European Federation of Psychologists Associations

Task Force on Disaster and Crisis Psychology

Report to Council of Europe

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Introduction

Over the past 25 years, there has been an increasing awareness of the impact of disasters on the civilian population. Throughout European Union Member States (EUMS) and European Economic Area Countries (EEAC), people recognise the emotional and related effects of natural and mass transport/technical disasters that occur both within the countries and outside; affecting both EU Citizens and their families at the site of the disaster and back home. There are a number of possible reasons for this increased awareness:

- The impact of electronic news gathering and 24 hour news coverage on television
- A greater focus on psychosocial aspects of critical events
- The increased involvement of survivors in planning responses to future disasters
- The recognition of Posttraumatic Stress Disorder (PTSD) in 1980

It is, therefore, important to consider how psychology can assist counselling organizations and other IGOs and NGOs to deliver appropriate psychological assistance following a crisis or disaster. Psychologists can give advice on preventing distress as well as on other aspects of crisis management. An important role is to provide an authoritative perspective on normal reactions to crises so that healthy responses can be reinforced and premature pathologising of reactions be avoided.
Psychologists can contribute advice on how best to inform survivors and relatives on what has happened and is likely to happen. The media may need advice on how to report disasters without contributing to further distress. In other words, psychologists do not only deliver one-to-one interventions, but have an important role to play in many post disaster activities.

All this has been most recently highlighted by the response of EUMS and EEACs to the 26 December 2004 Tsunami that struck in the Indian Ocean. Many thousand of EU citizens were on holiday and many were killed or injured, with their fate remaining unclear for many days. There were immediate responses by different countries to assist their own citizens in the Asian countries as well as to try to meet the needs of families back home. There was also an enormous response to requests for financial aid and many altruistic offers from mental health professionals and others to provide assistance, even to the extent of flying to affected countries without any planning.

Ironically, a far-sighted article was published in the *Lancet* on 4 December 2004, only 3 weeks prior to the earthquake. In this paper, Mollica et al discussed the "Mental Health in Complex Emergencies" and argued that no country in the world had then developed an adequate national plan to meet the mental health needs following a major disaster. The article lists what is largely known and agreed concerning mental health need after disasters and points to the relative lack of sound empirical evidence to support any post-disaster interventions. It also lists a set of research questions answering which would greatly improve the situation.

Parallel with this increase in interest for disasters, there has been an upsurge of attention to the effects of day to day crises and traumas on individuals, families and smaller groups across Europe. Psychosocial responses by health personnel and community agents following events such as rape, robberies, blind violence, sudden bereavement etc., has gradually become part of human service delivery as well as becoming more expected by citizens throughout Europe.

EFPA and its Task Force on Disaster and Crisis psychology

EFPA (European Federation of Psychologists Associations) has 32 Member Associations and it is representing 250 000 psychologists in Europe. EFPA Has had a Task Force on Disaster and Crisis Psychology since 1997. This Task Force has been in existence since July 2003.

In addition to making recommendations concerning the psychological input to disaster planning and disaster response, the Task Force has also given consideration to Quality Standards for Psychological Interventions in Disaster and Crisis. These are reported separately. The Task Force recognises that psychology as a science and as an applied profession has a great deal to contribute. At the same time, it recognises that much of the delivery of services to those affected directly and indirectly by disasters will be by other professionals and lay people involved in Non Governmental Organizations. The role of psychology is both to provide direct services based on sound psychological principles and sound evidence base, as well as to provide good quality training to these other groups.

This report reflects the expertise of the group and the findings of a number of recent publications including the Report prepared by the British Red Cross (May 2004) (*Working Together to Support Individuals in an Emergency or Disaster*) that originated in the European Commission Civil Protection Directorate and drew on evidence from many EUMSs; the UK National Clinical Practice Guideline Number 26 on *Post-traumatic Stress Disorder: The management of PTSD in adults and children in primary and secondary care* (National Institute for Clinical Excellence, March 2005); and the Australian Emergency Management "*Guidelines for Psychological services Provision" (2003).*

During the time the Task Force has been meeting, there has been a heated debate about the effectiveness of "debriefing" following disasters. This debate has distorted the discussion of the needs of survivors of disasters and we need to begin by making our own position absolutely clear.

When a disaster of any type threatens people's lives, many survivors will experience acute stress reactions as well as depression and bereavement reactions. They look to the rest of society, including their families and other support systems, for help. We fully recognise that survivors have the right to expect the best immediate help to reduce their distress.

Survivors and other affected people are clear about the kind of help they want. They want:

- early help,
- outreach help,
- information about the event and potential reactions and guidance in important questions,
- possibility to meet with others who experienced the same or a similar situation,
- stating the possibility of further help as time unfolds,
- qualified and competent help,
- flexible and individually tailored help, and
- help over time and stability of helpers involved.

We also recognise that it would be an advantage if very early intervention were shown to prevent later debilitating psychopathology such as PTSD. However, even if this proves not to be feasible in the present state of knowledge, it is still worthwhile to concentrate on reducing immediate distress for its own sake. The primary focus of the interventions immediately after a potentially traumatizing event, whether for individuals, families or groups, are to a) provide comfort and care

to reduce arousal (creating a caring climate) and b) secure information for those affected. This will ensure that people start on the path of recovery and can re-establish control of their life as soon as possible.

Range of traumatic experiences

There is an ever widening range of traumatic events and natural disasters that may result in considerable psychological distress. These include:

- Terrorist attacks (as in Madrid)
- Nuclear, radiological, biological or chemical disasters
- Mass transport disasters and other technical disasters, including smaller road traffic accidents
- Natural disasters:
- Earthquakes as in Bam, Iran or Greece or Turkey
- Tsunamis that precipitate earthquakes
- Avalanches
- Flooding
- Hurricanes
- Fires
- Wars (as in Iraq or Sudan) and collective violence (torture)
- Internal and international displacement resulting in asylum seeking
- Sexual and physical abuse
- Rape and other forms of violence (such as harassment, stalking, robbery, school shootings)
- Sudden, unexpected bereavement or suicide

In all these instances, the survivor's lives and belief systems are challenged and sometimes shattered. Studies show they seek accurate information about what is happening to them and their loved ones. It is well established that effective social support is one of the main buffers against the development of long-term psychopathological reactions. However, where the disaster happens away from the usual community or even country, then there is a practical problem in mobilising effective support.

Whatever the source of the major stressor, the immediate human reaction is usually fairly similar and now well described. Traumatic stress reactions are similar across all EU settings and increasingly the evidence shows that they are almost universal, being found in every country and culture studied to date. There is increasing agreement on how best to help survivors and this core psychological knowledge needs to be imparted to all those offering to help the survivors. Over time culture will be important in determining how reactions will enfold.

Disasters will continue to happen in the future. Some types of disasters will have very specific issues that need to be addressed. For example, the recent Tsunami resulted in many deaths and so issues of multiple bereavement were very important from the outset. With so many bodies missing, issues of grieving when no confirmation of death had been received posed considerable challenges. Issues of identifying bodies have yet to be properly studied, although it is already clear that even with modern DNA typing, not all bodies will be identified. Together with the 2001 September 11 terrorist attack we can expect to increase our knowledge on how similar situations can be handled in the future.

Already there are plans to produce an airplane that will hold between 500 and 800 passengers. Someday, one of these will crash. The size of the catastrophe might overwhelm current services, but with forward planning, the impact might be lessened. It can be assumed that such a disaster will involve services from many countries, not only EU member states and so international planning of responses to disasters, incorporating modern psychological knowledge, is essential.

Some indications of incidence and prevalence: the need for psychosocial support

The majority of people in modern society will encounter an event that might give rise to a serious stress reaction at least once in their lives. Fortunately, even in the most serious disaster, not everyone develops a serious mental disorder. There are individual differences in people that determine how they react to stress, although everyone may break down in the face of overwhelming challenges.

Most people who develop PTSD do so in the first month after exposure to a traumatic event. About 15% may have a delayed onset. In general, the clearest indicator that the survivor will go on to develop PTSD is the severity of their initial reactions. Fortunately, acute distress subsides rapidly for many affected people.

A large study in the USA (Kessler et al, 1995) estimated that there is a lifetime prevalence of 10.4% for women and 5.0% for men. At any one point in time, somewhere between 1.3% and 3.4% of people suffer from PTSD.

The rate of PTSD does vary according to the nature of the stressor with sexual assault, war and exposure to horrific injury and death resulting in high rates. Breslau et al (1991) estimated that 13% of men and 30% of women develop PTSD after a traumatic event. In children, it has been reliably estimated that between 20 and 30% of children who survive road traffic accidents will go on to develop PTSD and others will present with isolated, but nonetheless distressing stress symptoms. In one disaster in which many children were killed in their school, it was estimated that 33 years later some 29% still suffered from PTSD (Morgan et al 2003).

Mental health professionals have become increasingly aware that people presenting with a variety of problems may have experienced a psychological trauma that went untreated. It is increasingly seen as good practice to obtain a detailed trauma history in routine clinical practice. As seen earlier, the likelihood of a person having been exposed to a traumatic event in their everyday life is high and the possibility of having developed a PTSD, depression or other disorder is not inconsiderable.

People who develop PTSD are not only distressed, but in many cases their capacity for enjoyment and for productive work is severely compromised. The economic impact of a disaster is seen not only in terms of rebuilding the physical fabric of a community, but also in rebuilding the psychological well-being of the survivor. The economic costs of PTSD were estimated in the recently published NICE Report (2005). Twelve weeks of trauma-focused Cognitive Behaviour Therapy (TF-CBT) was estimated to be very cost effective in reducing the financial burden of an episode of PTSD.

What is a psychosocial intervention?

Until very recently, the initial response to any disaster seemed to focus on restoring the survivors to physical good health. Rescue and recovery predominated. Historically, the first-responder

emergency services of fire, police, ambulance and other rescue workers were accompanied to the scene by people, from a variety of social services, ministers of religion and people from non-governmental organizations dispensing sympathy and practical help. The professional mental health services did not figure in the early stages and were reactive to people presenting later on rather than proactive and reaching out to survivors in the first few hours.

That position has altered dramatically in the last few years, but in trying to get involved at an earlier stage, new problems have arisen. Merely recognising that there were mental health implications of disasters did not automatically mean that the sort of individual, long-term therapy that had been offered to people with established mental health problems was appropriate for early intervention. This lesson is still not fully understood as witnessed by many mental health workers travelling to countries affected by the Tsunami and offering to provide individual treatments during a two week stay!

According to the evidence summarised in the British Red Cross Report (2004),

"6.3a Individuals who may be affected by an emergency or disaster:

- Casualties
- Survivors
- Evacuees
- Relatives and friends
- * witnesses
- * emergency services
- * others responding

"6.3b Psychosocial needs:
"the practical, emotional, social and psychological needs of individuals affected by an emergency or disaster. Such needs will arise in the initial emergency response phase and may persist for a longer time-scale. They include:

- Practical assistance
- Social support
- * medical care
- * psychological support"

"6.3c Locations where individuals should have their psycho-social needs met:

- Hospitals
- Casualty centres
- Survivor centres
- Evacuee centres
- * relatives and friends centres
- * feeding centres (responders)
- * drop-in centres
- *mortuaries

"6.3d Common needs:

- Information
- Reassurance
- First aid and medication
- * access to television/radio
- * help with care of pets
- * emotional and psychological support (operating on a continuum from listening to long-term mental-health support)
- Protection from media and unwanted 'do-gooders'
- Refreshments
- Help with care of children
- Use of telephone
- * legal and occupational advice
- * pastoral care
- * self-help

- Transport
- Entertainment

* spiritual and cultural advice

"6.3e Services required to meet the psycho-social needs of individuals affected by an emergency or disaster:

- Searching for survivors
- First aid
- Rescue
- Transportation
- Medical services
- Ambulance activities
- Hospital activities
- Documentation
- Referral to other organizations
- Mobility aid equipment
- Bedding
- Clothing

* listening
* befriending
* comforting
* advice
* counselling
* group therapy
* spiritual
* help lines
* hygiene packs
* communications
* messaging and tracing
* therapeutic care
* public training"

These lists of suggestions reflect well the complex needs of survivors of any disaster. At first reading, it may not be clear where psychological principles and knowledge fits in, but a moment's reflection shows that psychologists have a great deal to impart concerning how stressed individuals take in and deal with information. In addition, the sort of advice that is given – for example regarding viewing mutilated bodies, in identifying bodies, in regard to reuniting families, what to say to children and so on – all can be made easier with a basic understanding of how a trauma affects cognitive processing.

In order to ensure that immediate and proper follow-up is provided in a coordinated manner, both following day-to-day trauma and crisis situations, and following major disasters, structures have to be in place to coordinate the follow-up and to secure sound intervention. In Norwegian studies (Dyregrov, Nordanger & Dyregrov, 2003), it has been found that when the following structures exist in a community, people are best cared for: a) a formalized plan of action for both immediate and long-term support, b) a coordinator for intervention activities, c) a local crisis team, d) written procedures for what needs to be done.

It is also clear that the lists above will benefit greatly from input by psychologists well versed in current findings from crisis and disaster psychology. The timing of counselling and the difference between counselling and intensive or group therapy, for instance, needs to be properly spelled out.

The British Red Cross Report and other recent documents all demonstrate that there is a continuum of psycho-social need from the moment of the disaster to many months and years later. It is important, therefore, that all involved in delivering the services do so in a way that one service assists rather than detracts from another. All should respect the individual survivor and ensure confidentiality. This implies that all services involved should have a good understanding of each other's role and preferably have participated in joint exercises before needing to be involved in a real response to a disaster.

When criminal activity is suspected as being involved in any disaster – as in the case of suspected terrorism – then an additional dimension comes in to play. The disaster scene is potentially a scene of crime and while the needs of individuals are being met, so too the crime scene has to be preserved for evidential purposes. This can mean that traumatised individuals are left with only the clothes they stand in and no opportunity to return to their home for some time. It is important that the psychological needs of families at this difficult time are properly appreciated.

In recent years, the role of the investigating police officer has been expanded in many countries to support families through often protracted legal proceedings. These "Family Liaison Officers" were sent from the UK to support families in New York in September 2001, to Bali following the bombing and to the countries affected by the recent Tsunami. Many had had formal training in current findings on bereavement and trauma. Other professions and NGOs should also have some basic training in such aspects

The roles of the EU and of EFPA

In the last few months, it has become very obvious that considerable planning is underway within the EU and member countries to meet the needs of survivors of disasters. The principle of subsidiary dictates that each member country is free to respond in its own way, and so the EFPA may be able to influence both the general guidance and the country specific disaster emergency plans.

Unfortunately, it has also become all to clear that EFPA has had no direct input into recent EU planning discussions. Rather, individual member countries have sent delegates, many of whom come from NGOs who may not be familiar with current psychological thinking and findings. It is therefore of importance that EFPA finds a way of liaising with the relevant planning bodies both within the EU and the constituent member states.

Principles of psycho-social support

1. All survivors have the right to access appropriate psychosocial help and services.

2. Such services should be made available after all traumatic events, both everyday and major disasters.

3. Since not all survivors develop serious mental health problems, it is important that both the helpers and the survivors are made aware of the wide range of normal, albeit temporarily distressing, reactions to abnormal events.

4. Mental health services need to provide active out-reach services following disasters as often the survivors are in no state to take decisions to access help by themselves.

5. Different forms of psychological help may be needed at different points from impact to recovery. In the early stages, social support from family, friends and community are very necessary, with mental health professionals in the background advising on monitoring survivors to identify those at greatest risk of developing serious problems.

6. Help and support in the early stages may include formal screening of distress to ensure that effective treatment is available as required.

7. Collaboration across emergency services and NGOs will facilitate efficient delivery of appropriate psychosocial help.

8. Greater thought should be given to evaluating psychosocial interventions at all stages so that better services can be developed. This will require much more sophisticated research into service delivery.

Efficacy of crisis work

Unfortunately, to date there has been a paucity of scientifically robust studies of the effects of crisis intervention. Most survivors report that they are grateful for psychosocial interventions, but there is little evidence for the impact of interventions on either the initial distress or in preventing longer term serious mental health problems.

Many national emergency plans include reference to some variant on Critical Incident Stress Debriefing (CISD) (Mitchell 1983). This was originally developed by Mitchell as a way of helping emergency personnel deal with the emotional impact on themselves of having helped at the scene of a disaster. As such, it was developed as a brief intervention for a group of people who had been briefed to attend a disaster and were then "debriefed" about their emotional reactions.

Mitchell and Everly (1993) compared the impacts of two similar air disasters – San Diego in 1978 with 125 deaths, and Cerritos in 1986 with 82 deaths. The rescue personnel at San Diego received no crisis care and in the following year their use of mental health services increased by 31%. The Cerritos rescuers received CISD resulting in only 1% increased use of mental health services. There was considerably greater change in jobs following the untreated San Diego incident.

In a civilian setting, Leeman-Conley (1990) reported the impact of Critical Incident Stress Management in an Australian bank following a major armed robbery. Sickness absences and sick pay and compensation costs were reduced by 60% compared with the previous year. This indicates the need to consider broad measures of functioning as well as measures of symptoms when evaluating the effects of crisis interventions.

At some stage, Mitchell's clearly described techniques of CISD/CISM were applied to groups of civilian survivors, who sometimes had not formed any relationships with each other prior to the disaster. Initial experience showed that they rated the experience of meeting in a group very positively.

Then the model was further stretched to deliver single session (often less than one hour) "debriefing" to individuals within 48 hours of having experienced a major trauma. The notorious Cochrane evaluation (Wessely, Rose & Bisson, 1998) of seven such disparate studies criticised them for not demonstrating clear evidence that the brief procedure had reduced the incidence of later PTSD. Why a brief discussion with an often inexperienced person given during the time when people could be still in shock was ever expected to have any long term effect is beyond belief (Dyregrov, 2001; Yule, 2001). However, that study caused such a controversy that for many years the focus has been taken off improving psychosocial interventions.

The current, more balanced position is that most people involved in delivering psycho-social services see them as part of a continuum from initial emotional first aid and normalising through groups support to effective individual therapies for PTSD, depression, anxiety disorders and bereavement reactions. No one is recommending single, one-off, brief interventions after a disaster.

Rather, some sort of unobtrusive surveillance should be in place so that those most distressed can access effective therapy the soonest.

In the recent meta-analysis undertaken by the NICE Report (2005), two therapies stand out as having good evidence base with clinically meaningful treatment effect sizes – trauma-focused cognitive behaviour therapy and Eye Movement Desensitization and Reprocessing. This is clearer for adults than for children. Pharmacological therapies were found to have small, although reliable effects, that were not clinically worthwhile.

Thus, while there is a great need to evaluate the early psychosocial interventions aimed at dealing with the immediate distress (irrespective of whether this reduces the risk of later PTSD), the good news is that there are now flexible individual therapies that are very effective and this needs also to be reflected in all national emergency plans.

Education and training

As noted above, there is now considerable knowledge about how to respond to the psychological needs of survivors following disasters. It should be stated that rescuers also have psychological needs, but we will only note those in passing in this report.

There are many professionals and lay people who are involved in a comprehensive response to any complex emergency. They all require some basic training in how people respond emotionally to serious threats and how best to help them at different stages.

Mental health professionals play an important part in the organization and provision of structured interventions, and although they do not necessarily have to be part of the practical delivery of "psychological first aid", they should have the responsibility for conducting psychological debriefing and other more specialized services, including specific help to those who need more than immediate support. To achieve this, mental health professionals need knowledge of crisis and trauma theory, experience from providing crisis intervention or psychological first aid, a non-psychiatric attitude (skills in meeting ordinary people who have experienced an unusual situation) and understanding of family dynamics. Through psycho-educational activities, reframing, helping people re-establish social contact and occupational activities, mental health professionals can help people regain control and reduce untoward effects of the situation they have experienced.

Thus, there is a need to develop training at a number of different levels so that all involved in disaster work can not only look after themselves but can deliver more effective services to survivors. As seen in the accompanying document on our Proposals for quality standards for psychological intervention in disaster and crisis, we believe that there are three working levels of psychosocial support and services and we suggest quality standards for each level:

1. Psychological first aid

The first level of training is basic knowledge of traumatic crisis and psychosocial support. This training should be included in the basic training of all those professionals who work with victims of disasters. These professionals are police officers, rescue workers, nurses, physicians, social workers, church workers, journalists etc. Also volunteers in NGOs and IGOs providing psychosocial support should have this level of training.

2. Multi-professional psychosocial support and services

Those professional, who work with the victims of disasters and critical incidents doing acute crisis work, leading debriefing sessions and using traumatic management methods. This work is usually organised in a multi-professional way. This work calls for deeper special knowledge and skills.

3. Special expertise in crisis, trauma and disaster psychology

This training is needed in further developing the field, in training of others and supervision. This level of training includes all level one and two and also mastering of additional skills.

A special task is the leading and planning of psychosocial support and services in greater disasters and catastrophes. This provides both special abilities and skills, certain kind of personality and high standard of theoretical and professional knowledge both on crisis reactions and process and intervention methods. It could be defined as a fourth level of disaster work with extra qualification needs. (Attachment 1)

Recommendations

The national and international experiences of both every day disasters and large disasters in Europe and of the psychosocial work with victims of these disasters have created good gound from which to proceed in crisis and disaster psychology, both on the national and on the European level.

EFPA recommends that European countries should decide of following political actions:

1. To get a statute in the national laws or regulations stating that the victims, family members of the victoms and rescue personnel of disasters should receive psychosocial support and services.
2. To define which authority and organisations has the responsibility for organising psychosocial support and services after both every day disasters and major disasters.
3. To make action plans for major disasters in both national and local level. These plans should include:
    - Naming the parties responsible for organising psychosocial support and services
    - The way in which the services will be organised (methods, personnel resources etc.)
    - timing of the services.
4. To produce an organisation of special services for long term effects of major disasters. That means that the victims of disasters (accidents, robberies etc.) should have access to crisis and trauma therapy when needed.
5. To take care of training of psychologists and other professionals in crisis and disaster psychology. (more in attachment 1)
6. To take care of the quality standards for psychologists and other crisis workers and of the quality of the crisis work and traumatic stress management.

On European level

1. European Council and European Union should include psychosocial support and services after disasters in its civil protection and crisis management plans.

2. Take actions in creating an emergency plan within the EU, which would include psychosocial support and services for large disasters in Europe.
3. To take care that enough financial resources are directed to this work.
4. To support the Member nations to create an organisation for psychosocial support and services and to take care that in the case of large disaster in each European country the victims of disaster can get psychological help. This means also financial support in training professionals in psychological crisis interventions in different countries.
5. There is a need for a special team of psychologists on disaster and crisis psychology in Europe. The tasks of this team in case of large disaster, when there is not enough readiness and expertise in the country, are consultation, training of professionals and helping in organising the crisis work. The services and the costs of the maintenance of this team should be financed by European Union.

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Attachment 1

Proposal for quality standards for psychological interventions in disaster and crisis

Proposal for quality standards for psychological interventions in disaster and crisis

Background

In these last years there has been scientific discussion about the benefits of psychosocial work after disasters. Especially psychological debriefing has got many critical comments on its effects. The evaluation of these critical studies shows the poor knowledge on the psychological debriefing and on the total psychosocial work after disaster. It leads to focus on quality of the psychological work among disaster victims, not on the ineffectiveness of the methods used.

The psychological work with victims of disasters sets a special need for knowledge, skills and personality. The quality of the psychological work on the field of disasters and crisis is especially important, because the victims of the disaster are in a very vulnerably state. This and the conditions of the work mean that the work is very difficult. That is the reason why it is important to decide commonly about the quality standards for psychological interventions in disasters and crisis.

The fields of speciality

Five special fields can be separated in the psychology of disasters and crisis. These fields need different knowledge and different expertise, but they are connected with each other and support each other. These fields are:

1) Early intervention in disasters and crisis
2) Leading and planning the psychosocial support and services in major disaster
3) Educational work before disasters
4) Psychosocial support with children
5) How to intervene in Post-traumatic Stress Disorder and Trauma therapy

In planning the quality standards all these fields should be taken into account.

Personality requirements in working in the field of disaster, crisis and trauma psychology

The work with victims of disaster provides special personality requirements. All persons, not even all psychologists, physicians or other professionals are suitable to this work. The requirements are:

- good stress tolerance
- good tolerance to be an object to strong emotions
- special talents on holding and storing of emotions
- focus in action
- good leadership and ability to organise action
- good interaction skills

Three working levels of psychosocial support and services and quality standards for each level

Working on all levels of psychosocial support and services provides special training. Three various kinds of levels of training and working can be differed.

1) Psychological first aid

The first level of training is basic knowledge of traumatic crisis and psychosocial support. This training should be includes in basic training of all those professionals, who work with victims of disasters in their work. These professionals are police officers, rescue workers, nurses, physicians, social workers, church workers, journalists etc. Also voluntaries used in psychosocial support should have this level of training.

Knowledge and theoretical background needed in this level
Mastering in both adults and children

- the criteria of traumatic events and critical incidences
- the broad concept of defining psychological victims
- psychological reactions and process in traumatic crisis and disasters
  - crisis theory and phases of traumatic crisis
  - traumatic stress and process of stress
  - death and grief
- aims and principles of early interventions
- psychological intervention methods in early interventions
  - psychological support, psychosocial first aid

Some knowledge of

- the disorders in the process
  - dissociation
  - developing psychic trauma
  - posttraumatic disorder
- long term reactions after disaster
- professional intervention methods
  - psychological defusing
  - psychological debriefing
  - long term collective support and activation of the psychological working through process
  - screening those in need of crisis or trauma therapy
  - follow up of the effects of interventions

2) Multiprofessional psychosocial support and services

Those professional, who work with the victims of disasters and critical incidences doing acute crisis work, leading debriefing sessions and using traumatic management methods. This work is usually organised in multiprofessional way. This work calls for deeper special knowledge and skills.

Knowledge, theoretical backgrounds and skills needed in this level
Mastering of all that is needed in the first level and

- the disorders in the process
  - dissociation
  - developing psychic trauma
  - posttraumatic disorder
- long term reactions after disaster
- psychological debriefing

- long term collective support and activation of the psychological working through process
- screening those in need of crisis or trauma therapy
- follow up of the effects of interventions

Some knowledge of Post trauma therapy
- social and cultural factors and trauma
- adaptation to trauma memory and its mechanism and process
- development of psychological trauma
- diagnosing psychological trauma
- principles of trauma therapy
- special trauma therapeutic intervention methods
  - trauma seminar
  - EMDR
  - CBT
  - NLP
  - Hypnosis
  - Cognitive and behaviour therapies
  - Etc.

On this level also some abilities and skills are needed. These are:

- some evaluation and diagnostic of both traumatic events and reactions in individual
- choosing the right method in right time
- the methods of early intervention
- linking post-traumatic situations with Public or National Mental Health Services or others
- giving psychological support to workers, different services and agents after post-traumatic situations
- group dynamics
- the leading of the psychological process both individually and in group
- communication with media

3) Special expertise in crisis, trauma and disaster psychology

This training is needed in further developing the field, in training of others and supervision. This level of training includes all level one and two and also mastering of:

- Education and communication
  mastering of
  - theory and methods of teaching
  - communication theories and method of working with media
- Post trauma therapy
  mastering of
  - social and cultural factors and trauma
  - adaptation to trauma memory and its mechanism and process
  - development of psychological trauma
  - diagnosing psychological trauma
  - principles of trauma therapy
  - special trauma therapeutic intervention methods
    - trauma seminar

    - EMDR
    - CBT
    - NLP
    - Hypnosis
    - Cognitive and behaviour therapies
    - Etc.
- Abilities and skills

  Mastering of all mentioned above and also
  - evaluation and diagnostic of both traumatic events and reactions in individual
  - leading and planning psychosocial support and services in major disasters
  - teaching and communication with media
  - trauma therapy methods

A special task is the leading and planning of psychosocial support and services in greater disasters and catastrophes. This provides both a special abilities and skills, certain kind of personality and high standard of theoretical and professional knowledge both on crisis reactions and process and intervention methods. It cloud be defined as forth level of disaster work with extra qualification needs.