

**SHARED TRAUMA AFTER A FLOOD: A MANUAL FOR THERAPISTS**

**JOHNATHAN BOWN**

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**JOHNATHAN BOWN**

Approved:

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Supervisor: Blythe Shepard, Ph.D.

Date

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Committee Member: Noella Piquette, Ph.D.

Date

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Assistant Dean of Graduate Studies and Research in Education:  
Richard Butt, Ph.D.

Date

## **Abstract**

Floods disasters are the most common type of natural disaster, and represent the most costly natural disaster in terms of property loss for Canada. Strong evidence shows that floods can have powerful long-term negative effects on mental health and can lead to post-traumatic stress disorder, depression, and anxiety. When counsellors are also victims of the disaster, a shared trauma scenario is created where resources and relationship boundaries are strained. The contentious issue of therapist self-disclosure needs to be considered as disclosures occur both willfully and unintentionally. A research-based manual was created for use in post-disaster situations to guide clinicians via effective and safe recovery strategies. The manual is based on a thorough literature review and synthesizes the findings into a two-part document. The first section of the manual is a concise presentation of the most high-impact concepts clinicians need to know. The second section of the manual is a brief and clear presentation of the key strategies readers can leverage to help their clients. The final product is expected to alleviate the stress of decision-making for counsellors under distress and facilitate rapid effective responses.

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## Table of Contents

Abstract .....	iii
Acknowledgements .....	iv
Table of contents .....	v
Chapter One: Introduction .....	1
Purpose and Value of Project .....	5
Personal Interest in the Research .....	6
Summary and Overview .....	7
Chapter Two: Literature Review .....	9
Natural Disasters .....	9
Floods .....	10
Floods in Canada .....	11
Floods in Alberta .....	11
Negative Psychological Effects of Floods .....	13
Posttraumatic Growth .....	15
Shared Trauma .....	17
The therapeutic relationship and shared trauma .....	21
Therapist Self-disclosure .....	24
Types of self-disclosure .....	26
Usage of self-disclosure in therapy .....	27
Outcomes of therapist self-disclosure .....	29
Relationships and Recovery .....	30

Narrative Exposure Therapy.....	31
Summary .....	32
Chapter Three: Methods ...	34
Search Terms .....	34
Developing the Manual .....	36
Ethical Considerations .....	37
Summary .....	37
Chapter Four: Synopsis .....	38
Overview of the Manual .....	38
Expected Outcomes and Strengths .....	40
Limitations .....	40
Reflections .....	40
Summary .....	41
References .....	43
Manual .....	59

## Chapter One: Introduction

In the middle of June, 2013, rain had been falling in the Canadian province of Alberta for many days. On the 19<sup>th</sup> day, major rivers and their tributaries could no longer contain the deluge. This would be the costliest natural disaster in Canada's history.

Graveland (2013) writes:

Abandoned vehicles, smashed out windows and total devastation make this flood ravaged town closely resemble a war zone, right down to the soldiers and rumble of military vehicles on the streets.

The flood waters that overran the community south of Calgary on Thursday are receding but mainstreet is littered with several abandoned vehicles. There's a sour smell in the air, and the ground is covered with mud. A lazy boy rocking chair was sitting in the middle of one intersection.

The windows in a shop were smashed, perhaps from the force of the water, and the merchandise may have floated out the door. ("Alberta floods", para. 1-3)

The cities, towns, and residences in the flood zone were not prepared for the magnitude of this disaster despite contending with numerous floods in the past. The impact of this flood will be felt for decades.

Natural disasters are a global phenomenon, affecting people from all walks of life. Earthquakes, tsunamis, tornadoes, fires, and floods are a few types of natural disaster - all of which have serious and long-term negative impacts on people's lives. Floods are among the most disruptive and costly form of natural disaster (Alliance Development Works, 2012), and their occurrence is projected to increase as Earth's climate changes and the polar icecaps melt (Huntington, 2006; Wilby & Keenan, 2012). The severity of each flood disaster will also increase over time as (a) the size of the hydrological event intensifies, (b) the global economy grows leading to higher financial damages, (c) the human population increases, and (d) land development continues inside hazard zones

(Andersen & Shepherd, 2013; Irish & Resio, 2013; Kollat, Kasprzyk, Thomas, Miller, & Divoky, 2012).

The need for comprehensive research around disaster response is paramount. To date, most research looking at the mental health outcomes of disasters is focused on either first-responders or victims (Alderman, Turner, & Tong, 2012; Stanley, Bulecza, & Gopalani, 2012) - less attention has been given to second responders, and even less so to second responders who are also victims of the disaster to which they are responding. When such a scenario occurs, scholars have used the term "shared trauma" to describe the relationship between second responders and people who endured the same trauma (Tosone, Nuttman-Shwartz, & Stephens, 2012). In shared trauma situations, relationships and roles inevitably become quite complex. Service workers often cannot avoid crossing relationship boundaries due to physical restrictions or emotional emergencies (Baum, 2010; Phelps, Lloyd, Creamer, & Forbes, 2009).

Counsellors, psychologists, and mental health workers have a precarious role in the aftermath of a natural disaster. In many instances, these people live and work in the same location and could be victims of the same trauma that their clients endured. As second responders, they must work with clients who have emergent problems related to very similar experiences that they personally experienced. Oftentimes, therapists will not have a choice about which clients they work with after a disaster for two reasons: more clients seek therapy while many therapists move away (Jones, Immel, Moore, & Hadder, 2008; Madrid & Grant, 2008; Mitchell, Witman, & Taffaro, 2008). Research has indicated that in the wake of a natural disaster, not only do recovery resources become scarce, but so do second-responder personnel like counsellors and therapists. This is due



to increased demand for their services; but also due to many therapists choosing to immediately relocate along with the general population to less hazardous geographical locations. The reality is often that remaining therapists are forced to make the best of a bad situation - and that often means taking risks in the client's best interest. The most common therapeutic risk that occurs in shared trauma situation is the usage of self-disclosure (Tosone et al., 2003), which is when a counsellor reveals something personal about themselves. Often this is done with the intention of normalizing the situation or building rapport, but it carries significant risk. This is a subject of much debate among scholars, but some therapists and scholars are calling for a greater understanding and acceptance of this risky maneuver (Audet, 2011).

Therapist self-disclosure is a subject that is particularly relevant in post-disaster scenarios because it serves to validate reality and normalize the situation for clients (Bedi, Davis, & Williams, 2005; Kar, 2009; Madrid & Grant, 2008). Furthermore, depending on circumstances, self-disclosure is also a way to share resources or to facilitate individual growth. Other outcomes include the building of rapport or fostering greater understanding and respect between counsellor and client (Barnett, 2011; Nyman & Daugherty, 2001). The role of self-disclosure in therapy under normal circumstances has been part of a contentious debate spanning nearly one hundred years of research (Cozby, 1973; Glue & O'Neill, 2010). Proponents of therapist self-disclosure generally align themselves with a humanist or feminist theoretical orientation (Hanson, 2005; Simi & Mahalik, 1997), whereas those who discourage therapist self-disclosure do so from an ethical standpoint, warning that it can be exploitative (Craig, 1991; Lazarus & Zur, 2002). Ultimately, the usage of self-disclosure by the therapist is likely a contextually dependent

variable and subject to the personal style of the therapist, but is nonetheless a highly relevant topic when it comes to disaster recovery.

Outside of therapy, self-disclosure is related to core components in the process of posttraumatic growth (Joseph & Linley, 2005; Tedeschi & Calhoun, 1996) – which is a surprising phenomenon that can occur for individuals after surviving a disaster. Rather than impaired interpersonal relationships, negative mental states, and emotional dysregulation, a person who experiences post-traumatic growth will have their life enriched. Through the telling of personal hardships and successes, people are forced to confront their perceptions of value and meaning and are compelled to consider new perspectives on a given situation (Tedeschi & Calhoun, 2004). In a counselling situation, this dynamic exists but becomes more complicated. Therapist self-disclosure is a part of the larger discussion occurring between client and therapist, and elicits the client to compare, consider, and communicate their experience back to the therapist. This results in the therapist reprocessing their traumatic experience, while at the same time experiencing the client's stories (Hernández, Engstrom, & Gangsei, 2010; Splevins, Cohen, Joseph, Murray, & Bowley, 2010); both events are components of posttraumatic growth and may lead to the strengthening of the real relationship in the dyad and therefore an increase in the quality of life for the client.

Ultimately, when therapist and client have a relationship of shared trauma it seems that the process of self-disclosure assumes an uncertain but potentially powerful role. The relevance of the therapist's disaster-related experiences is increased and these experiences can be explored with the client to achieve a deep level of understanding. Posttraumatic growth may result from this process due to the acknowledgement of a

common ground or simply through the elicited reprocessing of the traumatic event by either client or counsellor. In turn, the strength of the therapeutic relationship may be influenced by this technique or the experience of shared trauma.

### **Purpose and Value of Project**

With the increasing impact of disasters around the world, a deep understanding about the processes of recovery is needed. The main objective of this project is to provide counsellors in shared trauma situations an empirically valid knowledge base for decision making geared towards reducing risk and maximizing client outcomes. To do so, the following research question will drive this project:

- What do counsellors need to know to successfully and ethically navigate shared trauma following a flood disaster?

To address the question, this project will outline the creation of a brief manual for use by mental health professionals. With the increasing impact of flood disasters around the world, a synthesis of research findings about disaster response would be beneficial for all secondary responders and those they help. Specifically, there is a lack of information on how to navigate a shared trauma scenario after a flood disaster in an effective and ethical manner. The impact of a large flood disaster places people in vulnerable positions and sensitive counselling work is paramount - as research has highlighted the volatile nature of post-disaster scenarios. The present study attempts to gather important information about disaster recovery and thereby provide counsellors with some tools for helping clients heal. Shared trauma scenarios occur infrequently, but when they do it is usually during times of community recovery and scarce resources. Shared trauma situations require skilled and sensitive navigation guided by research. Therefore, this project also

attempts to contribute to the growing body of knowledge about shared trauma resources by providing mental health professionals with a useful and practical resource for navigating the therapeutic and ethical demands of a flood disaster.

### **Personal Interest in the Research**

My interest in this topic comes from having friends and family who directly experienced the flooding of central Alberta in 2013, as well as my proximity to the event. I encountered people who were devastated from the disaster and doing their best to recover. The community of High River came together to support each other – from collecting community donations at commercial restaurants to relentless volunteer efforts. Living away from the disaster and focused on school, I recognized that I was limited in how I could contribute to the recovery, but I could make a scholarly contribution. A manual is often a practical resource for professionals and it would be a product I could create within the bounds of my academic program. Brief, concise, and informative – a manual with an empirically valid knowledge base could be instrumental when the next inevitable flood occurs. I believe that this work could not only benefit the victims of future Alberta floods, but also provide a meaningful contribution to the counselling profession in the area of disaster recovery in other contexts.

This project was conceived during my time as a student in the Master of Education (Counselling) program at the University of Lethbridge. While considering the impact of the floods, the question of how shared trauma relates to self-disclosure in practice arose. I became curious how this complicated dynamic affects the outcome for clients, and hoped that something of value could be discovered or synthesized from existing research.

## **Summary and Overview**

More than ever in Alberta, research towards improving natural disaster relief services is needed. The flood disaster of 2013, affecting thousands of Albertans and costing upwards of \$6 billion dollars in terms of economic damage, may be analyzed to help future efforts. The present study seeks to help second-responder mental-health workers by developing a practical manual to help guide therapeutic interventions and practices after a major flood. More precisely, this research will explore what techniques practicing psychotherapists use in counselling contexts where they were victims of the same disaster their clients endured, and what advice they can give for future occurrences. Among other elements of counselling, the exploration of therapist self-disclosure and post-traumatic growth for their potential benefits will be emphasized.

Following this introduction, chapter two of this proposal reviews key literature about natural disasters and floods in a Canadian context. Particular emphasis is placed on floods in Alberta, as they are a recurrent hazard and a recent Alberta flood provides a rich dataset to refer to and creates the context for the issue. The review then explores important facets of shared trauma in a counselling scenario and draws from reports and research from past large-scale societal disasters (i.e., the World Trade Centre attacks in New York on September 11, 2001, etc.). The concept of post-traumatic growth is introduced since it has implications for the therapeutic relationship and may be related to self-disclosure practices. This is followed by key research about therapist self-disclosure with a discussion about the many categories of self-disclosure and the controversies surrounding its usage. Additional significant elements to disaster recovery will be touched upon before concluding with a summary of the concepts covered in the literature

review to tie them together to form the theoretical foundation for this study.

Chapter three describes the methods used to address the research question and create the manual. A detailed description of how information will be gathered, curated, and synthesized into the final product is included. Additionally, an outline of the manual's overall organization is presented along with the rationale. The chapter concludes with a brief discussion about ethical considerations and a summary.

Chapter four presents a detailed description of the content of the manual, why it was included, and the intended purpose of the information. Additionally, the expectations of the manual are outlined along with some of its strengths and limitations. Finally, a personal reflection on the outcome of the manual precedes a summary of the chapter.

Following chapter four and the references section is a copy of the manual itself. It includes a cover page and copyright information in addition to the content so that it may be extracted from this document and distributed to interested parties. However, for readability, the manual's table of contents reflects the pagination of this document and should be updated if extracted.

## **Chapter Two: Literature Review**

This chapter provides an overview of the literature related to the present research question, “What do counsellors need to know to successfully and ethically navigate shared trauma following a flood disaster?” This review begins by introducing some of the research on global natural disasters and then focuses on flood disasters in Alberta. The subsequent sections explore the concepts of shared trauma and post-traumatic growth followed by a detailed review of therapist self-disclosure. This section of the project concludes with a summary of the literature.

### **Natural Disasters**

Natural disasters are widespread crises that can affect people on all levels of functioning. The International Federation of Red Cross and Red Crescent Societies (IFRC) defines Natural disasters as, “... a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, and economic or environmental losses that exceed the community’s or society’s ability to cope using its own resources” (<http://www.ifrc.org>). Between 2002 and 2011, more than one million people were victims of 4,130 reported natural disasters worldwide, which resulted in more than one trillion dollars (USD) of economic damage (Alliance Development Works, 2012). In 2012 alone, 357 natural disasters were recorded across the planet (Guha-sapir, Hoyois, & Below, 2012). Natural disaster incidents are a basic characteristic of our planet, and as such cannot be avoided. The Geneva Conventions acknowledge the pervasive danger of natural disasters around the world and declared that people affected by disasters will be protected under international law and mandated that states must take all necessary measures to ensure the protection and safety of victims

(Terminski, 2011).

Natural disasters include events like tornadoes, tsunamis, earthquakes, floods, fires, droughts, and severe storms among others (IFRC, n.d.). Regional features and climates are related to natural disaster types and frequency. However, their impact can be mitigated through better preparation and response guided by research.

### **Floods**

Floods accounted for 49% of types of natural disasters in 2012 and are the most common type of natural disaster around the world (Guah-sapir et al., 2012). Floods are the least likely form of natural disaster to cause deaths, but are among the most disruptive to daily life (Alliance Development Works, 2012). Compared to fires, earthquakes, tornados, storms, and droughts, floods affect the largest amount of people and are a leading cause of property damage. Floodwaters destroy homes, disable community infrastructure, displace communities, destroy farmland, and have the longest lasting events. Research indicates that the number of victims and the economic costs of flooding continue to increase as the population and economy grow, and as new human developments are built in danger zones (Ashley & Ashley, 2008). Global flood occurrence is projected to increase over time as Earth's climate changes and sea levels rise (Huntington, 2006; Wilby & Keenan, 2012), and the size of floods will intensify (Andersen & Shepherd, 2013; Irish & Resio, 2013).

Flood prediction is the single most effective method of reducing risk and damage (Hunt, 2002). Over the last 10 years there have been major improvements in flood forecasting and prevention, although most efforts have been directed at forecasting coastal flooding. In contrast to coastal flood disasters, which generally occur from



hurricanes, earthquakes, or underwater seismic events, river flooding is caused primarily from precipitations (Hartmann & Andresky, 2013; Lane et al., 2013; Viero, D'Alpaos, Carniello, & Defina, 2013). Therefore, inland regions focus their flood prevention strategies on building dam systems and catchments to control river overflow. Organizations responsible for ensuring proper flood preventions are exist at local and provincial/territorial levels.

**Floods in Canada.** Floods are Canada's most costly natural disaster in terms of property loss (Government of Canada, 2001). Across Canada, provincial and territorial governments are responsible for the legislation about natural disaster response and hazard plans, and for providing emergency response assistance to municipal governments (Public Safety Canada, 2013a). Municipal governments are directly responsible for implementing project teams to mitigate risks and respond to disasters, including floods (Groeneveld, 2006; Public Safety Canada, 2013a). Unfortunately, the costly nature of flooding often overwhelms even the best-laid plans of local authorities, and crisis situations emerge. When assistance is requested from provincial or federal bodies, the response can be delayed or misappropriated due to the large number of actors involved – and communities suffer (Madrid & Grant, 2008). This unfortunate reality compounds the problem of people's lifestyles, routines, careers, and accomplishments being disrupted.

**Floods in Alberta.** Hayashi (2006), a geography professor at the University of Calgary, reports that southern Alberta suffered major floods in 1902, 1915, 1923, 1929, 1932, and 2005. A series of dams were sufficient to prevent major flooding between 1932 and 2005. Unfortunately, the flooding of June 2005 overwhelmed the dams and caused the death of three people as well as \$165 million dollars in disaster recovery service

payments (Groeneveld, 2006). Forty thousand homes were damaged and over 7000 people were evacuated in the disaster (Public Safety Canada, 2013b). In 2008, floodwaters threatened the town of High River once again and nearly paralleled the disaster of 2005, but preventative measures managed to mitigate the threat.

In June 2013, Alberta suffered the worst flooding in its history according to government officials (Godkin, 2013). The floods affected southern Alberta, leading to 27 local states of emergency being declared (Harris, 2013), including the city of Calgary, the town of High River, and the town of Turner Valley, which were heavily damaged. Canadian Armed Forces evacuated all 13,000 residents of High River for more than one week (Gignac, 2013), and hundreds needed rooftop rescue. As of September 2013, three months after the flood, more than 2,000 residents were still living in emergency housing, one thousand students remained displaced from schools, and five health facilities had been operationally damaged (Capstick, 2013). Over \$200 million dollars had been disbursed to municipal governments and residents directly for assistance and, ultimately, the floods are estimated to cause in excess of \$5 billion dollars of economic damage making them the most costly natural disaster in Canada's history (Canadian Press, 2013).

The Alberta government declared in October, 2013 that land titles held in flood hazard areas will not be eligible for assistance in the future (Range, 2013), increasing the vulnerability of those affected. The provincial and federal governments are sending financial aid to the victims, as many do not have insurance or their insurance will not cover their losses. However, there are many other people who will not even be heard or helped in the wake of any widespread disaster.

## **Negative Psychological Effects of Floods**

The need for effective disaster response and management is paramount, and must include a framework for case identification and intervention of mental health within existing emergency medical and trauma response (North & Pfefferbaum, 2013). Strong evidence shows that floods can have powerful and long-term negative effects on mental health (Green, 1998; Kõlves, Kõlves, & De Leo, 2013; Rubonis & Bickman, 1991), and can lead to post-traumatic stress disorder (PTSD), depression, and anxiety (Neria, Nandi, & Galea, 2008; North & Pfefferbaum, 2013; Wang, Chan, & Ho, 2013).

The clinical disorder most commonly found among people exposed to a natural disaster is PTSD (Friedman, Keane, & Resick, 2010). The symptoms include emotional numbing, unwanted mental re-experience of the event, avoidance, nightmares, and anxiety (American Psychiatric Association, 2013). The acquisition of PTSD is not solely dependent on the associated event; rather, it is determined by an individual's perception of events. Regarding the prevalence of PTSD following a natural disaster, estimates vary widely (Mason, Andrews, & Upton, 2010). Reports of PTSD one to two years following the disaster range from five to sixty percent prevalence rate, with the mean towards the lower half of this range (Galea, Nandi, & Vlahov, 2005). Specific to floods, Mason and colleagues (2010) performed a cross-sectional study following extensive flooding in the United Kingdoms and found that twenty-eight percent of people scored over the threshold for potentially having PTSD on the Harvard Trauma Questionnaire.

Norris, Friedman, and Watson (2002) found that the second most commonly found disorder following any type of natural disaster was depression. Estimates of prevalence also vary widely. The same researchers also reported that the third most

common psychological disturbance was anxiety with more frequent diagnoses of generalized anxiety disorder. Specific to flood disasters, Mason and colleagues (2010) found that twenty-five percent of flood victims met the criteria for anxiety, and thirty-five percent of victims met the criteria for depression. These results are broadly consistent with past research on all types of natural disaster.

Researching a 6.3 magnitude earthquake in Italy, Tempesta, Curcio, De Gennaro, and Ferrara (2013) found that victims suffered reduced sleep quality and increased disruptive nocturnal behaviours even two years after the event. This research suggests that some of the long-term effects of experiencing a natural disaster can be pervasive yet difficult to detect. Another significant consideration about natural disasters is the loss of pets. Hunt, Al-Awadi, and Johnson (2008) examined the effects of losing or abandoning a companion animal during hurricane Katrina and discovered that psychopathology was strongly associated with the loss of the pet. Acute stress, depressive symptoms, and peritraumatic dissociation were found when controlling for other losses. These symptoms are known risk factors for long-term posttraumatic stress disorder (Thomas, Saumier, & Brunet, 2012). When disasters occur people may lose their pets or be separated from them during an enforced evacuation. Natural disasters also cause major psychosocial resource loss, which amplifies the negative psychological effects of a disaster (Smith & Freedy, 2000). For example, floods can destroy the physical place of business for some people, their means to conduct business, or even cause the loss of contracts leaving people with severely reduced resources. Compounded negative psychosocial effects with psychological distress can lead to profound long-term, gradual, co-morbid psychosocial

problems (Friel et al., 2011). However, humans are resilient beings and some traumatic events can be transformed into positive outcomes.

### **Posttraumatic Growth**

Not all psychological outcomes of disasters are negative. There is a growing body of evidence that suggests post-traumatic growth can also follow from a flood disaster (Joseph & Linley, 2005; Joseph, Murphy, & Regel, 2012; Tang 2006). Post-traumatic growth is a wide-ranging concept still in development (Joseph et al., 2012), but has been described as a catalyst for positive change following a traumatic experience (Tedeschi & Calhoun, 1996). As a catalyst, posttraumatic growth requires three necessary precursors (Stanton & Low, 2004). The first is a significant challenge to core cognitive schemas regarding self or the world. That is, an event must occur that defies how a person has come to accept themselves or the environment they live in. For example, if a person felt ineffectual or helpless but found that they were bravely working through a disaster situation they may be challenging some long-held self-perceptions. The second precursor is stressor-induced distress. In other words, an external event must occur which is stressful enough to place someone in a disturbed and emotionally elevated state of mind. The third precursor to posttraumatic growth is cognitive processing – which is simply the act of consciously or subconsciously experiencing the stressful event. Considering these three antecedents to posttraumatic growth, clearly there are numerous situations which could lead to some degree of growth.

Posttraumatic growth is an organismic event, which means it proceeds holistically and towards improvement within the organism across three domains (Joseph, 2012; Tedeschi & Calhoun, 1996). Firstly, relationships are enhanced in some way – such that

people come to value their friends and family more or feel more compassion towards others. People express more altruistic thoughts and behaviours and they begin to appreciate the relationships in their lives more intensely. Secondly, people develop a more optimistic and positive self-perception, which could include increased self-acceptance or wisdom. For example, feelings of being more resilient or strong are common, or even a new acceptance of personal flaws and limitations develop. Thirdly, personal philosophies on life typically become more clear and purposeful. Generally speaking, people tend to adopt more existential personal philosophies. They value each day more and shift their energy towards more meaningful things due to an increased perception that life is finite.

Research on posttraumatic growth is limited but quickly advancing. It has been found in war veterans (Moran, Schmidt, & Burker, 2013), cancer survivors (Koutrouli, Anagnostopoulos, & Potamianos, 2012), and even people who have experienced strong threatening perceptions such as news reports of terrorism (Stasko & Ickovics, 2007), among many other examples. Given the three precursors to posttraumatic growth (Stanton & Low, 2004), it is no surprise that posttraumatic growth can follow from natural disasters. Strong research exists supporting the causal link between natural disasters and posttraumatic stress (Neria et al., 2008; North & Pfefferbaum, 2013), and posttraumatic stress is strongly correlated with posttraumatic growth (Koutrouli et al., 2012; Lowe, Manove, & Rhodes, 2013). Currently, the relationship between posttraumatic growth and posttraumatic stress disorder appear to be curvilinear (Joseph et al., 2012; Park, Aldwin, Fenster, & Snyder, 2008), which suggests that the severity of a natural disaster plays a role in the degree of posttraumatic growth for the victims. This

research indicates that too much or too little posttraumatic stress results in smaller amounts of posttraumatic growth. Furthermore, the severity and unique consequences of the natural disaster seems to mediate the degree of posttraumatic stress and posttraumatic growth that follows (Johannesson et al., 2009; Joseph & Linley, 2005). Personal characteristics also have a role in posttraumatic growth. Predictor variables appear to be openness to experience, optimism, self-esteem, acceptance, positive reframing, social support, turning to religion, and problem solving (Linley & Joseph, 2004). According to Corey (2009), many of those variables are characteristics that healthy and skilled therapists possess.

Generally, post-traumatic growth is perceived as a positive change in people alongside the negative consequences of a disaster. These events often have a lasting impact on all people involved, many of whom choose to seek counselling to help sort through the changes in their lives. However, since natural disasters impact entire communities of people, counsellors are commonly victims of the same disaster their clients are seeking help with and face the same challenges. The term “shared trauma” has been used to describe this type of scenario.

### **Shared Trauma**

Counsellors are often considered second responders after emergency teams have concluded their work, and they treat clients while simultaneously working through their own trauma and problems (Faust, Black, Abrahams, Warner, & Bellando, 2008). Shared trauma has been defined as a situation where both client and counsellor have been victims to the same traumatic event (Saakvitne, 2002). Shared trauma is distinct from the related concept of vicarious trauma in that it refers to a single unique traumatic event shared

between client and counsellor (e.g., the World Trade Centre attacks on September 11, 2001) as opposed to a counsellor becoming traumatized by hearing about traumatic experiences from the client. Shared trauma is also distinct from shared experience since shared experience conventionally refers to situations where the therapist has experience with an activity the client discusses (e.g., alcohol addiction) but generally not the specific event (e.g., using alcohol together on a specific date in the past).

A large number of publications on shared trauma emerged from the aftermath of Hurricane Katrina in 2005 and the terrorist attacks in New York in 2001. In these scenarios, counsellors have reported extremely challenging obstacles to overcome such as being emotionally unavailable for clients yet needing to earn an income, losing a secure and confidential office for sessions, or profound shifts in the relationship's balance due to circumstances challenging the traditional treatment boundaries.

Describing the work she did with trauma counselling after the September 11<sup>th</sup>, 2001 terrorist attacks in New York City, Saakvitne (2002) recalls, "... I was aware of my greater emotionality. I was stunned at how frequently I became teary in response to my patient's material" (pp. 444-445). Depending on the circumstances, there may be times where therapists simply cannot hide from their clients the fact that they are in distress. Saakvitne goes on to say that therapists often strive to conceal their distress, but the task becomes so extremely difficult in disaster situations because they are continually being forced to remain conscious of their own vulnerability.

A report by Boulanger (2013) provides personal accounts from four practicing psychotherapists in New Orleans after Hurricane Katrina. In this article, the therapists describe operating in a mental state akin to being on auto-pilot – that they had no



personal time to reflect and reprocess their experiences and instead had to bear the heavy burden of their own problems while channeling their energy towards helping their clients cope with the trauma. Countertransference becomes an especially relevant problem, as therapists must have a very strong ability to segregate their lives in order to provide ethical service when under the stress of shared trauma. Boulanger (2013) warns that therapists must be cautious not to shift therapy away from exploring the client's pain and towards avoiding the counsellor's painful countertransference issues. The unfortunate reality is that in post-disaster scenarios when resources are decreased and the need for help is increased, many helpers must face the ethical dilemma of choosing to work or not – and some find that continuing to provide service is in their client's best interest. When therapists continue to work despite having to make professional compromises, the balance of the therapeutic relationship tends to change.

Although both client and counsellor maintain their roles in the relationship, they now have a shared identity as primary victims of the same disaster (Bell & Robinson, 2013). When the disaster struck, the relationship dynamic between both parties was equalized. One of the outcomes of this is blurring of professional boundaries with clients (Baum, 2010; Phelps et al., 2009). Boundary shifts can be physical (e.g., hosting therapy sessions at a private home or unsecured location due to office damage) or relationship boundaries (e.g., discussing and sharing personal disaster-recovery strategies or contacts). For example, a client may learn that their therapist had the same sort of property damage but a more cooperative insurance broker. The client in this situation may request a referral to that insurance broker. In the aftermath of a natural disaster, this type of information sharing may be prudent but it does come with some risk – such as conflicts

of interest, the blurring of boundaries in the real relationship, or even fostering dependence in extreme cases.

Baum (2010) suggests that two different relationship boundaries become blurred for psychotherapists in shared trauma situations. First, the therapist's internal separation between personal and professional selves appears to weaken. Several therapists report that their thoughts and feelings became increasingly intrusive and intense during counselling sessions (Baum, 2010; Saakvitne, 2002). The effect can be so draining that professional performance is impacted and the ability to be empathetic in certain situations is compromised as a result of the therapist's preoccupation with inner dialogue. The second compromised relationship boundary is the therapeutic dyad. Primarily, the asymmetrical nature of the relationship (which allows the clients to receive help without perceiving the need to reciprocate) is altered. This shift may occur from the apparent distress and increased defensiveness of the therapist (Tosone, 2006), or from the client's growing empathy for the therapist's personal difficulties.

However, there are some positive outcomes to shared trauma, such as the potential to increase therapeutic rapport by quickly establishing the presence of a deep understanding between client and counsellor (Tosone et al., 2003). In recalling a therapy session with a client who was a victim of the World Trade Center attacks in New York, Tosone, Nuttman-Shwartz, and Stephens (2012) describe how shared trauma experiences can be leveraged for the benefit of the client. In this case, a client appeared isolated with his thoughts and feelings about recovering the body of a colleague from the ruins. The counsellor had experienced a similar situation rife with parallel emotions, and so he felt a deeper and more intimate connection with the client's story – and believed that the client

benefited from this. The authors suggested that the therapist's increased sense of intimacy helped him integrate the shared trauma scenario into therapy and increased the level of therapeutic rapport in the relationship. While some variables of shared trauma scenarios are obstacles in the way of client healing, there are some benefits to the therapeutic relationship – and therefore benefits also to client success.

**The therapeutic relationship and shared trauma.** When facilitating client change, the therapeutic relationship existing between the helper and client is generally regarded as the best predictor of psychotherapy outcome (Horvath & Symonds, 1991). A therapeutic relationship is an expansion of a simple relationship, defined by Gelso and Carter (1985) as, “the feelings and attitudes that counseling [sic] participants have toward one another and the manner in which these are expressed” (p. 159). The concept of a therapeutic relationship has been divided into three distinct aspects: (a) the real relationship, (b) transference and countertransference, and (c) the working alliance (Gelso & Carter, 1994).

The real relationship generally refers to the dimension of the total relationship that is independent of transference. In other words, it is the relational dynamic that is created spontaneously and is not distorted from the various processes of therapy. The real relationship has two defining features: genuineness and realistic perceptions (Gelso & Carter, 1994). The former refers to the extent that one is authentic, open, and honest about oneself in therapy. The latter refers to the extent that an individual is able to see the other in an accurate and realistic way free from distortions of transference.

Transference and countertransference together form the second component of a therapeutic relationship. The concept of transference has traveled through many

iterations, but a general definition offered by Gelso and Carter (1994) describes it as a client perceiving the therapist to have the same attitudes, beliefs, behaviours, and perceptions of significant others the client had had conflict with in the past. Therefore, transference describes the distortions a client experiences about their therapist that makes them perceive their therapist as though they were someone familiar. Countertransference is essentially the same phenomena but defined from the therapist's side of the relationship.

The working alliance is regarded as the most fundamental element of the therapeutic relationship necessary for counselling to be effective (Bordin, 1979). This element can be described as the cooperation of the client's reasonable-self with the therapist's analyzing-self. The strength of alignment is correlated with the degree to which the therapist and client agree on goals and work towards attaining them (Gelso & Carter, 1994).

When client and counsellor experience the same traumatic event, all three of these components are affected. First, the real relationship is inevitably altered due to the shared identity as primary victims. Clients will perceive the counsellors as being vulnerable, and genuine treatment in either direction becomes threatened as the client may feel empathic or even protective of the counsellor; and the counsellor must navigate between personal and professional feelings. Issues of transference and countertransference come to the forefront of the therapeutic relationship in shared trauma contexts. Existing client transference issues may be exacerbated while counsellors may struggle with countertransference if confronted with uncomfortably similar client problems. For example, a client describes a story about an authority figure forcing them to abandon a

pet during an evacuation, which also happened to the therapist. The client experiences transference to the therapist, who is also an authority figure, which is exacerbated when the therapist's countertransference causes them to self-disclose. Finally, the working alliance may be compromised out of necessity from physical restrictions (such as a destroyed office or community evacuation) or involuntarily reduced service due to strained resources.

In a shared trauma situation, elements of the therapeutic relationship may become more pronounced depending on the context. Boulanger (2013) describes how the therapeutic relationship can either be enhanced or hindered by shared trauma. If both client and counsellor have a new shared identity as survivors, they also share a deeply understood appreciation for the resilience each has demonstrated. On one hand, rapport and mutual appreciation can be strengthened, but alternatively boundaries may be violated if this new shared identity leads the therapist to be overly friendly – and this may even cause clients to lose confidence in their counsellors. For example, a shift in the therapeutic relationship due to shared trauma could lead to therapists analyzing their clients less and spending more time relating to them, which is not necessarily therapeutic. Some researchers have positioned therapist self-disclosure as significant variable among these outcomes (Tosone et al., 2003), such that the disclosure of personal information is unavoidable in shared trauma scenarios and it is a strong influence on the therapeutic relationship.

As soon as Hurricane Katrina passed, clients wanted to know the experiences of their therapists and how they fared (Boulanger, 2013). Some therapists reported concerns over disclosing personal information to their clients; however, in many instances the

personal distress of the therapists simply could not be concealed, which conveys some personal information automatically. While shared trauma experiences risk increased countertransference and reduced relationship asymmetry, some researchers have proposed that sharing some stories of personal experiences with the client is not only unavoidable, but can also carry benefits such as increased empathy and insight for either party.

### **Therapist Self-disclosure**

Hill (1992) defines therapist self-disclosure as any statement in which the counsellor shares something personal. Self-disclosure has a turbulent history among psychologists, beginning with Freud. Freud's theory of psychoanalysis completely eliminated self-disclosure so that the psychologist could remain a neutral and blank canvas for the client to project upon (Corey, 2009). The tradition of an anonymous therapist persisted until the 1950s, when Carl Rogers's theory of person-centered therapy began to emerge. Person-centered counsellors were the first to fully embrace the technique of self-disclosure (Farber, 2006). The technique was an effective method for quickly building rapport and establishing a relationship of trust and understanding. For instance, Carl Rogers indicated that therapists could self-disclose to reflect understanding to the client and increase congruency – the measure of therapeutic understanding and integration in Rogerian theories (Goldfried, Burckell, & Eubanks-Carter, 2003). Since then, proponents of humanist theory have continued to regard therapist self-disclosure as a tool to model positive client behaviours, if used skillfully (Hanson, 2005; Simi & Mahalik, 1997). Self-disclosure is also crucial to feminist theorists (Knox & Hill, 2003),

addictions counsellors (Martino, Ball, Nich, Frankforter, & Carroll, 2009), and sexual orientation counselling (Satterly, 2006).

Self-disclosure has been described as a high-risk but high-reward technique that novice counsellors should avoid (Young, 2008). One of the risks involved with therapist self-disclosure is that, in certain circumstances, the client can begin to feel that the counsellor is too self-concerned, which can result in the client feeling unimportant or not cared for. Clients with self-esteem problems are particularly vulnerable to feeling alienated when this technique is used inappropriately. Another significant risk is that therapist self-disclosure can undermine the therapist's authority as a transference figure (i.e., a safe individual for the client to ascribe important characteristics from past relationships on to) and thereby reduce the effectiveness of modeling. Finally, too much therapist self-disclosure can drive clients away out of boredom or the stress of not having enough time to explore their problems in session.

Among the benefits of using this technique, therapist self-disclosure can increase trust in the relationship by establishing a mutual understanding and/or the sharing of important personal information (Young, 2008). Therapist self-disclosure can also deepen the client's self-disclosure and encourage the expression of feelings through modeling. Another particularly important outcome is the ability for self-disclosures to be "self-involving." These are statements that related to thoughts the therapist has about the client and they can be especially therapeutic in some situations. The different categories of self-disclosure are discussed in greater detail in the next section.

Despite being one of the most effective techniques in certain situations, self-disclosure is among the least commonly used in session (Hill & Knox, 2001). This is

typically due to therapist training or theoretical orientations. When some therapists do choose to disclose, they do so very sparingly and often experience marked internal struggles about the appropriateness of the intervention. Hill and Knox (2001) suggest that therapists need to be mindful of the content of the revelation to strategically minimize risk. They assert that disclosures must avoid highly intimate information, sexual issues, religious beliefs, or political views. The approaches to self-disclosure are outlined below.

**Types of self-disclosure.** Knox and Hill (2003) assert that there are at least seven subtypes of therapist disclosure: disclosures of (a) facts, (b) feelings, (c) insight, (d) strategy, (e) reassurance or support, (f) challenge, and (g) immediacy (p. 530). Disclosures of facts and feelings are simply communications about the therapist's personal information or thoughts and emotions (e.g., "As I listened to your story I felt very hopeful"). Disclosures of insight involve the description of a time when the therapist had a realization or personal discovery (e.g., "I was also unsure about a similar situation until I realized that I had the power to decide for myself"). Disclosures of strategy are the description of actions the therapist personally took to overcome a problem, and the client can often misinterpret this type of disclosure as advice (e.g., "I was also confused about what to major in so I decided I would go talk to my parents"). Disclosures of reassurance are similar to disclosing feeling, except that they communicate empathy or shared experience – which can undermine the therapeutic relationship in some circumstances (e.g., A therapist saying "I was just as scared as you were once, when the airplane shook like that!" when the client meant to convey excitement rather than fear). Disclosures of challenge are recounts of when the therapist dealt with a similar issue the client was having, but more successfully (e.g., "I also lost my brother in a car accident, but managed



to overcome my grief by reprocessing it.”). Finally, disclosures of immediacy involve communicating to the client during the session to describe thoughts or feelings the therapist has in that moment (e.g., “As you describe your relationship with your father I am feeling a lot of sympathy for you because my relationship with my father is similar.”). These different types of disclosures are used at different points in therapy, and have very different outcomes. Knox and Hill (2003) suggest that disclosures of immediacy are perhaps the most therapeutically effective approach, since they highlight the interactional processes occurring between the client and the counsellor – processes which may be occurring with others in the client’s life and contributing to their distress.

**Usage of self-disclosure in therapy.** Scholars often warn about the risks of self-disclosure – especially how grievous misuse can alter the relationship and cross ethical boundaries (Craig, 1991; Lazarus & Zur, 2002). For example, if a therapist was to disclose some personal hardships to the client, and the client becomes genuinely sympathetic, a role reversal may occur. Such an event violates relational, professional, and ethical boundaries. From a literature perspective, most debate over the usage of self-disclosure is in the realm of ethics. For example, self-disclosure may cross ethical boundaries by shifting the focus of the session away from the client, facilitating a dynamic favourable for friendship, arousing empathy or sympathy within the client directed to the therapist, or creating an inverse relationship dynamic (Zur, 2004). However, some researchers have suggested that it is impossible to completely avoid self-disclosure in therapy (Peterson, 2002). Peterson suggests that the therapist’s clothes, ethnicity, style, office decorations, manner of greeting, and many other characteristics are all forms of self-disclosure and cannot be avoided. Therefore, the question moves away

from whether some degree of self-disclosure is ethical, and towards exploring the circumstances of when it is appropriate (Audet, 2011). In situations where the therapist is ill or experiencing distress, the issue of informed consent is a stake. If some event has occurred which influences the performance of the therapist in a meaningful way, Peterson (2002) suggests that self-disclosure becomes the ethical action to take. In fact, research tentatively supports that in shared trauma scenarios, self-disclosure frequency increases (Baum, 2010; Lijtmaer, 2010; Tosone et al., 2012). Therefore, some scholars might argue that in situations of shared trauma, self-disclosure is the only ethical procedure to follow.

No specific criteria exist for when self-disclosure is best suited, however the empirical and theoretical literature clearly reveals that some clients respond better than others, and that self-disclosure should only be used with clients whom the therapists have strong existing relationships (Bishop & Lane, 2001). Strength in the therapeutic relationship is a necessary safeguard against discomfort or misunderstanding regarding the content of the therapist's disclosure. Self-disclosure should not be used with clients who have very defensive beliefs about personal boundaries or who respond negatively to compliments (Geller, 2003). Such clients tend to feel uncomfortable when they learn personal information from their therapist whom they view as an authority figure. Geller (2003) goes on to explain that in his experience, self-disclosure is best reserved for times when clients become perniciously resistant. At times like that, some self-disclosure will dramatically shift the tone of the session and sometimes compels the client to cooperate.

The type of information contained in self-disclosures has been the major focus of researchers in the field. In a large review of qualitative research, Henretty and Levitt

(2010) determined that the following types of information are empirically supported as being beneficial to disclose: facts, feelings, insights, reassurances, and statements of immediacy. However, the last two types can be dangerous at times because they may encourage clients to censor themselves or foster competition in the relationship. For example, if a therapist is self-disclosing some past hardships in an attempt to reassure the client, the client may begin to sympathize with the therapist. Feelings of care and protectiveness may emerge in response to hearing about times when their therapist was in distress. This increased sympathy may motivate the client to self-censor in an attempt to not cause further perceived discomfort in the therapist. Statements of immediacy may cause a client to feel as though their therapist is actively comparing their personal experience with that of the client, making the client potentially feel insecure, undermined, not respected, or unheard, and fostering a sense of competition.

**Outcomes of therapist self-disclosure.** The range of reasons why therapists choose to self-disclose is vast (Henretty & Levitt, 2010), but among them is the purpose of validating reality. When intrusive events happen, therapists have reported that it is useful to self-disclose about the nature of those events to help the clients deal with real-life factors (Simon, 1988). Failing to address the reality of the situation may leave clients anxious about being able to access future service (e.g., Can the therapist cope with the intrusive events well enough to provide help to others?). The disclosure of personal yet obvious difficulties the therapist may be experiencing is reassuring to the client and leads to an overall stronger alliance (Hill & Knox, 2001). Perhaps the strongest effect of self-disclosure can be to normalize the experience of the client (Audet & Everall, 2003). Both validating reality and normalization are effective and widely used processes in

counselling victims of natural disasters (Bedi et al., 2005; Kar, 2009; Madrid & Grant, 2008).

Disclosure of common experiences between the client and counsellor validate the client and foster a sense of understanding and respect (Barnett, 2011). Furthermore, mild dissimilarities in the respective experiences between client and counsellor can lead to the development of new perspectives for clients about their situation. A study by Simone, McCarthy, and Skay (1998) found that when therapists self-disclose in order to validate or normalize a client's experience, the clients found it helpful only when the information was both similar and relevant. In their study, relevance was gauged by how strategically applicable the disclosed information was for the client.

Self-disclosure has been suggested to play a role in post-traumatic growth by enabling and facilitating relationships (Tedeschi & Calhoun, 1996). The action of disclosing personal stories of endurance or survival forces people to confront questions of meaning – which include subjects like relationships, compassion, and interpersonal values (Tedeschi & Calhoun, 2004). Relationships are key components of disaster recovery and, however a therapist chooses to promote them, reinforcement and reliance upon them can lead to healing.

### **Relationships and Recovery**

Regarding the potential for post-traumatic growth, relationships are important factors in the wake of a flood disaster. Kaniasty and Norris (2008) performed a longitudinal study on the prognosis of PTSD in flood victims related to their perceived-social support. The researchers found that perceived social support was associated with reduced rates of PTSD within one year of the disaster and that less social support was

associated with increased PTSD after one year. To determine if the degree of social support can predict PTSD symptoms following a disaster, Cherry et al. (2015) used self-report measures with 219 participants to measure these variables. The results showed a protective effect for all mental health outcomes (i.e., PTSD, depression, and generalized anxiety disorder).

Extending beyond the individual, Breckenridge and James (2012) have suggested that therapeutic services at the family or community level are needed to effectively recover from any disaster. They argue that through community initiatives, people are given the enhanced opportunity to develop meaningful relationships and establish new connections. They suggest that the role of the therapist is to facilitate discussion, clarify facts, and explore circumstances in an effort to integrate people. Through this approach, clients process any conflicted feelings associated with traumatic events in a healthy manner. Ultimately, a communal “story” can be developed upon themes of survival if therapists broaden their scope of practice to encompass communities, which can be healing.

### **Narrative Exposure Therapy**

Closely related to the construction of a story is narrative exposure therapy which has the practical characteristic of being short term and able to address complex trauma (Jongedijk, 2014). Recently, narrative exposure therapy has been used effectively to treat survivors of a natural disaster (Zang, Hunt, & Cox, 2014). Researchers in China effectively treated thirty earthquake survivors diagnosed with PTSD with typical and revised forms of narrative exposure therapy. Both groups showed a significant reduction in PTSD and all associated symptoms, along with an increase in post-traumatic growth,

active coping behaviours, and perceived social support. The revised version of the therapy called for clients to focus on a single traumatic event (e.g., the disaster), and canceled the testimony sign-off portion (i.e., signing the narrative with a witness to officiate the sense of closure) to increase the counsellor's capacity to see clients. No significant difference was found between approaches and, given the broad applicability and ease of use, the researchers suggested that the revised narrative exposure therapy protocol could be an effective treatment for natural disaster survivors.

### **Summary**

Natural disasters are a global threat, and floods rates are increasing along with flood severity. Floods affect both coastal and in-land residents, and are an extreme hazard for regions near mountain ranges such as southern Alberta. The major Calgary area (including municipalities within 50 km) is home to over one million people (Statistics Canada, 2012) but has a long history of catastrophic floods. When disaster strikes, whole communities are affected, including any practicing therapists in the area. As second responders, these therapists now face complex situations where professional boundaries are blurred in the aftermath of crisis. Resources are stretched thin as people's needs increase. The shared trauma between therapists and clients creates many new risks and precarious dynamics. Often the distress of the helper cannot be concealed from clients, so the disclosure of personal information occurs automatically – and often times the impact can be dramatic. The information can help normalize the situation for the client or potentially lead to posttraumatic growth, but on the other hand, self-disclosure has been criticized by some as being exploitative. What is clear is that self-disclosure has some role to play in counselling the survivors of a flood and can be healing if used

appropriately. Disclosures can enhance the perceived relationship between the client and counsellor and provide some benefit in terms of making the client feel supported and understood. They can also promote the importance of relationships outside the counselling office. Research has shown that perceived social support is negatively correlated with PTSD symptoms, depression, and anxiety. A positive correlation also exists between it and post-traumatic growth. Finally, the use of narrative therapy has recently been suggested as an effective and rapid means of helping natural disaster victims.

In the next chapter, details of the research design are presented along with a discussion of the outlining questions used to guide this literature review. The section contains a description on how the manual was developed, including the broad organization of its content. The chapter concludes with a brief presentation of ethical considerations and a summary.

### **Chapter Three: Methods**

This section describes the process used to complete the literature review, the process for creating the manual, ethical considerations, and the trustworthiness of the design. A description of the search terms and databases used to find relevant literature is also included. The following methods were employed to answer the research question: What do counsellors need to know to successfully and ethically navigate shared trauma following a flood disaster?

#### **Search Terms**

Guided by the research question, specific databases were chosen due to their relevance to psychology, economics, sociology, and geography. The following databases provided the literature for the search terms: Academic Search Complete, PsycInfo, ScienceDirect, EconLit, GEOBASE, SocINDEX, Wiley Online Library, SAGE Journals Online, Canadian Business and Current Affairs Complete, and Web of Science.

The intention of the literature review was to provide peer-reviewed resources to draw practical conclusions for improving flood disaster recovery efforts. Therefore, the following questions guided the literature search:

- What are the psychosocial effects of a flood disaster?
- What are the effects of shared trauma?
- What are the effects of self-disclosure?
- What special considerations are there for counselling after a natural disaster?

Specific search terms included various combinations and variations on the following words: counsellors, floods, natural disaster, shared trauma, post traumatic growth, self-disclosure, quality of life, secondary responders, disaster



recovery, and interventions. Literature searches extended into searching the references of peer-reviewed articles I found, if relevant. Additional searches were made by exploring articles citing articles I found, via the Academic Search Complete, PsychInfo, and Web of Science databases. Furthermore, certain academic books and textbooks were reviewed when exploring various counselling or psychological information. Finally, government and news media websites were included in the search when information about various disasters was required.

To explore the question about the psychosocial effects of a flood disaster, I primarily searched psychology and sociology based databases, for articles on the impact of flooding or, more broadly, of large-scale catastrophes and disasters. The majority of research appeared to be associated with post-traumatic stress disorder, but there are significant contributions in the area of relationships, mood, socioeconomic factors, and memory.

In order to understand the effects of shared trauma, I had to differentiate from shared experience when searching. The majority of publications appeared to be memoirs or first-hand accounts of disaster recovery, with occasional reflective pieces. The events of Hurricane Katrina and the terrorist attacks on the World Trade Center provided the context for much of the research on shared trauma.

Self-disclosure emerged as a prominent theme among the reports of shared trauma from psychologists, and in order to understand its role in disaster recovery, I studied review articles and key publications on the subject. Knox and Hill (2003) provided the first major overview of the technique, and appear to be among the most central researchers on the subject.

Finally, in searching for special considerations for counselling after a natural disaster, I searched among all psychology and sociology related databases for reports or studies on disaster outcomes. The search included reports from Red Cross workers and from therapists volunteering with Hurricane Katrina relief.

### **Developing the Manual**

The subject matter of the manual is intended to help people after a flood disaster, in cases when the helper is also a victim. The situation is complicated and time is a valuable resource. Therefore, for this manual to be most effective it needs to be concise, direct, and easily understood. Primarily, the manual is a resource to be shared immediately after a flood disaster has struck a community, however it can also be used as a general overview of best practices during disaster preparation.

In the interest of the above, the manual is divided into two major sections. First, there is a section providing descriptions, definitions, and distinctions between the various factors of effective flood disaster recovery. This includes much of the foundational information clinicians need to understand to proceed with treatment, but does not give supporting details or prolonged descriptions. The second section provides concise and directive guidance for practitioners, should they find themselves in a shared trauma situation. Recommendations are made from empirically proven research data and synthesized into safe and effective directives. Additionally, the manual includes an introduction section, a conclusion, and a reference section.

The ultimate purpose of the literature review is to record all practical conclusions derived from the analysis in a separate document. This list is organized to form a distinction between explicit and implicit practical suggestions from the various authors.

This document represents the raw form of the final manual, which will ultimately be reorganizing and framed to create a brief yet informative expository text.

### **Ethical Considerations**

I alone will collect all the data in this study, review it, and synthesize it into the final product. No participants are required or human subjects. All conclusions will be derived from peer-reviewed scientific articles with clear indications where I have made interpretations. The manual will not be empirically validated; therefore a disclaimer of its usefulness will preface the content. Complete credit and references will be given for the research base used in the creation of the manual.

### **Summary**

In this chapter, the methods for reviewing the literature were presented. Details of specific databases and search terms were provided to give readers an idea of the breadth and depth of this research. The literature for this project was based on concepts of flood disaster outcomes, shared trauma scenarios, the use of self-disclosure, and the unique considerations of counselling people after a flood disaster. A manual was created to provide responders with a practical, concise, and easily understood resource to maximize the outcomes for their clients.

## Chapter Four: Synopsis

This chapter contains a detailed description of the flood-disaster response manual. Additionally, the expected impact of the manual, including its strengths and its limitations, will be discussed. Following that, a brief section of closing reflections about the process and a summary is included.

### Overview of Manual

The purpose of the manual is to relieve some of the pressure from mental health therapists after a flood disaster. Rather than spending already strained energy and resources on decision making and research, clinicians referencing this manual can focus their efforts on their clients. As such, it needs to be concise, clear, and powerful enough to give readers valuable information. Therefore, the manual is not recommended for a lay audience – it requires education, skill, and understanding in common psychotherapy theories, interventions, and processes.

The first section of the manual gives readers some context for flood disasters with the intention that this information can be passed on to survivors to help clarify the devastation and normalize the experience. Next, a presentation of the four most common disorders that arise for natural disaster victims includes symptomology and diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders 5* (American Psychiatric Association, 2013). This information is intended to be a reference for clinicians, not a diagnostic tool.

Following the common clinical disorders is an outline of post-traumatic growth – a powerful phenomenon for survivors of a flood that therapists could integrate into their process with clients. Shared trauma is defined and explained next. A major caution about

boundary shifts is presented so that therapists can be aware of the primary risk factors of a shared trauma situation, which is followed by a separate piece on boundaries. The issues regarding shifts in the therapeutic relationship are described in relation to how they may lead to problematic relationship boundaries. Finally, the section concludes with a description of the most likely ethical dilemmas therapists may face in shared trauma scenarios, as well as some possible consequences of them. The ethical decision making model from *The Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) is presented as a convenient option for therapists.

The second section of the manual presents strategies to navigate the complexities of psychotherapeutic flood recovery in a shared trauma situation. The section opens with some humour to those familiar with the works of Douglas Adams, a popular British novelist. The intention of humour is to help ground the reader and draw their attention towards their own level of anxiety. Cognitive-behaviour therapy is indicated for each of the most common psychological disorders following a flood disaster. This is followed by a detailed description of self-disclosure, why it occurs, and the various categories of disclosures. Each category is followed with a recommendation for or against its usage with rationale. The purpose of this is to give readers a bearing on what disclosures they are making so they can intervene on the process if needed.

A brief description of the modified narrative exposure therapy protocol is presented along with guidelines. This revised protocol has not been extensively tested, but has shown promise and has the desirable characteristic of being rapidly deployable and less demanding than typical narrative exposure therapy for the therapist. A reminder of proper sleep hygiene standards follows and they are intended to be integrated with

CBT techniques. Finally, a description of the three dimensions of post-traumatic growth is included so that therapists can emphasize these areas in counselling when appropriate.

### **Expected Outcomes and Strengths**

The manual is expected to be a useful reference and guide for any mental health clinical working with survivors of a flood disaster – doubly so for those in a shared trauma situation. Although simple in construction and not exhaustive of possibilities, the redirection of focus that this manual puts on high-impact factors in post-disaster scenarios is expected to make an overall positive impact for communities that use it. Each client and counsellor is unique so no single manual, no matter how detailed, could provide perfect guidance for everybody. The skill of the counsellor and quality of the therapeutic relationship are, as always, paramount. Therefore, though the broad focus on high-impact factors without belabouring details that cannot be universal, this manual is expected to have wide applicability.

### **Limitations**

This manual is limited in that it has not been empirically evaluated. The information contained has been gathered from peer-reviewed research; however, it has never before been organized and/or interpreted into a practical application. This manual does not include every intervention, theory, or concept effective for, or related to, the topics addressed.

### **Reflections**

One of the theories why medical students are pushed to work extremely hard on very little sleep is to see who makes mistakes under stress and strain. It is not terribly difficult for a therapist to remember that PTSD is the most common clinical disorder

following a natural disaster when they are operating in normal circumstances. It is another situation entirely when they have lost their home, their insurance company is irksome, and their client is threatening suicide. In times like that, even the best therapists might make mistakes so basic yet pertinent and organized information can have tremendous value. I believe in the power of “minimal effective doses” when it comes to making changes. This manual is my attempt at giving that to therapists for the time where their cognitive decision making resources are at a premium.

My outstanding concern is ultimately about the population this manual is best suited for. My sense is that this manual is most applicable for the weeks following a disaster, where demand for therapists is high and a relatively rapid response is needed. The applicability for counsellors seeing clients many months to years after the event seems less relevant to me. However, in situations like those, personal resources are not as strained and clinicians can better afford to rely on the wealth of literature and training available, which goes much deeper than the “minimal effective dose” that this manual attempts to provide.

## **Summary**

This manual represents a concise attempt to relieve some of the decision-making burden from mental health therapists in the aftermath of a flood disaster. It provides readers with an overview of the most common disorders that arise, their associated symptoms, and the first line treatment for them. It also attempts to describe some of the other powerful phenomenon at play for survivors of a disaster as well as avenues therapists can take to emphasize or empower these aspects. Among the precarious factors of a shared trauma situation, the shifts in therapeutic boundaries are often of a nature

clinicians have not encountered and can be problematic. The manual attempts to shed light on this occurrence. Additionally, self-disclosure is presented concisely as a way to either harm or heal the client. The result of creating this manual is expected to be generally positive, as it provides a scaffold for therapists to guide their practice during difficult times. Ultimately, as flood disasters affect more and more people around the world, counsellors are inevitable victims themselves and this manual might serve as a mental floatation device for the rough waters of shared trauma.



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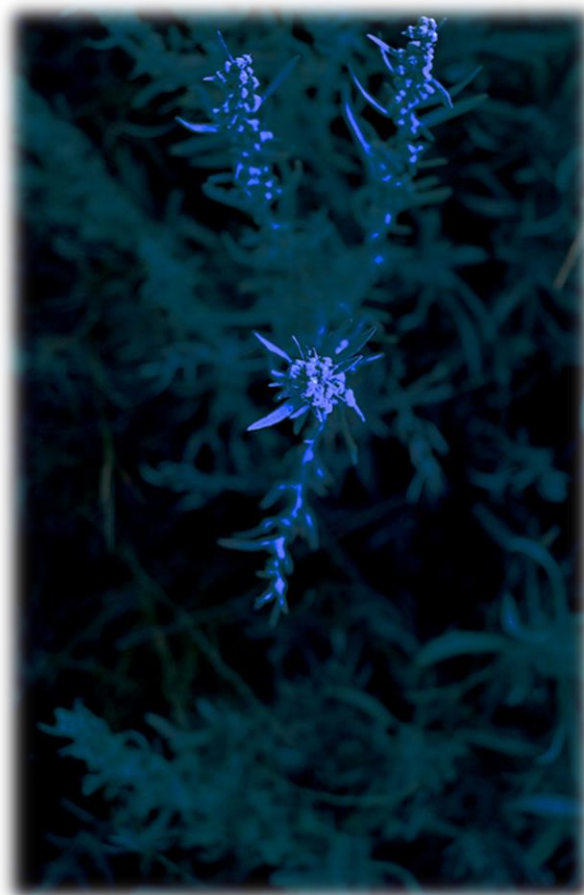
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## **Recovery After a Flood**

A practical manual for mental health clinicians



Created by Johnathan Bown, B.A.

University of Lethbridge

Master of Education Project

**Table of Contents**

Table of Contents .....	60
Copyright .....	61
Limitations .....	62
Preamble .....	63
Section 1: Basic Knowledge .....	64
Impact .....	65
Post-traumatic Growth .....	69
Shared Trauma .....	69
Boundaries .....	70
Ethics .....	72
Section 2: Strategies .....	74
Disorders .....	75
Cognitive-Behaviour Therapy (CBT) .....	75
Self-disclosure .....	76
Narrative Exposure Therapy .....	77
Sleep Hygiene .....	78
Post-traumatic growth .....	79
Conclusion .....	80
Additional Resources.....	80
References .....	81

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**Johnathan Bown**

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### **Limitations**

This manual is limited in that it has not been empirically evaluated. The information contained has been gathered from peer-reviewed research; however, it has never before been organized and/or interpreted into a practical application. This manual does not include every intervention, theory, or concept effective for, or related to, the topics addressed.

## Preamble

Floods accounted for 49% of types of natural disasters in 2012, are the most common type of natural disaster around the world (Guah-sapir, Hoyois, & Below, 2012), and the most costly in Canada (Government of Canada, 2001). Strong evidence shows that floods can have powerful and long-term negative effects on mental health (Green, 1998; Kõlves, Kõlves, & De Leo, 2013; Rubonis & Bickman, 1991), and can lead to post-traumatic stress disorder (PTSD), depression, and anxiety (Neria, Nandi, & Galea, 2008; North & Pfefferbaum, 2013; Wang, Chan, & Ho, 2013). Shared trauma is a situation when the helpers are victims themselves. The situation is complex and the therapeutic dynamics for counsellors sometimes become unpredictable. In such cases, it is often difficult to avoid making self-disclosures – however, some research has pointed to the benefit of doing so (Baum, 2010; Lijtmaer, 2010; Tosone, Nuttman-Shwartz, & Stephens 2012). In some cases, and with careful navigation, traumatic events can be transformed into opportunities to grow, (Joseph, Murphy, & Regel, 2012).

The author's hope is that this manual can free up some of the reader's energy and resources, which are at a premium, so that they may focus more of their efforts on their clients.

Section 1: Basic Knowledge

**- Section 1 –**

**BASIC KNOWLEDGE**

## Section 1: Basic Knowledge

So there's been a disastrous flood? Mental health workers need to know:

- Floods are the **most common** natural disaster in the world
- Floods are the **most disruptive** natural disaster to daily life
- Floods, compared to other types of natural disaster, affect the **largest number of people**
- Floods, compared to other types of natural disaster, cause the **most property damage**

### *Impact*

Floods affect more and more people as the size of the global population grows, Earth's climate changes, and more people settle in coastal regions or flood zones. Research has shown that flood disasters lead to powerful and life-changing psychological effects for some of the survivors – which may not fully develop for up to 24 months. The following definition and symptomologies are based on information in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013).

1. The clinical disorder that occurs most commonly after a flood is **post-traumatic stress disorder (PTSD)**. A complete diagnosis of PTSD requires the presence of symptoms for at least one month and functional impairment, among other criteria. You can predict the onset of PTSD by looking for the following behavioural markers:
  - I. *Re-experiencing* – The disturbing event is persistently re-experienced in some way, such as with recurrent intrusive memories, nightmares, dissociative reactions (flashbacks), prolonged distress after the threat has passed, and/or prolonged exaggerated physiological reactivity after the event has passed.
  - II. *Avoidance* – Effortful avoidance of either trauma-related feelings or trauma-related external reminders like objects, people, or places.
  - III. *Negative Cognitions* – Negative alterations in mood or thoughts that worsened after the event. A diagnosis of PTSD requires two of the following: inability to recall key features of the event, persistent and distorted negative beliefs

## Section 1: Basic Knowledge

- IV. about self or the world, persistent trauma-related negative emotions, significantly diminished interest in pre-traumatic event activities, feeling alienated from others, and/or persistent inability to experience positive emotions.
  - V. *Arousal* – Trauma-related alterations in arousal or reactivity that began or worsened after the event. A diagnosis of PTSD requires two of the following: Irritable or aggressive behaviour, self-destructive behaviour, hypervigilance, exaggerated startle response, problems in concentration, and/or sleep disturbance.
2. The second most common clinical disorder is **depression**. A complete diagnosis requires the presence of symptoms concurrently within a two-week period, which must be a change from previous functioning. One of the first two criteria, and a final total of five criteria, must be present in order to formally give a diagnosis of depression. You can predict the onset or presence of a major depressive episode from the following symptoms:
- I. *Depressed mood* – Most of the day nearly every day, as indicated either by self-report or the observations of others.
  - II. *Loss of interest* – Markedly diminished interest or pleasure in most activities for the majority of time awake.
  - III. *Weight change* – A change in body weight of more than five percent in a month when not dieting.
  - IV. *Sleep disturbance* – Inability to sleep or sleeping significantly more than usual.



## Section 1: Basic Knowledge

- V. *Psychomotor disturbance* – Third-party reports of agitated or slowed body movements nearly every day.
  - VI. *Low energy* – Fatigue nearly every day.
  - VII. *Negative beliefs of self* – Feelings of worthlessness or inappropriate guilt nearly every day.
  - VIII. *Lack of focus* – Diminished ability to concentrate or increased indecisiveness nearly every day.
  - IX. *Preoccupation with thoughts of death* – Recurrent thoughts of death or suicidal ideation.
3. The third most common clinical disorder is **anxiety**. A complete diagnosis requires the presence of three or more of the following symptoms more days than not within a six month period. You can predict the onset or presence of generalized anxiety disorder from the following symptoms:
- I. *Restlessness* – Restlessness or feeling keyed up or on edge.
  - II. *Fatigue* – Being easily fatigued.
  - III. *Poor focus* – Difficulty concentrating or mind going blank.
  - IV. *Irritability* – Feeling irritable.
  - V. *Physical tension* – Muscle tension.
  - VI. *Sleep disturbance* – Difficulty falling or staying asleep

## Section 1: Basic Knowledge

4. Research has demonstrated that for at least two years after a natural disaster, survivors can experience **reduced sleep quality** and disruptive nocturnal behaviours. The Pittsburgh Sleep Quality Index is an empirically proven screen for quickly making an assessment for the client. A score of “5” or great indicates poor sleep quality.

### The Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions. During the past month,

1. When have you usually gone to bed? \_\_\_\_\_
2. How long (in minutes) has it taken you to fall asleep each night? \_\_\_\_\_
3. When have you usually gotten up in the morning? \_\_\_\_\_
4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed) \_\_\_\_\_

5. During the past month, how often have you had trouble sleeping because you...	Not during the past month (0)	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
a. Cannot get to sleep within 30 minutes				
b. Wake up in the middle of the night or early morning				
c. Have to get up to use the bathroom				
d. Cannot breathe comfortably				
e. Cough or snore loudly				
f. Feel too cold				
g. Feel too hot				
h. Have bad dreams				
i. Have pain				
j. Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s):				
6. During the past month, how often have you taken medicine (prescribed or “over the counter”) to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
	Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)
9. During the past month, how would you rate your sleep quality overall?				

Component 1	#9 Score.....	C1 _____
Component 2	#2 Score ( $\leq 15$ min=0; 16-30 min=1; 31-60 min=2; >60 min=3) + #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3).....	C2 _____
Component 3	#4 Score (>7=0; 6-7=1; 5-6=2; <5=3).....	C3 _____
Component 4	(total # of hours asleep)/(total # of hours in bed) x 100 >85%=0, 75%-84%=1, 65%-74%=2, <65%=3.....	C4 _____
Component 5	Sum of Scores #5b to #5j (0=0; 1-9=1; 10-18=2; 19-27=3).....	C5 _____
Component 6	#6 Score.....	C6 _____
Component 7	#7 Score + #8 Score (0=0; 1-2=1; 3-4=2; 5-6=3).....	C7 _____

Add the seven component scores together \_\_\_\_\_ **Global PSQI Score** \_\_\_\_\_

Buyse, D.J., Reynolds III, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index: A new instrument for psychiatric practice and research. *Journal of Psychiatric Research*, 28(2), 193-213.

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## Section 1: Basic Knowledge

### *Post-traumatic Growth*

Despite the multitude of potential negative consequences from a flood, survivors can ultimately be empowered to feel stronger or make positive changes in their lives due to their traumatic experience. Research has demonstrated that in order for this phenomenon to occur, an individual needs to experience a significant challenge to core cognitive schemas, stressor-induced distress, and some cognitive processing of the event (Stanton & Low, 2004).

Post-traumatic growth is an organismic event that proceeds holistically and towards improvement in the individual within three domains:

- I. *Enhanced relationships* – People come to value their friends and family more and/or feel more compassion towards others. People tend to express more altruistic thoughts and behaviours while they more intensely appreciate their relationships.
- II. *Positive self-perception* – People become more optimistic about themselves and others. This can include increased self-acceptance, wisdom, and feelings of being more resilient.
- III. *Developed personal philosophy* – Personal philosophies of life tend to become more clear and purposeful. People tend to experience increased value in each day and shift their energy towards more meaningful activities.

### *Shared Trauma*

Shared trauma is a situation that describes a client and counsellor dyad, where both people are victims of the same historical traumatic event. After a natural disaster, when resources are thin and survivors need support the most, many mental health workers must attempt to give help while feeling personally strained or even triggered by the help they give. Boundary shifts are common, and Baum (2010) suggests they exist in two categories.

## Section 1: Basic Knowledge

- I. The therapist's internal separation between personal and professional selves appears to weaken. Their thoughts and feelings become increasingly intrusive and intense during counselling sessions. The effect can be so draining that professional performance is impacted and the ability to be empathetic in certain situations is compromised as a result of the therapist's preoccupation with inner dialogue.
  
- II. The second compromised relationship boundary is the therapeutic dyad. Primarily, the asymmetrical nature of the relationship (which allows the clients to receive help without perceiving the need to reciprocate) is altered. This shift may occur from the apparent distress and increased defensiveness of the therapist (Tosone, 2006), or from the client's growing empathy for the therapist's personal difficulties.

### *Boundaries*

Therapy is inherently an asymmetric relationship, such that the therapist is there to give and not receive. When this is compromised (e.g., equalized when both therapist and client gain a shared identity as flood survivors), many hazards appear in counselling as well as ethical concerns. Although there are differing opinions to what constitutes a boundary violation based on theoretical perspectives, there is one guiding question you must adhere to: **Does this serve my client's therapeutic best interests?**

After a shared trauma incident, research as shown that boundary shifts do occur. The following is an outline of the various shifts you should look out for and some potential consequences.

- I. The *real relationship* is altered as clients may perceive their therapists as being vulnerable. If so, clients may start to empathize or sympathize, which can undermine the process of therapy. Clients may feel protective and withhold disturbing details or stories in an attempt to shelter their therapists.

## Section 1: Basic Knowledge

- II. *Transference and countertransference* can lead to problems as the sharing of personal stories and hardships trigger memories in the opposite person. Therapists may be targets of increased transference due to the shared trauma and this can lead to both positive and negative outcomes. Changes in transference will shift the relationship and that carries the risk of boundary violations. Therapists must be cautious in shared trauma scenarios to avoid countertransference, which is an increased risk due to familiar problems that clients inevitably present.
- III. The *working alliance* may be compromised by physical obstacles such as an uninhabitable office due to floods or from service restrictions due to increased demand and strained supply. During these times, the professional structure of therapeutic service delivery is impacted and compromises might be made. Professional boundaries are at risk of being discarded for convenience, such as agreeing to see a client at your home or meeting for lunch. Each avenue carries additional risks of serious violations like treating your client to lunch after they explain how the insurance company will not be covering the loss of their home.

The proper maintenance of professional boundaries includes, but is not limited to, the following:

- Regularly scheduled sessions, rescheduling only for emergencies;
- Sessions all occur in one professionally designated office for all clients;
- The location of therapy is private;
- Clients are billed on a regular basis;
- Clients pay on a regular basis;
- The therapist is transparent about professional beliefs and practices;
- Confidentiality is ardently maintained;
- The focus of therapy is on the client; and
- The therapist adheres to all assumed standards of practice and ethical codes.

## Section 1: Basic Knowledge

### *Ethics*

The nature of a shared trauma situation, especially immediately after the catastrophic events, is an opportunity for many ethical dilemmas to arise. Most likely, therapists will need to navigate some of the following ethical problems:

- **The ability to work** – Therapists may feel the need to continue supporting clients yet is already contending with overwhelming crises in their personal lives. Therapists may also have the need to maintain an income, which puts pressure on returning to work even if they are not mentally prepared.
- **A location to work** – If the office is unavailable, therapists may consider having clients meet at their home, or vice versa. Public locations may not offer privacy and raise the question of ethical record keeping.
- **Who to prioritize** – A therapist may have increased demand for their time among clients with various needs. Considerations may be required about extending work hours or reserving time for specific people, but such actions may lead to favouritism.
- **How to charge** – After a client loses most or all of their assets, a therapist may be faced with deciding what to charge. Many clients will be strained financially and therapists may desire to excuse their fees. In shared trauma situation, the therapist may have a strong need for the income, but clients in crisis may not be able to pay.

In deciding a course of action for any of the above situations, **all mental health workers are advised to rely on the Canadian Code of Ethics for Psychologists ethical decision making model** (Canadian Psychological Association, 2000):

- I. Identification of the individuals and groups potentially affected by the decision.
- II. Identification of ethically relevant issues and practices, including the interests, rights, and any relevant characteristics of the individuals and groups involved and of the system or circumstances in which the ethical problem arose.
- III. Consideration of how personal biases, stresses, or self-interest might influence the development of, or choice, between courses of action.

## Section 1: Basic Knowledge

- IV. Development of alternative courses of action.
- V. Analysis of likely short-term, ongoing, and long-term risks and benefits of each course of action on the individual(s)/group(s) involved or likely to be affected (e.g., client, client's family or employees, employing institution, students, research participants, colleagues, the discipline, society, self).
- VI. Choice of course of action after conscientious application of existing principles, values, and standards.
- VII. Action, with a commitment to assume responsibility for the consequences of the action.
- VIII. Evaluation of the results of the course of action.
- IX. Assumption of responsibility for consequences of the action, including correction of negative consequences, if any, or re-engaging in the decision-making process if the ethical issue is not resolved.
- X. Appropriate action, as warranted and feasible, to prevent future occurrences of the dilemma (e.g., communication and problem solving with colleagues; changes in procedures and practices)

Section 2: Strategies

**- Section 2 –  
STRATEGIES**



## Section 2: Strategies

This section provides concise and directive guidance for practitioners should they find themselves in a shared trauma situation.

Firstly, **DON'T PANIC.**

### *Disorders*

Secondly, assess for the common disorders. Screen for symptoms of:

- Post-traumatic stress disorder
- Major depressive episode
- Generalized anxiety disorder
- Sleep-disturbances

The first-line psychotherapeutic treatment for all of these disorders is **cognitive-behaviour therapy**. Additional treatments and considerations are below.

### *Cognitive-Behaviour Therapy (CBT)*

First, (a) build rapport and trust, (b) set goals with the client, then (c) plan treatment by selecting interventions. Below are some of the most commonly used techniques, but the list is not exhaustive.

- **Psychoeducation** – Introduce the client to the CBT model: Thoughts lead to emotions, which lead to actions. By targeting dysfunctional thinking, we can change feelings.
- **Thought-change record** – A self-report record of noticed automatic thoughts with columns to indicate associated emotions with scaled intensity ratings. Also included are potential thoughts they could be replaced with, followed by a scaled re-evaluation of the original thought.
- **Examining the evidence** – A document with a selected core belief that client and counsellor systematically list all the evidence for and against the reality of the belief. Emphasis on cognitive errors.
- **Socratic questioning** – Questions designed to compel the client to think abstractly or to think through ideas they have not previously considered.
- **Exposure therapy** – Guided and monitored gradual exposure (physical or visual) to distressing stimuli paired with deescalating techniques and/or talk therapy.

## Section 2: Strategies

### *Self-disclosure*

Thirdly, consider the role of **self-disclosure** in therapy. Given the complex situation of flood disaster aftermath and the threat against relationship boundaries, the question of whether or not you should self-disclose your flood experience is at the forefront. Disclosures sometimes occur unintentionally due to many factors such as living in a small community or through body-language and appearance. If used properly, they can be powerful transformative techniques for disaster recovery. Self-disclosures depend heavily on the quality of the existing therapeutic relationship (Bishop & Lane, 2001), and the details are below.

There are seven types of self-disclosures therapists can make (Knox & Hill, 2003) – in short:

- I. *Facts* – Communication about the therapist’s personal information. This type of disclosure is **OK**, as it normalizes the situation for the client.
- II. *Feelings* – Communication about the therapist’s personal emotions. This type of disclosure is **OK**, as it validates the client.
- III. *Insight* – The description of a time when the therapist had a realization or personal discovery. This type of disclosure is **OK**, as it can model post-traumatic growth.
- IV. *Strategy* – The description of actions the therapist personally took to overcome a problem. Therapists should **AVOID** this type of disclosure, as it can be interpreted as advice and/or can be exploitative.
- V. *Reassurance* – Similar to disclosing feelings, except that they communicate empathy or shared experience. Therapists should **AVOID** this type of disclosure, as it can undermine the relationship if the client begins to sympathize with the therapist and attempts to avoid causing them distress through their stories.

## Section 2: Strategies

- VI. *Challenge* – Recounts of when the therapist dealt with a similar issue the client was having, but more successfully. Therapists should **AVOID** this type of disclosure, as it is disempowering to the client and unhelpful.
- VII. *Immediacy* – A communication to the client during the session to describe thoughts or feelings the therapist has in that moment, which are relevant to the discussion. This type of disclosure is **OK**, as it builds rapport and highlights interactional processes occurring in the moment.

**NOTE:** If self-disclosure is used, either intentionally or not, and the client begins asking more follow-up questions it is important to quickly redirect back to the client. If not, a role reversal may occur which violates professional and ethical standards (Lazarus & Zur, 2002). Also, self-disclosure should not be used with clients who have very defensive beliefs about personal boundaries or who respond negatively to compliments (Geller, 2003).

### *Narrative Exposure Therapy*

Narrative exposure therapy is a short-term treatment with promising results for post-traumatic stress disorder symptoms following a natural disaster. Revising the protocol, as below, has proven effective to reduce symptoms and encourage post-traumatic growth (Zang, Hunt, & Cox, 2014). Please note that this protocol has not been extensively tested for efficacy.

- **Session schedule:** 3 or more sessions, 60-120 minutes in duration, 1-2 days apart
- **Session 1:** Introduction, pre-treatment diagnostics, psychoeducation
  - During this session you will seek informed consent and educate the client on what this therapy will look like. Administer the appropriate measures or screening instruments to identify the possible symptoms associated with common disorders described in Section 1. Discuss the brain model (e.g., neuroplasticity) and the dangers in avoidance.

## Section 2: Strategies

- **Session 2:** Begin flood narration
  - Facilitate narration beginning at birth and proceed swiftly towards the traumatic flood event, but be careful not to compel the client past important life events too forcefully.
- **Session 3:** Continue narration if needed
  - Focus on the events related to the flood and associated trauma symptoms.
- **Last session:** Create lifeline, narrate from birth to present including flood disaster, read final autobiography.
  - Depending on resources, you may wish to create a lifeline with the client (e.g., flowers and stones, different colored cards, or simply drawing on paper). Have the client narrate this lifeline once complete from birth to death. The therapist may read the final autobiography as a summary for the client.

### *Sleep Hygiene*

In addition to cognitive-behaviour techniques for reducing sleep disturbance, the following guidelines should be implemented and supported with cognitive skills and/or behavioural programs.

- **Avoid napping during the day.** Naps can disrupt a person's normal sleep pattern and shift circadian rhythms.
- **Avoid stimulants close to bedtime.** All stimulants diminish the depth and restfulness of sleep. Stimulants prevent the body from getting the rejuvenating rest it needs. The most common stimulants are caffeine and nicotine. Alcohol can have a stimulating effect during the withdrawal phase.
- **Exercise.** Exercise promotes healthy restful sleep and can assist with falling asleep. Vigorous exercise should be avoided at night, but slow exercise is OK.
- **Avoid food right before sleep.** Large meals before bedtime lead to shifts in blood sugar that can interfere with proper sleep.
- **Exposure to natural light.** Getting enough natural light is important for the brain's natural rhythms of sleeping and wakefulness.

## Section 2: Strategies

- **Establish a regular bedtime routine.** A routine will condition people to fall asleep when the cues are perceived.
- **Use the bed only for sleeping.** Do not watch TV or read books in bed, as that conditions the brain to stay awake in bed.
- **Proper bedroom environment.** A supportive and comfortable mattress, darkness, silence, and a cool temperature are ideal.

### *Post-traumatic Growth*

Therapists can promote the experience of post-traumatic growth in several ways. Often, a flood provides the foundation for growth despite the hardships, and occasionally survivors need some support to capitalize on it. The following areas of a client's life should be explored when appropriate and nurtured:

- I. *Interpersonal relationships* – Explore the supportive role that specific people have played in the client's life related to the trauma. Emphasize the support that the client has been able to give to those they care about. If appropriate, highlight the strength of the therapeutic relationship.
- II. *Positive self-regard* – Explore the resilience and strength the client expressed during and after the traumatic event. Consider the application of motivational interviewing and strength-based approaches to therapy. Explore the changes in the client's self-perception and look for areas of increased self-acceptance and/or wisdom.
- III. *Personal philosophies* – Explore and develop the client's beliefs about life, existence, and purpose. Consider integrating theories of existential therapy. Focus on the perceived value of each day and highlight areas of new or reinforced meaning in the client's life.

## **Conclusion**

This guide was intended to be a scaffold for therapists to cling to in the midst of a shared trauma scenario post-natural disaster. The complexities of the situation can be overwhelming and giving care and attention to clients can be made more difficult. Certain disorders are common after a flood and therefore can be targeted by helpers. However, the element of self-disclosure becomes a serious consideration – given the shared circumstances. Occasionally, the choice to self-disclose is not given.

The author's hope is that this guide can serve therapists by giving them clear and safe guidelines for dealing with shared trauma, disaster recovery, and the amplified role of self-disclosure after a flood. This manual is not meant to be exhaustive; rather it is a quick reference for a likely-to-be-successful holistic approach to helping clients after a flood disaster, which allows therapists to direct more of their energy and resources to their clients' increased need for support.

And most importantly, in the words of Douglas Adams: DON'T PANIC.

## **Additional Resources**

### Traumatic stress guide

<http://www.helpguide.org/articles/ptsd-trauma/traumatic-stress.htm>

### Dealing with trauma: A self-help guide

<http://store.samhsa.gov/shin/content/SMA-3717/SMA-3717.pdf>

### A discussion about shared trauma and how to cope

<http://www.tandfonline.com/doi/pdf/10.1080/10481881209348678>

### Disasters and Behavioral Health – Helping Survivors Recover from Trauma

<https://www.youtube.com/watch?v=txT3PiQPO7E>

### Alberta Flood Relief Calming Hypnosis June 2013

<https://www.youtube.com/watch?v=9p8AAvgvthY>

### First Steps to Salvage Water-logged Objects

[http://www.museums.ab.ca/media/33398/first\\_steps\\_to\\_salvage\\_water-logged\\_objects.pdf](http://www.museums.ab.ca/media/33398/first_steps_to_salvage_water-logged_objects.pdf)

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