Email: jewls@global.co.za

Yours sincerely

Mrs Nerina Blackburn

Researcher

Mr Kempie Van Rooyen

Supervisor

Prof. Mark B. Watson

Head of Department

Prof. Greg Howcroft

Co-supervisor