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Guidelines for Local Mental Health Care Activities after a Disaster

Preface

In the wake of recent natural disasters such as the Great Hanshin Earthquake Disaster (January 17, 1995) and disasters due to human crime or accident, the public as well as specialists in mental health in Japan have become keenly aware of the need for post-disaster psychological care, and a variety of practical work has been performed. In order to widely share what has been clarified through that experience, and link it to better programs in the future, we have drawn up these "Guidelines for Local Mental Health Care Activities after a Disaster." Posttraumatic stress and various other psychological reactions occur after a disaster, and it is vital to ensure not only accurate diagnosis, but also continued comprehensive provision of mental health care.

These guidelines are designed for the integration of all types of programs, with proposals based on accomplishing what is possible amid the chaos of a disaster situation. We have included with as much specificity as possible what has been learned in actual practice up to now about first contact, the importance of natural recovery from trauma, responding to multicultural contexts, and cooperation with volunteers and the press.

We hope that these guidelines will be widely used in disaster situations, and that the further experience of many caregivers will lead to their improvement in the future.

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Introduction

When a disaster occurs there are many kinds of psychological effects upon numerous residents of the area, and it is therefore necessary to provide mental health care services at the local level, under the leadership of a local government bodies, a public health center, or a mental health and welfare center. We hope the items presented in these guidelines will be carefully noted by the physicians, public health officers, nurses, mental health and welfare staff, and other specialists and officials involved in those services.

In these guidelines, a disaster is taken to be an event with serious effects felt not only by individuals but by the entire area, and quite possibly an event that disrupts the basic life-support services of the area. In other words, it is an event that necessitates not only specific responses to individuals who are suffering effects, but also measures which serve the entire community of persons living in the area. Specifically, the range of disasters can include an earthquake, flood or other natural disaster, or fire, accident, environmental contamination, or a criminal act. Some examples from the recent past are the release of sarin gas in the Tokyo subway, the Hanshin Earthquake, the poisoning of a curry pot at a community festival in Wakayama, and the uranium criticality accident in Tokaimura.

I. The Need for Local Mental Health Care after a Disaster

1. Disaster Experiences and Local Mental Health Care Activities

As a terrible event that almost nobody has expected, a disaster inflicts heavy psychological burdens. Family members may be killed, or there may be the pain and sorrow of losing home and belongings (loss and grief reactions). Moreover, the aftermath may bring major life changes and uncertainty about future life, making everyday realities stressful. Above all, those who are most vulnerable to disaster including the elderly, infants, the ill or wounded, and the handicapped, may have great difficulty coping with life after the disaster and suffer from higher levels of stress. In particular, the interruption of medical treatment in the wake of the disaster, certainly for mental disorders and also for physical disorders, can negatively affect the patient's mental health. Further, during the disaster people may witness the occurrence of death or injury, or personally feel the physical effects of an earthquake or fire, causing a shock that is permanently engraved on the psyche and may return in the form of flashbacks.

Mental changes that commonly result from the above include depression, loss of motivation, insomnia, loss of appetite, crying spells, irritability, lower ability to concentrate, poor memory, and stupor. Usually such states are temporary and recovery is natural, but if the stress is prolonged they can become long-term. Depending on the extent and duration of the symptoms, they may be diagnosed as a mental disorder such as bipolar disorder, panic attacks, or posttraumatic stress disorder (PTSD). Such symptoms have been known to be associated with suicide or accidents, increased use of alcohol or tobacco, family or neighborhood discord, delay in recovering normal life and, in some cases, socially deviant behavior. One example is that a person tends to make trouble when people go out of their way to come and provide care, and gradually becomes a recluse.

These types of changes can arise without a disaster, from ordinary isolated accidents or crime experiences, but when there is a disaster and the suffering extends to the entire family and community, city blocks are reduced to rubble or ash and routine life is completely

disrupted, then individual psychological reactions become magnified. Moreover, in the wake of a disaster there are numerous victims, and the normal health care system, which may well be physically ruined, cannot smoothly deal with them. The freedom to utilize the health care system as one pleases may be lost, or the entire system may be in chaos. Furthermore, as the entire neighborhood focuses its attention mainly on the nuts and bolts of rebuilding their lives, people may not notice their own invisible stress or mental symptoms.

In providing local mental health care services after a disaster, we must devise strategies based on these circumstances. In providing services, while keeping in mind the mental stress factors in the community, the symptoms presented and differentiation of conditions, we must also strive to improve efficiency as time passes after the disaster.

2. Local Mental Health Care after a Disaster

1) Policies for Local Mental Health Care after a Disaster

There are two main types of local mental health care activities following a disaster:

- (1) Activities within the chain of general assistance programs which are designed to improve the mental health of the entire community as a group and to reduce the stress and mental trauma (explained in section II below) of the group.
- (2) Prevention, early detection and treatment of particular mental disorders.

(1) consists mainly of ordinary assistance givers and local mental health treatment staff going to the disaster area in outreach activities (see glossary), delivery of disaster-related information, and psychology education for the general public (see glossary). In addition, practical assistance for disaster recovery and life support in itself helps to improve the mental health of the community. (2) consists mainly of screening individuals with mental disorders, encouraging people to come for consultations, psychology education for individuals (see glossary), and referrals to specialists. Effective performance of (1) can serve to prevent the mental conditions under (2).

To begin with, most relief workers entering the scene immediately after the disaster will not be medical personnel. Even among medical personnel, few are likely to have experience handling people with disorders like PTSD. Yet for the first one to two weeks or longer, (1) will be the main focus, and so it is not really necessary to have sufficient knowledge for handling such disorders. The health level of the community will be enhanced as relief workers enter the scene to meet and talk with survivors and victims and respond to their actual needs. At the same time they will need to distribute information about the scope and extent of the disaster and recovery efforts. During this period mental conditions are still changeable so it is difficult to proceed to diagnosis of disorders. Therefore, rather than making diagnoses, aid from the standpoint of (2) should be directed toward alleviating states of confusion, excitement and disorientation. Non-medical relief workers (hereafter, lay workers) should be trained to recognize, understand and offer simple responses to such states and to call in specialists when needed. When mental health professionals make contact with the residents, it will not be very hard for them to identify which people in those states have serious symptoms. Disaster conditions aside, it is sufficient for them to perform normal, routine mental health care activities, case work and consultations.

2) The Need for Patience

For a time it was asserted that the special technique of debriefing (see glossary) had to be performed, but this is now discredited. It has been internationally recognized that such gratuitous "treatment" is likely to aggravate psychological aftereffects. Instead it is best to perform routine mental health care activities with full confidence. The single most important need with regard to such activities is continuity. It is absolutely essential to avoid having the person who provides mental health care today disappear tomorrow. People with close ties to the neighborhood must carry the core of this work.

Yet amid the special situation of a disaster area, it can be quite difficult to carry out normal, routine mental health care activities. To begin with it is not known who among the survivors needs what type of assistance. Taking stock of people's situations and providing counseling will have to be done in cooperation with people of various backgrounds, perhaps with people who are not mental health specialists. Sometimes upon arrival at the disaster scene, while it is necessary to get down to work, the first requirement is liaison and coordination among a crowd of mental health relief workers who suddenly pour in from the outside or from the local area. In this regard, measures must be taken not so much toward the survivors as toward the mental health care providers themselves. It is necessary to stop and figure out how best to perform mental health care in an extraordinary situation. In practice, if one encounters a citizen in need of mental health care, the best way to avoid confusion is to contact a mental health care practitioner who has roots in the area.

II. Psychological Reactions after a Disaster

1. Types of Psychological Burdens

1) Mental Trauma

- (1) Physical experience of disaster (shaking or sound of earthquake, flames or heat of fire, noise or hot blast of explosion, etc.)
- (2) Suffering due to disaster (injury, death of loved one, damage to home, etc.)
- (3) Witnessing of disaster (corpses, fires, collapsed houses, disoriented people, etc.)

2) Grief, Loss, Anger, Guilt

- (4) Grief over bereavement, injury, loss of household
- (5) Guilt (survivor's guilt, unresolved issues)
- (6) Anger toward surroundings (assistance delays, confusing information, etc.)
- (7) Anger toward organizations or persons seen as responsible for an accidental disaster, or toward persons involved in a criminal incident

3) Social and Lifestyle Stress

- (8) Evacuation and relocation (new living environment, group living)
- (9) Breakdown of life routines (school, work, neighborhood, customary health care, care systems for children, elderly, handicapped)
- (10) Burden of new relationships and information (contacting people to receive information or assistance, processing information received)
- (11) Burden of receiving attention as a survivor (being seen by others, worrying about being the object of sympathy or curiosity)

• Explanations

- 1) **Mental Trauma (Shock from actual experience of disaster events):** The strong direct stimulus of a disaster event leaves the sympathetic nervous system in an over-stimulated state. This brings heightened anxiety and fear, inability to take in the entire scene in front of one's eyes, focusing of attention on the most fear-inducing stimulus, and acute memory of the disaster scenes and fears which are deeply engraved in the mind. Those memories may come up of their own accord over and over again as flashbacks that the person cannot control, and return the person to the same distress as the actual horrific moment. This condition is called mental trauma (hereafter, trauma). The causative factors, in addition to the shaking, pain, flames, heat or other things that were personally experienced, may also include sufferings of others that the person witnessed. Strong shock can be caused by witnessing the death or injury of a loved one, the collapse of one's home, or seeing a corpse (especially if it is seriously wounded or mutilated). Even if there are no flashback episodes, such experience can lead to loss of motivation, depressiveness, anxiety, insomnia, decreased appetite, or accidents due to inattentiveness.
- 2) **Grief, Loss, Anger, Guilt:** Practical judgment may be numbed by shock and confusion in the immediate aftermath, but gradually the injury, loss, and uncertainty about the future tend to show up as practical problems. After the initial disorientation and excitability have settled down, serious feelings of loss and sorrow may come to the fore. Whether or not one is actually a victim, there may be a sense that somehow one is at fault. Especially when a loved one has died, a person may be beset by a sense of heavy obligation for being the one who survived (survivor's guilt), or a feeling of having been unable to do the right thing. And at the same time, resentment at the fate that has befallen them may lead to anger toward relief workers or other people around them.
- 3) **Social and Lifestyle Stress:** Stress induced by a new living environment. Increases in various sorts of physical or mental malaise, indefinite complaints, insomnia, irritability, etc. are to be expected. When a large group of displaced people live together in a gymnasium or other public facility for a long time, issues arise concerning privacy, the living space (food, toilets, garbage, duty assignments), care for children, the elderly and the handicapped, and measures taken against infectious diseases. Shielding personal lives from news reporters is another important issue.

2. Types of Psychological Reactions

1) Initial Period (One month after the disaster)

PTSD centering on flashback episodes is a reaction that is characteristic among disaster survivors, but the diagnosis of this disorder cannot be made until at least one month after the event. Symptoms tend to be unstable during the initial period, so psychiatric diagnosis would be difficult. Therefore survivor difficulties during the initial period are generally regarded as stress reactions, and while allowing time for natural recovery, it is best to focus on disseminating information and giving specific assistance to resolve practical uncertainties, while treating serious symptoms of insomnia, anxiety or the like with medication or consultation. Nevertheless, during the process of recovery from initial stress reactions, anxiety or carelessness can lead to unexpected accidents or secondary incidents, hence it is necessary from the start to build sufficient public awareness, through information and education, about psychological changes and prospects of recovery. Informing the public

and providing assistance in the initial stage will not only lower the anxiety level of the area, but also reduce long-term problems such as alcoholism.

If there is a strong stress reaction and an especially heavy psychological burden, or if the individual has been vulnerable (see glossary), there can be onset and recurrence of typical mental conditions including depression, anxiety disorder, panic, dementia and schizophrenia. Also, previously unnoticed dementia may be recognized through a recurrence of night delirium. A person already under treatment for a nervous disorder may worsen due to the shock of the disaster or interruption of medication. In particular, sudden interruption of epilepsy suppressant medication may be followed by seizures after 48 hours. It should be noted that treatment of these common mental conditions is all in a day's work for a professional mental health caregiver.

Note: The First Few Days

During this phase people show symptoms that are variegated and in most cases transient, so strict diagnosis would have little meaning. Also, at this time it is very hard for a mental health professional to interview people, as in most cases contact is made by a lay worker. Hence the following classification is practical.

(1) Practical Anxiety Pattern

Practical anxiety comes from not knowing the cause, scale or extent of the disaster damage or what kind of assistance is available. It will be aggravated by such issues as rescue of family members, firefighting activities, or delayed evacuation. The symptoms are by no means always visible to others, but are often kept inside. Alleviating practical anxiety as far as possible is the most important way to prevent a later psychological reaction. The best response is to determine exactly what sort of suffering each person is facing and what he or she needs.

(2) Distracted Pattern

Inability to calm down or be still, caused by strong anxiety. Speech and behavior lose coherence. Forgetting what one has set out to do and turning to something unrelated. Palpitations, shortness of breath, or heavy perspiration may be seen. There may be emotional turbulence with agitated, angry outbursts or sudden crying. For treatment, it is essential to ensure rest and quiet sleep. Practical problems causing anxiety should be promptly resolved.

(3) Stupefied Pattern

Caused by unanticipated terror or shock. The appearance, at first glance, that thinking and feeling are numbed or stopped. Little speech or action, questions go unanswered, needed items in plain sight are ignored. Inability to understand what's going on, or to remember names or faces. The individual's own experience is of having lost touch with reality, and being unable to speak even when there is something to say. Though the condition may be mistaken as "very calm," the person feels intense sadness and fear on the inside. This pattern should be considered especially for people who "don't react" or "seem extremely calm."

2) Long Term (After the first month)

In the long term, it is likely that some people's symptoms will become chronic and PTSD or other psychological disorders will linger. In the wake of disasters and wide-area crime incidents in Japan, the most violently affected districts have shown a 30 to 40% incidence of PTSD (including partial PTSD – see glossary) within six months. About half of these cases subsided naturally, but the other half were chronic. In temporary housing populations after the Hanshin Earthquake, in several instances there was a 10 to 20% incidence of PTSD after one year. Besides PTSD, long term problems may include chronically lowered ability to concentrate, social maladjustment, and stronger reliance on alcohol.

By this time, alongside efforts to alleviate stress and trauma for the group as a whole, the focus has fundamentally shifted toward professional treatment of individuals who show symptoms. In principle that treatment could be shifted into normal health care facilities, but as long as evacuation centers are still operating, it may be necessary to include them in the assistance system or at least deploy response teams.

As time passes after the disaster, the mental health of the community as a whole will recover and reconstruction of the area will advance, and yet those people whose psychological burdens were heaviest may well be slow to recover, and be left behind. Each person's recovery will proceed at his or her own speed. In other countries, survivors of forest fires have been reported to suffer from PTSD for up to several years, with some cases persisting for longer. These people are agonized by memories that will not fade, by suffering they cannot put behind them. In some areas, the suffering may remain in people's memories and assistance will have to keep being provided to those who suffered directly. Certainly if a local mental health care professional still encounters complaints of psychological damage when more than a year has passed, it cannot be considered an extraordinary situation.

Lastly, there are the problems of the relief workers themselves. Giving the best possible assistance always means reducing the stress on the providers and keeping fatigue to a minimum. Of course stress will arise if the workers themselves, or their families, are disaster victims, or if they have come a great distance and are living away from home for a long period. The topic of assistance providers is covered further in the last section of these guidelines.

III. Development of Local Mental Health Care after a Disaster

1. Planning for Mental Health Care at the Disaster Relief Headquarters

It is important to have a psychiatrist familiar with local mental health care services, such as the director of the public mental health center, on the staff of the Disaster Relief Headquarters from the time it is established. In cases up to now where mental health care activities have been successful, they started within a day or two of the disaster, and the Headquarters issued announcements and named a supervisor for psychological response. Conversely, in cases where the policy is to call in a psychiatrist if and when the need arises, there is likely to be a delay in recognizing that the need exists, and a significant backlog of problems by the time a psychiatrist is added to the planning staff.

The main roles of the psychiatrist at the Disaster Planning Headquarters should be:

- Determining the Headquarters policy for mental health care activities
- Assessing the mental health situation among disaster survivors, based on reports from assistance providers on the scene
- Providing advice on mental health care activities to the various assistance providers on the scene
- Providing mental health care services for the various assistance providers on the scene

In addition, in order to effectively perform local mental health care services, it is important to provide a degree of discretionary authority to a mental health care supervisor on the scene (a professional from a public health center or mental health and welfare center). Because people's mental states can shift rapidly in response to news reports, fresh incidents, or secondary events, the care system should be flexibly adaptable. Specifically, modifications guided by on-the-scene determinations must be possible regarding the organization of local visits, selection of locations to visit, frequency of visits, decisions to stop visits, coordination with mental health staff from outside the area, and the degree of reliance on professional advice. In a past situation, even though almost everyone in evacuation centers had returned to their homes, the decision to stop making the rounds at the centers was delayed, and there was not enough staff available to perform the necessary home visits.

A critical element is the way in which the special health care activities which were set up on a temporary basis after the disaster, including visits to evacuation centers and the opening of special counseling facilities and hotlines, will be terminated so that the work load can be shifted smoothly to the normal local mental health care facilities. That process should be accomplished in such a way, with adequate public announcements and explanations, that it does not look like the disaster-related mental health program is being pulled back. The public must be clearly informed that even though the special counseling sites and phone lines are closed, disaster-related counseling remains available through the regular channels for mental health care. When reverting to the normal health care framework, guaranteeing the continuation of services for people affected by the disaster usually requires special budget and staffing arrangements.

2. Initial Response (During the first month)

Guidelines for responding to the crisis must be followed for at least the first four weeks after the disaster. Thereafter it can be expected that the necessary information will be

available, teams for professional assistance will be formed, and advice will be available from other areas. Still the nature of the area or the disaster could make the situation unusual, requiring special measures which match the actual circumstances. Following are the common elements that should be considered in making the initial response.

1) Practical responses and mental health

Immediately after a disaster has struck, the area residents will feel the anguish of actual damage which may include death or injury or loss of home, and at the same time will feel indescribable terror and unease over the fate that has suddenly befallen them. With regard to the anguish arising from actual damage, the best response is to take whatever practical measures are obviously required. Issues of survival, bodily health and living arrangements must of course be speedily resolved as the precondition for starting to deal with anxiety or other psychological reactions. But since those steps alone will not be enough to alleviate all of the terror, worry or other reactions, it is important to keep mental health issues in mind while responding to the urgent practical problems.

For example, after the Tokaimura criticality accident, people who feared they had been exposed to radiation were offered individual radioactivity measurements through the first several days. That prompt practical response to issues of survival and bodily health substantially relieved the anxieties of the area residents.

2) The immediate response – First Contact

"First contact" means meeting and talking with survivors as soon as possible after the event by visiting them at the disaster scene and evacuation centers.

As a rule, the early responders making first contact should be people who have served the needs of the local population on previous occasions. Naturally the immediate priorities will be rescue, firefighting and life support, and the responders who go through the site first to seek people out should be led when possible by people with local experience.

While carrying out first contact, when possible the responders should try to identify individuals who are under especially strong stress and provide basic mental health information (availability of psychological services). Refer to the following paragraphs on screening and emergency treatment.

The value of first contact lies in its being done as soon as possible after the disaster event. If it is delayed, people will be left in anxiety, despair and confusion. It is also important for responders to inform the public that they should move to special locations where assistance will be available, and delivering that information will give the survivors a sense of confidence about assistance activities afterward. During the acute stage, although numerous relief workers may go through the site, there may well be some residents who are not found by a first-contact team. With the relief teams under intense performance pressure, some people may not receive first-contact attention even when responders reach their locations. The Disaster Relief Headquarters should obtain comprehensive information on the progress of first-contact activities and the resulting assessments of the stress levels affecting people in various locations. That capability will depend on prior disaster preparedness, including policies and coordination to promote the delivery of mental health care by teams of people with varying backgrounds.

3) Screening for people who need observation

While it is essential to take note of serious symptoms and identify people in urgent need of mental care, at the initial stage professional diagnosis will probably be impossible because most first responders are laypeople. Nevertheless, even the layperson can perform a preliminary screening for cases where observation is necessary, and maintain a list of people who need psychological first aid (see the next paragraph). Ideally, lay responders should be informed as early as possible about screening, and furnished with a checklist of indications of the need for observation, and their briefing must contain guidance on privacy considerations. In practical terms it will hardly be possible to provide such a briefing right after a disaster, so it is best to incorporate it into disaster preparedness drills. A clear contact system should also be established so that the layperson can seek the advice of a local mental health facility when making a determination about the need for observation, and when possible or appropriate, direct follow-up can be carried out by a professional. Successful screening will depend on the amount of advance practice that lay responders have had with a checklist and simulations during disaster drills.

4) Psychological first aid

As noted above it is almost always lay responders who are the first on the scene after the disaster event. Yet laypersons, too, can perform psychological first aid (see Litz and Gray, "Early Intervention for Trauma" on the website of the National Center for PTSD). Their capacities for this will depend, as with the screening process described above, on advance practice during disaster drills.

In the initial stage, most psychological changes are acute-stage stress reactions, with varied and rapidly changing symptoms. Hence there is little value in precisely describing the medical symptoms or making diagnoses. Attention should instead be focused on identifying persons who seem to have serious symptoms or severe distress. The best way to do this is to actually meet and speak with people. Taking physical discomfort as an example, one can learn that headache or nausea is present by observing and conversing with the person, whether or not one has any medical skills. Meanwhile, the responders' one-by-one contact with the entire community will in itself help to reduce the general anxiety level and provide reassurance. Of course this contact process cannot discover every symptom, but it is appropriate as a means of addressing the entire group right after the event. During this contact process, people having difficulties should be informed about the counseling hotline and plans for special consultation offices.

When an unstable person is in fact encountered during the initial outreach, immediate medical treatment will not be possible. Whether or not a medical specialist or aid supervisor can be promptly contacted will depend on the scope of the disaster. As the basis for an on-the-spot response, the following message should be communicated: In the immediate aftermath of a disaster, anyone may experience temporary anxiety, depressiveness, irritability, etc., so it is best to just settle down and see how things develop—but in an extreme situation, do not hesitate to call the hotline or use the counseling facilities, and furthermore, be assured that psychological assistance will be available on a continuing basis.

If there is severe insomnia, panic, agitation or absentmindedness, medical personnel should be contacted as soon as possible. In such a case the disaster is not the only cause. There was previously some sort of strong shock (e.g. loss of a family member) or other triggering experience, or a mental disorder. Such unusually severe cases are often discovered by a somatic physician, who may be able to provide psychological first aid or transport to a mental health care facility. Another important thing to watch for is cases where a condition is aggravated due to the interruption of prescribed medication. Epileptics are especially vulnerable, as a potentially life-threatening seizure may occur as soon as 48 hours after

medication is stopped. Other situations that may be encountered include panic or anxiety attacks and aggravation of schizophrenia. Yet it is inappropriate and unproductive to ask in the presence of others whether a person has been diagnosed with a psychiatric condition. Instead the person should be asked in general terms about their health conditions, whether they have stopped taking any regular medication, or whether they are worried about any lost medicines.

5) Medical screening

Symptoms persisting after the third week following the disaster are semi-fixed, and medical screening is recommended if the circumstances allow it. The standard timing for screening is about one month after the disaster event, though it may be delayed by the circumstances of the particular situation. Psychiatric diagnosis for all conditions arising after the disaster is desirable, but there are often not enough psychiatrists available for everyone. Even without diagnosis, it is still possible to identify individuals with severe symptoms or with high-risk family or community backgrounds, and obtain the data needed to arrange treatment on a priority basis. For the required data, the questionnaire can be completed under the supervision of any medical professional, not necessarily a psychiatrist. The recommended procedure is to perform simple screening, by completing a comprehensive mental health questionnaire and an interview, followed by a diagnostic interview with a psychiatrist. In addition, to increase the rate of mental health examinations in the community, it is useful to offer a general health checkup under the non-threatening label of a "stress checkup," in which mental health observation can be combined with a physical health examination.

The screening work performed at this stage provides basic data for later planning of local mental health care services and evaluation of the need for continuing assistance. It must be remembered that about half of the serious cases, such as acute stress disorder (ASD – see glossary), diagnosed at this stage are likely to heal naturally within a month or two.

6) Public information

It is essential to provide public information on a consistent basis, starting immediately after the disaster.

(1) Practical information

Working with news organizations to quickly disseminate full information on the scale of damage, safety of families, future prospects, and assistance and health care options will do much to ease public anxiety, relieve feelings of isolation, and prevent unwarranted confusion or panic. Printed bulletins provide information in a form that is easy for the public to digest.

(2) Psychological information

In addition, from the local mental health standpoint, information can be delivered to the public concerning common psychological changes in post-disaster situations and ways of responding to them, as well as local programs for mental health care. Denial of psychological changes, on the part of both the individuals and those around them, is very common, so it is important to let people know that such changes are something that is well known. Counseling options including hotlines should also be widely publicized from the early stage. Actual rescue activities may not be quickly reported to the general public, and disaster information

may also be vague in some respects. When this occurs, providing advice about preventing mischievous agitation or deception by false rumors is another important role.

7) Counseling hotline

While the overall anxiety level of the community can be reduced through appropriate public information, there will still be individuals facing anxiety or other mental issues. A telephone hotline through which these people can voluntarily seek counseling is a highly effective service. The actual experience after recent disasters in Japan is that hotline utilization is not always high. This is not because the service is not needed, but because there is widespread reluctance to acknowledge the positive value of psychological counseling. In this situation, it is probably best to provide a general hotline for all kinds of information on the community, health issues, and daily life, and to refer individual callers who seem like they would benefit from counseling to a separate counseling hotline or to a mental health care professional.

8) Dealing with PTSD

(1) The context of PTSD

PTSD (posttraumatic stress disorder) tends to receive a lot of attention in the mass media, yet the experience of disaster does not necessarily lead to PTSD, and indeed may lead to various other kinds of psychological conditions, as mentioned above. After the recent eruption of Mt. Uzu, there was almost none of the sort of trauma that leads to PTSD, because the dead and wounded were evacuated as were residents living on the verge of the fire disaster area, and most of the psychological problems of the local residents had to do with anxieties about their life circumstances and the stress of living in evacuation centers. After the Tokaimura criticality accident, most of the reactions among area residents were caused by worry about invisible radiation or confusion arising from insufficient information. Elsewhere, there were high incidences of PTSD among firefighters and temporary housing residents following the Hanshin Earthquake, and the poisoned community in Wakayama. Thus whether or not PTSD occurs depends on the particular nature of the disaster. And it is a given that the particular experiences of survivors of a given disaster will vary greatly.

In general, experiences that are likely to lead to PTSD are those which threaten the survival of that person or someone close to that person. In disaster situations the most commonly observed causes are personal experience of fire, flooding or house collapse, the death or injury of a loved one, or seeing corpses.

Even when there is a suspected chance of PTSD, mental health treatment is not focused on early detection and treatment of PTSD. This is because many other kinds of psychological reactions may occur, and even after PTSD symptoms have subsided, there may be some sort of trauma-reaction aftereffects such as reclusiveness or maladjustment. It is important always to maintain the basic approach of readiness to identify a broad range of psychological changes, and to respond as appropriate with diagnosis, evaluation or assistance.

(2) Responding to trauma and posttraumatic stress

What, then, should be done when there is strong concern about PTSD? Careful performance of normal assistance activities is actually the best thing. In particular, assistance should be provided to minimize the survivor's responsibilities for the care of children or the elderly, for visiting family members in hospital or accompanying them on outpatient visits,

and for doing household chores. The point of this approach is to ensure that the survivor finds security, peace of mind, and restful sleep as soon as possible. Security means providing a living space that is removed from the damage and aftereffects of the disaster. Peace of mind means alleviating feelings of isolation and supporting the sense that the person is being cared for by an assistance network. Though in actuality this may not always be possible for those whose family members are among the casualties, the conditions that would best support security and peace of mind should be provided. A restful environment must be provided immediately, as it is very important to ensure adequate sleep during the early stage.

The Checklist on Need for Observation (at the end of these guidelines) should be filled out for any individual who has serious symptoms, whose condition is getting worse, who is considered high-risk, or who has had strong sleeping difficulty or nightmares for two or more days, and delivered to a psychiatrist for evaluation.

No method has been established for identifying individuals who are at high risk for PTSD. But we do know that special attention must be given to individuals who were strongly exposed to the trauma-inducing situations mentioned above, who lost a family member in the disaster, who have substantially lost the underpinnings of their lives, or who had previously experienced such trauma as an accident that killed a family member. Of course it may not be easy to obtain this kind of information, but it may help to talk with neighbors and friends or refer to earlier local public health records.

At the onset of PTSD, it must be reconfirmed that the survivor has an environment that supports the essentials of security, peace of mind and restful sleep. Furthermore, whenever the person exhibits especially strong anxiety or a heightening of symptoms, a psychiatrist must be consulted about how to proceed.

As a rule, in counseling soon after the event, do not ask the survivor to recount the story and emotional impact of the disaster experience. This can be harmful. It was previously thought that using this counseling technique (psychological debriefing) at an early stage could help to prevent the future onset of PTSD. But the technique is now discredited, and its avoidance is clearly recommended in guidelines of international psychologist associations and the US National Center for PTSD. If psychological debriefing is done it may result in a good feeling at that moment, but in the long run it may heighten future PTSD symptoms. Even now, proposals for assistance based on this old idea are sometimes presented. Do not use psychological debriefing.

What is important is to build a network around the survivor of understanding people who can talk together about the actual suffering in the disaster and subsequent difficulties in moving forward. That will depend on the cooperation of friends and neighbors, and may not involve hearing the full details of the experience or releasing all the feelings. It has been reported that building good personal connections with caregivers tends to lower survivors' long-term alcohol dependence.

3. Natural Recovery from Trauma

For most survivors, even if there is some temporary mental instability, they will naturally return to their normal selves. Among temporary housing residents and firefighters after the Hanshin Earthquake, the poisoned community in Wakayama, and employees surviving the “A” factory fire of 2003, after one year had passed there was a rather low rate of 10% with PTSD in the strict sense, or 20% when partial PTSD is included. These figures, which can be taken as a rough outlook, represent the incidence of PTSD one year after the event among personally impacted survivors of groups that suffered casualty levels of several percent. Naturally the figures will vary according to the definition of the survivor population and the intensity of the disaster. Surveys after the Wakayama poisoning found incidences of

18% for PTSD and 20% for partial PTSD at three months, and of 8% and 10% at both six months and twelve months afterward.

Thus under the above definition of the survivor population:

- (1) About 20% suffer from PTSD in the broad sense.
- (2) About 80% show natural recovery.
- (3) It may be inferred that after six months have passed, there will be virtually no natural recovery.

Therefore, as a policy for mental health care for the community as a whole, it should be assumed that natural recovery will occur in most cases, and support can be provided for that process. Toward that end it is necessary to:

- (1) Provide conditions that encourage natural recovery, and
- (2) Diminish factors that impede natural recovery.

This approach can be compared to treating a bodily ailment by ensuring adequate rest, cleanliness and nutrition. Of course, in order to serve survivors with severe symptoms or high-risk backgrounds, it will still be necessary to encourage screening and voluntary counseling in order to identify them so individual assistance can be provided.

1) Conditions that encourage natural recovery

A normal external body wound would be treated by providing sufficient rest and nourishment in a clean and peaceful environment. For trauma it is similar, and when the conditions are not present, there is not need to give professional treatment. The following are the conditions that encourage recovery.

• Practicalities

- (1) Guaranteeing bodily safety
- (2) Protection from secondary events (fire after earthquake, contamination by poisons, etc.)
- (3) Maintenance of living conditions
- (4) Continuity of daily life (school, work, household chores)
- (5) Prospects for recovering economic footing (finances, job security, home reconstruction)
- (6) Protection from day-to-day stress (group life in refugee shelter, reporters, etc.)

• General support

- (7) Information on damage and assistance
- (8) Regular visits by relief workers
- (9) Giving people the sense that "a helping hand" is extended
- (10) Prompt responses to requests and questions

• Psychological care

- (11) Information about psychological changes (including healthy states and recovery states as well as symptoms)
- (12) Suggestions for counseling when needed (hotline, counseling office)

2) Factors that impede natural recovery

Factors that impede recovery are intrusions that cause secondary trauma or threaten the stability of daily life. In the wake of a disaster such things as site inspections by public officials, or questioning about compensation by insurance companies will occur, and it must

be kept in mind that such processes impose psychological burdens. Yet the aspect of mental health is just one part of the decision on whether a process is permissible, and a comprehensive determination is needed for the site. At the least, attention should be given to psychological changes before and after these processes.

The factors that impede recovery are so diverse that they cannot all be enumerated here. Those which are most frequently encountered are listed here.

- Delay of practical assistance

- (1) Delay in rebuilding life
- (2) Deterioration of living conditions at temporary residence, difficulty in maintaining privacy
- (3) Family member or acquaintance killed, injured or missing

- Especially vulnerable groups (Including their families)

- (4) Infants
- (5) The elderly
- (6) The handicapped
- (7) The sick or injured
- (8) People whose first language is not Japanese

- Social milieu

- (9) Single persons
- (10) People with nobody outside the family to talk to

- Other

- (11) News interviews against a person's will
- (12) Inspections by police, public officials, insurance companies, etc.

4. Liaison with Outside Volunteers

1) Assistance policy should be set by the Disaster Relief Headquarters

After a disaster, volunteers from many different occupational backgrounds rush to the area, and few of them have any systematic knowledge about mental health care following a disaster, nor awareness of international health care standards. In particular, there is an organization for practicing the previously mentioned technique psychological debriefing, which was formed before its effectiveness was disproven, and even now there are still proposals for interventions using this technique. Furthermore, most volunteers leave after a few days without handing over in a manner that would allow continuity of their activities. The result is that the overall assistance policy is set in accordance only with advice from outsiders who do not care what problems are left unresolved. Proposals for cooperation from such diverse occupational categories should be handled by recruiting the skills that are necessary at particular times to meet particular needs, with overall assistance policy kept entirely as the responsibility of the local Disaster Relief Headquarters.

2) Contact with residents should be controlled by the Disaster Relief Headquarters

When volunteers who have rushed in from the outside make direct contact with residents of the disaster area, they must definitely provide information and services authorized

under the uniform direction of the Disaster Relief Headquarters. Otherwise, they will wreak havoc with the information and policies that are transmitted to the public. In a large-scale disaster situation it can be very difficult to maintain sufficient control of volunteer activities in the field, and every effort must be made to do so.

Volunteers have been known to independently introduce the long-discredited technique of acute-stage psychological debriefing in their interactions with local residents, and to deny the effectiveness of medications and take other measure which are detrimental to the area. Caution is required.

3) Surveys by outside groups should be controlled by the Disaster Relief Headquarters

During some recent disaster relief efforts, teams from outside the disaster area have surveyed residents and then gone home without reporting their findings. Casual survey taking can, depending on the questions, further arouse the anxieties of the residents. Often there are also problems in the ways the survey is explained and consent is obtained. Survey activities too should be kept under the control of the Disaster Relief Headquarters, and when a survey is deemed necessary for some reason, it should be designed carefully to include the participation of an ongoing assistance program.

5. Working with the Press

1) The importance of informational assistance from the press

Swift and impartial news coverage is quite beneficial, as it provides information about not only the disaster situation but also relief activities. In addition, news coverage promotes a sense of connection between the disaster area and the rest of the world, which can aid trauma recovery when it is perceived as a sort of treatment network. It is also effective for countering rumors and lessening victims' feelings of stigma.

2) Risk of triggering PTSD through newsgathering

Certain types of newsgathering activity, including the use of a flash without warning, an interview conducted by several correspondents, or photography of homes and refugee shelters, will aggravate the mental insecurity of the survivors. In particular, among the symptoms of PTSD is hypersensitivity (hypervigilance) toward visual and auditory shocks, which can be triggered by excessive newsgathering.

3) Dealing with the press

It is the duty of the Disaster Relief Headquarters to recognize the positive importance of press coverage and actively disclose appropriate information, and at the same time to obtain cooperation from the press to avoid such excesses as concentration on particular survivors or coverage of persons who are not fully aware of the newsgathering intent. It is important to adequately inform representatives of the press about the potentials for aggravation of psychological conditions through newsgathering activities. As a rule, press liaison activities should not be done by relief workers in the field, but handled in a uniform manner in the Disaster Relief Headquarters.

6. Multicultural Issues

Along with globalization, the number of people living in Japan who are not native speakers of Japanese has grown. Whether they are here as temporary visitors, students, or workers, most foreigners are regarded as especially vulnerable to disaster because of their limited comprehension of the Japanese language. In general they cannot fully grasp public information, and are therefore liable to suffer secondary uncertainty anxiety. They also tend to have difficulty in obtaining medical care or other assistance.

In addition, depending on their native culture, foreigners are likely to have different patterns of reaction to a disaster. This may well lead to complications in the course of group activities and refugee shelter living, and mental health care supervisors will need some special understanding to rectify them.

It would be helpful to have volunteers who can speak the native languages of the foreigners, but it is often impossible to have the right people on hand in the disaster setting. When there are multicultural needs, it may be possible to have linguists from outside the area prepare special messages for public information releases, or to request the media to prepare multilingual versions of disaster information broadcasts. Even though foreign-language versions may be less complete than the originals, the mere fact that information is provided in their native language will provide valuable reassurance to these survivors.

Foreign citizens who hold permanent residency are usually very well accustomed to Japanese life and will not suffer from the cultural dissonance described above. During certain disasters in the past there were instances of mob psychology in which foreigners became targets. Yet the amicable multicultural cooperation that was seen during the recovery from the Hanshin Earthquake demonstrates that in Japan today, adequate information delivery and administrative guidance can effectively bring everyone together. There is no need to include multicultural issues as a topic of disaster relief communications or refugee shelter arrangements, and indeed such special discussion would be likely to generate confusion.

7. Mental Health of Relief Workers

1) Background

Relief workers are, obviously, charged with providing assistance to disaster survivors, and because of this they may tend to neglect their own health issues or, even when they recognize them, have too strong a sense of mission to take breaks or seek treatment. Moreover, relief workers may develop different types of stresses than the survivors, and may have problems readjusting to their regular jobs after the relief work. If they seriously succumb to their own health problem, they may also lose awareness that they are impeding the smooth execution of relief work. Adequate care for relief workers must be provided, based on the recognition that they can accomplish their tasks only after adequately minding their own health.

2) Stress factors for relief workers

(1) Fatigue from ongoing pressure of relief work

Even if one is capable of working without sleep or rest during the immediate post-disaster emergency, if overwork continues for a longer period the accumulated fatigue is likely to become a problem. In contrast to the emergency phase when everyone works without

a clear structure, the longer-term work must be more precisely assigned to avoid excessive burdens and possible exhaustion or confusion. Thus care is needed to avoid "burnout syndrome."

(2) Sense of mission vs. practical limitations

Many relief workers are motivated by a pure sense of mission to assist victims. If for some external reason, such as insufficient water for continued firefighting work, they are unable to perform a task in the ideal fashion, it is possible that a psychological conflict between the sense of mission and the limitations of reality will cause feelings of guilt or powerlessness.

(3) Emotional outbursts from victims

Amid the extensive damage and suffering, area residents often display emotional reactions such as anger and guilt, and anger is particularly strong in the wake of a disaster caused by human action. As there is no opportunity to vent their anger at a directly responsible party, it is not unusual for pent-up anger to be released toward relief workers who are in the vicinity. If the workers feel like the anger is personally directed toward them, they may come under considerable stress. As described in the previous paragraph, if there is a sense of limitation on the completion of one's task, relief workers may have guilt feelings or a sense that they are avoiding their proper work.

(4) Viewing the horrors of the disaster area

Relief workers are quite likely, even more than most local residents, to be exposed to the sight of terrible damage, corpses and the like, which may result in PTSD or other trauma reactions.

(5) Vulnerability of self and loved ones

Relief workers who live in the affected area or their families, may also suffer, or fear they may suffer, damage and loss. When family members or acquaintances are among the disaster victims, the dedicated care given to relief activities can cause extra psychological tensions and exhaustion.

(6) Adjusting to a new place and being away from home

Relief workers who have come from other areas may have trouble adjusting to their sleeping, eating or working arrangements, and the stress may build up further because they are unable to release it through their normal recreation or exercise activities. Aside from the disaster situation, there may be ongoing problems at home that build up tension, especially if the relief work assignment continues for a long time. The stress will be heightened if the assignment is for an indefinite period.

3) Psychological reactions of relief workers

The following types of reactions could occur among relief workers in a disaster area:

(1) Acute stress disorder (ASD)

- (2) PTSD
- (3) Adjustment disorder
- (4) Phobia
- (5) Aggravation of existing mental disorders
- (6) Other reactions

4) Countermeasures

- (1) Definite work rotation and assignments

Though it may not be possible during the emergency phase just after the event, as soon as it is practical the activity periods, relief schedules, responsibilities and job descriptions must be clarified for all mobilized relief workers.

- (2) Education about stress on relief workers

It is effective to teach relief workers that stress is nothing to be ashamed of, but instead must be recognized and adequately treated.

- (3) Self-awareness of mind and body and health counseling

It is important to give each relief worker a checklist of potential physical and mental irregularities, and when necessary to offer health counseling.

- (4) Education about survivors' psychological reactions

Relief workers should be informed that they may be the target of intense outbursts of anger or other emotions by survivors undergoing psychological reactions. It may be useful to hold trainings that include role-playing exercises.

- (5) Simulation of disaster scenes

Slide shows or simulations of disaster scenes including bodies, wounded people, etc. can help to prepare relief workers for shocks they may encounter in the field.

- (6) Making the work meaningful

Expressions of admiration or gratitude for the efforts of particular individuals within the relief work organization is surprisingly rare. It is important to clearly acknowledge the value of the work, through accounts in a community newsletter about the significance and results of certain activities, or in group meetings where supervisors highlight special achievements.

IV. Things to Start Doing Now

1) Public education about mental health care and disasters

As a part of regular mental health care activities, information should be provided to the local public, as described in part II of these Guidelines, about the types of psychological

reactions that may occur in the event of a disaster and how to respond to them. Regarding PTSD in particular, inaccurate information has been presented by the mass media, and this should be corrected. The following points should be emphasized:

- (1) After a disaster, psychological changes affect more than half of the affected community, and most of the reactions are normal.
- (2) PTSD cannot be diagnosed until at least one month after the symptoms appear.
- (3) When PTSD is diagnosed, most people are capable of recovery, and natural recovery can be facilitated by avoiding secondary shocks and getting adequate personal support. Building a network of supportive people in the neighborhood is very important.
- (4) Psychological debriefing done soon after the disaster experience does not work to prevent PTSD.
- (5) Between 10 and 20% of people who had very strong experiences are likely to have long-term PTSD symptoms. If it doesn't seem to be subsiding naturally, a specialist is always available for consultation.

2) Mental health care simulations during disaster drills

Simulations of physical rescue activities are commonly included in disaster preparedness drills, but simulations of mental health care relief activities are not. Policies for mental health care should be included in discussions at mock disaster headquarters, rescue squads should practice providing basic psychological tips to people at disaster sites, and there should be rehearsals of consultations about insomnia or anxiety. It is helpful for a community leader to play the role of a citizen who complains of anxiety and comes for counseling, as this example is likely to reduce the stigma that many people place on the topic of psychological aid.

3) Arranging funding for mental health care

Arrangements need to be made in advance for the human resources that would be needed for services in a time of disaster. This includes lists of contacts for each occupational category, as well as contact information for persons who can provide advice. If people from different cultural backgrounds are likely to be in the area, it will be helpful to include foreigners and foreign language speakers in the volunteer lists.

4) Making mental trauma care part of routine mental health services

Aside from disaster situations, mental trauma is a problem that routinely occurs among victims of abuse, accidents, domestic violence or crime. The mental symptoms that occur in these cases are hardly any different from those which occur among residents of areas struck by disaster. Mental health professionals should make efforts to amass experience in dealing with mental trauma cases and become accustomed to them, and make opportunities to exchange information with women's and children's counseling centers where such cases tend to be concentrated.

5) Training for mental health care providers

To enhance the skills of supervisors who handle mental trauma in disasters and other situations, professional trainings and related events should be actively arranged. Not only psychology professionals, but also those with supervisory positions in disaster preparedness committees and public agencies should receive training. Public officials who are also

qualified physicians should be especially encouraged to take training, so that they can be prepared to combine administrative and clinical skills in managing local mental health care policies in the event of a disaster.

Note: The 2002 annual in-service training of the Japan Psychiatric Hospital Association is about policies for building local mental health. The particular focus of their trainings changes every year.

Checklist for Necessity of Observation (Immediately after disaster event)

Recorder	District				
Recorder's affiliation	Date/Time	Date:	Time:	AM	PM
	Name				
Recorder's phone number	Age				
	Gender				
		Extreme	Definite	Some-what	None
Cannot settle down and be still					
Incoherent speech and behavior					
Absentminded, unresponsive					
Afraid, frightened					
Crying, sad					
Appears anxious, scared					
Palpitations, breathing difficulty, trembling					
Agitated, speaks loudly					
Unable to sleep since disaster event					

Major accident or disaster experience before this disaster 1 Yes 0 No

Family member missing, dead or seriously injured in this disaster 1 Yes 0 No

Medical care interrupted, medication lost (including physical ailments) 1 Yes 0 No

Condition:

Medication:

Special vulnerability (elderly, infant, handicapped, ill or injured, non-native Japanese speaker, etc.) 1 Yes 0 No

Vulnerability:

Especially vulnerable family member 1 Yes 0 No

Glossary

Posttraumatic Stress Disorder (PTSD): A trauma reaction arising from mental trauma which consists of recollection of an experience which brings on terror of an intensity comparable to a life-threatening situation. A vivid scene of an event and associated feelings of terror are intrusively recalled e.g. as a flashback, accompanied by increased arousal (hypervigilance) with strong stimulation of the sympathetic nervous system, numbing with inability to distinguish between present events and the past experience, and avoidance of stimuli that trigger recollection of the experience. Symptoms continuing for one month or longer. Diagnostic criteria listed in next section. Drug therapy with SSRI antidepressants and cognitive behavioral therapy are effective for treatment. Preconditions for treatment are prevention of secondary trauma, and availability of social and psychological support. Remission may occur with only such support.

Outreach: Service provided not by waiting at the provider's own facility or desk for those seeking service to visit, but by going to their locations (neighborhoods, workplaces, etc.) to provide service. Where needs are not clearly defined, outreach must begin by uncovering the needs. Notwithstanding the fact that most residents of disaster areas have post-disaster psychological reactions that require temporary assistance, in Japan people are extremely hesitant to seek psychological care which would pursue further practical responses, and only rarely do individuals seek mental health care at their own initiative. It is therefore important to respond to latent needs through outreach programs.

Psychology Education: Public education activities following a disaster or other major event, concerning the types of psychological changes that occur, what their causes may be, what kinds of responses are needed, and what type of assistance is available. Normally performed by means of publicity, visits by mental health professionals and other relief workers, and opening of consultation centers. As a rule, people who have experienced a disaster event are unable adequately to comprehend the psychological changes which they are experiencing, the realization that their psychological condition differs from usual times usually is a source of yet greater anxiety, and they don't know what kind of treatment they should seek. Psychology education is an important way to provide appropriate information and strengthen the motivation to seek treatment. Psychology education is aimed not only at those who have reactions, but also at the surrounding community, in the hope that people will recognize their own psychological reactions and will receive support from those around them when they seek treatment.

Debriefing (Psychological Debriefing): An acute-stage intervention carried out between several days and several weeks after a disaster experience, which has been claimed to be a way of preventing the worsening of stress reactions and the onset of PTSD and has been practiced in various countries. Its effectiveness in preventing PTSD onset has been repudiated, and indeed there are reports that in some cases it aggravates the disorder. Encouraging a person to talk about a traumatic experience – as is stressed in psychology education material about trauma treatment – sometimes provides a detrimental stimulus and impedes the natural recovery process. In Western countries it is often used with firefighters, police officers and soldiers. During the acute stage it is necessary to surround the victim with helpful consideration, but there is no need to push into the content of the experience and encourage the venting of emotions.

Vulnerability: Among survivors of the same experience, some develop PTSD and some do not, and there are also individual variations in the intensity of symptoms and the recovery process. Therefore, aside from the experience of an external traumatic event, it is suspected that individual factors (vulnerability) are also involved. In many cases the experience seems to have been identical, yet the actual content of the experience varies greatly from person to person. In statistical analyses, there is good correlation between the intensity of the shocking experience and the later incidence of PTSD and seriousness of symptoms. Another important aspect is social support. After considering this factor, we should consider individual vulnerability. Research on vulnerability is by no means complete, but studies are examining correlations between PTSD and prior individual or family history of mental disorders, low self-respect and low intelligence, past trauma experience, introverted character, unclear boundary between the self and the world, and female gender.

Partial PTSD: A posttraumatic stress reaction where all criteria of PTSD are not necessarily present. To fulfill the diagnostic criteria for PTSD, specified minimum numbers of symptoms of reexperiencing (flashbacks, distressing dreams, etc.), of avoidance and numbing (social withdrawal, diminished memory, etc.), and of increased arousal (sleeping difficulty, irritability, etc.) must all be present. Partial PTSD is the name used for a condition that displays some PTSD reactions but does not meet all of the diagnostic criteria.

Acute Stress Disorder (ASD): Occurrence of transient excessive stress reactions immediately following a major disaster. ASD symptoms are similar to those of PTSD, but the diagnosis depends on dissociation symptoms, in addition to the three types of indications for PTSD., ASD symptoms appear between two days and four weeks after the disaster, whereas PTSD is diagnosable when symptoms continue for more than one month after the event. While a high possibility of natural recovery is noted for ASD, it has been argued that it is a strong predictor of the onset of PTSD.

Diagnostic Criteria for Posttraumatic Stress Disorder

(Excerpt from DSM-IV™ – *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, © American Psychiatric Association)

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.
Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event.
Note: In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
Note: In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating

- (4) hypervigilance
- (5) exaggerated startle response

- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor