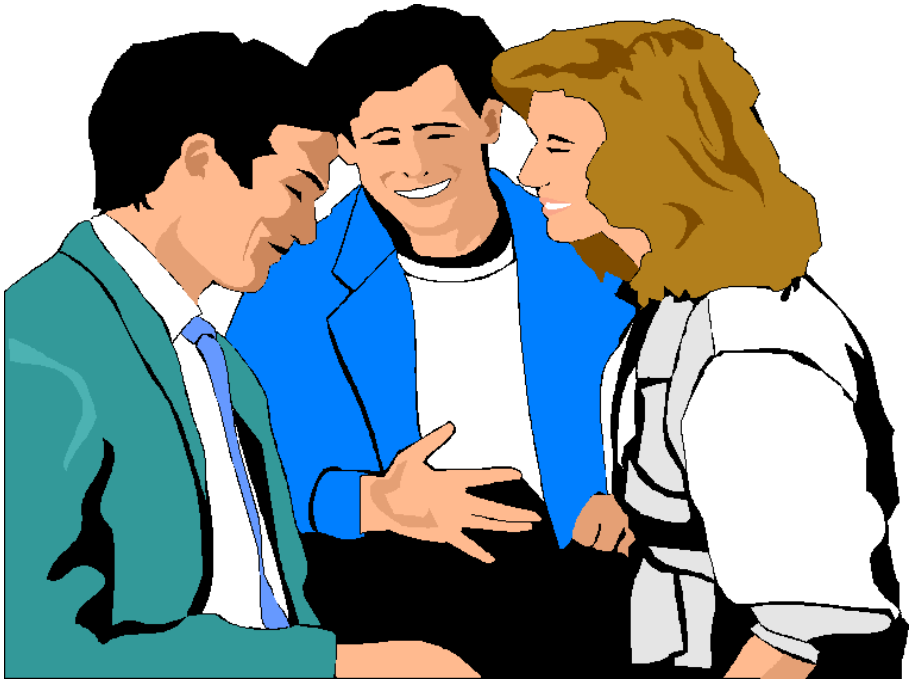
FACILITATING PSYCHOSOCIAL RECONSTRUCTION

A Manual for Crisis and Disaster Intervention

Gilbert Brenson-Lazan and
María Mercedes Sarmiento D.



GFSC
Global Facilitators Serving Communities

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FACILITATING PSYCHOSOCIAL RECONSTRUCTION: A Manual for Crisis and Disaster Intervention

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INTRODUCTION to 9th Edition

This is the ninth edition of this manual and its two accompanying manuals (one for children and one for adult survivors). These manuals have been published in several languages and are available free of charge to non-profit agencies and organizations from Global Facilitators Serving Communities, Inc. These manuals are not for re-sale.

In November of 1985, Colombia suffered one of the worst tragedies in its history: the eruption of the Arenas Volcano and the ensuing avalanche that buried one of the most beautiful towns in the country: Armero. Twenty five thousand people lost their lives on that ill-fated night when tons of rock and mud covered thousands of homes with families asleep inside. Another two hundred thousand people were affected by the human and financial loss of this tragedy.

At that time, we wrote the first edition of this manual to meet the immediate needs of hundreds of volunteer workers and professional caregivers. Since that tragedy we have trained and mentored close to one thousand professionals in facilitating psychosocial reconstruction throughout Latin America (Argentina, Bolivia, Colombia, Ecuador, Honduras, Mexico, Nicaragua, Peru and Venezuela), as well as in Canada, Hong Kong, Malaysia, and Taiwan. Most recently, GFSC has facilitated a dynamic and successful process of community capacity building in New Orleans after the disaster of Hurricanes Katrina and Rita.

Presently we face some tremendous challenges: natural and social disasters hit every social class in every corner of the world. Facilitation techniques are proving to be some of the most effective intervention tools for grief management and psychosocial reconstruction, building the resilience and self-reliance of individuals and communities everywhere.

The success of our support to the institutions and professionals that provide help to the victims and those affected by tragedy, directly or indirectly, is made possible, in great part, by the hundreds of professionals and other volunteers who have trained to work in this area, and who have donated time and money to train hundreds of facilitators and distribute tens of thousands of manuals.

We dedicate this publication to you, our reader, who will use this guide to bring relief to people's pain. We only ask one thing in exchange: that you recognize and develop your potential to help others with professional responsibility.

Gilbert Brenson-Lazán
Global Facilitators Serving Communities
Santafé de Bogotá, Colombia
3 August 2006

I - THE CONCEPT OF CRISIS

Any traumatic event can trigger a personal, family and/or community crisis. Crisis is not bad. Crisis is normal, natural and even necessary for a life transition. Asian philosophy views crisis as something very different from the Western concept.

As indicated in this Chinese symbol, a crisis is a combination of two realities: a danger (top symbol) and an opportunity (bottom symbol). The danger enters when people have a dysfunctional reaction to the tragedy. The opportunity presents itself when they have a functional reaction to it, bringing about personal growth, strengthening of family ties, and community solidarity.

Crisis intervention is a special field within the human and social sciences that requires knowledge from disciplines such as psychology, education, group dynamics and social work. It is not and should not be considered psychotherapy because grief is not pathological. Nonetheless, it can be very "therapeutic" when an individual, a family or a community goes through an appropriate grieving process and come out strengthened. The vast majority of survivors, victims and those hurt by the tragedy do not need psychotherapy or drugs, nor is it useful for them to be treated with those traditional methods. They need help finding new and effective resources within themselves to avoid the dangers, to be able to overcome their desperate circumstances, and to take advantage of the opportunity for personal growth.

II - THE PROCESS OF GRIEF

Grief is the process through which the victim and family deal with the emotional and cognitive impact of a trauma. Let's examine the process of grief, the reactions to trauma, and the recovery process.

A) THE TRAUMATIC EVENT: Any change can generate stress and even a crisis. When that change is massive or transcendental (exceeding normal limits and having a strong formative effect), it is normal to see physical, emotional and social symptoms which, under other circumstances, would be considered "pathological." The symptoms themselves are not the problem; what we do with them can be.

The classic study of Holmes and Rahe (1968) gives us an indication of the depth and severity of the trauma we can expect from a crisis. They studied a series of traumas and their existential impact on people in terms of the probabilities for a reactive depression. After researching all the events that can cause or contribute to a secondary crisis, they assigned a numerical value of 1 (less impact) to 100 (maximum impact) to each one.

"Scoring" 300 points within a relatively short period of time greatly increases the probabilities for a secondary, reactive depression to occur. While in many cultures and subcultures the specific point value may vary due to certain culturally-determined values, beliefs and assumptions, the overall profile has been validated in most cultures. The studies were conducted in different cultures and social/economical levels. The (+) or (-) after each event signifies a greater or lesser impact tendency in many non-Anglosaxon cultures.

EVENT:	
Death of a spouse:	***100 +***
Death of another family member:	***63 +***
Personal wounds or illness:	***53 -***
Loss of a job or income:	***47 -***
Family member wounded or ill:	***44 +***
Personal possessions or financial losses:	***38 -***
Death of a close and personal friend:	***37 +***
Changing jobs or a new position:	***36 -***

Overwhelming debt:	***31 -***
A change in lifestyle or relocating:	***25 +***
A change in personal habits or routines:	***24 +***
A new school or a change in recreational activities:	***20***
A change in social activities:	***18***
Small debt:	***17 -***
Christmas, Anniversaries, Birthdays:	***12***

A simple math exercise will show us how victims who have lost everything in a natural or social disaster can easily accumulate up to 548 points, almost double the limit for a reactive depression. Victims with a partial damage can accumulate up to 390 points, and those slightly affected can approach 300 points. Keep in mind that these studies are based on statistical averages; it is not possible to accurately predict which individuals will undergo a reactive depression.

B) DENIAL: The process by which a person discounts, refuses to accept or underestimates:

- the ***existence*** of the traumatic event;
- the ***significance***, seriousness or extent of the traumatic event;
- the ***options*** available to avoid it or recover from it;
- the ***resources or people*** that can help.

Just as the body reacts to physical trauma by going into a state of shock, the mind can also go into a "state of shock," denying the existence of the traumatic event. This state of mind generally begins immediately after the trauma. It is a coping mechanism to give the victim the time he or she needs to prepare and be able to bear the tremendous impact of what has happened and of what is to come. Generally, the denial of the existence of the event only lasts a few minutes and it is not an indication of a psychological problem unless it continues for several days or longer. The other types of denial may continue for some time.

Here are some real examples from different tragedies:

> ***"My son can't be dead. They made a mistake in the identification."*** **(existence).**
> ***"No big deal! The mudslide went mainly through swampland."*** **(significance).**
> ***"What can we do? This is earthquake territory."*** **(options).**
> ***"A grief workshop? What a waste of time."*** **(resources/people).**

C) INITIAL REACTIONS: Almost immediately after the traumatic event, people start to make an assessment of the situation and accept (or not) the reality of it. A set of symptoms generally develop and are part of the initial reaction. These are all very normal and necessary within the context of the traumatic experience. Although in other contexts they may be seen as pathological, they should never be considered as such as they are all important aspects of the process of grieving and eventual recovery.

These manifestations can be seen in the physical, psychological, social or spiritual dimensions of the human being or more commonly, in a combination of two or more. Some of these more common manifestations are:

1. **Psychosomatic disorders:** Very often one of the first reactions is the change from emotional shock to psychosomatic (physical) symptoms. Among the most frequent signs of this phenomenon are: headaches and migraines, dizziness, fainting, increased heart rate, abrupt changes in blood pressure, chest pressure or "shortness of breath," lethargy, chronic tiredness and digestive system dysfunction. These symptoms tend to decrease as the first phase ends, and while those that suffer these symptoms should be seen by a medical doctor, they should only be treated with medication that is necessary for the overall well being of the person.

   These psychosomatic disorders should not be confused with hypochondria, a psychopathology. In the former, the anxiety produced by the tragedy is converted into physical pain and discomfort (such as that feeling in your stomach as you look down while leaning over the rail of a 15th floor balcony). The latter is a much more complex, pathological elaboration that generally requires psychotherapy.

2. **Anxiety:** The following are some of the symptoms that may be seen in this category of initial reactions. They can be manifested all at once, partially or alternately:

   a) Apathy: The victim is usually uninterested in and detached from the world around him or her. Frequently associated signs are a desire to sleep all the time or to remain totally inactive.

   b) Hyperactivity: The total opposite of apathy, hyperactivity is marked by excessive physical activity. There is constant movement, restlessness, inability to sleep, and a need to be always actively working. For example, after a tragedy such as an earthquake, we see in the victim a desire to look for survivors beyond hope of finding anyone alive, or to help other victims to the point of exhaustion.

   c) Distorted Perceptions: Though often associated with psychotic behavior, this is a very common symptom in victims of a tragedy or trauma related to a natural disaster. A person may become completely convinced that he/she heard or saw a loved one that is either lost or dead. The perceptions are very selective, and even when faced with reality, the victims own personal reality takes precedence over any other proof in the form of facts.

   d) Sleep Disorders: these may include different forms of insomnia, nightmares, etc.

   e) Thoughts of Suicide: Who under the pain and stress of a traumatic experience hasn't had a suicidal thought? Victims who don't sometimes can be more troubled than those who do. If these feelings get out of control and become a real attempt to commit suicide, professional help should be sought for the victim (see Section III-A).

3. **Hypersensibility and Emotional Variability:** The third group of initial reactions to a trauma is the emotional variability. This type of reaction is absolutely normal and even necessary, not only to feel the emotions, but also to express them. This allows for the grieving process to take its natural course so the victim can find healing and closure. When emotions are not allowed to surface due to cultural, social or family values, they are

repressed. This can trigger serious consequences long after the tragedy. Sometimes it can take years for them to surface.

The four emotions that are most intense after trauma and possibly for months afterwards, even though they may be masked, rationalized or denied by the person, are:

a) Sadness: This is an intense feeling of pain and sense of loss because of the circumstances surrounding the tragedy affecting the victim, the families and the community. These feelings come and go when remembering or talking about the tragedy, or when receiving condolences. This emotion is evoked by anything that would recall the victim's sense of loss.

b) Anger: A very intense emotion, sometimes aimed at different things or people such as:

   - Nature
   - God
   - Destiny
   - The deceased (Why did they leave me?)
   - The survivors (Why them and not my parents?)
   - Even the people trying to help them (Volunteers)

   Because of social and cultural values, sometimes this is the most commonly repressed emotion among the victims of such tragic circumstances.

c) Fear: Victims of a tragedy or any other traumatic circumstance always fear a life without their loved ones or the material possessions they have lost. These feelings are made worse by a constant fear of the possibility of the tragedy repeating itself, e.g., when you have after-shocks for several days following an earthquake.

d) Guilt: Even in the case of a natural disaster, it is very common to see victims suffering from "survivor's guilt." They feel guilty because:

- They survived (while others perished),
- They did not (or could not) help rescue other victims,
- They might be doing better than the other survivors in some ways, for example, access to food, clothing, shelter, etc.
- They did not behave in a nicer way to some of the victims while they were still alive.

4. **Personal Disorganization:** When faced with a traumatic situation, the value system and personal standard for living for the victims, their families and their community frequently "fall apart." They start to function in a state of limbo or social vacuum. Their ability to perform everyday responsibilities and activities goes into total disarray. Sometimes they abandon strong spiritual beliefs, and even lose sense of otherwise very important moral ethics that they had before the trauma.

During the first few weeks and even months after the traumatic event, the victims need nothing more than time and understanding of the grief process, of themselves and, of their initial reactions, which soon diminish in intensity and frequency. Unfortunately, many choose to see these initial reactions as psychological problems, often using sedatives or anti-depressive medication for "treatment." Numerous studies show that the use of medication only tends to cover-up or delay the feelings and reactions that should surface during the grieving process. An exception, of course, would be those cases in which the person becomes a risk to him or herself, or to others.

It has proven very helpful for these people to participate in workshops where they can talk about what has happened to them, especially to describe their feelings, and realize that what they are going through is completely normal, natural and necessary. Program designs for such workshops are available in several languages at the Global Facilitator Service Corps Virtual Library, https://globalfacilitators.org. Five- and ten-year followup research of disaster victims has shown that the greatest perceived value of these workshops was that of "feeling like a normal person" in the light of the multitude of initial reactions.

One special consequence of the traumatic event is the so-called Post-Traumatic Stress Disorder (PTSD) or Primary Traumatic Stress (PTS). The PTSD reflects a psychological state that develops in a person who has been involved in an accident, act of violence, or overwhelming tragedy or disaster. The main trait of this condition is that it leaves an imprinting, or mental print, on the victim. This traumatic anxiety can begin as soon as the victim gets past the initial shock or a few months later and can last for several years, as in the case of a post-war neurosis. It is to be expected that the victims of a severe natural disaster or social catastrophe may have deep, emotional scars for several years. Their intensity and duration, however, are dramatically reduced by adequate facilitation of the grieving and social reconstruction process in its appropriate time.

D) THE CHOICE OF STRATEGIES: As external events and the initial reactions develop and play out, the affected person will generally try different strategies, almost all well-intentioned, to try to cope. These strategies can be functional or dysfunctional, in spite of the best intentions.

"Everything can be taken from a human being except one thing: his or her free will to choose an attitude in a given circumstance." **Dr. Viktor Frankl**

1. Functional Strategies: The first functional strategy is to survive and then to elaborate the reactions mentioned earlier. As this evolutionary process continues, the victims start to function dealing with their new reality. Not only do they overcome the crisis, but they also learn from it: they mature as individuals; their family relationships become healthier and more cohesive. This strengthens their relationships within the community. These functional strategies are the "opportunity" of a crisis.

In a 1999 United Nations Commission on Education in the XXI Century, Jacques DeLors and his colleagues developed a model of four learnings that are necessary for the new millennium. We have found this model very useful in disaster intervention:

- Learn to Learn: The more traditional ways of learning are often not useful after a tragedy, especially "talking head" interventions. We favor group-based, experiential and participative learning facilitation methodologies for adults and their groups, based on constructivist and andragogical (adult learning), as opposed to pedagogical (child learning) principles.

- Learn to Achieve: Once meaningful learning is taking place, it becomes necessary to act and to achieve new goals. To start a new life it is often necessary to learn new skills and new ways to live and to produce.

- Learn to Grow: It is the opportunity to grow and develop as a person: physically, mentally, socially and spiritually.

- Learn to Cooperate: It is not enough that a person learns to achieve and to grow as an individual. Groups and communities also must learn to live together. After a disaster the new community has to organize itself and begin to work together towards its reconstruction. This also means learning to respect other opinions and to value diversity.

The following table (Brenson, Sarmiento, and Rodas, 2001) summarizes the evolutionary process of psychosocial reconstruction after a disaster:

EVOLUTIONARY PROCESS OF PSYCHOSOCIAL RECONSTRUCTION

RECOVERY STAGE & BASIC NEED:	**FUNCTIONAL STRATEGY:**	**ACTIVITIES:**	**SKILLS NEEDED:**	**APPROPRIATE LEADERSHIP STYLE:**
Stage: Reactive Basic Need: Survival	Accommodate: Come Through	Awareness about the new reality and its impact. It is necessary to initiate a catharsis of the emotions related to the grief. The person needs to adapt to the new situation of survival.	Physical, mental, social and spiritual survival.	Directive
Stage: Receptive Basic Need: Security	Assimilate: Come Along	Identify, understand and admit personal reactions to the crisis as something normal, natural and necessary for healing and growth. It will be necessary to understand the implications, to explore new options and recognize the positive aspects of the negative event.	Accept the new reality with awareness, persistence, reflection, compliance, analysis, observation, flexibility, adaptation, etc.	Coordinating
Stage: Proactive Basic Need: Autonomy	Activate: Come Forward	Remember, use and actively develop all the internal and external resources that one has, has had in the past and which will continue existing in spite of the tragedy, in order to achieve personal growth. Implement plans and introduce new alternatives.	Participate in one's own growth by doing, becoming, assertiveness, validation, authenticity, personal mission, empowerment, achievement, creativity, accountability, etc.	Monitoring
Stage: Interactive Basic Need: Transcendence	Associate: Come Together	Contribute, cooperate, collaborate and co-create with others so that together the problem can be converted into an opportunity for personal and group growth.	Strengthen social bonds and intimacy through affiliation, sharing, advocacy, solidarity, alliances, win-win, cooperation, etc.	Consulting

Our first and most important conclusion indicated by the evolutionary process described above is that disaster intervention and disaster management must follow the same precepts as Situational Leadership (Tannenbaum and Schmidt, 1958; and Blanchard-Hershey, 1996): each stage requires a different kind of leadership strategy in order to be effective.

- In the **Reactive** Stage, a ***directive*** leadership style is most effective in order to establish order and facilitate survival. Decisions are announced and clarified.

- In the **Receptive** Stage, a ***coordinating*** leadership style is most effective. Bureaucratic structures are generally necessary and the Leader-Coordinator continues to have a high profile to facilitate greater personal and group security, while relying on participative processes to be able to have the criteria to make equitable decisions.

- In the **Proactive** Stage, a ***monitoring*** leadership style is most effective. Here the leader assumes a much lower profile, facilitating democratic and participative group consensus methodologies and alternative conflict resolution. Decisions are consensus-based.

- In the **Interactive** Stage, a ***consulting*** leadership style is most effective. The leader is a very low profile consultant-mentor that facilitates synergistic and co-evolutionary processes.

2. Dysfunctional Strategies: Paul Watzlawick (1989) was the first to introduce the concept of a "pseudo-solution" – a difficulty turned into a more serious problem by the use of a "solution" that is more dangerous than the initial difficulty that needs to be resolved. Pseudosolutions (Watslawick, 1984) are what we do, with the best intentions, when we try to solve a problem with a strategy that ends up making it worse. These dysfunctional strategies are the “danger” in a crisis:

- **Agitate – Get Away:** avoid awareness of the current reality through flight, escape, denial, hallucinations, drug abuse, hyperactivity, depression, anxiety, suicide, etc.

- **Abdicate - Get Helpless:** become passive-dependent when faced by the new reality through indolence, co-dependence, renouncing responsibility for self, illusion, magical thinking, conformity, resignation, symbiosis, fatalism, etc.

- **Automate - Get Stuck:** redouble the effort in an unproductive behavior with the hope that it might become productive, through excessive valuing of the past, blind struggle, excessive individualism, inflexibility, obstinacy, rigidity, resistance, manipulation, etc.

- **Alienate - Get Control:** a primitive fight response through hostile and/or aggressive behavior, excessive competitiveness or hoarding, win-lose attitude, control at all cost, power struggles, etc.

E) SECONDARY CRISIS: When dysfunctional strategies are frequently chosen to cope with the initial reactions, normal in their original content, they can rapidly become part of a new personal and social pathology. This Secondary Crisis frequently requires professional psychotherapeutic intervention.

There are a number of specific factors that increase the risk of a Secondary Crisis:

- A delay in the start of the grieving process.
- A previous ambivalent relationship with the deceased or the lost possessions.
- A lack of preparedness for the loss, both in the mental and material sense.
- An absence of moral and spiritual values.
- Traumatic anxiety at the same time of the loss.
- Excessive dependency on the deceased.
- Difficulty in tolerating or expressing emotions.
- A background that includes previously unresolved losses, the death of a key figure during childhood, or depression or other psychological problems.

With appropriate professional help, the person suffering from a Secondary Crisis can break this vicious cycle (dysfunctional reaction-secondary crisis-dysfunctional reaction-worse secondary crisis) at any time. These interventions are best managed by mental health professionals and our experience shows that they respond best to methodologies of brief systemic group and family therapy, EMDR (Eye Movement Desensitization and Reprocessing) and several other specialized techniques beyond the resources of a group facilitator.

The principal manifestations of a Secondary Crisis are as follows:

1. Hyperactivity: The initial hyperactivity can become a habit with an obsessive pattern, due to the systemic reinforcement by other people and events. People can become workaholics, sometimes to the benefit of others, but soon discover they can't hide from reality and it can be even worse for them in the long run. This manic reaction is alarmingly common among the professionals and volunteers who work in the zones affected by catastrophes.

2. Apathy: This is an extension of another initial reaction (passivity) but in a much more prolonged manner. The person may choose to remain isolated or in bed most of the time. There may be no attempt to look for work and often there is very little if any affectionate behavior given or received.

In some cases there is a strong environmental reinforcement of this apathy by overly protective or paternalistic attitudes and behaviors on the part of the people trying to help: being a victim is good business. Their standard of living can improve considerably and they may be much better off than before the tragedy. It would be a great mistake to attribute this situation to just laziness. On the contrary, it should be recognized as a secondary crisis and dealt with in the most appropriate way.

3. Excessive Identification: Some people excessively identify with a deceased person, adopting certain characteristics of their personality, habits, gestures, activities and even their diseases. This condition can seem innocuous, but it reflects a serious depression. Like any other prolonged manifestation of Secondary Crisis, the attention of a competent professional is required.

4. Chronic Psychosomatic Disorder: Because of physiological, psychological, and social reasons, the initial psychosomatic disorder can become a habitual behavior pattern. It is not hypochondria and they are not pretending. The disease is real and generally it requires medical and psychiatric treatment.

5. Relational Crisis: When personal turmoil becomes a pattern, social relationships begin to suffer stress, especially on a conjugal and family level. Even in a previously stable relationship, and much more in openly unstable relationships, it is common to see a 300-400% increase in marital separations, infidelity, loss of sexual interest, etc. The best approach in these cases is marital or family therapy.

6. Drug/alcohol Dependency: Another social indicator that triples is drug abuse. It is very common after a trauma to find alarming increases in alcohol consumption

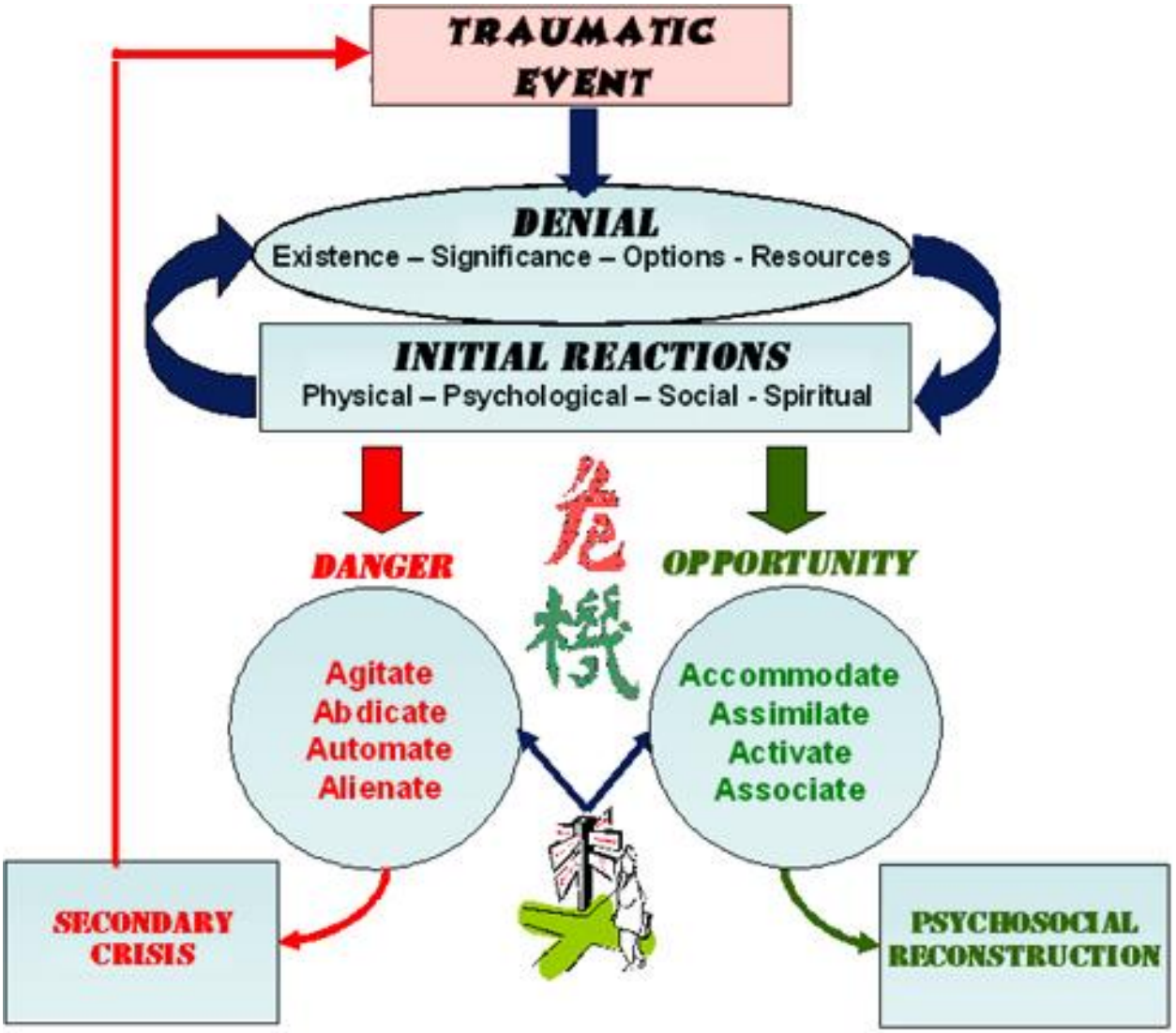
and the use of psychotropic drugs, including those prescribed by a well-meaning doctor. People can easily end up with an alcohol or other chemical dependency.

7. Aggression or Suicide Attempts: When the feelings of the initial stage are not dealt with in a suitable way, the result can be extreme aggression against others or against oneself. We frequently see a very high incidence of intrafamily physical violence after a disaster, especially directed toward children.

8. Psychotic Depression: As a result of not allowing the normal and necessary grieving process to take place, we see a vicious circle of one secondary crisis after another. These tend to intensify to the point where a person can choose to escape and live only within his or her internal reality: psychosis. These people require immediate psychiatric attention to aid their recovery.

F) PSYCHOSOCIAL RECONSTRUCTION AND GROWTH: Our objective as facilitators is not merely "getting people through the crisis." We are dedicated to the creation and maintenance of spaces and processes of group and individual self-development. While we recognize the importance of facilitating the reduction of pain and suffering during the "danger" in a disaster, our energies are mostly dedicated to taking advantage of the "opportunity" for a real and meaningful reconstruction and for individual and group development. We have seen many, many cases of poor communities, dysfunctional families, interpersonal conflicts and individuals in crises who have been able, not only to "recover" from a disaster, but also to take advantage of the opportunities that it provides for important personal, conjugal, family, group, organizational and community growth.

RECOVERY PROCESS SUMMARY



III - FACILITATING PSYCHOSOCIAL RECONSTRUCTION

In spite of several references previously made to the need for professional therapy during a secondary crisis, we realize that it is almost impossible to provide adequate and qualified therapy for the survivors of a tragedy of great magnitude. It is possible, however, to mobilize caring people who are willing to learn a few basic facilitating tools in order to prevent the secondary crisis in the majority of disaster victims. The following skills and interventions, some of which have been adapted from psychotherapy and others from more traditional group facilitation, are shared with the purpose of enabling any responsible person to help individuals and families in crisis to survive the tragedy, to recover from it, and to grow as a result of this process. Because some of these interventions are not part of the normal "toolkit" of a group facilitator, she/he may not be prepared or willing to do the intervention. Nevertheless, it is her/his responsibility to facilitate the necessary contacts with the professionals who can employ these techniques.

A) INTERVENTION STRATEGIES:

1. Facilitate Catharsis: Listening with empathy to the victim of a tragedy facilitates a catharsis, the release of repressed feelings. You must carefully choose the appropriate time and place to facilitate this process, since it can be lengthy and very emotional. Many people do not want to express their feelings due to different social and cultural constraints. Nonetheless, the repression of feelings during an extended period of time often provokes a secondary crisis.

In some cultures a serious problem in disaster areas is that many well-meaning professionals who want to help the victims, frequently block – deliberately or unconsciously – the healing benefits of catharsis.

One refugee shelter manager in Venezuela, a military officer, tried to prevent victims from attending a very helpful grief management workshop by saying, "It's not good for you to go to that workshop and talk about all your pain. You need to forget about the earthquake, not re-live it."

We cannot deny the good intention of this person, but at the same time we must recognize the great damage that can be done to someone when we ignore the importance of catharsis in the recovery process. Do not hesitate to talk with the

victim about his/her emotions. If it has been previously discussed and resolved, there will be no problem. If not, or it has been several months and slow in coming, then this will be the best opportunity for her/him to start the healing process. If a person repeatedly does not want to open up and talk about these issues, don't insist beyond saying that you have experienced or read of the importance of expressing all these feelings. There is a right time for everything.

2. Confront the Possibility of Suicide: Honesty is an essential part of dealing with any suicidal situation. The experience of many professionals in the field of crisis intervention indicates that therapies such as hospitalization, excessive drug use, or a moralistic approach are not effective. In most cases, they have the opposite effect, accelerating suicide as an option.

Obviously anyone who has suffered a great loss is going to consider suicide as an option. If the loss is very great, as in the case of many of the victims of a natural disaster, the suicide idea is very predominant in their minds. In fact, it has been the option chosen many times after such tragedies. What does it matter to people who have lost their parents, their spouse, their children, their home, or a limb?

We openly recognize suicide as an option for people who suffered very significant losses, but strongly encourage and facilitate exploring other options before turning to suicide.

a) Signs that would indicate a high risk for suicide.

A person is considered a high risk for suicide when exhibiting one or more of the following:

- Chronic lack of sleep (total insomnia)
- Chronic illness or handicap
- Hallucinations (voices or visions) that give commands
- Loss of several or all of their loved ones
- Suicide threats
- Personal or family history of suicide attempts
- Desperation or hopelessness
- An increase in drug abuse or alcoholism
- Openly expressed opinion by relatives or friends that it would be "better" (because of handicaps, etc.) if the person died

- Suicide-related behaviors such as:
    - Taking care of personal matters for the future
    - Getting ready for a "long trip"
    - Requests to "take care of my family"
    - A sudden and unexplained peace or serenity
    - Chronic complaints that things will never get any better
    - A sudden interest in death
    - Great concern for or interest in someone that has committed suicide

b) What to do.

Helping these people requires two strategies:

- Address the possibility of suicide in general very honestly and clearly, and confront any idea, threat or attempt of suicide. Following are some examples of questions that can be used to approach this type of conversation:

    Are you planning to kill yourself?
    Are you feeling so bad that you would try to hurt yourself?
    Have you thought of taking your own life?
    What are you planning to do with respect to this situation?
    What are you expecting will happen if you kill yourself?

- Refer the person to a trained professional (see next section).

3. Timely Referrals: There are going be many cases that require referral to various professional services such as: medical services, social work, rehabilitation, psychiatry, clinical psychotherapy, education, loans and other types of aid. The people who wish to help the victims of a tragedy must have access to the information necessary to make these referrals in a proper and informed way.

Unfortunately, these referrals are often not made due to competition among the different organizations that work in natural disasters. This professional fervor and jealousy makes most of them go into a collector mode. They see each victim as a sort of trophy, an accomplishment to list in their resume (and their request for international funds). This is one of the main obstacles in the coordination of services and a hindrance in reaching the victims as quickly as possible.

In the area of psychotherapeutic and psychiatric services, the following conditions generally indicate the need for referral:

- Duration of more than one day in the stage of total denial of the event
- Any initial reaction that extends beyond six months
- Any dysfunctional pattern that has become a habit
- Any secondary crisis that is not improving
- Suicide threats and especially attempts

All referrals should be made with compassion and understanding, avoiding the appearance of being judgemental. The following approach has proven useful:

> ***"John, I know that you have suffered very much with this tragedy and I just wish I could help you in a more effective way. I know several people in similar situations that have received help after participating in this workshop through the _____ Center. I believe that you would greatly benefit by taking advantage of this important opportunity. Would you like me to get more information for you? "***

4. Facilitate New Social Structures: One of the greatest problems in a tragedy of great magnitude is the loss of the victim's social structure. Even though members of their social circle are not dead, most of these groups have been restructured due to relocations or a change in their priorities. For many of the victims, this is a threat to the foundation of their emotional support system.

Beyond taking care of the medical, psychological, and material needs of the victim, it is important to help them establish new social structures. If these do not exist they need to be organized as soon as possible through worship or social service groups. Such organizations can help facilitate activities that will aid in the formation of these new structures for emotional support. A good start in this direction is the sound organization and eventual self-administration of the refugee shelters.

The leadership in the new structures that has formed as a result of a tragedy must be appropriate to the level of development and one of the most important roles of the facilitator is to assure and mentor an appropriate leadership:

- **INITIAL REFUGEE SHELTER:** The principal need is individual and group survival and the most effective leadership style to achieve it is a fair but authoritarian approach. There can be no effective "democracy" in a chaotic situation.

- **NEW GROUP OR COMMUNITY:** The principal need in a new group is security and the leadership should move toward a more consultive but still directive style.

- **MORE ADVANCED GROUP:** The principal need soon becomes that of autonomy and self-direction. Therefore, the leadership should reduce its "visibility" and become much more democratic and participative.

- **EXPERIENCED GROUP:** Here the principal need has become that of transcendence and the most appropriate leadership is generally consultive.

5. Do Only 50%: One of the most praised negative behaviors in caregivers is overprotection. When you think, feel, or do for another person what she or he is capable of doing for her/himself, you are sending a very destructive message: "You are incapable of thinking/feeling/doing this." This applies to employees, children, and especially victims of disasters. Self-esteem is destroyed when a person feels that he or she is no longer able to manage his/her own life and that is the message received when a caregiver overprotects a person, a family, or a group. No amount of use of the previous competencies will be effective if you do for others what they are capable of doing for themselves.

6. Helping Children Start Again: Children are often the ones most affected by a trauma. Also, with the help of the adults around them, they are the ones that can recover most quickly. The following suggestions are offered as a guide when helping children affected by a trauma:

- As a facilitator, make sure that you have gone through your own personal grieving process either by participation in the workshops, use of written materials, or any other means considered appropriate and necessary.
- Believe in the child's ability to overcome the trauma. Support this belief with your actions and words. A sort of "walk the talk" so to speak.

- Constantly recognize and give importance to the child's activities, intelligence, abilities, creativity, and efforts to get ahead.
- Provide children with a safe environment, protection, and understanding. This will encourage free expression of their feelings regarding the tragedy and how they are dealing with the change.
- Allow the child to express all of his/her emotions. Teach by example how they may express their feelings using age-appropriate vocabulary.
- Establish a dialogue with the child regarding his present conflict as a result of the tragedy. It is important to be careful to not discount his/her feelings as "infantile" or "silly," etc. Use simple and clear language. Avoid abstract terms and oversimplification of their emotions or ideas.
- Allow the child to have some privacy to sort out his/her feelings and at the same time the freedom to play and do things that are fun and enjoyable for children.
- In a refugee shelter or school, give the child a small, private storage area where personal belongings can be kept.
- Remember that regardless of the child's behavior, be it aggressive or withdrawn, he or she needs help and understanding, not punishment.
- It is never justified, under any circumstances, to lie to a child. Always be honest with your thoughts and feelings.
- Enjoy, with the child, your mutual recovery.

7. Have and Communicate Faith and Optimism: Faith is still the most powerful therapy in the world: faith in God, in life, in the future, and in the ability of the victim to overcome these difficulties and move on beyond the tragedy. You can share this faith by referring to the future in terms that communicate your conviction that their personal recovery is a future reality that can be taken as a certainty in the present.

To "presuppose" successful recuperation, you can use phrases such as:

- ***"When you overcome this sadness..."***
- ***"Once you begin to work again... "***
- ***"When you are in your new home... "***
- ***"Someday you'll remember this whole experience only as a bad dream... "***

- ***"When you see the outcome of your prayers..."***
- ***"You have come such a long way in a very short period of time, just imagine... "***

B) FACILITATION SKILLS

1. Active Listening: What people need most during a crisis is to be heard and understood with empathy. Empathy is the ability to "put yourself in the shoes of the other person" in order to see and hear and feel the world as they perceive it. More than just compassion, it is a rational and emotional understanding – it's "living" the other person's reality.

To listen with empathy is first to capture the other's words, gestures, tone of voice, posture, face, etc., then to capture his/her feelings and finally to place yourself in front of the other person as a mirror image reflecting through your words and gestures, his/her thoughts and feelings. First you capture the essence of his/her reality and personal experience with appropriate questions and then you give feedback in a caring and understanding way.

a) Guidelines for listening with empathy:

- Put your own criteria temporarily on hold.
- Remember that there are several ways to accomplish the same goal.
- Commit yourself, body and soul, to listen.
- Concentrate on what the person says and does.
- Avoid getting defensive.
- Recognize the validity and the "logic" of their feelings and perceptions, even though they may come across as illogical at the time.
- Unconditionally accept people for what they are, regardless of how much you disagree with their opinions or disapprove of their behavior.
- Listen attentively without interrupting.
- Recognize the signs of your own anxiety.
- Share with the other person when you are lost, confused, or stressed.
- Accept the possibility that you might not reach a solution to the problem.

- Resist the temptation to:
  - Give too many warnings
  - Moralize
  - **Direct**
  - *Exhort*
  - Threaten
  - Impose
  - **Give solutions**
  - Criticize
  - Give orders
  - Judge
  - Interpret
  - *Patronize*
  - **Blame**
  - Embarrass
  - *Label*
  - Lecture
  - Ridicule
  - *Give advice*
  - Psychoanalyze
  - *Organize*

b) Results of listening with empathy:

- People feel supported. This has very reaffirming and even therapeutic effects.
- People will feel more comfortable talking about their problems instead of holding back or repressing them.
- People realize that they are not crazy and that their reactions are normal, natural and necessary and that everything is going to work out eventually.
- Frequently people become aware of their responsibilities and their ability to find a solution for their own problems.
- Aggressiveness and defensiveness are reduced and often even neutralized.
- Strengthening of interpersonal relationships often occurs.

c) Obstacles that hinder the process of listening with empathy:

- Interruption: The listener has a premature response to what is being told.
- Anxiety: The listener develops anxiety because of something the victim has said and begins to get mentally defensive.
- Judgmental: The person listening passes judgment as they listen to what is being said– "right" from "wrong," or "correct" from "incorrect."
- Self-centered: The listener believes that only his or her opinion counts or matters.
- Self-conscious: The listener is more interested in him/herself than in others and their problems.
- Fantasizing: The listener looses proper perspective and creates his/her own opinion or perception about what is being described.

- Omission: The listener "omits" part of the message to make it fit into a certain, preconceived view, perspective, perception or theory.
- Self-Fulfilling Prophecy: A case of "selective hearing" in which the listener only hears what she or he wants to hear or expects to hear.
- Overwhelmed: The listener can't handle the amount, intensity or complexity of the information being received.
- Distortion: The listener changes or distorts the message to fit his/her own opinion.

d) The Empathetic Response: Listening with empathy leads to responding with compassion. This type of response can come in four different ways, depending on the circumstances.

- Understanding: The listener verifies the validity of his/her perceptions and understanding of the problems and feelings of the victim by repeating in his/her own words what was just heard. This response helps the people suffering to clarify their feelings and perceptions, improving the mutual understanding regarding the meaning of these circumstances.

  Client: "I've had it with all this paperwork to apply for a loan!"
  Response: *"Do you mean to say that you are angry and frustrated with all the difficulties associated with applying for this loan? Is that it?"*

- Probing: An answer that facilitates more information and options. The listener asks the right kind of questions to have a better understanding. This response helps others to explore all the implications of their decision or affirmation and the possible alternatives.

  Probing response to previous comment: "*Which requirements do you still need to meet?*"

- Support: An answer indicates to the person that the listener not only understands but also wants to support what has been done or said. When people need approval, this is a very useful response.

  Support response to previous comment: "*I also get very impatient with all these requirements. It is very frustrating. How can I help you?*"

- Evaluation: This type of response can be useful at times as an option when the listener is called upon to give his or her opinion, judgment or assessment, but only when these are presented as possible options, not the best or only options.

  Evaluative response to previous comment: "*Since you've asked for my opinion, I don't think it's too good idea for you to count on that money before the end of the month."*

e) How to give answers: No type of answer is bad or good in itself. It can be excellent and functional according to the circumstances and the people involved. Nevertheless, the following generalizations can be considered:

- When there is stress or tension, the listener should limit him/herself to the first three types of responses (understanding, probing and support).
- Understanding and support responses are especially important during the initial stages of the relationship.
- In most cases it's better to avoid an evaluation unless you have established a strong relationship, or the person requests it and does not have dependent or co-dependent behaviors or tendencies.
- Any excessive use or lack of use of a given type of response can be detrimental in that it limits the listener's effectiveness with a wider range of people and situations.
- Choosing the wrong kind of response to the person or circumstances of the moment is a determining factor leading to a reactive, defensive, or ineffective communication.

f) Practical Examples:

Example # 1:

Client: *How dare you treat us this way?*
Aid Worker: It seems to me you are very upset with us.
Client: *Of course! How can you expect me not to get upset? You people don't keep your word.*
Aid Worker: If I understand correctly, you feel that someone here hasn't kept her word to you. Could you tell me more about this, please?
Client: *That idiot at the reception told me my check would be ready today, and it isn't. My family is hungry and we have nothing to eat.*

Aid Worker: I can certainly understand how you were counting on receiving this check by today, and your anger at not being able to buy the food your family needs. Let's see what we can do here.

As we can see in this example the Aid Worker resisted the temptation of getting defensive. He opted to paraphrase the client in a caring and non-threatening way, recognizing and validating all the feelings, reasons, anger, frustration, etc. that he expressed.

Example # 2:

Teen-Age Daughter: *Dad, a friend has invited me to stay with them in the city while our new home is being constructed.*
Father: I imagine you would like to go, right?
Daughter: *Of course Dad! It's a great opportunity to get out of all this rubble and to continue going to school.*
Father: I can certainly understand that. What adults will be living there?
Daughter: *It's the apartment where my friend Jan lives with her older brother, but we are old enough. We don't need any supervision.*
Father: It seems like a very logical alternative. Nonetheless, I have several concerns and I think it would not be the best alternative.
Daughter: *You never trust me. I am old enough to make my own good choices regarding my life.*
Father: Sweetheart, I don't mistrust your good intentions. I well know that you have the intelligence and common sense to make the right choices. At the same time, I don't think you and your friends are old enough or have the kind of experience needed to deal with potential problems that may arise. I don't want you to have any more difficulties than those we are currently facing. I understand you feel sad, and maybe even angry with me; this is natural. At the same time I have a responsibility as a parent and I would like to keep my family together as we go through this situation.

The father didn't grant his daughter's request, so she was probably not very happy. There was an open dialogue established, in which he recognized and accepted her feelings and perspective, even though he didn't agree.

Example # 3:
Johnny: *My grandparents died in the natural disaster.*
Teacher: Yes, I know. Your mother told me all about it. You must be very sad, Johnny.
Johnny: *Yes!*(with tears). *I loved them very much.*
Teacher: They were very special for you, right?
Johnny: *Yes, very special. I always spent my vacations at their farm. They loved me so much.*
Teacher: You have a lot of beautiful memories about them.
Johnny: *Yes, I remember them all the time.*

Here the teacher accepts the boy's feelings, his logic and the inevitable sense of loss, without introducing his own perspective or feelings.

2. Reframe Attitudes: Our follow-up studies of numerous disaster intervention workshops have conclusively shown the greatest benefit that disaster victims have perceived from the workshops has been that afterwards they feel "normal," instead of bad, sick, immoral, stupid, weak, or ignorant. They realize that their initial reactions and their corresponding attitudes (thoughts, feelings and actions), as negative as they may seem to some, are normal and natural in disaster or crisis situations. That is why we put so much emphasis on the need to reframe these reactive attitudes and put them in an appropriate perspective.

It is imperative that the person understands, from the very beginning, that these initial symptoms and reactions to a trauma are normal and natural manifestations of this experience. By listening with empathy, the person's thoughts, feelings, and actions can be reframed and redefined as normal strategies; some productive and some not. We are not justifying negative behavior, just emphasizing that normal, healthy, mature, stable, well-intentioned people can have negative thoughts, feelings or behaviors, and these are even normal in certain situations. We can use supportive phrases such as:

- ***(nodding head) "I understand."***
- ***"Of course!"***
- ***"Many people feel that way."***
- ***"That's only natural."***
- ***"In spite of your overreaction, your good intention was to…."***

- ***"I see that in many, many people in crisis situations."***
- ***"If I were in your shoes, I would probably think/feel/do the same."***
- ***"That's a very normal way to see things in a situation such as this."***
- ***"What you describe is very normal and healthy; NOT thinking and feeling that way would be abnormal."***
- ***"I'm sure you would have acted differently in another situation."***

3. Pacing: One of the most important contributions of the work of Milton H. Erickson and those that followed him in the advance of professionally responsible work in Neurolinguistic Programming, is the dynamic of pacing. It has been shown in numerous studies that when the facilitator assumes certain non-verbal (and some verbal) mirroring behaviors, the other person tends to feel a sense of unconditional acceptance and empathy with the facilitator.

While the degree of sophistication of these techniques in clinical hypnosis and other uses of hypnologic states is far beyond the realm of disaster intervention facilitation, simple exercises of corporal pacing have proven very useful. This consists in assuming the same basic body posture as the person with whom you are speaking, including:

- head-neck angle
- shoulders
- arm and hand position
- waist angle
- legs and feet

A complement to this is the use by the facilitator of approximately (without mimicking) the same tone and volume of voice.

An example of this would be the case of dealing with a person that is seated and crying. Many "professional" texts affirm that the facilitator should assume an attentive, forward-leaning posture and an optimistic and encouraging voice. We do not agree with this "correct" interviewing physical or paralinguistic posture. We have found that the most effective way to achieve rapport is to sit in approximately the same posture as the other person, at least for the first few minutes, and replicate approximately the same tone of voice. Again, it is not a case of copying the other

person, but rather to depart from your own posture and tone of voice and move closer to those of the other person.

4. Use Questions to Explore Options: The success of a facilitator does not depend upon having the right answers but upon asking the right questions. In crisis situations, people tend to become perceptually rigid and, therefore, are aware of few options. We can open up the perceptual options and, therefore, the behavioral options, through creative questioning. Michael Gelb, writing about Leonardo de Vinci, says: "The questions that occupy our minds reflect our goals and influence our quality of life."

One of the most useful techniques that we know of in this area is the Focused Conversation Technique (Stanfield, 1997) or ORID. The letters stand for:

- **Objective Level:** the external reality that I/we sensorially perceive.
- **Reflective Level:** my/our internal reaction to what I/we perceive.
- **Interpretive Level:** The meaning and significance of what I/we perceive and our reaction to it.
- **Decisional Level:** What I/we are going to do about it.

(Stanfield, R. Brian: The Art of Focused Conversation, 1997, ICA, Toronto)

Our experience has been that when we facilitate the elaboration and separation of these four levels, by means of open questions that are appropriate to each level, people and groups become immediately aware of new options. Here is an example of some of the questions we used in a workshop at a refugee shelter, three months after the Armenia, Colombia earthquake:

a) Objective Level:

- What do you see around you now in the refugee shelter?
- What sounds do you frequently hear?
- What do you feel in and upon your body?
- What words and phrases do you frequently hear?
- What odors are present?
- What are people doing in the evenings in the shelter?
- What do you notice in the faces of the children?

b) Reflective Level:

- What different feelings do you have when you are in the shelter?
- What anger still exists within you?
- What fears do you still have?
- When do you feel especially sad?
- What do you still feel a little guilty about?
- What especially vivid memories do you still have?
- What nightmares do you still have?
- In what moments have you felt good?

c) Interpretive Level:

- What is really happening here?
- What does all that has happened mean for our individual and community lives?
- How is this situation going to affect our work and homes in the future?
- What are we learning from all this?
- Which strategies have worked and which haven't?
- What values are still predominant here?

d) Decisional Level:

- What are we going to do now?
- What are the next steps?
- Who is going to do what?
- What is the commitment of each person here?

Any answer given to one set of questions that belongs in another level should be identified. We usually approach these four levels in a sequence (sometimes in more than one session) and often with four flip charts, one for each level's answers (especially in more polychromic cultures). The most common response after an ORID session is: "I never realized how many options I really have."

5. Use Adequate Recognition: Also very important is the constant praise and support of the qualities of the victim and all their efforts to make progress in the recovery process. It is not enough to praise determined behaviors; individual and group qualities must also be reinforced to maintain an acceptable level of self-esteem. These must be sincere expressions of admiration and not manipulative "stock phrases."

To praise qualities and not just behaviors, you can use some or all of the following:

PRAISE THE PERSON:	**NOT JUST THE BEHAVIOR:**
You are an excellent student.	You learned a lot today.
You're a very capable leader.	You handled the meeting well today.
What a great friend you are.	Thanks for the help you gave your neighbor.
You are very intelligent.	Great job on the test today.
You are a fine daughter.	You help out a lot around the house.
What a fun group this is to work with.	You work well together.
You people are very efficient.	You organized that social event very well.
What a lovely family.	You all work very well together.

It is not that the praise of behavior is negative. It is just insufficient, in itself, to stimulate the needed level of self esteem that only the praise of personal qualities can achieve.

These kinds of intervention create positive thinking, a valuable tool to help a person to realize her/his real capacity to overcome a difficult situation. It's beneficial for them to use mental images of better things to come once they go beyond their present circumstances. This is more than just using the "power of positive thinking;" it is the foundation for one of the most effective therapeutic techniques used today: self-fulfilling prophesy.

IV – TAKING CARE OF THE CAREGIVER:

One of most difficult aspects of disaster intervention is that of caring for the caregivers. The adverse physical conditions, the constant stress, and the permanent contact with pain and suffering, frequently take a heavy toll among the volunteers and professional aid workers. It is not uncommon to see suicides, psychotic breaks, and relational disintegration among the caregivers in a major tragedy.

Our experience has taught us that there are three basic strategies for maintaining physical and mental health while working as a facilitator and while mentoring other facilitators and other caregivers in a disaster situation:

- **KNOW YOUR PERSONAL LIMITS.** Every caregiver should become aware of her or his limits in four dimensions: physical, psychological, social, and spiritual. Most of the "caregiver collapse" syndrome we see is directly related to exceeding known or unknown limits.

- **MONITOR YOUR OWN GRIEF PROCESSES.** We cannot give what we do not have. Caregivers who have experienced the same disaster that their clients are dealing with must be sure to dedicate FIRST the time and energy necessary to deal with their own grief and psychosocial reconstruction processes.

- **MAINTAIN A STRONG SUPPORT NETWORK:** We dedicate considerable time and energy to integration and teambuilding with new caregiver teams. This is not just to increase their productivity or effectiveness, but to give them a strong support network. We generally designate two hours a week for sharing experiences and for personal growth work in caregiver teams during the first few months.

V - ADDITIONAL RESOURCES:

Global Facilitators Serving Communities, Inc. offers these additional disaster intervention manuals in several languages, free of charge to non-profit organizations and with written permission to distribute. These manuals are not available for resale.

- Brenson, G. and Sarmiento, M.: "A Light in This Dark Valley: A Guide for Emotional Recovery."

- Brenson, G. and Sarmiento, M.: "And Now What? A Helping Hand for Children Who have Suffered a Loss."

Additional materials and bibliography are available free of charge at the GFSC website, https://globalfacilitators.org in the Virtual Library.

For more information about GFSC, our facilitator mentoring programs, workshops and how you can get involved, visit https://globalfacilitators.org.

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DR. GILBERT BRENSON LAZAN
DR. MARÍA MERCEDES SARMIENTO DÍAZ

Dr. Gilbert Brenson-Lazan, a North American living in Colombia since 1972, is Founder and Executive President of Amauta International, LLC, dedicated to the training and mentoring of facilitators of social and organizational change. He is a social psychologist, organizational consultant, educator and author of 28 books. He has been recognized internationally for his pioneer work in Latin America in the field of facilitation, organizational development, brief systemic therapy, crisis intervention, and stress management.

In 1986, as a result of his work with the victims of the tragedy in Armero, Colombia, Dr. Brenson and his then colleague-wife, Dr. María Mercedes Sarmiento Díaz (1947-2003), became interested in the field of psychosocial reconstruction after natural and social disasters. That was the beginning of a twenty year journey to many parts of the world, developing the model, materials and training facilitators in disaster intervention processes focusing on the psychological and social reconstruction of individuals and their communities.

Dr. Brenson was International Vice-Chair of the International Association of Facilitators (IAF), a founding Board member of Global Facilitators Serving Communities, Inc. and past president, as well as an active member of several other professional groups and organizations.

Dr. Sarmiento was a clinical psychologist and educator, with post-graduate studies in facilitation, brief systemic therapy, education and theology. She was Co-Founder of Amauta International, a teaching member of Eirene International, co-founder of the IAF Community Outreach Task Force, a founding Board member of Global Facilitators Serving Communities, Inc., and a pioneer in Latin America in the field of virtual education and mentoring.

Gil is an avid outdoor photographer, enjoys classical music, training his Rottweilers, playing Colombian folk music, and studying social theology. He has five sons, three grandchildren and is married to Parcia Sansary Gómez.

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