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THE SOCIAL ECOLOGY OF DISASTERS

A HURRICANE SWEEPS across the Florida Keys, damaging homes, businesses, and roads, injuring and killing people. In northern Uganda, a civil war rages for more than twenty years, resulting in many deaths, maimings, and the forcible abduction of children as soldiers and concubines. The majority of the population is relocated to internally displaced persons camps (IDPs). In Sichuan Province, China, an earthquake levels villages, collapses schools, and triggers avalanches, leaving nearly one hundred thousand people dead and many more displaced. The Asian tsunami kills nearly a quarter million (World Health Organization, 2005) in more than ten countries, some at peace and others enduring ongoing armed conflicts.

After a high school senior prom, a car accident kills four students. Another survives but is left partially paralyzed. In a small city, a fire destroys an apartment building and twenty-five residents are displaced, losing their belongings and, in some instances, their pets. A man murders his estranged wife and then kills himself outside a courthouse after she obtains a restraining order against him.

What is a disaster? Most would agree that the natural disasters and Ugandan civil war cited here constitute disaster, but what about the other examples? If all of the examples fall into the category of disaster, then what qualities and attributes do they share? What is *not* a disaster?

And how do we respond to disasters? Who responds? What activities do they engage in? What are the consequences of disasters, and what helps individuals, families, and communities to recover from them? How universal are these reactions, and how are they influenced by culture and social structures? Are there interventions that are harmful or that make things

worse? Can the same people, using the same skill sets, respond to all kinds of disasters, no matter what they are?

These are among the questions that this book seeks to explore. It considers a range of disasters and applies a variety of concepts and techniques to illustrate how professionals and volunteers in the helping professions (social workers, community psychologists and psychiatrists, teachers, counselors, clergy, and public health workers) can work effectively with individuals, groups, and communities to support them in their recovery from disaster. This book focuses not on rebuilding physical structures, such as homes and businesses, but rather on restoring people (reconstructing meaning, reconnecting people with one another, revitalizing hope), linking life before the disaster with the consequences of the disaster, and looking to the future. This is not to say that the repairing of infrastructure is distinct from the renewing of psyches, spirits, and a sense of collective community efficacy—using a social ecology framework, I emphasize how interconnected these processes are. But the primary focus of this book is how people responding to disaster can effectively work to develop the psychosocial capacity of those living and working in the affected community. In so doing, responders can help those affected by disaster help themselves and others to feel empowered and to regain control over their lives, as they rekindle hope for their futures.

DEFINING DISASTER

Disasters come in many sizes, some affecting entire regions or nations, others upsetting small communities or subcommunities. Some disasters are considered acts of God, or natural events, such as earthquakes, tsunamis, and floods, while others are the result of either bad intentions (terrorism, war) or incompetence and human error (chemical explosions, mining disasters, train crashes). The length or duration of disasters varies considerably—some occurring in the tremor of an earthquake or flash of a gunshot, others staggering on for years, such as an ongoing civil war.

Rosenfeld, Caye, Ayalon, and Lahad (2005) have identified the following six characteristics of disasters. While these characteristics are relevant and helpful, they still raise a number of questions and merit further investigation.

1. *Has a footprint of a certain size.* Loss of life and destruction of property are certainly hallmarks of a disaster. But how does scale factor into the

characterizing of disaster? If a one-family home burns to the ground and the inhabitants are displaced to temporary housing in an otherwise unaffected community, is this a disaster? Does the situation change if an entire apartment building or a nursing home burns? What about an entire block? Does it matter if the fire was caused by a faulty fuse box or a bomb?

2. *Has an identifiable beginning and end, occurs suddenly, and has long-lasting effects.* When does a disaster begin or end? With Hurricane Katrina, for example, did it begin with the hurricane gathering force over the Atlantic Ocean and Gulf of Mexico? Did faulty engineering and maintenance of levees sow the seeds of the disaster? What about the risk factors amplified by racism, which left many low-income African Americans living in areas of higher risk than wealthier white residents? These social and group vulnerabilities have a history that extends back hundreds of years (Park & Miller, 2006).
3. *Negatively affects large numbers of people.* The examples presented in the first part of this chapter clearly involve large numbers of people. But what of those mentioned that are not natural disasters or atrocities of war? If an adult dies in a single car crash because of icy conditions, is this a disaster? Does it matter if the driver was drinking? What if the car hits a group of schoolchildren waiting for the school bus? How many people need to be affected directly, or indirectly, for something to be deemed a disaster?
4. *Affects more than one family in a public arena.* Is the boundary between private and public always that clear? If a child's parent dies of natural causes, is this a public event? What if the child needs to be taken into custody by the Department of Social Services because there is no other caretaker? Does it matter if the parent was a drug user? What if the parent was the victim of domestic violence? What if many children in a neighborhood are taken into custody? At what point does a private tragedy become a public disaster?
5. *Is out of the realm of ordinary experience.* This is an important, although subjective, criterion. Disasters are not everyday occurrences, although their impact is mediated by many factors, such as culture, beliefs, spiritual practices, and other value systems. The varied experiences of people determine whether an event or series of events is outside of the realm of ordinary experience. People living in hurricane zones or tornado alleys are more familiar with powerful storms than those living in less tempest-prone areas. Even acts of terrorism are more usual for some and abnormal for others.
6. *Has the power to induce stress and trauma in anyone who experiences the event.* This statement heralds one of the most controversial debates in the

field of disaster mental health. When there is a disaster, do many people experience stress that is clinically considered trauma? Those trained in Western psychology are more likely than non-Westerners to answer this question in the affirmative, although there is not a consensus on this. One question that the trauma criterion raises is this: If the majority of those who experience the event do not develop severe stress and trauma, can it still be considered a disaster?

I return to many of these questions in chapter 3 and explore them in greater depth. Although it is important to define a disaster, both for the purposes of planning responses and for researchers studying this phenomenon, what constitutes a disaster is contested terrain. Some researchers would not see the small-scale set of examples as disasters but rather as “emergencies,” while also viewing very large-scale disasters as “catastrophes” (Quarantelli, 2006). Conceptual clarity is always helpful, but I have found in my practice that there are areas of similarity and overlap between small- and large-scale events, as well as differences, and that the realities of practice involve the existence of some measure of ambiguity in what is always or sometimes present in a disaster.

CRITICAL INCIDENTS

A concept related to disaster is that of a “critical incident” (Mitchell, 1983). Although this notion originally evolved from a peer-driven movement to assist emergency responders, such as police, firefighters, and ambulance drivers (Armstrong, O’Callahan, & Marmar, 1991; Bisson, McFarlane, & Rose, 2000; Conroy, 1990; Everly & Mitchell, 2000; Mitchell, 1983; Mitchell & Bray, 1990; Solomon, 1995), its application was widened to include many different kinds of populations (Dyregrov, 1997, 2003; Miller, 2000, 2003; Raphael, 1986) and many of the responses of affected people, and suggestions about how to help them overlap with disaster mental health. A critical incident, like a disaster, leads to strong reactions and makes it difficult for a person to continue to exercise normal responsibilities and functions (Mitchell, 1983) and results in a heightened sense of vulnerability and loss of control (Solomon, 1995). Critical incidents are sudden and unexpected and may involve one’s life being threatened. They can lead to psychological and emotional wounds, undermine one’s sense of how the

world works and of what is fair and normal, and challenge a person's sense of self-worth (Solomon, 1995), all of which have been described in the disaster mental health literature (Halpern & Tramontin, 2007; Rosenfeld et al., 2005).

THE COLLECTIVE CONTEXT OF DISASTERS

An important dimension of disaster is, what happens to individuals and families occurs within the context of collective wounds and losses as well as public policies. As Kaniasty and Norris (1999, p. 26) have put it: "Individual suffering unveils itself within the parameters of other people's suffering." It is in the nature of disaster that there is a collective context for individual suffering and a public dimension of private loss.

Thus, the example of the car crash after the senior prom, with multiple deaths, involves personal and private losses, but the crash also has public consequences. The incident may overwhelm other students in the school who were about to graduate, as well as the school personnel who taught the students or who were chaperoning the prom. Law enforcement officers may feel a sense of guilt and inadequacy over having failed to check for alcohol and drugs before the students left the prom in their cars. First responders may have a particularly strong reaction to being called to a scene where a number of young people have died. Other families who knew the teenagers may be devastated, and the event may trigger evocative reactions for parents or siblings who have suffered similar losses in the past. But there are also policy issues that arise from such events. Should the school continue to hold a prom? Are there psychoeducation programs that can reduce the inclination of teenagers to drink and drive? Are there cultural norms about drinking that need to be interrogated? Is this a community in which tragic events are more likely to happen?

The interaction of individual and collective, private and public, also applies to a large-scale disaster, such as 9/11. There are those who are directly affected, such as families who lost loved ones or those who escaped from the World Trade Center. First responders have a strong sense of fraternity and camaraderie, which was put to the test with 9/11, where there were massive casualties and injuries, particularly among firefighters. Rippling out from this core were numerous other affected groups: eye-witnesses, children evacuated from schools, residents cleared from their neighborhoods, and

neighbors living in communities that lost residents in the attack. Local businesses in adjacent neighborhoods as well as workers who served the World Trade Center were also affected. Construction workers who responded to Ground Zero, both in the immediate aftermath and in the long months of clearing the debris, subjected themselves to health and mental health risks (Miller, Grabelsky, & Wagner, 2010). Schools that served children who lost parents were impacted, and thousands of therapists absorbed painful and tragic stories that put them at risk for disaster distress, compassion fatigue, or secondary trauma. New York City as a collective entity was affected in many ways, ranging from the cordoning off of streets and neighborhoods to the collective loss of safety, self-esteem, and a sense of basic trust in the world. At the time, people did not know whether this was a single attack or the beginning of a series of assaults. As we now know, the attacks led to two wars—in Iraq and Afghanistan—and many other military encounters and skirmishes and attempts at future terrorism.

In Washington, DC, similar processes were at work, as they were in Boston and Newark from which the planes had departed, and in Shanksville, Pennsylvania, where one of the planes crashed. Airline employees were distraught, as were travel agents who had sold tickets to passengers on the airplanes. Modern media brought scenes of the disaster into millions of living rooms, and people all over the nation and the world watched the coverage of the events. Among those most at risk from this exposure were people with their own psychological vulnerabilities and especially those who had previously experienced terrorism or armed conflict. Both the initial attacks and subsequent responses involved policy decisions at many levels of government and between many state and nonstate actors.

Did the disaster of 9/11 end after the initial attacks? It certainly did not for the people of Afghanistan and Iraq or for the soldiers and their families. Should the subsequent bombings in London and Mumbai be seen as a continuation of this disaster or as new and discrete disasters? There are many different perspectives on and social constructions for the 9/11 disaster. In many ways, this disaster is still in process ten years after the original event, although the specific phases and the impact of these on individuals and communities have varied over time. And was 9/11 the opening salvo in this disaster or were there earlier events that are part of this disaster narrative? The answer depends on one's social and political positioning and accompanying disaster narratives, a theme that is explored in subsequent chapters.

The examples illustrate the contingencies and instabilities involved when trying to define disaster. Any disaster narrative comprises numerous perspectives and diverse and varied players. What is most salient for disaster responders is having an understanding, within a sociocultural context, of the subjective experiences of individuals, groups, and collectivities that have lived through disaster and recognizing the many stories, meanings, reactions, and needs engendered by a specific disaster.

We can therefore say that certain qualities constitute a disaster, but they are contingent and subjective criteria and need to be applied flexibly and situationally. While a disaster contains an event, or series of events, that affects multiple people, groups, and communities and has a public dimension as well as private suffering, it is more helpful to think of a disaster as a process (Oliver-Smith, 2002). A disaster *does not* always have a clear beginning or end, and, yet, it is socially constructed as an event outside of ordinary experience that overwhelms a group's individual and collective coping capacities, destabilizing and disrupting everyday life and normal functioning. Disasters lead to horizontal and vertical disruptions. They interrupt social connections and relationships. They sever people and their communities from past sources of strength and wisdom and from their vision of a hopeful future. And whether or not disasters lead to traumatic reactions, they are stressful events involving losses and evoking powerful responses.

Thus, my working definition of disaster is *a process that encompasses an event, or series of events, affecting multiple people, groups, and communities, causing damage, destruction, and loss of life. There is a public and collective dimension to a disaster, as well as individual suffering. The disaster process is socially constructed (at least by some) as being outside of ordinary experience, overwhelming usual individual and collective coping mechanisms, disrupting social relations, and at least temporarily disempowering individuals and communities.* And by using this definition, I believe that the similarities between the large-scale and small-scale examples given earlier, particularly when considering the activities of responders engaged in disaster mental health and psychosocial capacity building, outweigh the differences. It is a theme that is developed further in chapter 3. This is particularly true when working from a social-ecology perspective, in which there is an integration of micro, mezzo, and macro factors and disaster is viewed not as an event but as a process. Rather than viewing something purely as a disaster or non-disaster, the book considers the spectrum of disasters, ranging from small to large, local to international.

THE SOCIAL ECOLOGY OF DISASTERS

Disasters are contextualized and are formed and shaped by history, culture, social structures and processes, and political economies. Every disaster has a unique social ecology that influences perceptions and experiences before, during, and after the disaster (Park & Miller, 2006, 2007). The social ecology includes the history of how people arrived in certain geographic areas and the patterns of relationships among ethnic groups in these areas. It encompasses social and economic disparities as well as differential access to resources and services. Unequal power, status, and social capital are part of the social ecology as are different cultural beliefs and practices; socio-political factors interact with geographic and geological forces—they are inseparable. Figure 1.1 illustrates how the process of disaster involves the interaction between a precipitating event and the affected people and their community within the context of a social ecology.

Because of the social ecology of disaster, families and groups are differentially affected by the same disaster and often develop different narratives of the disaster and its consequences. Such narratives not only reflect the disaster experience but construct and shape its meaning. Thus, understanding

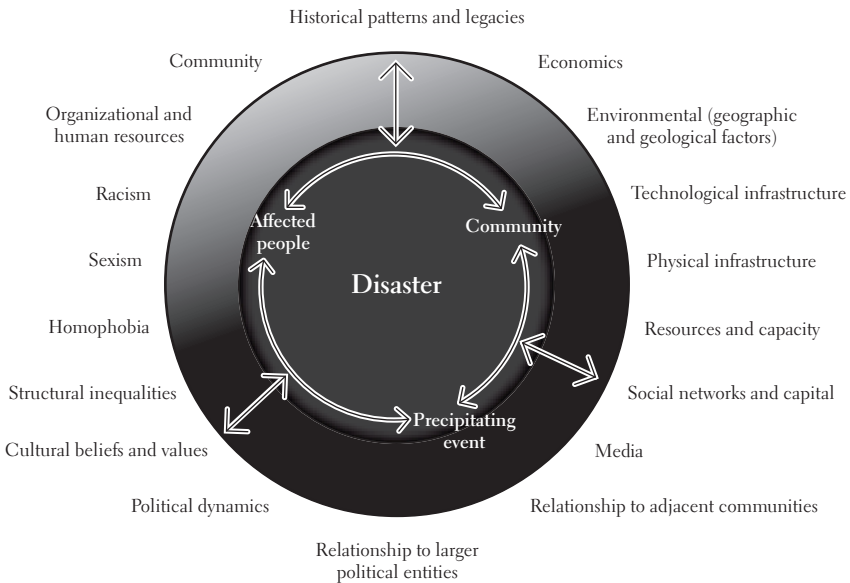


FIGURE 1.1 Social Ecology of Disaster

the social ecology of a given disaster has implications for who needs help and how to respond, as well as who is best positioned to respond.

Hurricane Katrina was a “natural” event, but because of the social ecology of the Gulf Coast, it had a differential impact. White middle-class people living in New Orleans suffered terribly during the storm but lost fewer lives and less property—and recovered more quickly—than poor African Americans living in the same city (Kates, Colten, Laska, & Leatherman, 2006). These inequalities did not just emerge during the storm; they were present for centuries before Hurricane Katrina. However, they were amplified during the storm and further augmented afterward. The Lower Ninth Ward, a predominantly low-income African American area, is a neighborhood that still has not been rebuilt. The same is not true of the whiter and more affluent Garden District and the French Quarter. Government policies and private market factors, such as who had home insurance and who did not, interacted with political agendas (reducing public housing for poor African Americans, for example) to contribute to the situation (Dreier, 2006; Frymer, Strolovitch, & Warren, 2005; Green, Bates, & Smyth, 2007; Masozera, Bailey, & Kerchner, 2007; Sommers, Apfelbaum, Dukes, Toosi, & Wang, 2006).

When the Asian tsunami struck on December 25, 2004, it killed more than two hundred thousand people in Asia and Africa, particularly in Indonesia, Sri Lanka, India, and Thailand. The relief agency Oxfam estimated that in many areas, up to four times as many women as men were killed because they were either on the beach waiting for fishermen to return or at home caring for their children (British Broadcasting Corporation, 2005). One of the hardest hit countries was Sri Lanka, where more than thirty thousand perished, mostly on the eastern and southern coasts. But the social ecology of Sri Lanka meant that these two regions experienced very different trajectories for rebuilding. The south of Sri Lanka is dominated by ethnic Sinhalese and has not experienced armed conflict based on ethnicity. (The south of Sri Lanka was the site of political and social conflict in the past but not at the time of the tsunami.) For more than twenty years, eastern Sri Lanka had been in a civil war. Three major ethnic groups live there: the Sinhalese, who are Buddhist; the Tamils, who are Hindu; and Muslims, who speak Tamil but are regarded as a distinct ethnic group. The civil war was between the Sri Lankan government and two separatist organizations—the Tamil Tigers, whose stronghold was in northern Sri Lanka, and Colonel Karuna’s breakaway faction that had greater strength in the east. The army, which had a large presence in the area, is dominated by the Sinhalese.

The government at the time, under the leadership of Chandrika Kumaratunga, worked out a cease-fire with the Tamil Tigers, and foreign governments and nongovernmental organizations (NGOs) were able to provide immediate relief. Even during this period, there was mistrust and tension between the three ethnic groups as well as between the Tamils and the army. And over the course of six months, there were daily assassinations in the east, culminating in the assassination of the foreign minister (one of the few Tamils in the government) in Columbo by the Tamil Tigers. This was followed, in 2005, by the election of Mahinda Rajapaksa as president, who had pursued ultranationalist policies favoring the Sinhalese and aggressively fought to pacify and to finally eliminate the Tamil Tigers. After his ascension to power, the region devolved into all-out war. Consequently, post-tsunami rebuilding and reconstruction slowed, and many NGOs and representatives from foreign governments withdrew. On top of the dislocations caused by the tsunami, there are now many Tamils living in refugee camps as a result of the final (and successful) push by the government to eliminate the Tamil Tigers. The International Crisis Group, a nonpartisan NGO, has alleged that there were massive war crimes committed by the government against Tamil citizens and has called for further investigation (“Atrocities Against Tamils,” 2010).

This contrasts strongly with southern Sri Lanka, where there is a clear Sinhalese majority and no war. Rebuilding from the tsunami has continued at a much faster clip, and there are far more resources. While the south witnessed a resurgence in tourism since the tsunami, the east became an isolated, violence-plagued zone, where few outsiders dared enter. The differing fates of two regions within the same country hit by the same natural disaster illustrate how the social ecology profoundly affects the arc of recovery after the storm. All this has occurred within an international context where there have been pressures from investors to use the storm as an opportunity to open up prime beachfront, previously inhabited by poor families, to hotel and tourism development (Klein, 2007). Thus, the social ecology of disaster has, like many things, become globalized.

TREATING TRAUMA OR PSYCHOSOCIAL CAPACITY BUILDING?

DISASTER MENTAL HEALTH

A field known as disaster mental health has coalesced over the past twenty-five years (Halpern & Tramontin, 2007). It has its roots in crisis intervention,

which evolved after World War II in response to such disasters as fires in nightclubs and airline crashes (Halpern & Tramontin, 2007; Roberts, 2005). In the 1980s, debriefings and other group-oriented measures were used to help emergency personnel and others directly or indirectly impacted by disasters (Armstrong et al., 1991; Curtis, 1995; Mitchell, 1983; Raphael, 1986). Organizations such as the American Red Cross, the National Organization for Victim Assistance, and the International Organization for Victim Assistance used these methods on a large scale, over time adapting and amending them based on information gained from research and practice. The International Critical Incident Stress Foundation became the center for training hundreds of emergency management teams set up to serve firefighters, police officers, ambulance drivers, and other first responders around the nation. Over time, controversy emerged over the use of debriefings (Bisson et al., 2000; Chemtob, Tomas, Law, & Cremniter, 1997; McNally, Bryant, & Ehlers, 2003; Miller, 2003; Raphael, Meldrum, & McFarlane, 1995) and a more complex range of disaster response services was developed, often using some form of cognitive behavioral method (Halpern & Tramontin, 2007; Rosenfeld et al., 2005; Ritchie, Watson, & Friedman, 2006).

The disaster mental health complex usually involves psychologists, psychiatrists, and social workers from the United States or Europe, or practitioners from other parts of the world who are trained in the West. The application of disaster mental health methods increasingly expanded from the United States and Europe, and soon they were used in responding to disasters all over the world. Although practitioners within this paradigm may value clients' resiliency (Watson, Ritchie, Demer, Bartone, & Pfefferbaum, 2006), there is a tendency to emphasize trauma as a common disaster response, particularly post-traumatic stress disorder (PTSD). Schlenger (2005) has reviewed studies of adults immediately after 9/11. His results found that 44 percent had at least one PTSD symptom. Although some of the studies bear out that these symptoms decreased over time, other research cited by Schlenger found 7.5 percent of adults in New York City had PTSD two months following the 9/11 attack. Somasundaram (2005) mentions a study in northern Sri Lanka that found 25 percent of children had PTSD and 57 percent were unable to deal effectively with daily life because of the stress of the war. Many more studies, too numerous to summarize here, have found high rates of PTSD.

Trauma reactions, particularly PTSD, have informed the dominant paradigm used to organize the efforts of professionals who seek to help people recover from disaster (American Red Cross [ARC], 2006; Gist & Lubin,

BOX 1.1**COMPARISON OF DISASTER MENTAL HEALTH AND PSYCHOSOCIAL CAPACITY BUILDING****Disaster Mental Health**

- Universal biophysical reactions
- Psychological consequences
- Pathology
- Trained professionals
- Individual recovery

Psychosocial Capacity Building

- Strength and resiliency
- Family, social groups, and communities
- Self-healing versus medicalization
- Empowerment of indigenous people
- Mutual aid and self-help groups
- Cultural responsiveness
- Gender, race, ethnicity, and social class
- Human rights and equity
- Wariness of iatrogenic effects

1999; Halpern & Tramontin, 2007; Lystad, 1988; Ritchie, Watson, & Friedman, 2006; Rosenfeld et al., 2005). The assumptions for this approach are summarized in box 1.1 and are accompanied by discussion.

UNIVERSAL BIOPHYSICAL REACTIONS It is assumed that people have similar biophysical reactions to disaster. The nature of disaster, its impact, and the history of each individual all interact to influence what the reactions will be. There is some recognition that the nature of the community (its social capital and networks) has some bearing on the outcomes. Culture is seen as a variable determining how trauma reactions are expressed, but it is secondary to the universal human response to disaster.

PSYCHOLOGICAL CONSEQUENCES This approach emphasizes the psychological, emotional, and biophysical reactions to a disaster. Although the impact on families, groups, and communities is acknowledged, this is usually secondary to the individual's psychological reactions.

PATHOLOGY Disaster mental health professionals have emphasized, more than most mainstream clinicians and therapists, that an individual's strengths and resources are foundational for his or her recovery. And these professionals put an admirable emphasis on "normalizing" reactions. A common mantra is that "these are normal reactions to an abnormal event"; yet, much of the literature concentrates on the adverse consequences of disaster and the need for psychological first aid and crisis intervention in the early stages (Everly, Phillips, Kane, & Feldman, 2006; Halpern & Tramontin, 2007; Watson, 2007), moving to counseling and treatment for those who continue to experience symptoms months, and even years, after the disaster (Gist & Lubin, 1999; Halpern & Tramontin, 2007; Lystad, 1988; Ritchie, Watson, & Friedman, 2006; Rosenfeld et al., 2005; Ursano, Fullerton, Weisaeth, & Raphael, 2007; Yule, 2006).

TRAINED PROFESSIONALS A logical outcome to this is that there is a need for trained professionals—psychologists, counselors, social workers—to help individuals recover from disaster. Cognitive behavioral approaches are viewed as being most efficacious in helping people to recover once psychological first aid has been applied (Halpern & Tramontin, 2007; McNally, Bryant, & Ehlers, 2003; Ritchie, Watson, & Friedman, 2006). As disaster often overwhelms the capacity of local professionals to respond, outsiders are generally called in. When the focus eventually turns to helping the helpers, particularly uniformed responders (fire, police, ambulance workers), there is more of an emphasis on training peers to debrief their fellow responders (Everly & Mitchell, 2000; Miller, 2000, 2003, 2006a; Mitchell, 1983)—yet even this model has the expectation that a clinician will be a part of the debriefing team.

INDIVIDUAL RECOVERY Many early disaster mental health interventions focused on using groups, such as debriefings, particularly for uniformed responders. In recent years, debriefings have been de-emphasized and psychological first aid and cognitive behavioral treatments encouraged (Halpern & Tramontin, 2007; McNally, Bryant, & Ehlers, 2003; Ritchie, Watson, & Friedman, 2006). What has been implicit in all of these approaches is that the target of recovery is the psychological well-being of the individual, which is consistent with most Western notions of mental health intervention. This is not to say that there is not also concern for improving social functioning and interpersonal relationships, but these are usually secondary to the recovery of the individual.

PSYCHOSOCIAL CAPACITY BUILDING

Although these assumptions have dominated the disaster mental health field for many years, there has been concern about the field's Western focus on the individual, the tendency to "pathologize" reactions to disasters, and a response system primarily predicated on professionals (Ager, 1997; Kleinman & Cohen, 1997; Strang & Ager, 2003; Summerfield, 1995, 2000; Wessells, 1999; Wessells & Monteiro, 2006). This has been reinforced by the Inter-Agency Standing Committee (IASC) (2007) guidelines for mental health and psychosocial services when there are emergencies. This organization has the backing of the United Nations and many major NGOs. It has international participation and recognition for setting standards in response to all kinds of disasters. According to the IASC, it is wrong to assume most people develop significant psychological problems in response to disaster. An emerging paradigm is that of psychosocial capacity building. The assumptions of this model are summarized in box 1.1 and accompanied by discussion.

STRENGTH AND RESILIENCY Although all individuals feel consequences in a disaster, psychosocial capacity building moves a person's strengths and sources of resiliency to the forefront. People are viewed as being inherently durable and resilient and capable of recovering from disaster, often using their own or local resources (Mollica, 2006).

FAMILY, SOCIAL GROUPS, AND COMMUNITIES This approach does not assume that individuals are the fundamental focus of intervention. Families (including extended families and clans), tribes, and other social group categories; cadres (for example, trained local government units in Chinese villages, comparable to civil service employees in the West); and communities are often seen as the fundamental units of psychosocial rebuilding after a disaster. This method places a greater emphasis on collective capacity and how to strengthen and reconstruct it after a disaster. Individual recovery is inextricably linked to collective recovery (Farwell & Cole, 2002; Landau & Saul, 2004; Saul, 2000) as well as economic recovery (Weyerman, 2007).

SELF-HEALING VERSUS MEDICALIZATION Critics of a disaster mental health model (Farwell & Cole, 2002; Reyes & Elhai, 2004; Summerfield, 1995; Wessells, 1999) are wary of Western tendencies to overly medicalize social phenomena and to work with individuals in a decontextualized way

that is not culturally and socially grounded. Although professionals have a role in psychosocial capacity building, it is more often as consultants in creating the conditions that allow people to self-heal (Mollica, 2006) and using training-of-trainers models (Corbin & Miller, 2010; Miller, 2006a).

EMPOWERMENT OF INDIGENOUS PEOPLE Psychosocial capacity building is predicated on the reconstruction and restitution of collective life—the social threads and braids that connect people and give their lives meaning. Rebuilding collective capacity relies on the empowerment of local people who know their culture, community, and one another. Local participation in planning and decision making is essential (IASC, 2007). This is not always straightforward, as there are schisms and struggles within communities and between groups (Wessells, 1999). This makes peace and reconciliation work (see chapter 9) a particularly critical component of psychosocial capacity building, especially when there have been political struggles or armed conflict, but also when there are ongoing social catastrophes, such as endemic racism or religious persecution.

MUTUAL AID AND SELF-HELP GROUPS Narratives—individual, familial, and collective—are an essential part of acknowledging loss, mourning death and destruction, and reconstructing hope and meaning. They are important ingredients of both disaster mental health and collective capacity building approaches. But whereas many disaster mental health activities rely on conversations (often versions of talk therapy or crisis intervention), psychosocial capacity building places a greater emphasis on self-help and mutual aid groups. Such groups often engage in activities, whether they are recreational, social, or psychoeducational, frequently aimed toward mourning and memorializing or geared toward reconstructing social connections and networks or meaning-making systems—narratives are enacted as well as spoken.

CULTURAL RESPONSIVENESS Disaster challenges our sense of what is normal, fair, and possible, and it can cause great pain and sustained losses. How we make sense of this and what we see as being helpful (or unhelpful) greatly depends on our cultural values and worldviews. Culture is not static. Generally, a variety of cultural traditions exist before a disaster. Once disaster strikes, it disrupts cultural traditions and ties with ancestors (Landau, 2007). Frequently, a postdisaster temporary culture then forms, perhaps

among people living in shelters or refugee camps. Although people yearn for a return to their vision of their lives before the disaster, things are rarely the same. A central question is how can people reconnect with their cultural past while acknowledging the losses sustained by the disaster—and how can they then draw on these cultural practices and traditions to face a changed landscape while sustaining a sense of efficacy and hope? Disasters, and war, often disrupt traditional cultures with information and influences from the outside. Disaster response workers are often the ambassadors of these external stimuli, particularly if they are imposing models and techniques that reflect *their* cultural assumptions rather than those of the people affected by the disaster. Thus, cultural responsiveness is a key principle of psychosocial capacity building.

GENDER, RACE, ETHNICITY, AND SOCIAL CLASS Disaster does not strike everyone in the same way. A lack of resources, whether it is economic, social, or personal, affects the vulnerable and their capacity to recover. Social identity—how a person constructs his or her race, gender, class, and so on, as well as how others socially construct that identity (Miller & Garrahan, 2008)—has profound consequences before, during, and after a disaster. Everyone suffers when disaster strikes, but women, due to their social roles and identities, are more vulnerable to assaults, social marginalization, and physical and economic exploitation. Their lack of access to external sources of social support and economic security, as well as the burden of their caretaking responsibility, contribute to their vulnerability during disaster. In many societies, certain ethnic and racial groups have fewer privileges and less access to resources than other groups, which heightens their risk for negative outcomes. Also, they may be socially constructed as less worthy, as were African Americans in New Orleans during and after Hurricane Katrina, which not only dampens public support for their plight but can lead to their treatment as social outcasts and even criminals. Social identity and social oppression are major factors in many of the disasters that serve as case examples in this book—9/11, Hurricane Katrina, the Asian tsunami, and armed conflicts in many parts of the world—and paying attention to them is central to a psychosocial capacity building approach.

HUMAN RIGHTS AND EQUITY Respect for the human rights of all is essential to a psychosocial capacity building approach (IASC, 2007). Given

the inequities that are amplified during any disaster, an important principle of psychosocial capacity building is that all people affected are entitled to humane and equitable treatment by those who are responding (IASC, 2007). Although this is a principle that most responders would assume as part of their professional ethics, it is easier to imagine than to implement. Predisaster inequities were often very entrenched and there are vested interests among those with social privilege for maintaining social hierarchies and divisions. Thus, disaster responders may find themselves in conflict as they seek support and resources from those with greater social and political power, while also advocating for those who had the least, have lost the most, and face the greatest challenges to recovery.

WARINESS OF IATROGENIC EFFECTS Medicine is always alert to well-intentioned interventions that lead to unintended negative consequences. The same holds true for responding to disaster. For example, resettling people in refugee camps where they have food and shelter is often essential, but this can isolate people from their jobs, social networks, and geographical communities. Offering aid and assistance directly addresses emotional and psychological needs; however, this can create dependency and reliance on outside professionals who eventually must leave. Thus, when responding to disaster, it is always important to consider what unintended harm can come from “helpful” interventions (IASC, 2007; Wessells, 2009), and for outsiders, a clear exit strategy should be part of any intervention (Wessells, 1999).

INTEGRATING THE TWO APPROACHES

These two broad approaches, disaster mental health and psychosocial capacity building, have important areas of difference, yet they are not irreconcilable. They are not either/or poles of a dichotomy. Mental health approaches focus more on the psychological responses, while psychosocial capacity building places a greater emphasis on the social aspects of recovery. However, both are intended to promote greater psychosocial well-being (IASC, 2007). While psychosocial capacity building was developed, in some part, as a response to unexamined assumptions implicit in a disaster mental health approach, this does not mean that there is no validity or utility in employing some of the methods of disaster mental health work. And those

trained as disaster mental health responders can adapt their intervention styles and philosophies to respect the important principles inherent in a psychosocial capacity building approach. There is of course great stress and trauma in the wake of disaster and clinical interventions can be helpful. But it is important to conceive of these interventions in the context of a local culture and society and for those people from affected communities to have leadership roles in the planning, implementation, and evaluation of those efforts.

AREAS OF DIFFERENCE

When trying to integrate these approaches, it is helpful to consider three points of divergence (Ager, 1997). The first is the generalizable versus unique axis. What is common to all human beings and what is unique, contextualized, and culturally grounded? Psychological theories are more likely to stress what all people have in common, while psychosocial models stress what is local and distinctive. Summerfield (2004) cautions that even if a behavior seems to occur in different cultural contexts, it should not be assumed that it has the same meaning and resonance for all people. A second area of divergence is the balance between bringing in outside experts with technical expertise versus relying on the capacity of local indigenous people. Local people will continue to live in an area, are local experts, and can interact with many more people than can outsiders. They simply lack the skills of professionals. This is not an either/or situation and many projects have used outside experts to train local professionals, who in turn work to develop the capacity of local nonprofessionals. (This approach is discussed in subsequent chapters.) The third question is whether to try to reach a broad population or to target vulnerable people. Most public health models grapple with this question. The IASC (2007) has developed an intervention pyramid to illustrate how a mental health and psychosocial model can be integrated along this dimension (see figure 1.2). In the pyramid, basic services and security for all represent the widest swathe, followed by community and family support, whereas focused and specialized interventions are part of the intervention spectrum but reach a much smaller number of people.

Other helpful areas to consider are differences in cultural orientation—that is, divergent worldviews and values between cultures in some core areas

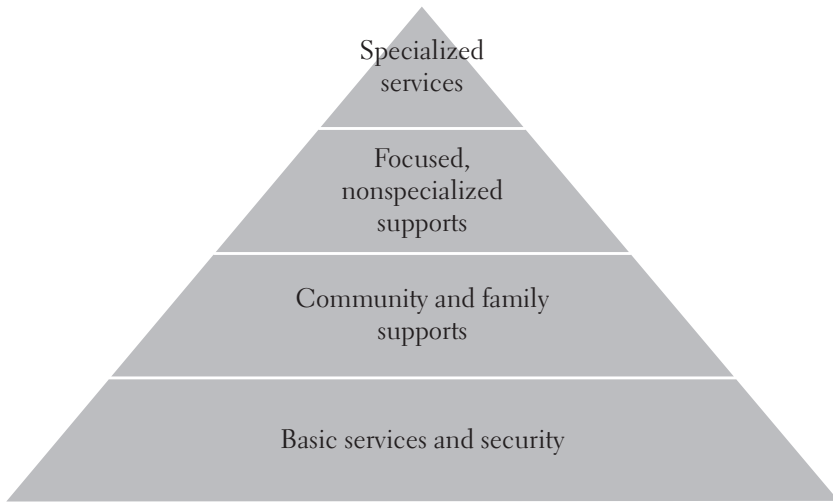


FIGURE 1.2 Inter-Agency Standing Committee (IASC) Intervention Pyramid

(see box 1.2). Nisbett (2003) has identified a number of areas in which Asians and Westerners differ in how they think and view the world, which is interactively connected with differences in history, social structure, and customs. Although it is important not to generalize about gross differences between cultures, as there are also similarities between and variations within cultures, his schema highlights important issues to consider. For instance, many collectivist Asian cultures place a greater emphasis on relationships, while in the West there is more of a tendency to view people as being independent and freestanding. Thus, there is also more of a belief in the East that context matters, while in the West there is a greater inclination to look for logical patterns that are universal and intrinsic. Nisbett also found that Westerners tend to see progress and recovery as a more linear process than Easterners, who may view patterns in a more cyclical fashion. Another continuum is stability versus flux: Is the world basically a place where things are fixed and constant (Western) or always flowing and changing (Eastern)? And how much agency (Western) do we have when preventing or recovering from disaster, and how much is fate and karma (Eastern)?

It is prudent to be wary of painting group differences with broad brushstrokes. Nisbett (2003) does not claim that these patterns are absolutes, and there is increasingly cross-fertilization and hybridization as cultures and nationalities interact, migrate and immigrate, and study and work in multiple

BOX 1.2

DIVERGENT CULTURAL ORIENTATIONS

1. Are objects and people freestanding or always embedded in larger networks?
2. Do people have personal agency or are they subject to an external locus of control in the form of beliefs such as karma or fate?
3. Is progress linear or cyclical?
4. Is the set point of normal stability or flux?
5. Do events have a self-contained intrinsic logic or are they part of larger patterns and processes?
6. Should we strive to reduce contradictions or embrace paradox?
7. Is behavior more attributable to personality traits or situational factors?
8. Is it safe, healthy, and healing to talk about thoughts and feelings with others, particularly painful or negative reactions?
9. Have our ancestors died and departed or are they with us at this moment?

NUMBERS 1 THROUGH 7 FROM NISBETT, 2003.

settings—but these patterns represent tendencies that have implications for how to structure, design, and implement disaster responses.

I have found two other areas of divergence between Western and non-Western cultures, which have significant implications for disaster response. One is whether it is both safe and helpful to share feelings. A fundamental assumption of Western psychological counseling is that it is helpful to talk about feelings. “Ventilation” is often a goal in disaster mental health, whether it is in the early stages or in the mid- to long-term phases of response (Dyregrov, 1997; Halpern & Tramontin, 2007; Miller, 2003, 2006a; Ritchie et al., 2006; Rosenfeld et al., 2005). It is seen as being useful and cathartic to share feelings, including distressing or sad feelings. However, in non-Western cultures, there is often less of a tradition of sharing feelings with others, let alone with professionals or strangers. The expression of negative feelings may lead to negative outcomes, karma, or consequences. In Balinese culture, expressing bad feelings can even leave one vulnerable to harm from others (Wikan, 1989). When I responded to the tsunami in eastern Sri Lanka, I found that many Tamils smiled when relating very sad or tragic events (Miller, 2006a). When I inquired about this, I was told that it is not considered socially appropriate to share one’s sadness publicly.

A second area of major departure is the relationship between ancestors, being, and time. Most Westerners view ancestors as existing in the past, perhaps to be remembered, but they are not seen as having an actual

presence. When I have conducted workshops and asked participants if they believe that their ancestors are in the room, right at this moment, most white Westerners are surprised at the question and look confused. But if they are participants from Africa, the Caribbean, Asia, and from other non-Western parts of the world, the answer can be “of course they are!” In Chinese cultures, there is a more active sense of the presence of ancestors than in most Western traditions (Chan et al., 2005). Differing beliefs about the temporal presence of ancestors has implications for grieving, mourning, and recovery, which is discussed in subsequent chapters.

THE WHEEL OF RECOVERY: AN INTEGRATED MODEL

Mollica (2006) has made an explicit link between psychological and social interconnectedness, particularly when there is armed conflict or disaster. He considers the neurological consequences of disaster and distinguishes between declarative and emotional memory, which are stored in different parts of the brain. Like many who work with trauma (Ochberg, 1988; Van der Kolk, 2002, 2006), he describes how traumatic memories (emotional) are stored in the amygdala, whereas rational words and narratives are declarative memories stored in the prefrontal cortex. Emotions are often overwhelming and it can be difficult to understand why the emotions are occurring. Thus, people “lose their capacity to use emotions as guides for effective action” (Van der Kolk, 2006, p. 5). This helps to explain why traumatic memories can be triggered by sights, sounds, and smells that are logically not at all the same as the sensory stimulation from the disaster and yet can evoke a panicked, physiologically overwhelming response. For example, after 9/11, those who escaped from the World Trade Center towers often experienced burning smells or sounds of airplanes and intrusive and evocative physical flashbacks of what they sensed and how they felt when they were fleeing the towers.

But Mollica (2006) links this traumatic focus with a psychosocial approach by stressing the power of self-healing—a formulation that supports an empowerment-based outlook. He goes further, linking neurological healing with social connectedness, altruism, and spirituality. Wilkinson and Pickett (2009) cite studies of how certain neurological and endocrinological processes foster social cohesion and connection, but the reverse is also true: social interactions benefit neurological processes, leading to positive physiological consequences. Van der Kolk (2006) also cites research showing that

not only does meditation aid in self-awareness but it also leads to a thickening of parts of the brain associated with “attention, interoception, and sensory processing” (Van der Kolk, 2006, p. 12). Thus, the social and spiritual activities suggested by a psychosocial capacity building approach foster neurological changes that lead to self-healing and recovery. This is similar to the findings that skilled practitioners can “rewire” their brains through meditation and achieve neurological and endocrinological changes that lead to less anxiety and a greater sense of calm and well-being (Goleman, 2003; Wallace, 2007). There is a recursive interconnectedness between the plasticity of our neurological wiring and conscious thoughts, social interactions, and spiritual practices.

Figure 1.3, The Wheel of Recovery, attempts to illustrate some of these connections. It diagrams a strengths-based model of recovery for communities struck by disaster, emphasizing collective capacity while also acknowledging the need to respond to stress, trauma, and bereavement. Surrounding

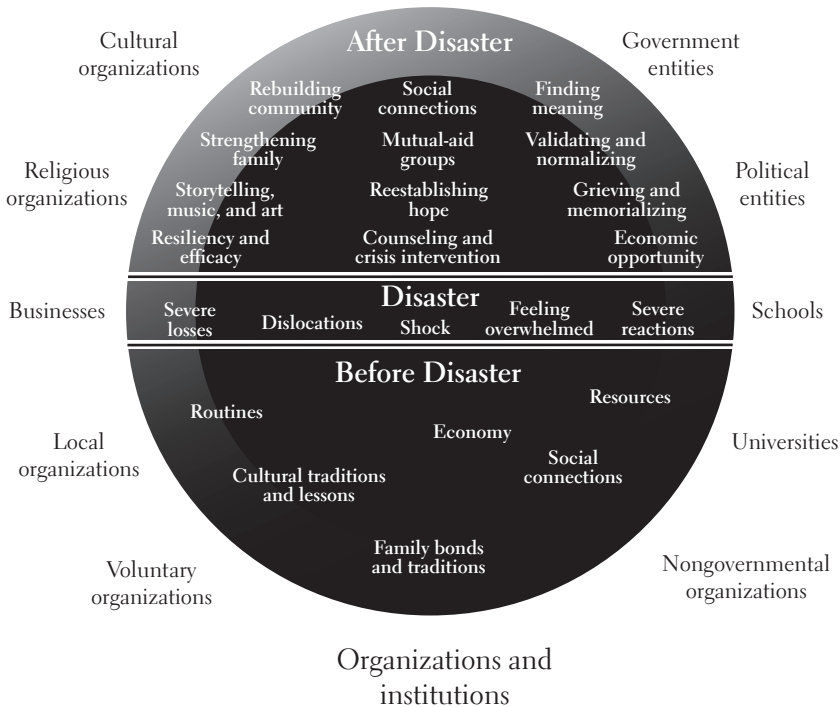


FIGURE 1.3 The Wheel of Recovery

the circle are entities—NGOs, self-help groups—that can support a community struck by disaster, offering resources and interventions in ways that respect the cultural and social integrity of the community. The bottom part of the circle describes the strengths and resources that individuals, families, and communities had before the disaster struck and that can serve as sources of wisdom and hope if this well of the past can be uncovered from the debris of the disaster. Resources antedating the disaster include wisdom gained from direct life experiences as well as lessons passed down from previous generations. The horizontal band in the middle of the circle describes the reactions and dislocations caused by the disaster. Above this band are a variety of postdisaster tasks and activities that contribute to collective and individual healing and recovery, incorporating ideas and interventions from both disaster mental health and psychosocial capacity building. And at the top of the circle are the three most important things for a community to strive for in the wake of disaster: a sense of hope, social connectedness, and constructing meaning forged from the font of the past and the ashes of the disaster. As this wheel turns, the social touchstones mentioned in the pre-disaster part of the circle meld with the postdisaster processes and become the new “normal” for people and their communities.

TRUTH AND PERSONHOOD

When professionals respond to help the people who have experienced disaster, they pack a suitcase full of assumptions, beliefs, and values about how people react and how to help them to recover. Summerfield (2004) notes that this baggage is often unexamined and culturally biased; the practitioner’s worldviews are applied universally and in a decontextualized, ahistorical fashion. Every historical period and culture has meaning-making systems to understand phenomena and human behavior. Living as a temporal and cultural insider leads to taking for granted these perceptual and conceptual lenses—they attain the status of truth. Those with greater power are in a better position to establish what is normal, valid, and meaningful, and those with differing understandings are often subordinated and repressed (Foucault, 1984). There are “battle[s]” for establishing “truth” as well as the rules for verification of truths (Foucault, 1984, p. 74). Given the world’s history of racism, class conflict, and colonialism, many truths about human behavior have been contested politically, economically, and militarily.

Doctors, psychologists, social workers, public health workers, and other non-governmental players have often been the social foot soldiers in attempts to impose some truths as being better than others, installing certainty over subjectivity, legitimacy over folklore. When disaster workers respond, they are not neutral players but rather embodied and embedded political actors in a world of colonialism or, at best, neocolonialism. We are not ever neutral, even when we actively strive to be.

Thus, in the Victorian era, a doctor responding to an upper-class white English woman, who had experienced the disaster of sexual abuse as a child and who was hypervigilant and emotionally labile after a rape attempt, might attribute the patient's reactions to "hysteria." If attending to a poor or working-class woman, however unlikely this would have been in this historical and social epoch, he (most doctors during this period were male) might have seen the woman's reactions as further evidence of "social degeneracy." And if by some freak of circumstance that same doctor were evaluating a refugee from (what is now) Kenya or Zimbabwe, he might conclude that this was a manifestation of superstitions carried by genetic inferiors. A doctor practicing today, whatever race and gender, would probably reject (or certainly criticize) all of these formulations. A female doctor from Kenya, however, would likely acknowledge the legacy of patriarchy and colonialism in both her assessment and responses. Helpers are always historically situated and politically positioned.

Given this, it might be advisable for disaster responders to be cautious about making assumptions and rather ask some questions about the nature of personhood. Summerfield (2004) defines personhood as the way that a person exists in the world—how an individual responds to adversity and risk in life. Summerfield suggests a number of questions, which are included in box 1.3. The answers to these questions help to map out the diverse and shifting parameters of personhood for dissimilar populations facing unusual situations in distinctive cultures and societies at different points in time.

ESSENTIAL ELEMENTS OF DISASTER RESPONSE

It is critical to understand social constructions of reality and sociopolitical and cultural factors when responding to disasters. It is also important to be guided by empirical confirmations ("evidence" is too strong a term, implying objective truth) about what helps and what does not. Hobfoll and his

BOX 1.3**QUESTIONS ABOUT PERSONHOOD**

1. What kinds of risk can be faced?
2. What kinds of adversity can be managed?
3. When are people likely to be fatalistic?
4. When are people likely to feel hopeful?
5. What constitutes a grievance?
6. What is normal and abnormal behavior?
7. What are acceptable reactions after a disaster?
8. How is distress expressed?
9. How is help-seeking behavior expressed?
10. What constitutes reconciliation?
11. What serves as just compensation?

ADAPTED FROM SUMMERFIELD, 2004.

nineteen colleagues (2007) have done an excellent job of reviewing the empirical studies of immediate and midterm mass trauma intervention and have found that five intervention principles are empirically supported. The research team constitutes many of the world's leading experts on disaster response and recovery, and they are culturally, racially, and nationally a diverse group. There were also many responses to their research published in the same issue of the original journal article. Many, if not most, of the authors have probably been trained in Western traditions of psychotherapy, and this should be taken into consideration when weighing their recommendations. But their research offers some of the most clear-cut guidelines presented about how to help people recover from disaster. (See box 1.4, which shows the original five principles and three that I have added—grieving and mourning, a sense of place [Prewitt Diaz & Dayal, 2008], and reestablishing a link to the past.) Their recommendations for intervention and my additions are incorporated in subsequent chapters that examine how responders can best intervene. The areas that they have identified are closely linked with one another, and interventions directed at one domain are likely to have an impact on other domains. What follows is a brief summary of the importance of the five areas.

PROMOTING A SENSE OF SAFETY When people feel unsafe, it is difficult to access strengths and resources. Acute or chronic insecurity saps resiliency

BOX 1.4**ESSENTIAL ELEMENTS WHEN RESPONDING TO MASS TRAUMA**

1. Promoting a sense of safety.
2. Encouraging a sense of calm.
3. Inspiring a sense of self and collective efficacy.
4. Promoting connectedness.
5. Instilling a sense of hope.
6. Allowing for grieving and mourning.
7. Establishing a sense of place.
8. Reestablishing a link to the past.

NUMBERS 1 THROUGH 5 ADAPTED FROM HOBFOLL ET AL., 2007.

and fosters hypervigilance, stress, and possible trauma. People feel unsettled and are unable to regroup, rebuild, and rebound from disaster. It is also difficult to grieve under such circumstances. A person is often left with severe reactions, such as high anxiety or deadening numbness.

Hobfoll et al. (2007) point out that lack of safety particularly undermines the relationship between children and caretakers, as safety of offspring and other dependent people is one of the major tasks for caretaking adults. The researchers also stress the physiological consequences of living in an ongoing state of danger, particularly neurological and endocrinological reactions. Social support is weakened and fear and anxiety can be amplified by media saturation and overexposure.

It is important to stress that responders cannot wait for conditions to improve to help engender a sense of safety for affected people. Many dangerous situations—such as the armed conflicts in northern Uganda and eastern Congo, northern and eastern Sri Lanka, and the Middle East—persist for a long time. And there is a recursive relationship between a sense of safety and ongoing disaster, particularly disaster involving armed conflict. When people feel more threatened, they are less likely to heal and more likely to harm others. When people and communities feel empowered, they are able to face and confront threats and contribute to creating the conditions that allow for even greater safety. One of the important questions to consider when we move to discussing psychosocial capacity building and mental health interventions is: how can children and caretakers attain a sense of safety while living in zones of violence, resettlement, and uncertainty?

ENCOURAGING A SENSE OF CALM Feeling unsafe is related to high states of physiological and emotional arousal. As Hobfoll et al. (2007) point out, this can lead to disruptions in routines—such as eating and sleeping—which are essential for healthy functioning. Even normal breathing can be disrupted. Anxiety, stress, and tension make it more challenging to maintain meaningful and supportive social relationships. Heightened levels of fear and anxiety can distort perceptions and lead to avoidance.

Hobfoll et al. (2007) draw on many studies of rape and other forms of personal assault that correlate with PTSD as an analog for disaster-induced trauma. This body of literature focuses on using mindfulness and meditation, body scans and awareness, guided imagery, as well as cognitive-behavioral and stress inoculation techniques that focus on perceptions, meaning-making, and behaviors. Fostering positive emotions is a related strategy, as are problem-solving and coping methods. Psychoeducation can normalize and render understandable the reactions people are having and lead to a greater sense of efficacy and control.

INSPIRING A SENSE OF SELF AND COLLECTIVE EFFICACY There is a reciprocal relationship between self and collective efficacy—the sense that one, or one’s group, can effectively respond to and cope with threats and challenges (Landau & Saul 2004; Miller, 2001; Samson, Raudenbush, & Earls, 1997). When individuals and families feel empowered, they act in ways that make their communities safer (supervising children in public places, for example), and safer communities lead to more people feeling secure, calm, and empowered. This interconnectedness means that interventions directed at the individual/psychological level, such as psychological first aid, counseling, and therapy, as well as those targeted at the community level, such as psychosocial capacity building, will complement and reinforce one another. This domain is a good example of how a disaster response approach that is both psychological and social is preferable over interventions that exclusively focus on only one of these dimensions.

PROMOTING CONNECTEDNESS Disasters displace and affect many people, yet they leave people feeling isolated and alone. The paradox of mass casualties leading to profound isolation hinders recovery from disaster. This has both social and psychological components. Socially, people are often scattered, loved ones are missing or dead, transportation and communication networks are severed, and public and social spaces are

damaged and even erased. The disaster of Hurricane Katrina exemplified this process. People who have been resettled to temporary living quarters or are besieged by armed conflict experience even greater social isolation. Hobfoll et al. (2007) cite research that confirms that terrorism and death make people more suspicious and mistrustful. Psychologically, they often become numb, feel alienated from others, and may even carry a sense of guilt and responsibility, fostering shame, all of which creates a deepening sense of loneliness and separation. Thus, activities that foster connectedness, whether they target a person's inner processes or ruptured social networks, or preferably both, are essential building blocks of resiliency and recovery.

Hobfoll et al. (2007, p. 296) cite the substantial weight of research confirming the human need for "sustained attachments to loved ones and social group[s] in combating stress and trauma." Even if one is not using a trauma formulation, social connectedness is a process, goal, and outcome of psychosocial capacity building. Social connections move in many directions (for example, vertically between parents or caretakers and children and horizontally between friends, colleagues, and extended family) and social connections are recursive (giving leads to receiving, which encourages more giving). Hobfoll et al. state that while social connectedness is the most empirically substantiated of their five principles, the interventions that foster it are less articulated than they are in the other realms. Subsequent chapters describe ways of fostering social connectedness, particularly when considering group interventions, collective activities, psychoeducational responses, the use of the media, community organizing, and collective mourning and memorializing.

INSTILLING A SENSE OF HOPE All professionals and volunteers who engage in clinical work or community organizing know that instilling hope is an indispensable and vital part of helping people and communities. Hopelessness closes the doors to social connection and shuts windows to the future. Frankl (1997) has written extensively about how hope was vital for surviving the most gruesome and degrading of situations—living in concentration and death camps. When facing challenging social inequities, such as racism, sexism, and homophobia, hope is necessary for sustained engagement (Miller & Garran, 2007). Hope is indispensable for constructing generative meaning. Hope leads to a sense of efficacy and social agency (Hobfoll et al., 2007). But hope is often the first casualty of disaster. Threats

lead to fear, destruction can cause trauma, and loss can lead to grief (Weyerman, 2007). How can hope be instilled?

Here, the cultural sensitivity of psychosocial capacity building is critical. In some cultures, hope is achieved through action or problem solving. In others, meditation or religious beliefs, or faith in the tribe, clan, or even in the national government may be fundamental (Hobfoll et al., 2007). Instilling hope is located at the nexus of disaster mental health and psychosocial capacity building—it is achieved through the interaction of internal beliefs, values, and emotions with social, economic, and political rebuilding. This can often take time and may be difficult to come by. While effective disaster intervention may focus on stress, trauma, loss and grief, and social alienation, all roads in disaster recovery need to lead to hope.

WHAT DO WE NEED TO KNOW?

This chapter serves as a conceptual foundation to this book. Subsequent chapters erect the scaffolding, by focusing on what disaster responders can do and presenting case examples to support the suggestions. Chapter 2 focuses on the various roles that professionals and volunteers play when responding to disaster, and chapter 3 builds the walls that elucidate a conceptual understanding of disaster. Using a disaster mental health framework, chapter 4 describes the many ways that disaster responders help people recover from disaster. Special attention is paid to the twin (and at times opposing) tasks of coping and grieving and mourning. The different phases of disaster recovery are described.

The book then focuses on a psychosocial capacity building approach: the political, sociocultural, and global issues and the kinds of activities that need to be taken into account. Ways of integrating disaster mental health and psychosocial capacity building are considered and then applied to specific situations, such as armed conflict, working with specific populations (children, women, the elderly). As well, activity-oriented approaches are used that foster social connectedness, efficacy, and hope. The final chapters focus on linking memory and memorializing—the losses of the past with the promise of the future—and conclude with recommendations for self-care of disaster workers.

The key concepts introduced in this chapter are developed throughout the book: the social ecology of disaster, fostering empowerment and resiliency,

respecting and responding to cultural differences, and integrating psychosocial capacity building with disaster mental health. The recursive relationships between individual recovery and collective recovery and among psychosocial healing, peace, and social justice are also central themes; these are dynamic relationships and cannot be separated. Individual recovery without collective recovery is at best partial and incomplete, and without peace and social justice, psychosocial healing is stymied or truncated. Conversely, when individuals feel empowered, communities can develop a sense of collective efficacy; when psychosocial wounds are healing, the bonds of human connection can be reconstituted. Then hope, forgiveness, and justice become enduring possibilities.

MINDFULNESS EXERCISE: BREATHING

Responding to disaster is stressful work. Mindfulness techniques constitute an important self-care strategy. Even reading about disaster can lead to an internalized sense of discomfort and unease; the act of empathically imagining the consequences of disasters can cause mirror neurons to resonate and lead to physiological, cognitive, and emotional reactions. Thus, there is a simple mindfulness exercise at the end of each chapter. Not only can these exercises help the reader tolerate any affect generated by the material, but they can offer a range of portable responses that can be carried into the field. They come from my own work with disaster and teaching about disaster; they are gleaned from many sources.

The most basic thing we do is constantly and continuously breathe. It is usually in the background as our awareness shifts elsewhere, unless it is disrupted and we find ourselves gasping for breath or breathing rapidly, such as when we experience a sense of panic. However, there are times when we might not notice that our breathing has become constricted or shallow, especially during deep engagement with stressful situations.

Try to find a location that is not overly noisy or filled with distractions, such as people talking or traffic whizzing by. Over time, this exercise can be done anywhere, even in frenetic places. Sit in a comfortable, upright position, either in a chair or on a cushion; good posture is important to good breathing. Either close your eyes or fix your gaze on the floor, whichever works best for you. You might want to try doing this with your eyes open and then closed to see which you find most effective.

Focus on your breath. It sometimes helps to concentrate on a specific body part—such as your lungs as they fill with air and deflate or your nose as air enters and leaves. Do not try and control your breath—simply observe it. If you hear sounds or other distractions, do not try and push them away. Simply note them and return to your breath. If you find yourself becoming distracted or thinking about something, merely notice it and return to your breath without judgment, self-criticism, or editorializing.

It can help to start small—do the exercise for three minutes. If it seems to be helpful, you can expand the time to fit with your own needs and schedule. Some people find that counting each breath helps them to stay focused. If you use this method and lose count or become distracted, just start over again. If you have an alarm on your watch or cell phone, it can free you from having to focus on the time. However this exercise works for you is fine; there is no standard or goal to measure yourself by. It becomes your own way of practicing mindfulness, wherever you are and whenever you want—deriving whatever benefit this activity offers you.