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THE EXPERIENCE OF A MENTAL HEALTH TEAM INVOLVED IN THE EARLY PHASE OF A DISASTER

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The reactions of a volunteer mental health team which convened in the aftermath of the 1983 Ash Wednesday bushfires are reported. A questionnaire designed to explore psychological and physical responses was completed by the 19 staff who made up the team. Using both open-ended and closed questions, the questionnaire tapped such areas as motivation, goals, expectations and observations, initial and later emotional and physical reactions, fantasies and evoked memories; an evaluation of the service and the experience was also included. Analysis of responses indicated that team members experienced considerable stress during their post-disaster work but also gained a great deal at both professional and personal levels. Sources of stress are discussed as are recommendations for their alleviation.

The aim of this paper is to describe the subjective experience of a volunteer mental health team which convened to provide services to victims of the 1983 Ash Wednesday bushfires.

While considerable literature has accumulated concerning the effects of disaster on victims, the reactions of those working in the aftermath of disasters has only recently become a focus of attention. Taylor (1983) used the term 'tertiary victims' of a disaster to refer to 'those whose occupations and duties require them to respond to any major alert in the community and to assist with any subsequent rehabilitation and restoration work', a term which in itself suggests that post-disaster relief workers are a vulnerable group.

In support of this, Frederick (1977) notes that 'personal contact with officials and crisis workers in recent disasters have (sic) highlighted the need for support of the mental health crisis workers themselves. Under such pressure, physical exhaustion inevitably takes its toll, along with the added ingredients of emotional stress and trauma. It often becomes necessary for workers to wear many hats, so to speak, by engaging in numerous activities which transcend the specific areas of expertise and training for which they have been oriented'. Lindy *et al.* (1981) observed that 'A frequent cycle seemed to plague those of us working in outreach: resistance, zeal, over-extension, frustration, and anger'. Raphael (1977) notes that feelings of helplessness and frustration are common in rescue workers and that anxiety, anger and horror may need to be worked through at a later date.

Perhaps the most extensive work in this area is that reported by Taylor (1983) and Taylor and Frazer (1982). In discussing questionnaire and interview data on the body handlers after the Mt Erebus plane crash, Taylor notes 'everyone complained of physical fatigue and many of melancholy moments during breaks in their work. Eighty-one per cent reported changes in their appetite; 85% in their sleep; about half reported changes in their feelings and their need to talk; and one-third reported a change in their social activities. After 28 days, the appetite and sleep reports were much the same, changes in feelings and activities increased, and the need to talk diminished'. Other symptoms which emerged included bad dreams, sleep disturbance and

tension. At the 20-month follow-up 'only 8 of the 100 continuing respondents expressed the need to talk over their experiences. Eighty considered that they had overcome any problems quite satisfactorily, but 15 others still had occasional and isolated "flashbacks" in which emotionally charged episodes returned to them momentarily. Three of the 15 reported general emotional problems as well as the "flashbacks"' (Taylor and Fraser, 1982). Five expressed anger that seemed out of proportion to the events they described, and four mentioned their marital troubles. One reported having undergone 'a complete personality change' and another having become 'more solitary with a cessation of sexual activity'.

Raphael *et al.* (1983-84) have also recently published a study focusing on the effects of disaster work on the helpers. Their questionnaire survey of about half of the rescue, organisational, support and medical personnel involved in rescue work following the Granville rail disaster revealed that almost all found the experience stressful, 70% expressed evidence of some strain, and about a quarter had symptoms of anxiety, depression and insomnia in the months after the disaster. On the other hand, the authors note that 'the experience of working in a disaster can have enriching effects as described by 35% of the respondents who felt more positive about their lives as a result of their involvement in the disaster'.

The disaster which provided the impetus for this study was the Ash Wednesday (February 16, 1983) fires that swept through certain areas of Victoria and South Australia. The mental health team to be described here worked in the Macedon area of Victoria. The particular feature of the bushfire in this area was that while an enormous number of homes was lost (approximately 450), and the countryside devastated, there were relatively few deaths (seven elderly people died) and few serious injuries or burns. The immediate emotional trauma experienced by the vast majority of the community related to the evacuation of about 5000 people, and the escape from the fires to areas of comparative safety. Many families went first to one home or centre and then, as the fires drew closer, to another. Nearly all retreated by car, and descriptions abound of families driving with virtually no petrol, of engines burning hot or stalling, and of the occasional accident where a driver was unable to see because of the blinding smoke.

The lack of communication by those responsible for alerting the public to the danger was regrettable. Some families only escaped because a neighbour warned them, others were given only a few minutes to evacuate. The State Emergency Service and the Country Fire Authorities were unable to meet the effect of the most extraordinary weather conditions, the blasting furious north winds, the sudden changes of direction of these winds which caused flames to leap to heights of 70 metres and fire bombs to hurtle through the air at unbelievable rates. It was for a few hours a holocaust, a time of intense heat, danger and grave concern.

The Intervention of the Mental Health Team

The volunteer multi-disciplinary team, made up primarily of staff from Prince Henry's Hospital, Melbourne, first met on the day after the fires on the initiative of the third author. He and the first author had a previous interest in the psychological effects of trauma and disasters and had made a video tape describing common reactions of disaster victims and rescuers. This was used as a focus of discussion of ways in which the team might be of assistance.

The team believed that intervention should take place as early as possible and thus five members made an exploratory trip to Macedon on the fourth day after the fires. They met people on the streets and set up links with the local general practitioners and hospital. They distributed copies of a pamphlet describing common reactions to disasters and ways of coping with these. As initial reactions were very positive, more pamphlets were run off for immediate use and an illustrated version, *After the Crisis is Over,* focusing on children, was developed by the second author. Within a few weeks, over 10,000 pamphlets had been distributed by the Health Commission of Victoria to the various bushfire areas.

During the following week, the team's presence in the community was established through negotiations with the general practitioners and hospital and contact with community leaders and representatives from Community Welfare Services and the Health Commission.

The team's knowledge of disaster work indicated that the basic principles of immediacy, proximity and flexibility be instituted in this disaster, as in other disasters. These principles were a natural extension of the ethos of liaison psychiatry practised by the Prince Henry's Hospital team of reaching out to populations in need, rather than waiting for their arrival, which may never eventuate.

Team members thus visited fire-affected people in their houses or in their caravans, always receiving a welcoming reception, and usually

being given the names of friends and relatives who were also thought to need the opportunity to talk through their experiences. This process continued for about four weeks during which team members estimate they talked with about 450 individuals and families. Contact was also made with various groups in the area, such as the local counselling and guidance services, teachers and women's groups.

The questionnaire
With the aim of exploring the issue of helper reactions, a questionnaire was distributed to the 19 members of the Prince Henry's team four weeks after they had stopped working in the Macedon area. All 19 questionnaires were completed anonymously and returned. The team comprised 10 men and nine women: seven psychiatrists, five psychiatric registrars, four psychologists, two nurses and one social worker. Nearly all had at least some experience in disaster work or bereavement counselling.

The questionnaire consisted of both closed and open-ended questions. In addition to demographic data, the major areas covered were helper motivation, goals, expectations and observations, initial and later emotional and physical reactions, fantasies and evoked memories and an evaluation of the service and experience.

Questionnaire results
Motivation. In response to a list of possible factors contributing to team members' decision to join the team, 18 of the 19 volunteers indicated that feelings of compassion played a considerable or moderate role. Seventeen indicated a similar role for interest and/or skill in crisis intervention and 16 noted a considerable or moderate desire to learn about disasters and their effects. Twelve team members noted a considerable or moderate desire to be actively involved in the crisis and the same number a personal need to accept responsibility for psychiatric stress.

Therapeutic goals. Thirteen of the 18 team members who responded to an open-ended question concerning goals noted abreaction and ventilation. The provision of support was indicated in eight team members' responses and prevention of future psychiatric distress by six respondents. Four noted identification of victims needing more intensive intervention as a goal.

Expectations and observations. In order to assess stress on team members, open-ended questions were asked about expectations and observations of both the countryside and disaster victims and responses analysed for discrepancies. For eight, observations of the countryside were worse than expectation, for six they were not as bad, and for five there was no discrepancy. Of interest is the fact that 13 of the 19 used the word 'devastation' in describing their expectations and observations.

Only three respondents felt that their observations of victims were what they expected and all of these answers were qualified. Whereas nine team members expected to see shock, only three observed it; similarly, 14 expected grief, sadness, depression and distress, but only seven observed these. On the other hand, more team members observed manic behaviour than had expected it (seven versus three) and similar responses were noted for anger (five versus three).

Emotional and physical reactions (at first encounter and after 3-4 visits). In describing their first reactions, most team members gave strongly worded responses. For example, one noted 'feelings of awe at the change in the countryside, as though I was being "hit" by those dark, burnt trees', while another wrote: 'I was shocked, very sad, speechless initially, very upset'. In response to a list of possible emotional reactions at first encounter, over two-thirds of the team members indicated that they experienced the following to severe or moderate degrees:

1) shock/bewilderment;
2) dependency/need for team support;
3) confusion/uncertainty;
4) depression/sadness;
5) helplessness.

Anxiety/distress, euphoria/excitement and anger/rage were noted by only a few. Two-thirds indicated severe or moderate fatigue, and one-third disturbance of sleep patterns and increased muscle tension. Other physical reactions such as restlessness, headaches, stomach and bowel upsets were relatively uncommon.

After three to four visits, emotional and physical reactions had decreased. Depression and sadness were still of moderate intensity in 11 team members as were dependency and need for team support. Ten noted that they still experienced severe or moderate fatigue.

In addition, nine indicated that they had become ill during their disaster work (usually colds and influenza), five had motor vehicle accidents, three domestic accidents, and eight felt their eating, smoking and/or drinking habits changed.

Fantasies, thoughts and dreams. In response to

open-ended questions, seven team members reported dreams or thoughts of themselves in the fire situation. A similar number described earlier traumatic experiences that were reactivated. For example, one person 'kept thinking of my experience in the war, especially travelling home and wondering if our family home had been bombed'.

Evaluation of the service. All 19 team members thought the service they provided was helpful, eight to a considerable extent, eight to a moderate extent and three a little. In response to an open-ended question concerning how the service was helpful, 10 team members stressed the provision of support, mainly through empathic listening. Eight team members felt that allowing ventilation and catharsis was of assistance.

Most team members experienced no difficulties in working with other organisations in the community. There were, however, difficulties in working with other relief teams. Nine of the Prince Henry's team assessed these as 'considerable' and another five as 'moderate' in degree. These were attributed to two major factors: seven team members pointed to the disruptiveness of differing philosophies or conceptual frameworks and seven to the detrimental effects of professional rivalry and jealousy.

Personal evaluation. Team members were asked to fill in a checklist concerning their evaluation of emotional, educational and social aspects of their experience. Almost all (18) found the experience to be emotionally valuable to a considerable or moderate extent. Most, however, also found it considerably or moderately frustrating (13) and stressful (9). Eight noted that the experience was depressing.

Most indicated that they had learned to considerable or moderate degrees about the effects of disaster (18), stress counselling (15), the local community (15), and organisational/administrative issues (12). Fifteen respondents indicated that they had gained from personal contacts with other team members and 12 from contacts with members of the community.

Of the 17 respondents who answered the question, 14 indicated that the experience gave them new insights into their conceptual thinking about their professional work. For five this was an increased appreciation of the value of community work, while four noted the value of seeing the evolution of post-traumatic neuroses.

Ten of 16 respondents indicated that the experience gave them new insights into their own personalities. There was little uniformity in description of these.

Discussion of Questionnaire Results

While the limited sample size and varied experience of the team members may impose limitations on the wider implications of the questionnaire data reported here, it is felt that the 100% response rate and care taken in completing the questionnaire lend considerable validity to the conclusions which may be drawn concerning the experience of a volunteer mental health team working in the immediate aftermath of a major disaster.

Motivation to become involved in this type of work was, for the most part, attributed both to professional factors (desire to provide a service, gain experience and learn about disasters and crisis intervention techniques) and the humanistic motive of compassion. The latter was powerfully evident in the whole community, both in and outside the fire-affected area and suggests a need for further research into the altruism, compassion and dedication that are observed following a disaster.

Therapeutic goals were those expected from professionals working in the disciplines of psychiatry, psychology, social work and nursing. It was believed that assisting the ventilation of the emotional shock, facilitating abreaction and providing support would be beneficial. Although only six members noted that their goal was the prevention of future psychiatric distress, this was accepted as the *raison d'être* of the team's involvement in the disaster.

While team members believed that they were providing a useful service, follow-up evaluation of the type reported by Singh and Raphael (1981) is clearly needed. Similarly, research into the impact of the widely distributed written material concerning reactions to disasters and ways of coping with these would be most valuable.

The questionnaire responses provide evidence of the impact on both emotional and physical health that the disaster work had on the team. The large majority felt shocked, confused, saddened and very tired. About half became ill, had accidents and/or noticed changes in their eating, smoking or drinking habits. They recognised feelings of helplessness and the need for team support. It is important that this finding be acknowledged so that supportive networks are provided for the helpers from outside the disaster-affected area, as well as those living and working in the community. The data show that even those

with lengthy training and considerable experience of psychological trauma found they were considerably stressed. It is our impression, furthermore, that those of the team who gave the most of their time and energy experienced the most personal stress, an observation which highlights the importance of scheduling adequate rest periods for disaster workers.

Sources of stress were numerous and varied. While about half the team found the burnt-out countryside to be worse than they had expected, their observations of the victims were the opposite. This may reflect the fact that no member of our group visited the area in the first three days after the fires. On the other hand, it is more likely due to ignorance about the actual behaviour of disaster victims. Other researchers have also commented on their failure to observe the commonly expected major emotional shock, psychological dysfunction and mental illness immediately following disasters (Quarantelli and Dynes, 1977; Taylor, 1977). As discrepancies between expectations and observations can impede efficient functioning, volunteers for a mental health team such as the one described here clearly must receive training based on available research concerning phases of reaction in disaster victims.

The actual devastation was made 'alive' by the graphic descriptions and vivid emotions of the affected people. Later came frustrations and feelings of inadequacy to deal with a mammoth task. Outreach work, in spite of the great willingness, sensitivity and increasing adeptness of technique among team members, was also stressful for those not accustomed to it. In the absence of clear and shared role definitions on the one hand and of a therapeutic contract (e.g. appointments, time limits, fees etc.) on the other, intense and intimate engagements with distressed victims often taxed all the empathy, emotional resources and therapeutic skill of helpers. Again, specific training in a conceptual framework and model of intervention suited to disaster work would seem necessary.

The experience, not surprisingly, reactivated previous traumatic experiences and produced much thinking and daydreaming and some nightmares about fires and escape. This is a common experience; even in the sheltered environment of a professional office, patients dramatically recalling and abreacting traumatic events produce in the therapist's mind memories or dreams, particularly if the events described 'touch on' experiences with similar emotions.

Finally, the difficulties in working with other relief teams were for some the most stressful part of the whole experience. This type of conflict has been described in the literature (Zurcher, 1968; Heffron, 1977) and was present following the bushfires in many post-disaster relief organisations. A priority must be given to the development of methods for circumventing it. In addition to the deleterious effect experienced by this team, community members were well aware of the conflicts of several organisations trying to provide similar services.

We feel that if team members had not often worked in pairs, ventilated to each other and had regular debriefing sessions, the effects of stress might have had greater impact. In addition, it must be remembered that, as found by Raphael *et al.* (1983-84), the experience proved both valuable and rewarding, with learning taking place on both professional and personal levels, and this no doubt also served to counteract the stresses and frustrations.

Finally, there were hidden rewards to the work which were not evident until months later. The need for and seeking out of team support was a healthy exercise, leading to improved staff relationships in some instances, and friendship bonds were made or strengthened.

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