

Green Cross Newsletter

VOLUME 1, ISSUE 5

OCTOBER, 2011

Presidents Message

2011 has been a year of incredible disasters around the country ... and around the world. I was just looking at some photos of Japan's destruction from the earthquake and tsunami in March of 2011. I was struck not only by the pictures of the destruction... but the pictures of recovery. One photo was a pile of steel, wood, concrete and many unidentifiable objects piled high... and then another photo taken just a few months later, the exact same location is a fertile field with green vegetation and volunteers working to pick up small rocks. I saw the strength of spirit and determination in that sequence. And I was reminded of the incredible pull towards life, health and hope that resides within the human spirit.

We as Compassion Fatigue specialists, mental health professionals, therapists, field traumatologists... whatever our title...we have the privilege of sometimes being a part of supporting that spirit as it accomplishes super human tasks. I, for one, occasionally need to be reminded that it's their spirit that is doing the work; I am only guiding and at times simply standing by so they know they aren't alone.

It also serves as a personal reminder to me that there are no guarantees of what tomorrow may bring for me or anyone I know. Now is the time to take care of business... whether that's

making sure you have copies of important documents in a safe place, having a family emergency contact plan, or simply telling someone what they mean to you.

I'll start by telling you how much you mean to me... without you, Green Cross simply wouldn't exist. And the people we touch, would be denied our guidance and our presence as they face whatever it is that is challenging them. So thank you for being there.

Mary Schoenfeldt
Board President

INSIDE THIS ISSUE:

Presidents Message	1
Happenings Since Our Last Newsletter	1
A Day with Green Cross in the Field	2-3
A View From a Student	3
Race-based Traumatic Stress in the African-American Population	4-5
You Can't be Happy and (Fill in the Blank) at the Same Time!	5-6
Haiti: The Psychological Impact of Natural Disaster	6-8

Happenings Since Our Last Newsletter:

By: Dr. Daniel Casey, CT, Executive Director, GCAT

Director's Report for the GCAT newsletter, bringing membership up to date since our last newsletter in July 2011.

Green Cross has been very busy this summer! Sixty seven (67) new members and we deployed twice this summer to the Floods of North Dakota.

Our services there were very needed and well provided. We deployed small groups as there were no accommodations for more than a few people at a time.

After watching our GCAT Personnel working with the Salvation Army group in Minot, the FEMA

Incident Commander on site called our office and asked how they could be provided the same services. This led to a long discussion and sharing a lot of information back and forth.

We couldn't deploy with them without a contract, and they couldn't sign a field contract, so we did not 'officially' work with them, but the last week we were there, the Salvation Army work lightened enough that I asked our last person to imbed in the FEMA camp and provide the same services we had been providing to the SA. This was very well received and I think it will lead to an M.O.U. with them in the near future.

GCAT participated in a Citizen Corps EXPO in the State of Washington in August, 2011. (see Laura's article this issue).

We provided field interventions, as well as a full day training to 500 individuals in De-Escalation Techniques.

Our Organization has grown to Four Hundred and Seventy Three (473) members as of October 31, 2011. This is the greatest number of members we have experienced since we assumed the Executive office in Minnesota in 2008.

A Day with Green Cross in the Field: It's A Drill, Only a Drill... But WOW!!!

By Laura Dahlstrom, Certified Field Traumatologist

Saturday dawned with a most gorgeous setting for those involved in the NW Citizen Corps EXPO 2011 in North Bend, Washington. Clear cobalt blue skies domed the open field nestled within incredible forest covered mountains and a warming sun began the day. Fresh summer morning air filled our lungs as we looked about and appreciated "the moment."

Then with an air of anticipation and excitement, the CERT (Community Emergency Response Team) teams headed out to the make shift Emergency Operation Center as the drill officially began. Volunteer Medical teams were under tent in their assigned area, the moulaged role players assumed their "victim or survivor" positions, radio operators in the Communications Van were poised in their chairs with radios, microphones and headsets in place and pads of papers to begin tracking the radio traffic about to begin. The Incident Commander hovered over a huge map and assorted lists of personnel he was about to be responsible for. His EOC crew was all assembled and ready to begin the herculean task of keeping the upcoming chaos organized and manageable.

The moment came when the On Scene Incident Commander (IC) reported that we've just been hit with a massive earthquake and there were multiple areas of need waiting for help. We could hear people screaming, smell smoke, and feel the chaos. We had people trapped in a burning building several stories high, multiple car crashes and an overturned fuel tanker that had ignited three out of the four vehicles. An airplane had crashed with many aboard. A huge wall had collapsed and trapped individuals underneath. More vehicle crashes were scattered throughout the area as well as buildings with people in them had collapsed, and panicked survivors could be heard screaming and crying from many directions at once.

The IC began directing human traffic, sending out CERT team as fast as he could. CERT team leaders began shouting directions and off they went with extinguishers and stretchers in hand, helmets on their heads and 40 pound packs on their backs. Green Cross Field

Traumatologists were called and arrived at the EOC to assist and to await the return of the emergency responders to the evacuation site as they came for further instructions and to rest between assignments.

Green Cross volunteers have been trained in providing stress management, compassion fatigue care and psychological first aid as Field Traumatologists to the first line volunteer responders in disaster settings. Today we were a team of six plus Bogey our very own Green Cross golden lab trained in companion therapy. As the request of the On Scene Incident Commander, we spread out and met the teams as they were returning after their deployed assignment in the field. We watched for any visual cues of stress and exhaustion due to both heat and the scenarios the teams were encountering. We greeted the teams with water in hand, energy bars, a kind word, an invite to share a bit of shaded grass, and an open invitation to talk about what they just encountered. Some were happy to share a short sentence or two and others chose to remain a bit more contemplative but grateful for the water and the warm smiles or gentle pat on the back, encouraging them to hang in there and stay safe. Interchanges such as... "Pretty intense out there, huh?" "You said it; I can't believe how hard this is" were common.

As the day progressed, the fast paced energy continued and the teams came and went in and out of assignments. Water bottles were a blur of transfer. The temperature rose into the upper 80's on the tarmac and around the scenes of mangled burned metal of crashed vehicles and fires waiting extinguishing. Carrying stretchers back and forth, lifting walls and climbing stairs up the tower of a burning building to rescue trapped survivors was taking a toll on our volunteer rescuers who continued without complaint for hours.

Green Cross volunteers saw an opportunity to be available to ease the stress of the radio operators and the EOC crew. They were located under tarp but the heat and stress of the day was becoming noticeable as the hours lingered on. Headaches and heat related fatigue were starting to become more prominent and yet the teams came and went. The IC kept all aware of the whereabouts of the teams and the status accounts of victims

and survivors in each response area. He too was appearing in need of a break and some relief from our Green Cross Field Traumatologist volunteers. We brought him a chair, a damp towel to drape around his neck, kept him hydrated and fed. There were occasional bursts of stress relief through gallows humor too!

This year was our first experience to include a non-human volunteer in a drill of this kind, and he did a fine job for us. Our team member with Bogey the companion response dog was very well received. It's hard to ignore a beautiful dog and everyone who approached, did so with a smile. The hard lines of stress just eased as they would pet him and talk to him like an old friend. Bogey stayed leashed and was easily commanded by hand signals and leash movements, but always knew just who to approach and stand near with those sweet brown doggy eyes staring up at the tired sweaty responder. Bogey and his "mom" were a great pair and addition to our Green Cross team of traumatologists.

As the day wore on and the field teams continued their work at the disaster site, some of the Green Cross team moved over to the Medical Team site to see how the stress and fatigue of the day was affecting the volunteer doctors, nurses and medical staff. They were hot, flushed and rushing about in a flurry of triage, moving wounded survivors about as needed, attending to the wounds with care and speed as each moment was critical. The Green Cross team stood by and observed these hard workers, offered encouraging and supportive words, cold water bottles and inviting them to step back and take a break as they could. It wasn't long before the medical personnel saw the Green Cross volunteers as part of the overall team and began to take heed of the suggestion to slow down, take the time to drink some water and to just breathe for a minute before the next wave of patients arrived.

Back at the EOC, I sat on the end of an old trailer platform visiting with a 14 year old volunteer who was working this drill as a Ham Radio operator. He was also CERT trained and was very much enjoying the opportunity to be a

part of this major field exercise. I was surprised at how young he was. He and the many other young people helping in the role playing were such an inspiration to me. It was great to know that our young people are also thinking about how to prepare and respond to disasters.

I found that throughout the day, many were interested in who Green Cross was and what we did, and how we were involved in the drill and where we fit into the scenario overall. We had a wonderful teaching opportunity to talk to our first line responders about the stress they experience with emergency response. This stress may not even be noticed by them at the time but it can have short and long

term affects and can manifest itself physically, emotionally and mentally over the next days and weeks. We shared with them about how best to manage it and also how to possibly minimize their reactions by requesting our presence and heeding our advice to step back, take a breath and pace themselves. Our presence with them is first and foremost as a means of emotional and psychological wellness. We were thanked over and over for being here with them.

It was a good day. A long day. A successful day. Green Cross became an even more valued presence in the team of emergency response. This was my first field experience with Green Cross and I too was very impressed

with the role of mental and emotional wellness being extended to those who so faithfully and graciously care for others in such horrific and chaotic conditions. It is definitely a much needed role to and for all of us.

VIEW FROM A STUDENT...

I recently attended the Green Cross Academy of Traumatology classes in Kirkland, WA. Dr. Dan Casey and Mary Schoenfeldt were the instructors. The classes were recommended to me by a friend who had taken them a year ago. I had never heard of Green Cross but decided to jump in anyway. They sounded intriguing and I was up for the challenge of learning something new!

I must say that on the first day when we went around the room to introduce ourselves and say what we did and why we were there, I felt like perhaps I had jumped in WAY over my head. I was in a room of professionals, either in the medical field, mental health, chaplain ministry or staff support persons for the International organization... World Vision. I have no college degree or job in any industry. I DO have a very compassionate and empathetic nature and frequently find myself in situations where I am stepping

in to counsel, minister to grief or set-up care giving situations. I did not feel like I was going to fit in with all of these professionals who were highly trained.

I was wrong. After the first hour of the first class, I knew I was in the right place at the right time. The class descriptions made me think they were geared for mental health professionals, and they are, but they were so well presented that a lay person with the right mindset could easily follow along and get just as much out of them as the professional. I not only learned valuable information that I can put to use in my personal life, I realized that there are opportunities to use my God-given gifts to minister to people without having to spend lots of years in a college program. I found that my life experiences translate into a job description that absolutely falls in line with the training and mission of GCAT. I am now certified as a Compassion

Fatigue Educator and Field Traumatologist and am very excited to see where this training will lead.

It was very exciting to see that there are places where people with the heart and desire can get the training needed to hone natural skills into highly developed skills that can then be employed in helping others who are in crisis.

Thank you, Green Cross for developing such an amazing program. I look forward to serving with other members of Green Cross in helping people in crisis following traumatic events.

Kerry Smith
Kirkland, WA

Race-based Traumatic Stress in the African-American Population

**Krystle Hays-Hurd, MA, PSYD
ABD**

Race-based traumatic stress is a phenomenon that has been studied by researchers under the various guises of racist-incident based trauma, race-related stress, insidious trauma, and intergenerational cultural trauma (Bryant-Davis & Ocampo, 2005; Loo et al., 2001; Root, 1992; Eyerman, 2001). No matter how we refer to it, the definition remains essentially unchanged and includes (a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race; (b) a racially motivated stressor that overwhelms a person's capacity to cope; (c) a racially motivated, interpersonal severe stressor that causes bodily harm or threatens one's life integrity; or (d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Carter, 2007; Loo et al., 2001).

The trauma, for many African-Americans in particular, begins with the collective memory of slavery. It is not the existence of it as a present institution or experience, but rather the remembrance that seeps in the collective consciousness of a group of people. It is the memory of the direct threat upon the physical safety of our ancestors, and the intergenerational transmission of the degradation, humiliation, exploitation, and fear that have created psychological trauma based upon racial constructs. This type of cultural trauma often causes a significant loss of identity and meaning and impacts the dissemination of values, symbols, and mores that will ultimately be mass-mediated and engrained amongst future generations. Layered on top of these intergenera-

tional transmissions are the continued covert, and sometimes overt, racially-motivated behaviors that function as polytraumas. These continued race-based intrusions and infringements can, in some cases, considerably multiply the traumatic stress effects, particularly if the individual has also encountered other psychological traumas such as sexual assault, war combat, etc. (Bryant-Davis, 2007).

Carter and Helms (2002) have defined racial discrimination as being aversive and avoidant strategies with intended or unintended effects of creating distance between members of two racial groups. Racial harassment, however, is a hostile form of racism that involves actions intended to subordinate a racial group. Both discrimination and harassment can lead to substantial outcome effects yet may be filtered through individual resiliency levels, predisposition, level of racial identity, racial socialization, and support systems. However, due to the more invasive approach of harassment, racial trauma is more likely to result from this action. Yet, the research indicates that many individuals suffer in silence (Carter & Helms, 2002). The distress resulting from race-based traumatic stress is not generally verbalized due to the pervasive nature of these behaviors which suggests a level of normalization and expectancy. However, this type of trauma has, in fact, been implicated in various studies that have confirmed significant physical and psychological effects of perceived racial trauma. Kwate, Valdimarsdottir, and Guevarra (2003) found that that racism was related to both psychological distress and health-compromising behaviors. Similarly, Nyborg and Curry (2003) found that personal experiences of racism were correlated with self-reported internalizing symptoms, higher levels of hopelessness, and

lower levels of self-concept. The authors also found that experiences of racism were related to externalizing symptoms such as aggression and fighting. It has also been found to correlate with somatic symptoms, paranoia, anger, frustration, resentment, anxiety, helplessness/hopelessness, low self-esteem, subjective distress, dissociation, as well as higher levels of blood pressure, stress, and cardiovascular disease (Bryant-Davis & Ocampo, 2005; Clark et al., 1999; Harrell, 2000; Jackson, Brown, Williams, Torres, Sellers, & Brown, 1996; Klonoff, Landrine, & Ullman, 1999; Krieger, 1990; Landrine & Klonoff, 1996; Thompson, 1996, 2002; Fang & Myers, 2001; Guyll et al, 2001, Klonoff & Landrine, 1999). There are also cognitive effects such as difficulty focusing, and remembering, and relational effects that usually present as mistrust of others. Many survivors will self-medicate through substance abuse or self-harm. Others individuals also will begin to question their faith in a higher power or humanity. Clinicians are called to address race-based trauma through their own education of the phenomenon and its parallels with Post-traumatic Stress disorder, to utilize in-depth assessments of clients that reviews race-based traumatic histories, and seeking to utilize liberation psychological practices to acknowledge the multiplicity of the effect, not only on the individual, but on their collective consciousness.

References

- Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist*, 54, 805-816.
- Carter, R. T., & Helms, J. E. (September, 2002). Racial discrimination and harassment: A racially based trauma. American College of Forensic Examiners Conference, Orlando, FL.
- Fang C.Y., Myers, H.F. The effects of racial stress-

(Continued on page 5)

ors and hostility on cardiovascular reactivity in African American and Caucasian men. *Health Psychology*. 2001, 20:64–70.

Guyl M., Matthews, K.A., Bromberger, J.T.. Discrimination and unfair treatment: Relationship to cardiovascular reactivity among African American and European American women. *Health Psychology*. 2001;20:315–325

Harrell, S. P. (2000). A multidimensional conceptualization of racism related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry*, 70, 42-57.

Jackson, J. S., Brown, T. N., Williams, D.R.,

Torres, M., Sellers, S. L., & Brown, K. (1996). Racism and the physical and mental health status of African Americans: A thirteen year national panel study. *Ethnicity and Disease*, 6, 132-147.

Klonoff, E. A., Landrine, H., & Ullman, J. B. (1999). Racial discrimination and psychiatric symptoms among Blacks. *Cultural Diversity and Ethnic Minority Psychology*, 5, 329-339.

Krieger, N. (1990). Racial and gender discrimination: Risk factors for high blood pressure. *Social Science and Medicine*, 30, 1273-1281.

Landrine, H., & Klonoff, E. A. (1996). The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health conse-

quences. *Journal of Black Psychology*, 22, 144-168.

Thompson, V. L. S. (1996). Perceived experiences of racism as stressful life events. *Community Mental Health Journal*, 32, 223-233.

Thompson, V. L. S. (2002). Racism: Perceptions of distress among African Americans. *Community Mental Health Journal*, 38, 223-233.

Author's Note: Krystle Hays-Hurd PSYD ABD is a psychotherapist with primary interest in cultural factors and trauma. She is currently a psychotherapist at UCLA-Santa Monica Medical Center. Krystle can be reached at Krystle-Hays@aol.com.

You Can't be Happy and (Fill in the Blank) at the Same Time!

Frederick J. Cowie, Ph.D.

Lately, one of my most popular courses has been Stress Management in Stressful Times. Many of my friends know I travel around the country training first responders. Yesterday morning I had coffee with a friend in a chronic stressful situation, with an ailing, failing father and other ongoing family issues, who asked me to condense my course stress course into “something I can understand” and “something I can do now”—in the fifteen minutes he had before he went off to church.

Using the two napkins that came with our bagels, I broke my course into two sections (let's call them Napkin 1 and Napkin 2). Not having the same amount time I would have in a course (he was going off to church, after all), I did not use my favorite interactive mode to take an hour to elicit responses, but rather gave him the answers that class participants usually give to the following query: What are the emotional, physical, mental, and behavioral changes that take place when you are under stress?

There are usually more responses from class attendees, but having

church-start time restraints, I filled the four columns on Napkin 1 with the following standard answers. Emotional: anger, fear, frustration, sorrow, overwhelmed, numb, etc. Physical: high blood pressure, increased heart rate, irregular breathing, exhaustion, headaches, muscle aches, sick to stomach, puke and poop and pee, etc. Mental: can't think, can't remember, can't analyze, can't be logical, can't concentrate, don't care, automatic negative thoughts, etc. Behavioral: drink too much, temper tantrums, over/under sleep, over/under eat, smoke too much, be a jerk, etc.

Hmm. This is when I ask the question: Which of these is conducive to having a good day, being a good parent/spouse/etc., being a good supervisor/employee, being a decent human being, or just being happy? Or to bring home the point more effectively, I start repeating “You can't be (fill in the blank with any and all of the above) and happy at the same time!” This is when I put them on break, and when the course resumes transition to the second half of the course, or in this case, to Napkin 2. During the course, I elicit and/or explain the effects of the freeze-fight-flight syndrome, the adrenaline rush, and

the sympathetic nervous system. I basically try to define or redefine stress as the strain, as the effects of all the hormonal, neurological, and neuropetidal changes taking place in an individual's body. To my friend I just said: “Those things are the stress, or they are the effects of stress, and if you want to be happy and healthy and stay alive, you will have to aggressively deal with them. Period. No if, ands, or buts!”

Aggressive Relaxation, that's what I call my stress management plan, that's what goes at the top of Napkin 2. The first word under that heading is BREATHING. You can't directly control your heart rate and you can't directly control your blood pressure, but you can directly control your breathing, and that will “entrain” and indirectly help with reducing your heart rate and blood pressure, while at the same time begin to shut down those powerful survival-related responses of the freeze-fight-flight and adrenaline rush syndromes. Breathing management is the most immediate, the most effective, the most critical and the most necessary component of stress management. It must be practiced daily, it must become an habitual ritual. Humans have three

(Continued on page 6)

states: excited, alert, relaxed. Our goal is to drop the excited state down to the alert state, using the same breathing techniques yoga, Zen, and meditation masters use to drop themselves from the alert to the relaxed or super-relaxed state. We don't need relaxed when we are stress, we just need to quit being over-excited and out of control. We need to practice controlled breathing during our good times, so we have the skill, the habit, to implement during the not-so-good times!

The rest of Napkin 2 had the oft-repeated duo of diet and exercise, along with necessary additions of: A) daily or regularly doing something creative (gardening, artistic endeavors, writing, etc.); B) volunteering or somehow making the world a better place because you got out of bed; and C) practice smiling,

laughing, giggling, or otherwise just being silly.

And so my friend went off to church clutching his two napkins. And I felt was hope for him. Why, you ask? Because he seemed to get it, that one can be silly, giggly, smiley, laughy, creative, a helper, a good breather, and HAPPY at the same time! It's his choice, it's my choice, and it's your choice, Napkin 1 or Napkin 2. Really, it's that simple, to be or not to be, happy!

Frederick J. (Fred) Cowie, Ph.D.

Upcoming presentations booked in 2011 include Rural Hazmat and Secrets of Grantwriting at Continuing Challenge Hazmat Conference in Sacramento in September; and Senior Safety for the Montana

Council on Aging in MT in October. I also sit on a couple National Academy of Science grant panels on risk modelling and tribal transit. Contact me about thought provoking presentations on stress, rural hazmat, grants, etc.!

Please check out my art for sale at myspace.com/fredcowie under PHOTOS.

PO Box 6214

Helena, MT 50604

24 hr cell: 406-431-3531

Website: fredcowie.com

E-mail: fredcowie@aol.com

MySpace: myspace.com/fredcowie

Haiti: The Psychological Impact of Natural Disaster

Krystle Hays-Hurd, MA, PSYD ABD

The Republic of Haiti was established as the world's first independent Black republic in 1804 (Verner & Egset, 1997). Due to this, the country was founded upon a strong sense of solidarity and pride. However, in recent history, the small island nation, with a population of approximately nine million, has began travelling down a troubled trajectory and has been described as "the least-developed country in the Western Hemisphere and one of the poorest in the world," (United States Department of State, 2009.). This description is of a multifaceted function that attempts to collectively encompass a state of affairs regarding the country's lack of fiscal resources which significantly contributes to a low, but burgeoning, level of industrialization and urbanization (Verner & Heinemann, 2006) as well as social

infrastructure indicators including poverty, inequality, political conflict, low rates of literacy and limited healthcare (Verner & Heinemann, 2006). Due to the many unresolved social and economic issues in the country, Haiti has a high-level of fragility.

The psychosocial insubstantiality of the country was furthered on January 12, 2010 when the country was rattled by a 7.0 magnitude earthquake. This cataclysm follows over 15 other natural disasters that have taken place in the country since 2001, each adding to the country's death and displacement rates (Borenstein, 2010). This record of recurrent disaster cannot be disentangled from the country's social ills, as there appears to be a relationship or even a correlate, whereby the "vulnerability to natural disasters is almost a direct function of poverty" (Borenstein, 2010). On the front end, a significant level of poverty disallows the op-

portunity to create formidable buildings and structures that can withstand the severe hurricanes and earthquakes that the country often experiences, or to implement proactive public services. On the back end, it is the lack of resources that inhibits the country from rapidly managing the medical needs of its people or rebuilding. This provides a rationalization as to how a 7.0 magnitude earthquake in Northern California in 1989 led to approximately 60 deaths, while the same size earthquake in Haiti this year has led to an estimated 50,000 deaths and 2 million homeless citizens (Brooks, 2010, Curry, 2010). The country remains ill-equipped, which begets a cycle of poverty leading to disaster and the inverse. This is furthered by the notion that these events are not equally proportionate around the world, with 86% of reported disasters, and 78% of all associated deaths, occurring in devel-

(Continued on page 7)

oping and impoverished countries, countries such as Haiti (Green & Solomon, 1995; International Federation of Red Cross and Red Crescent Societies, 1993).

The people of Haiti can be said to cope with polytraumas, those related to their daily lives that include both internal and external impoverishment. The internal world of the Haitian may be filled with economic problems, lack of education and job opportunities, and health concerns related to chronic disease and high mortality rates. The external world of the Haitian may be filled with conflict in the sociopolitical landscape, and because of their frequency, a fear of natural disasters. Once a natural disaster occurs, the citizen of Haiti then must cope with the adversities that are faced in a post-disaster period; such as disruption of normalcy, disconnection from social networks, property damage and destruction, exposure to disease due to decreased sanitation, and food scarcity (Solomon and Canino, 1990) all of which can significantly impact a person's psyche, especially when laden on top of daily internal struggles. Due to this initial influx of hardship, acute psychological effects may occur. In developing countries, these symptoms may be primarily related to resource loss, particularly those losses of social supports or possessions, due to the threat or forfeiture of already limited resources. Freedy, et al. (1992) determined that 1) resource loss is positively related to psychological distress; 2) resource loss is a greater predictor for psychological distress than personal characteristics and coping behavior; and, 3) resource loss functions as a risk factor for the development of clinically significant psychological distress. Some of the most commonly seen psychological distress reactions seen following natural disasters are post-traumatic stress disorder (McMillen, Smith, & Fisher, 1997;

North, Kawasaki, Spitznagel, & Hong, 2004) depression and anxiety (Green, Lindy, Grace, & Leonard, 1992, Phifer & Norris, 1989; Ginexi, Weihs, Simmens, & Hoyt, 2000) anger, aggression and conduct-related issues (Khoury et al., 1997) dissociation (Koopman, Classen, Cardefia, 1995; Foa & Hearst-Ikdea, 1996) and substance use and abuse (McFarlane et al., 1994).

Although psychological stress and distress can abate over time, there is also a potential for significant adjustment problems that persist following exposure to a disaster (Freedy, Shaw, Jarrell, & Masters, 1992). Briere and Elliott (2000) determined that the potential for long-term symptomology related to natural disasters may be hinged on whether the event included loss, physical injury, and/or fear of death. If these characteristics are involved, there is an indication that symptoms can persist for over a decade, indicating a strong need for clinicians to provide long-term therapies to address the chronic sequelae of the disaster experience, in addition to the customary short-term crisis interventions. Without ongoing treatment, an individual's symptoms may continue to linger in the form of anxious arousal, defensive avoidance, intrusive experiences, and other comparable symptoms, and potentially remain at similar levels to those individuals who have been much more recently exposed to a disaster.

In order to provide the most appropriate treatment services to the people of Haiti during this time, it is imperative to utilize their existent strengths and values to provide culturally-congruent therapeutic services that will provide a sense of stability, rather than add to the disconnection. Often following a disaster, a loss-reduction model that

seeks to return individuals to a baseline level of functioning is utilized, however, more comprehensive and progressive models that emphasize creating and developing community resilience would be beneficial to the country of Haiti based on their strong reliance on the *lakou*, which functions as extended mothering manifested through multiple-generations of family, friends, and neighbors (Edmond, Randolph, & Richard, 2007). *Professionals that are navigating into the Haitian community to provide assistance can utilize the lakou as a means of pooling strengths, and potentially lending to transformational coping (Aldwin, 1994) and even posttraumatic growth (Tedeschi & Calhoun, 2003).*

Gopaul-McNicol (1993) proposed a model for working with Haitians, the multicultural/multimodal/multisystems approach - Multi-CMS. In this model, there is a need for the clinician to meet the individual where they are at, particularly in light of the fact that therapy remains a relatively new phenomenon amongst Haitians, who typically heal themselves through spiritual or family contexts. For instance, the belief in Voodoo lends to increased optimism and a sense of control over their destiny (Desrosier & Fleurose, 2002). Similarly, mental health symptoms such as psychosis or depression may be viewed as the result of a spell or a curse. In this vein, it is of particular importance to understand those methods of healing and utilize them as adjuncts to therapy, as opposed to imposing a traditional model of treatment upon them that may not be understood, desired, or efficacious. This flexibility is important, and will help to increase the level of trust that the individual has in the practitioner as a credible healer. Actively engaging the Haitian will promote positive transference that

(Continued on page 8)

may lend to a buy-in for treatment, and once engaged the individual will often actively progress and return to activities of daily living rather rapidly (Desrosier & Fleurose, 2002). There is also a great need to implement psychoeducation and linkage to supports that will provide them with the opportunity to rebuild their sense of positive interpersonal relationships, self-perception, and life philosophy (Tedeschi, Park, & Calhoun, 1998). This model is created in a circular method, rather than linear, allowing the opportunity to re-address areas, as necessary, to help the survivors grieve, heal, learn, and become empowered – all of which are key when providing disaster recovery treatment. Treating Haitians during this time will be a rewarding and important experience for growing and established clinicians alike.

Aldwin, C.M. (1994). *Stress, Coping, and Development*. New York: Guilford Press.

Borenstein, S. (2010, January 14). Haiti history: A disaster-prone nation. 3 News. Retrieved January 16, 2010, from <http://www.3news.co.nz>.

Briere, J., & Elliott, D. (2000). Prevalence, characteristics, and long-term sequelae of natural disaster exposure in the general population. *Journal of Traumatic Stress, 13*(4), 661-679.

Brooks, D. (2010, January 15). Poverty is the underlying tragedy in Haiti. The Seattle Times. Retrieved January 18, 2010, from <http://seattletimes.nwsourc.com>

Curry, A. (Broadcast Journalist). (2010, January 21). The Today Show. [Television Broadcast]. New York: National Broadcasting Company.

Desrosier, A., & Fleurose, S. (2002). "Treating Haitian Patients: Key Cultural Aspects." *American Journal of Psychotherapy* 56(4), 508-522.

Edmond, Y.M., Randolph, S.M., Richard, G.L. (2007). The Lakou System: A Cultural, Ecological

Analysis of

Mothing in Rural Haiti. *The Journal of Pan African Studies, 2*(1), 19-32.

Foa, E.B., & Hearst-Ikeda, D. (1996). Emotional dissociation in response to trauma: An information processing

approach. In Michelson, L., & Ray, W.J. (Eds.), *Handbook of dissociation: theoretical, empirical and clinical perspectives* (p.215). New York: Plenum Press.

Freedy, J.R., Shaw, D.L., Jarrell, M.P., & Masters, C.R. (1992). Towards an understanding of the psychological impact of natural disasters: An application of the conservation resources stress model. *Journal of Traumatic Stress, 5*(3), 441-454.

Ginexi, E. M., Weihs, K., Simmens, S. J., & Hoyt, D. R. (2000). Natural Disaster and Depression: A Prospective Investigation of Reactions to the 1993 Midwest Floods. *American Journal of Community Psychology, 28*(4), 495-518.

Green, B. L., & Solomon, S. D. (1995). The mental health impact of natural and technological disasters. In J. R. Freedy & S. E. Hobfoll (Eds.), *Traumatic stress: From theory to practice*. New York: Plenum Press.

Gopaul-McNicol, S. (1993). *Working with West Indian Families*. New York: Guilford Press.

Gopaul-McNicol, S., Benjamin-Dartigue, D., & Francois, E. (1998). Working with Haitian Canadian families.

International Journal for the Advancement of Counselling, 20, 231-242.

Green, B. L., Lindy, J. D., Grace, M. C., & Leonard, A. C. (1992). Chronic posttraumatic stress disorder

and diagnostic comorbidity in a disaster sample. *Journal of Nervous and Mental Disease, 180*,

760-766.

International Federation of Red Cross and Red Crescent Societies (1993). *World disaster report 1993*.

Dordrecht, The Netherlands: Martinus Nijoff.

Khoury, E. L., Warheit, G. J., Hargrove, M. C., Zimmerman, R. S., Vega, W. A., & Gil, A. G. (1997).

The impact of Hurricane Andrew on deviant behavior among a multi-racial/ethnic sample of

adolescents in Dade County, Florida: a longitudinal analysis. *Journal of Traumatic*

Stress, 10,

71-91.

Koopman, C., Classen, C., Cardenta, E., Spiegel, D. (1995). When disaster strikes, acute stress disorder may

follow. *Journal of Traumatic Stress, 8*(1), 29-46.

McFarlane, A. C., Atchison, M., Rafalowicz, E., & Papay, P. (1994). Physical symptoms in posttraumatic stress disorder. *Journal of Psychosomatic Research, 38*, 715-726.

McMillen, J. C., Smith, E. M., & Fisher, R. H. (1997). Perceived benefit and mental health after three types of disaster. *Journal of Consulting and Clinical Psychology, 65*, 733-739.

North, C. S., Kawasaki, A., Spitznagel, E. L., & Hong, B. A. (2004). The Course of PTSD, Major Depression,

Substance Abuse, and Somatization After a Natural Disaster. *Journal of Nervous and Mental Disease, 192*(12), 823.

Phifer, J., & Norris, F. (1989). Psychological symptoms in older adults following natural disaster: Nature, timing, duration, and course. *Journal of Gerontology: Social Sciences, 44*, S207-S217.

Solomon, S.D., & Canino, G., J. (1990). Appropriateness of DSM-III-R criteria for posttraumatic stress disorder. *Comprehensive Psychiatry, 31*(3), 227-237.

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). Posttraumatic growth: Conceptual issues. In R. G.

Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Theory and research on change in the aftermath of crisis* (pp. 1-22). Mahwah, NJ: Lawrence Erlbaum.

Tedeschi, R.G., & Calhoun, L.G. (2003). Posttraumatic growth: A developmental perspective. *Psychological Inquiry, 15*, 1-18.

United States Department of State. (2009). *Bureau of Western hemisphere affairs background note: Haiti*.

Retrieved January 15, 2010, from <http://www.state.gov/r/pa/ei/bgn/1982.htm>.

Verner, D., Egset, W. (1997). Introduction. In Verner, D., Egset, W., World Bank, *Social resilience and state fragility in Haiti* (pp.1-7). Washington, DC: Library of Congress.

Verner, D., Heinemann, A. (2006). Social resilience and state fragility in Haiti: Breaking the conflict-poverty trap. *En Breve, 94*, 1-4.

