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EDITORIAL

Disaster Response and the Mental Health Counselor

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The events of September 11, 2001, the Asian Tsunami of 2004 resulting from the Sumatra-Andaman earthquake, and the devastation resulting from Hurricane Katrina in 2005 have increased our awareness of the need for trained mental health counselors able to respond within days and weeks of mass disaster events. In conjunction with the traditionally identified *first responders* (i.e., firefighters, law enforcement officers, and emergency medical personnel), the importance of maintaining a trained cadre of *early mental health responders* has become increasingly evident (National Institute of Mental Health [NIMH], 2002; U.S. Department of Health and Human Services [DHHS], 2004). In fact, in the months following the terrorist attacks of September 11, a group of experts in the field of mental health and mass violence was convened to identify best practices related to early psychological intervention following large scale disasters either from natural causes or those caused by human agency.

While the working group identified a number of general principles related to early psychological intervention in the aftermath of disaster (NIMH, 2002), it, likewise, recognized the need to develop more systematic training approaches to mental health disaster response and called for an increased focus on outcome research in this critical area. What has been identified clearly through the work reflected in these governmental documents (DHHS, 2004; NIMH) is that psychological intervention provided within days to the first few weeks following mass disasters is quali-

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tatively different from the services mental health counselors provide in their day-to-day professional work.

My personal experience providing support for first responders, construction workers, and support volunteers at *ground zero* following the attack on the World Trade Center taught me that lesson first hand (Rogers & Soyka, 2004). Believing that my experience in emergency psychiatric evaluation and intervention and my work in the field of Suicidology would translate easily into the disaster response setting, I became a local New York City Red Cross mental health volunteer assigned to *ground zero* shortly following the attacks. What I discovered was a need to step back from my advanced training and return to the basic principles of human connection and compassion. Fortunately, I was able to learn that lesson within the first few hours of my volunteer work at the World Trade Center site.

The lessons I learned related to early mental health response to mass disaster events are similarly reflected in two articles in this issue of the *JMHC*. The first article, written by Alise Bartley titled *Confronting the Realities of Volunteering for a National Disaster* (Bartley, this issue), provides a first-had account of her experience as a volunteer following hurricane Katrina. In this article, Dr. Bartley shares her experience of both adjusting to the challenges and demands of disaster mental health work and the struggles that can accompany returning home following a disaster response deployment. Most importantly, this article reminds mental health counselors working as disaster mental health providers of the potential for secondary or vicarious trauma reactions and the critical need for adequate self-care.

The second article by Josef I. Ruzek and his colleagues not only provides an overview of the empirical literature related to disaster mental health response, but introduces a model of psychological first aid as an empirically based framework for mental health counselors to use in helping disaster survivors cope in the aftermath of an event (Ruzek, Brymer, Jacobs, Layne, Vernberg & Watson, this issue). Ruzek et al. describe the Psychological First Aid model as "a systematic set of helping actions aimed at reducing initial post-trauma distress and supporting short- and long-term adaptive functioning" (p. 17) and they provide a Web site where the complete Psychological First Aid manual can be downloaded for use. As can be inferred from their description of the model, the goal of psychological first aid is to provide a caring and compassionate interpersonal context and insure that disaster survivors have the resources and information necessary to cope effectively in the immediate aftermath of a disaster and beyond. The underlying assumption of this approach is that

the reactions of survivors following a disaster are normal responses to abnormal events rather than signs of psychopathology.

Mental health counselors who have worked in disaster response or who have considered the possibility of engaging in disaster response work in the future will find these articles to be provocative as well as practical. I hope that together, they will inspire readers to volunteer in the likely event of future mass disasters and provide a set of concrete skills to increase their effectiveness as they support survivors in their quest to cope with traumatic experiences.

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