Disaster Behavioral Health

Adapted from the *Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan Appendix D-1*

Disaster Behavioral Health Concepts

Definition of Disaster Behavioral Health

Disaster behavioral health is a departure from traditional behavioral health practice in many ways. Disaster behavioral health interventions are designed to address incident specific stress reactions, rather than ongoing or developmental behavioral health needs. Outreach and crisis counseling activities are the core of disaster behavioral health activities. Behavioral health professionals work hand in hand with paraprofessionals, volunteers, community leaders, and survivors of the disaster in ways that may differ from their formal clinical training.

Key Concepts of Disaster Behavioral Health

1. NO ONE WHO SEES A DISASTER IS UNTOUCHED BY IT.
In any given disaster, loss and trauma will directly affect many people. In addition, there are many other individuals who are emotionally impacted simply by being part of the affected community. A disaster is an awesome event. Simply seeing massive destruction and terrible sights may evoke deep feelings. Often residents of disaster stricken communities report disturbing feelings of grief, sadness anxiety and anger, even when they themselves are not directly impacted. Such strong reactions confuse them when, after all, they were spared any personal loss.
2. THERE ARE TWO TYPES OF DISASTER TRAUMA.
There are two types of disaster trauma that can occur jointly and continuously in most disasters: individual and collective. Individual trauma is defined as “a blow to the psyche that breaks through one’s defenses so suddenly and with such brutal force that one cannot react to it effectively.” Individual trauma manifests itself in the stress and grief reactions which individual survivors experience.

Collective trauma is a “blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community.” Collective trauma can sever the social ties of survivors with each other and with the locale. These may be ties that could provide important psychological support in times of stress. Disaster disrupts nearly all activities of daily living and the connections they entail. People may relocate to temporary housing away from their neighbors and other social supports such as church, clinics, childcare, or recreation programs.

Work may be disrupted or lost due to business failure, lack of transportation, loss of tools, or a worker’s inability to concentrate due to disaster stress. For children, there may be a loss of friends and school relationships due to relocation. Fatigue and irritability can increase family conflict and undermine family relationships and ties.

3. MOST PEOPLE PULL TOGETHER AND FUNCTION DURING AND AFTER A DISASTER, BUT THEIR EFFECTIVENESS IS DIMINISHED.

There are multitudes of stressors affecting disaster survivors. In the early “heroic” and “honeymoon” phases there is much energy, optimism and altruism. However, there is often a high level of activity with a low level of efficiency. As the implications and meaning of the losses become more real, grief reactions may intensify. As fatigue sets in and frustrations and disillusionment accumulate, more stress symptoms may appear. Diminished cognitive functioning (short-term memory loss, confusion, difficulty setting priorities and making decisions, etc.) may occur because of stress and fatigue. This can impair survivors’ ability to make sound decisions and take necessary steps toward recovery and reconstruction.

4. DISASTER STRESS AND GRIEF REACTIONS ARE NORMAL RESPONSES TO ABNORMAL EVENTS.

Most disaster survivors are normal persons who function reasonably well under the responsibilities and stresses of everyday life. However, with the added stress of disaster, most individuals usually show some signs of emotional and psychological strain. These reactions are normal reactions to an extraordinary and abnormal situation, and are to be expected under the circumstances. Survivors, residents of the community, and disaster workers alike may experience them. These responses are usually transitory in nature and very rarely imply a serious mental disturbance or mental illness. Contrary to myth, neither post-traumatic stress disorder nor pathological grief reactions are rampant following a disaster.

The post-traumatic stress process is a dynamic one, in which the survivor attempts to integrate traumatic event into his or her self-structure. The process is natural and adaptive. It should not be labeled pathological (“a disorder”) unless it is prolonged, blocked, exceeds a tolerable quality, or interferes with regular functioning to a significant extent.

Grief reactions are a normal part of the recovery from disaster. Not only may individuals lose loved ones, homes and treasured possessions, but hopes, dreams, and assumptions about life and its meaning may be shattered. The grief response to such

losses are common and are not pathological (warranting therapy or counseling), unless the grief is an intensification, a prolongation or an inhibition of normal grief.

Relief from stress, the ability to talk about the experience, and the passage of time usually leads to the reestablishment of equilibrium. Public information about normal reactions, education about ways to handle them and early attention to symptoms that are problematic can speed recovery and prevent long-term problems.

5. MANY EMOTIONAL REACTIONS OF DISASTER SURVIVORS STEM FROM PROBLEMS OF LIVING CAUSED BY THE DISASTER.
Because disaster disrupts so many aspects of daily life, many problems for disaster survivors are immediate and practical in nature. People may need help locating missing loved ones; finding temporary housing, clothing, and food; obtaining transportation; applying for financial assistance, unemployment insurance, building permits, income tax assistance; getting medical care, replacement of eyeglasses or medications; obtaining help with demolition, digging out and clean-up.

6. DISASTER RELIEF PROCEDURES HAVE BEEN CALLED “THE SECOND DISASTER”.
The process of obtaining temporary housing, replacing belongings, getting permits to rebuild, applying for government assistance, seeking insurance reimbursement and acquiring help from private or voluntary agencies is often fraught with rules, red tape hassles, delays and disappointment.

People often establish ties to bureaucracies to get aid they can get nowhere else. However, the organizational style of the aid-giving bureaucracies is often too impersonal for survivors in the emotion-charged aftermath of the disaster. To complicate the matter, disasters and their special circumstances often foul up the bureaucratic procedures even of organizations established to handle disaster. Families are forced to deal with organizations that seem or are impersonal or inefficient.

7. MOST PEOPLE DO NOT SEE THEMSELVES AS NEEDING BEHAVIORAL HEALTH SERVICES FOLLOWING A DISASTER, AND WILL NOT SEEK OUT SUCH SERVICES.
Many people equate “mental health services” with being “crazy.” To offer behavioral health assistance to a disaster survivor may seem to add insult to injury – “First I have lost everything and now you think I’m mentally unstable.” In addition, most disaster survivors are overwhelmed with the time-consuming activities of putting the concrete aspects of their lives back together. Counseling or support groups may seem esoteric in the face of such pragmatic pressures. Very effective behavioral health assistance can be provided while the worker is helping survivors with concrete tasks.

8. SURVIVORS MAY REJECT DISASTER ASSISTANCE OF ALL TYPES.
People may be too busy cleaning up and dealing with other concrete demands to seek out services and programs that might help them. Initially, people are relieved to be alive and well. They often underestimate the financial impact and implication of their losses,

and overestimate their available financial resources. The bottom-line impact of losses is often not evident for many months or, occasionally, for years.

The heroism, altruism, and optimism of the early phases of disaster may make it seem that "others are so much worse off than I am." For most people, there is a strong need to feel self-reliant and in control. Some people equate government relief programs with "welfare." For others, especially recent immigrants who have fled their countries of origin because of war or oppression, government is not to be trusted. Pride may be an issue for some people. They may feel ashamed that help is needed, or may not want help from "outsiders." Tact and sensitivity to these issues are important.

9. DISASTER BEHAVIORAL HEALTH ASSISTANCE IS OFTEN MORE "PRACTICAL" THAN "PSYCHOLOGICAL" IN NATURE.

Most disaster survivors are people who are temporarily disrupted by a severe stress, but can function capably under normal circumstances.
Much of the behavioral health work at first will be to give concrete types of help. Behavioral health personnel may assist survivors with problem-solving and decision-making. They can help them to identify specific concerns, set priorities, explore alternatives, seek out resources and choose a plan of action. Behavioral health staff must inform themselves about resources available to survivors, including local organizations and agencies in addition to specialized disaster resources. Behavioral health workers may help directly with some problems, such as providing information for filling out forms, helping cleanup, locating health care or child care, and finding transportation. They may also make referrals to specific resources such as assistance with loans, housing, employment, permits.

In less frequent cases, individuals may experience more serious psychological responses such as severe depression, disorientation, immobilization, or an exacerbation of prior mental illness diagnosis.

These situations will likely require referral for more intensive psychological counseling. The role of the disaster behavioral health worker is not to provide treatment for severely disturbed individuals directly, but to recognize their needs and help link them with an appropriate treatment resource.

10. DISASTER BEHAVIORAL HEALTH SERVICES MUST BE UNIQUELY TAILORED TO THE COMMUNITIES THEY SERVE.

The demographics and characteristics of the communities affected by disaster must be considered when designing a behavioral health program. Urban, suburban and rural areas have different needs, resources, traditions and values about giving and receiving help. It is essential that programs consider the ethnic and cultural groups in the community and provide services that are culturally relevant and in language of the people.

Disaster recovery services are best accepted and utilized if they are integrated into existing, trusted community agencies and resources. In addition, programs are most

effective if workers are from the community and its various ethnic and cultural groups are integrally involved in service delivery.

11. BEHAVIORAL HEALTH STAFF NEED TO SET ASIDE TRADITIONAL METHODS, AVOID THE USE OF "MENTAL HEALTH" LABELS, AND USE AN ACTIVE OUTREACH APPROACH TO INTERVENE SUCCESSFULLY IN DISASTER.

The traditional, office-based approach is of little use in disaster. Very few people will come to an office or approach a desk labeled "mental health."

Most often, the aim will be to provide human services for problems that are accompanied by emotional strain. It is essential not to use words that imply emotional problems, such as counseling, therapy, psychiatric, psychological, neurotic, or psychotic. Behavioral health staff need to use an active outreach approach. They must go out to community sites where survivors are involved in the activities of their daily lives. Such places include impacted neighborhoods, schools, disaster shelters, Disaster Application Centers, meal sites, hospitals, churches, community centers, and the like.

12. SURVIVORS RESPOND TO ACTIVE INTEREST AND CONCERN.

They will usually be eager to talk about what happened to them when approached with warmth and genuine interest. Behavioral health outreach workers should not hold back from talking with survivors out of fear of "intruding" or invading their privacy.

13. INTERVENTIONS MUST BE APPROPRIATE TO THE PHASE OF THE DISASTER.

It is important that disaster behavioral health workers recognize the different phases of disaster and the varying psychological and emotional reactions of each phase[3]. For example, it will be counterproductive to probe for feelings when shock and denial are shielding the survivor from intense emotion. Once the individual has mobilized internal and external coping resources, he or she is better able to deal with feelings about the situation. During the "heroic" and "honeymoon" phases, people are seeking and discussing the facts about the disaster, trying to piece the reality together and understand what has happened. They may be more invested in discussing their thoughts than talking about feelings. In the "disillusionment" phase, people will likely be expressing feelings of frustration and anger. It is not usually a good time to ask if they can find something "good" that has happened to them through their experience.

Most people are willing and even eager to talk about their experiences in a disaster. However, it is important to respect the times when an individual may not want to talk about how things are going. Talking with a person in crisis does not mean always talking about the crisis. People usually "titrate their dosage" when dealing with pain and sorrow, and periods of normalcy and respite are also important. Talking about ordinary events and laughing at humorous points is also healing. If in doubt, ask the person whether they are in the mood to talk.

14. SUPPORT SYSTEMS ARE CRUCIAL TO RECOVERY.

The most important support group for individuals is the family. Workers should attempt to keep the family together (in shelters and temporary housing, for example). Family members should be involved as much as possible in each other's recovery.

Disaster relocation and the intense activity involved in disaster recovery can disrupt people's interactions with their support systems. Encouraging people to make time for family and friends is important. Emphasizing the importance of "rebuilding relationships" in addition to rebuilding structures can be a helpful analogy.

For people with limited support systems, disaster support groups can be very helpful. Support groups help to counter isolation. People who have been through the same kind of situation feel that can truly understand one another. Groups help to counter the myths of uniqueness and pathology. People find reassurance that they are not "weird" in their reactions. The groups not only provide emotional support, but survivors can share concrete information and recovery tips. In addition to the catharsis of sharing experiences, they can identify with others who are recovering and feel hope for their own situation. Behavioral health staff may involve themselves in setting up self-help support groups for survivors, or may facilitate support groups.

In addition, behavioral health workers may involve themselves in community organization activities. Community organization brings community members together to deal with concrete issues of concern to them. Such issues may include social policy in disaster reconstruction, or disaster preparedness at the neighborhood level. The process can assist survivors with disaster recovery not only by helping with concrete problems, but by reestablishing feelings of control, competence, self-confidence, and effectiveness. Perhaps most important, it can help to reestablish social bonds and support networks that have been fractured by the disaster.

Disaster Typologies

As defined under the **Stafford Act**, a major disaster is any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Geography of a Disaster

A **Local Disaster** is any event real or perceived that threatens the well-being (life or property) of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.

A **Regional Disaster** is any event real or perceived that threatens the well-being of multiple communities or contiguous geographic areas of Nebraska.

A **State Disaster** is any event, real and/or perceived, which threatens the wellbeing of citizens in multiple cities, counties, regions and/or overwhelms a local jurisdiction's ability to respond, or affects a State-owned property or interest. In these situations, the Governor is likely to issue a State Disaster Declaration.

A **Federally Declared Disaster** is any event, real and/or perceived, which threatens the well-being of citizens, overwhelms the local and State ability to respond and/or recover, or the event affects federally owned property or interests. If it appears that a disaster is of a magnitude to warrant a Presidential Disaster Declaration, then steps need to be taken to quantify the extent of needed human services to justify a request to receive federal funding for a Crisis Counseling Program (CCP). There are two types of Federally Declared Disasters: a) federally declared disasters eligible for public assistance and b) federally declared disasters eligible for individual assistance.

Types of Hazards

Natural disasters are of many types and have diverse characteristics. Their onset and duration can be rapid or slow, and the intensity of disruptions caused to people, property and human need vary greatly and are, in part, a product of the degree to which people are prepared, as well as the extent and severity of the event.
Natural disasters include many events such as floods, tornados, earthquakes, forest and bush fires. Natural disasters are often familiar to the survivors, and the affected communities may have developed a lot of experience with these particular hazards. Usually, these disasters are seen as unavoidable. Although early warning systems are developed to various degrees, the impact can be extremely powerful and may cause substantial destruction, social disruption and many secondary stressors, such as loss of both home and income.

Technological disasters are due to **human failures or accidents**, and are rarely preceded by warnings. Such incidents may have a sudden onset and produce reactions of shock. While the impact is extremely powerful, the destruction is often concentrated and causes little social disintegration. These disasters may result in a sense of loss of control, for which someone or some agency may be seen as responsible. The feeling that someone is to blame may make it more difficult for survivors to cope with the situation.

Security-related disasters are caused by **violence, war, and specific acts of human malevolence** (mass shootings, bombings). Chemical, biological and radiological (or nuclear) **terrorism** adds a new dimension to such human-made disasters. The threat may be sudden, focused or unfocused. The intent of such terrorism is, of course, to evoke terror, and the uncertainty and anxiety generated may lead to panic. Physical or physiological responses may be of 'epidemic' proportions, leading to further impact, even in otherwise unaffected populations.

Many authors have argued that human-caused disasters, both technological and security-related, are phenomenologically and etiologically different from natural disasters. Human-caused disasters seem to be more traumatic to mental health[6].

Their higher **unpredictability**, **uncontrollability** and culpability may partly account for this. Generally, natural and human-caused disasters are differentiated based on distinct qualities of the stressor (e.g. its **suddenness** and **severity**), mediating factors such as **sense of control** perceived by the victims, or modifying characteristics such as effect on **social support**. Each of these characteristics may theoretically have a differential effect on psychological outcomes.[7]

Psychological Phases of a Disaster

Heroic

This phase is characterized by individuals and the community directing inordinate levels of energy into the activities of rescuing, helping, sheltering, emergency repair, and cleaning up. This increased physiological arousal and behavioral activity lasts from a few hours to a few days.

Honeymoon

Despite the recent losses incurred during the disaster, this phase is characterized generally by community and survivor optimism. Survivors witness the influx of resources, national or worldwide media attention, and visiting VIPs who reassure them their community will be restored. Survivors begin to believe that their home, community, and life as they knew it will be restored quickly and without complications. However, generally by the third week, resources begin to diminish, the media coverage lessens, VIPs are no longer visiting, and the complexity of rebuilding and restoration becomes increasingly apparent. Concurrently, the increased energy that survivors and the community initially experienced begins to diminish and fatigue sets in, setting the stage for the next phase.

Disillusionment

Fatigue, irritating experiences, and the knowledge of all that is required to restore their lives combine to produce disillusionment. Survivors discover that: significant financial benefits are in the forms of loans rather than grants, home insurance is not what they understood it to be, and how politics rather than need can shape decisions. Often complaints about betrayal, abandonment, injustice, bureaucracy and incompetence are commonplace. Symptoms related to traumatic stress intensify and hope may diminish.

Reconstruction/Recovery

The groundwork laid during the previous months begins to produce observable changes. Applications have been approved, loans accepted, and reconstruction begins to take place. The majority of individuals regain their previous level of functioning. There is significant individual variance during this phase.

Essentially, some individuals are able to regain equilibrium within 6 months, while others it may often take between 18-36 months. A majority of survivors attribute their

increased appreciation of relationships, life, and their confidence to manage difficult circumstances to the lessons learned from the disaster.

Phases of Disaster Response for Organizations
Pre-Disaster/Preparation Phase
The primary goal during this phase is to insure that the behavioral health system continuously improves the capacity to competently respond to a disaster. During the pre-disaster phase, training and planning will occur that will increase the capacity of the system to respond to the needs precipitated by a disaster.

Immediate Response Phase
The primary goal during this phase is to ensure that there is an immediate and appropriate behavioral health response to the needs created by a disaster.
During this phase crisis counseling services may be provided, often implementing the existing local capacity of the behavioral health system. If it appears that the behavioral health needs precipitated by the disaster require a response greater than the capacity of local resources, additional resources should be sought.

Long-term Response/Recovery Phase
Recovery services continue beyond the first month of the immediate phase of disaster response services, up to several years depending on the nature of the disaster. Local service providers will often be expected to address the needs of disaster survivors during the recovery phase. In the case of a Presidentially Declared Disaster, federal funding may be available for those who are eligible for individual assistance.

Terms and Acronyms

ARC (American Red Cross) - The American Red Cross is a congressionally= chartered, humanitarian organization, led by volunteers, that provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies
ASD (Acute Stress Disorder) – Acute Stress Disorder, or ASD, is a psychological diagnosis used to explain extreme reactions to stress above what is often expected as a normal response to disaster.
CDC (Centers for Disease Control)
CERT (pronounced ‘sert’; **Community Emergency Response Team)** – The Community Emergency Response Team (CERT) is collection of individuals who are trained in basic disaster response skills, such as fire safety, search and rescue, team organization, and disaster medical operations. CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help.
CISD (Critical Incident Stress Debriefing) – CISD is a technique that is specifically designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing, ideally conducted near the site of the event, allows those involved with the incident to process the event and reflect on its impact. This is a central component of Critical Incident Stress Management. **See CISM**.

CISM (Critical Incident Stress Management) – CISM is an intervention protocol, consisting of several elements, that was developed specifically for dealing with traumatic events. This protocol is a formal, highly structured process for helping those involved in a traumatic event to share their experiences, vent emotions, learn about stress reactions and symptoms and receive referrals for further help if required.
CMHS (Center for Mental Health Services) – The CMHS is a federal agency contained within the Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services. This organization is mandated to adopt a leadership role in mental health services delivery and policy development. Further, CMHS has a specific interest in Disaster Mental Health and has created a branch specifically for this focus. CMHS disaster mental health programs are conducted by the Emergency Mental Health and Traumatic Stress Services Branch of the Federal Center for Mental Health Services (CMHS). In partnership with the Federal Emergency Management Agency (FEMA), this Branch of CMHS is responsible for assessing, promoting, and enhancing the resilience of Americans in times of crisis. The Branch disseminates mental health information about disasters and traumatic events in print and on the Internet.
CCP (Crisis Counseling Assistance and Training Program) – The Crisis Counseling Training and Assistance Program is funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The purpose of the CCP is to support short term interventions with individuals and groups experiencing psychological sequelae to large scale disasters. The CCP is implemented as a supplemental assistance program available to the United States and its Territories, by the Federal Emergency Management Agency (FEMA).
CC (Crisis Counseling) – CC refers to the short term intervention that is focused upon assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting survivors in reviewing their options, promoting the use of or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors recover to their pre-disaster level of functioning
CSAT (Center for Substance Abuse Treatment) – The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was congressionally mandated to expand the availability of effective treatment and recovery services for alcohol and drug problems.
Emergency – As defined by the Stafford Act an "Emergency" means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.
DAC (Disaster Application Center)
DFO (Disaster Field Office) – usually staffed by FEMA
DHHS (Department of Health and Human Services)
DHS (Department of Homeland Security)
DMH (Disaster Mental Health)

DTAC (Disaster Technical Assistance Center)
ECC (Emergency Coordination Center)
EMS (Emergency Medical Services)
ESF (Emergency Support Function)
EOC (Emergency Operations Center) – A central location where government at any level can provide interagency coordination and executive decision-making for managing response and recovery
FEMA (Federal Emergency Management Agency) – FEMA is a federal agency affiliated with the Department of Homeland Security (DHS) that reports to the President. FEMA is also the lead federal agency for disaster/emergency management. However, FEMA cannot direct a state or its agencies.
Hazard – Any situation with the potential for causing damage to people, property or the environment.
Hazard Mitigation Plan – Hazard mitigation plan means the plan resulting from a systematic evaluation of the nature and extent of vulnerability to the effects of natural hazards present in society and includes the actions needed to minimize future vulnerability to hazards.
HAZMAT (Hazardous Materials) – This refers to substances that are flammable, corrosive, reactive or toxic chemical, infectious biological (etiological) agent, or radioactive material. A hazardous material can be either a material intended for use or a waste intended to be treated or disposed of.
HHS – See DHHS
HRSA (pronounced 'her-sa'; **Health Resources and Services Administration)** – a division of HHS
ICC (Incident Command Center)
ICS (Incident Command System) – An all-hazards, functional incident management system that establishes common standards in organization, terminology, and procedures and further provides a means (unified command) for the establishment of a common set of incident objectives and strategies during multi-agency /multi-jurisdiction operations while maintaining individual agency/jurisdiction authority, responsibility, and accountability. The ICS is a component of the National Interagency Incident Management System (NIIMS).
ICU (Information Coordination Unit)
Immediate Response – Actions taken from the time a disaster/emergency strikes or is imminent to the time which Mental Health Response Teams (MHRT's) and other mental health responders begin leaving the scene and the transition to longer-term, follow-up services begin. **Please see MHRT**
ISP (Immediate Services Program) – This is the initial phase of a Crisis Counseling Program which includes screening techniques, as well as outreach services such as public information and community networking.
Immediate Services Application – The immediate Services Application is an application for funding for Immediate Services Crisis Counseling Program; this must be submitted within 14 days of the Presidentially Declared Disaster and is eligible for individual assistance.
JIC (Joint Information Center)
JOC (Joint Operations Center)

LEDRS (Livestock Emergency Disease Response System) – Veterinarians trained and deployed by the Nebraska Department of Agriculture to investigate suspected livestock disease.

Mental Health Needs Assessment – A mental health needs assessment is an assessment conducted by the state or local mental health agencies to determine the approximate size, cost, and length of the proposed mental health program.
The assessment also must identify why supplemental grant assistance will be needed. It is the basis for the Immediate Services Application (due 14 days following the Presidentially Declared Disaster) and therefore must be initiated as soon as possible.

MHRT (Mental Health Response Team) – MHRT's are multi-disciplinary teams of mental health professionals and paraprofessionals who provide necessary interventions in the initial phases of disaster/emergency recovery.

MMRS (Metropolitan Medical Response System) – This system is funded through the U.S. Department of Homeland Security and instituted in metropolitan areas of a certain size, including Omaha and Lincoln. The focus of this system is to focus on preparation and coordination of local law enforcement, fire, HAZMAT,
EMS, hospital, public health, and other "first response" personnel plan to more effectively respond in the first 48 hours of a public crisis. **See also LMMRS,**

MOA or MOU (Memorandum of Agreement OR Memorandum of Understanding)

NCP (National Oil and Hazardous Substances Pollution Contingency Plan) – The federal government's blueprint for responding to both oil spills and hazardous substance releases. This is the result of our country's efforts to develop a national response capability and promote overall coordination among the hierarchy of responders and contingency plans.

NDMS (National Disaster Medical System) – The National Disaster Medical System (NDMS) is a section within the U.S. Department of Homeland Security, Federal Emergency Management Agency, Response Division, Operations Branch, and has the responsibility for managing and coordinating the Federal medical response to major emergencies and Federally declared disasters including: natural disasters, technological disasters, major transportation accidents, and acts of terrorism including weapons of mass destruction events.
Working in partnership with the Departments of Health and Human Services (HHS), Defense (DoD), and Veterans Affairs (VA), the NDMS Section serves as the lead Federal agency for medical response.

NDMSOSC (National Disaster Medical System Operations Support Center)

NICC (National Interagency Coordination Center)

Non-PDD (Non-Presidentially Declared Disasters) – A Non-PDD is a disaster or emergency of any magnitude, which does not receive a proclamation of Presidentially Declared Disaster.

NPSC (National Processing Service Center)

ODP (Office of Domestic Preparedness)

POA (Point of Arrival) – The designated location (typically an airport) within or near the disaster-affected area where newly arriving staff, equipment, and supplies are initially directed. Upon arrival, personnel and other resources are dispatched to either the DFO, a mobilization center, a staging area, or directly to

a disaster site.
POD (Point of Departure) – The designated location (typically an airport) outside the disaster-affected area from which response personnel and resources will deploy to the disaster area.
PDA (Preliminary Damage Assessment)
PDD (Presidentially Declared Disaster) – A PDD is any natural catastrophe (including any hurricane, tornado, storm, flood, high water, wind driven water, tidal wave, tsunami, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Federal Disaster Relief Act. The PDD grant is intended to supplement the efforts and available resources of states, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering.
PIO (Public Information Officer)
Presidentially Declared Emergency – A Presidentially Declared Emergency is any occasion or instance for which, in the determination of the President, federal assistance is needed to supplement state and local efforts and capabilities to save lives and to lessen or avert the threat of a catastrophe in any part of the United States.
PTSD (Post-Traumatic Stress Disorder) – Posttraumatic Stress Disorder, or PTSD, is a psychological disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape.
People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.
RSP (Regular Services Program) – A Regular Services Program is a continuing portion of a Crisis Counseling Program designed to provide crisis counseling, community outreach, and consultation and education services to people affected by the disaster for the purpose of relieving continued emotional problems caused by the disaster. Funding is available for a period of 9 months beyond the 60 days of an Immediate Service Program for purposes of providing disaster crisis counseling services.
Robert T. Stafford Disaster Relief and Emergency Assistance Act – Public Law 93-288, as amended (P.L. 100-707); an act intended to provide an orderly and continuing means of assistance by the federal government to state and local government in carrying out their responsibilities to alleviate the suffering and damage which results from disaster/emergencies.
SAMHSA (pronounced ‘sam-sa’; **Substance Abuse and Mental Health Services Administration)** – an independent agency of the U.S. Department of Health and Human Services (HHS) that was created to focus attention, programs, and funding on improving the lives of people with or at risk for mental and substance abuse disorders. **See also CMHS and CSAT.**
SITREP (Situation Report)

Stafford Act - See Robert T. Stafford Disaster Relief and Emergency Assistance Act
Terrorism – As defined by the FBI, terrorism is the unlawful use of force against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in the furtherance of political or social objectives." This definition includes three elements: terrorist activities are illegal and involve the use of force, the actions are intended to intimidate or coerce, and the actions are committed in support of political or social objectives.
VAL – Department of Homeland Security Voluntary Agency Liaison
VOAD (pronounced 'voh-ad'; **Voluntary Organizations Active in Disasters)** or **NVOAD (National Voluntary Organizations Active in Disasters)** – This is a nation-wide coalition that is comprised of individual member organizations that typically specialize in an aspect of disaster response. Different organizations often have different specialty areas, so that by working in concert, they are able to provide a range of services with little duplication.
WMD (Weapons of Mass Destruction)

Websites
Government Agencies
Administration on Aging: Disaster Assistance Resources
http://www.aoa.gov/eldfam/Disaster_Assistance/Disaster_Assistance.asp
Links to web-based resources for older persons, their families and caregivers
Centers for Disease Control – Emergency Preparedness and Response
www.bt.cdc.gov and http://www.bt.cdc.gov/mentalhealth/
The Center for Disease Control is a governmental organization that is charged with the task of protecting the health of the populace. This includes: agents of bioterrorism, chemical agents, radiation emergencies, mass trauma, natural disasters, outbreaks of disease (i.e. SARS, Influenza, etc.)
Federal Emergency Management Agency (FEMA)
http://www.fema.gov/
An agency in Homeland Security, whose mission is to reduce loss of life and property and protect our nation's critical infrastructure from all types of hazards through a comprehensive, risk-based, emergency management program of mitigation, preparedness, response and recovery.
FirstGov: America Responds
http://www.firstgov.gov/Topics/Usgresponse.shtml
This site lists information on preparing for emergencies and disasters, information on chemical and biological weapons, safe travel tips, and a personnel locator.
Guide to Citizen Preparedness
http://www.citizencorps.gov
Citizen Corps, a component of USA Freedom Corps, was created to help coordinate volunteer activities. It provides opportunities for people to participate in a range of measures to make their families, their homes, and their communities safer from the threats of crime, terrorism, and disasters of all kinds.
National Institute of Mental Health - Information About Coping with

Traumatic Events
http://www.nimh.nih.gov/healthinformation/traumaticmenu.cfm
The National Institute of Mental Health conducts research not only on a wide range of mental health disorders, but also on the reactions that occur in a time of crisis or terror.
Substance Abuse and Mental Health Services Administration
• **Disaster Technical Assistance Center**
http://www.mentalhealth.samhsa.gov/dtac/default.asp
Established by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Disaster Technical Assistance Center (DTAC) helps SAMHSA ensure that our Nation is prepared and able to respond rapidly when events increase the need for trauma-related mental health and substance abuse services.
• **Emergency Services**
http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/after.asp
This site provides tips for talking about disaster. Some materials are available in Spanish. Includes links to other relevant mental health information.
U.S. Census Bureau
http://www.census.gov/
This is a link to the United States Census Bureau that provides a wealth of information regarding people (i.e. income, housing, population estimates), Businesses (i.e. economic census, government, etc.), Geography (Maps, etc.) and Current Events (i.e. recent news releases, etc). This site is often extremely valuable when writing grants and proposals.
U.S. National Library of Medicine
http://www.nlm.nih.gov/medlineplus/biodefenseandbioterrorism.html
This MEDLINE Plus site provides links to information on dealing with emergencies and disasters.
U.S. Food and Drug Administration
http://www.fda.gov/oca/sthealth.htm
This site lists contact information for each State Health Agencies and links to their web sites.
General Information About Psychological Responses to Emergencies
American Psychological Association Disaster Response Network
http://www.apa.org/practice/drnindex.html
American Red Cross
http://www.redcross.org/
Dart Foundation - PTSD
Gateway to Post Traumatic Stress Disorder Information
http://www.ptsdinfo.org/
This link service is a public Service of the Dart Foundation. It is a gateway to four nonprofit sites that offer PTSD information and resources.
David Baldwin's Trauma Information Pages
http://www.trauma-pages.com/
The purpose of this private site is to provide information for clinicians and researchers in the traumatic-stress field. This site includes both clinical and research aspects of trauma responses and their resolution.

International Society of Traumatic Stress Studies
http://www.istss.org/
The International Society for Traumatic Stress Studies provides a forum for the sharing of research, clinical strategies, public policy concerns, and theoretical formulations on trauma.
National Center for Post-Traumatic Stress Disorder
http://www.ncptsd.org/
The National Center for Post-Traumatic Stress Disorder is involved in multidisciplinary activities in research, education, and training related to PTSD.
National Mental Health Association
http://www.nmha.org/reassurance/anniversary/index.cfm
The National Mental Health Association has prepared several fact sheets for adults, seniors, children, individuals with mental illness, employers, and physicians on coping with war-related stress and terrorism. Many are also available in Spanish.
National Rural Behavioral Health Center
http://www.nrbhc.org/disaster.asp
This is the National Rural Behavioral Health Center rural disaster page.
National Voluntary Organizations Active In Disaster
http://www.nvoad.org/
NVOAD coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective and less duplication in service by getting together before disasters strike..
New South Wales Disaster Mental Health
http://www.nswiop.nsw.edu.au/Resources/Disaster_Handbook.pdf
This is a link to the New South Wales Disaster mental health handbook for professionals

New York State Office of Mental Health
http://www.omh.state.ny.us/omhweb/crisis/crisiscounseling10.html
This is the New York training outline for mental health professionals & nonprofessionals.
ReliefWeb
http://www.reliefweb.int/w/rwb.nsf
ReliefWeb is an electronic clearinghouse for those needing timely information on humanitarian emergencies and natural disasters – designed specifically to help the humanitarian community improve its response to emergencies.
Sweeney Alliance
http://www.sweeneyalliance.org/
The Sweeney Alliance is a nationally recognized non-profit organization that provides help to families and professionals coping with grief and stress.
Uniformed Services University of the Health Sciences
http://www.usuhs.mil/psy/infectiousoutbreaks.html
Site provides a wide range of useful links to sites and documents related to mental health and management of bioterrorism or public health perspective including risk communication, evidence-based practices and information about biological agents.
Resources for Faith Communities
American Academy of Experts in Traumatic Stress

www.aaets.org/arts/art82.htm
Article discusses roles of funeral, memorials, and spiritual fellowship for communities affected by disaster as well as the effectiveness of pastoral counseling.

Church World Service
http://www.cwserp.org/training/
This is the Church World Service disaster information for faith communities.

International Critical Incident Stress Foundation, Inc. – Pastoral Care
www.icisf.org/articles/Acrobat%20Documents/Pastoral%20Care/Special%20Article%20Everly.pdf
This is a link to a brief article that describes approach to pastoral care in an emergency or disaster event. Also includes links to related mental health sites.

National Center for PTSD
• www.ncptsd.org/publications/cq/v5/n1/decker.html
Sponsored by the national PTSD organization, this article discusses spiritual themes that may arise in secular therapy and distinguishes therapist role from spiritual adviser role.
• www.ncptsd.org/publications/cq/v5/n1/drescher.html
Addresses spirituality as a post-trauma coping resource and discusses group approaches.
• www.ncptsd.org/topics/spirituality.html
This provides lists spirituality-related fact sheets, articles, videos and website links sponsored by the National Center for PTSD.

National Council of Churches USA
www.ncccusa.org/nmu/mce/childrenterrorism.html
Sponsored by the National Council of Churches, this site provides a short list of tips for talking to children about terrorism and also lists religious and secular resources for work with children.

Resources for Families

Casey Family Programs, National Center for Resource Family Support
http://www.hunter.cuny.edu/socwork/nrcfcpp/support-and-retention/terrorismand-trauma.html
The National Center for Resource Family Support is a one-stop source of information, technical assistance, written materials, and referrals to both families and child welfare professionals who work with them.

Center for Mental Health Services – Child and Adolescent Trauma
http://www.mentalhealth.org/child/childhealth.asp
The Center for Mental Health Services sponsors this page on general topics related to child and adolescent mental health, including the Child Traumatic
Stress Network and school violence prevention.

Center for Disease Control - National Advisory Committee on Children and Terrorism (NACCT)
http://www.bt.cdc.gov/children/
The National Advisory Committee on Children and Terrorism (NACCT) provides recommendations for the preparedness of the health care system to respond to bioterrorism as it relates to children.

Community Resilience Project – Children and adolescents

• http://www.communityresilience.com/Information/DisasterWhatTeensCanDo.htm

A short fact sheet for teens that provides suggestions for coping after a disaster based on what was learned from working with teens affected by the 1995 Oklahoma City bombing.

• http://www.communityresilience.com/Information/StressManagementforTeensbrochure.htm

Defines stress for teens, how to recognize it, ways to manage stress and three helpful stress relief activities.

Helping Children After A Disaster

http://www.aacap.org/publications/factsfam/disaster.htm

Strategies for parents who are comforting children after a disaster. It explains that children must be allowed to talk about the frightening parts of the disaster and that their experience must not be minimized.

Helping Children Cope After A Disaster

International Center to Heal Our Children

http://www.dcchildrens.com/about/abt5a_mn.asp

This site provides several online publications on the emotional responses of children to disasters.

National Child Traumatic Stress Network

http://www.nctsnet.org/

The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.

National PTA: Helping Children Cope with Tragedy

http://www.pta.org/parentinvolvement/tragedy/index.asp

This website offered information on coping strategies such as how to adjust while living in a climate of uncertainty.

Substance Abuse and Mental Health Service Administration – Tips for Parents

http://www.mentalhealth.samhsa.gov/cmhs/TraumaticEvents/tips.asp#parents

Parents will find articles to guide them in providing mental health support for their children related to the emotional impact of war.

Resources for Educators

Community Resilience Project – Information for Parents and Children

http://www.communityresilience.com/InformationForParentTeacher.htm

Provides links to fifteen other resource pages to support parents and teachers in helping children cope.

National Center for Child Traumatic Stress

http://nctsnet.org/nccts/nav.do?pid=ctr_schlThis is a brief overview of child trauma and additional websites provided by the National Center for Child Traumatic Stress about trauma risk, normal reactions, best practices and other resources.

Substance Abuse Mental Health Service Administration – Tips for Teachers

http://www.mentalhealth.samhsa.gov/cmhs/TraumaticEvents/tips.asp#teachers

Teachers will find articles at this SAMHSA site giving them tips and suggestions for responding to children of different ages. Information also describes signs and symptoms that may indicate stress or fear in a child and coping strategies for dealing with fear and anxiety.

Special Populations and Needs

After the Disaster: A Children's Mental Health Checklist

http://www.fema.gov/kids/tch_mntl.htm

A checklist to assess a child's mental health status, following a disaster or traumatic experience.

American Red Cross – Persons with Disabilities

http://www.redcross.org/services/disaster/beprepared/prep.html

This is a link that provides guidance on disaster preparedness for persons with disabilities.

National Center for PTSD – Substance Abuse

http://www.ncptsd.org/facts/disasters/fs_substance_disaster.html

This is a fact sheet prepared by the National Center for PTSD regarding substance abuse after disasters.

National Organization on Disability

- http://www.nod.org/emergency/

This is a list of links and resources to help individuals with disabilities and their families plan for emergencies or disasters.

- http://www.nod.org/content.cfm?id=1267

This link provides both text and PDF formats of the *Emergency Preparedness Initiative Guide on the Special Needs of People with Disabilities for Emergency Managers, Planners & Responders*.

Cultural Competence

Federal Emergency Management Agency – Spanish Version

http://www.fema.gov/spanish/

Agencia Federal para el manajo de emergencias.

Massey University - Australasian Journal of Disaster and Trauma Studies

http://www.massey.ac.nz/~trauma/issues/1999-2/doherty.htm

This article reviews cross-cultural counseling research including studies involving disaster victims and workers in other cultures.

Project Liberty

http://www.projectliberty.state.ny.us/Resources/PLcultural.htm

A site developed as part of Project Liberty, New York's crisis counseling program post 9/11. The page provides specific information about why cultural competence is important in disaster services, tips for crisis counselors for cross-cultural engagement and therapeutic alliances, and links to other related information.

Substance Abuse and Mental Health Services Administration (SAMSHA)

http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/default.asp

Developing Cultural Competence in Disaster Mental Health Programs: Guiding

Principles and Recommendations was developed to assist States and communities in planning, designing, and implementing culturally competent disaster mental health services for survivors of natural and human-caused disasters.

Support in the Workplace

American Psychological Association - Workplace

http://www.apa.org/pubinfo/post911workplace.html

A brief article developed by the American Psychological Association that describes effective practices for organizations to prepare their workforce for emotional aftermath of violence in the workplace.

Center for Mental Health Services – Disaster Worker Stress

http://www.mentalhealth.samhsa.gov/cmhs/TraumaticEvents/tips.asp#workers

This site sponsored by SAMHSA focuses on managing job related stress and more for emergency workers and mental health workers. It also links to a catalogue of disaster-related and other mental health information that can be downloaded or ordered free of charge.

National Mental Health Association

http://www.nmha.org/reassurance/workforce_printpage.cfm

A brief overview of how employers can support their workforce in the aftermath of a terrorist attack. It includes specific key messages for communication to employees.

What It Takes To Survive

Why some people walk away from a plane crash or thrive after a job loss, while others don't stand a chance. And what's luck got to do with it anyway?

Ben Sherwood

NEWSWEEK

From the magazine issue dated Feb 2, 2009

The knitting needle pierced her heart. Then it saved her life. Ellin Klor savors the irony, but it wasn't always so, especially when doctors cracked open her chest in the operating room to pry out the wooden needle that had punctured her breastbone and penetrated her right ventricle. Jan. 9, 2006, was her lucky day. After dinner with her family, the 58-year-old children's librarian was anxious to show the gang in her knitting group some new patterns, so she grabbed three bags stuffed with books, yarn and needles and headed to a friend's house in Palo Alto, Calif. Already late, she could tell from the other cars that some of the knitters had arrived. She hoisted her bags from the back seat. "The scourge of a librarian," she recalls, "carrying too much stuff around." Klor climbed the first of two wide steps, stubbed her foot and suddenly fell down, landing chest first on a sack filled with unfinished knitting. Klor, 5 feet 4 with soft hazel eyes and a generous, round face, had long considered herself a bit of a klutz, so her spill wasn't exactly a surprise. When she took a breath, her chest hurt, but she figured it was nothing. Inside, the knitters were already working in the living room. Klor wanted to get started, but the ache in the middle of her chest was getting worse with each breath. It wasn't an ordinary pang. She looked down at her red Façonnable sweater and lifted it up. The next image is ingrained in her memory. A jagged splinter of a wooden knitting needle, nearly four inches long, was jutting from her chest. It had clearly broken in half, piercing her clothing and lodging in the middle of her bra right between her breasts. "Oh, my God," she whispered. Her friends gaped at the needle and urgently calculated the options. First and foremost, should they try to pull it out? "No, don't touch it," Klor declared. It was pure instinct: she didn't want anyone to go near the injury until she was at the hospital. Doctors would say later this was the first decision that helped save her life. Plucking the spike would have been like pulling a plug or uncorking a bottle, and she might have bled out in the living room.

Klor and her friends faced the next critical question: should they jump in a car and race to the emergency room? "No," Klor decided. "Call 911 right now." Waiting for the paramedics was a second lifesaving choice. If the needle had moved even the slightest amount in transit to the ER, the injury to her heart might have proved fatal. So Klor carefully sat down on a sofa to wait for the ambulance. She felt alert and even noticed something very odd. She had been impaled and yet there wasn't a single drop of blood anywhere. How was this possible? The next string of images flew by like a strange TV drama. Paramedics. Stretcher. Sirens. IV. Oxygen. Emergency room. CT scan.

At the Stanford University Medical Center in Palo Alto, Klor waited anxiously for the ER doctors to tell her the extent of her problems. To distract herself, she focused on her daughter, Callie. Her thoughts also turned to her husband, Hal, a rugged research engineer who once hiked two miles on a broken ankle. Sometimes he teased her lovingly that she was "a little wimpy." What would Hal say when he heard about this?

When the ER team finally briefed her on the results of her scans, she felt the first flood of fear. Their tone was urgent. The needle had penetrated her sternum, the long flat breastbone that's supposed to protect the heart, lungs and major blood vessels from trauma. Over the years, this team had extracted every imaginable object sticking from every conceivable body part, but they told her a knitting needle was unprecedented. Paparazzi style, a young doctor snapped her photo and then took mug-shot close-ups of the offending object. Then the doctors delivered the scary news: the point of the needle had grazed her heart, nicking the right ventricle. They could see internal bleeding. They needed to operate as soon as possible.

Less than an hour after her tumble, trauma surgeons would cut her open, crack her sternum, stitch up her heart, wire her breastbone back together and sew her up. They would leave a seven-inch scar from her neck to the middle of her chest. They would save her life. And then, by chance or fate, the knitting needle would save her life all over again. In fact, Klor's real struggle for survival was just beginning.

Why do some people live and others die? Why do a few stay calm and collected under extreme pressure when others panic and unravel? How do some bounce back from adversity while others collapse and surrender?

At ABC's "Good Morning America," where I worked as executive producer for two and a half years, I watched a veritable parade of survivors appear on television. The procession of death-defiers never seemed to stop, and I always wondered: How do these people endure their trials? Were they always so strong and resilient—or did these abilities suddenly materialize? And what do they know about surviving and thriving that we don't?

It's probably safe to say you're never going to end up with a knitting needle through the heart, but it's equally indisputable that eventually you will face some kind of life-changing crisis or struggle. How would you have responded if your airplane had landed on the icy Hudson River? Or what would you do if you were suddenly fired from your job or received a dire medical diagnosis? Dr. David Spain has a blunter way of putting it. He runs the trauma and critical-care department at Stanford Medical Center and sees what happens to regular people all the time. Every day, he says, some of us get dressed, kiss our families goodbye, walk out the door and get run over by cement trucks.

After two years of research, I discovered that everyone has a crisis personality—a Survivor IQ—that they marshal in a moment of adversity: a mindset and ways of thinking about a situation. The best survivors and thrivers understand that crisis is inevitable, and they anticipate adversity. Understanding that even misfortune gets tired and needs a break, they're able to hold back, identify the right moment and then do what they need to do. Psychologists have a clunky term for this: active passiveness. It means recognizing when to stop and when to go. In a critical sense, doing something can mean doing nothing. Action can be inaction, and embracing this paradox can save your life.

It was early Saturday morning, just 12 days after surgeons had delicately removed Ellin Klor's splinter and stitched her up. Klor had been home for a week, thankful for the attention of her husband and daughter, but she awoke with excruciating chest and back pain. Writhing and struggling to breathe, she had no idea what was happening, and she rushed to the emergency room.

Doctors poked and prodded her. They listened to her heart and lungs. They whispered their greatest fear: perhaps it was a pulmonary embolism, a potentially fatal blood clot in her lungs. They ordered immediate scans along with enough morphine to erase the pain.

When the doctors returned, they shook their heads and seemed confused. The tests were all negative. Her lungs were clear and her heart was healing just fine. So they explained it away as some kind of fleeting discomfort from surgery and gave her more painkillers before sending her home.

The next day, Klor was home alone when the phone rang. A radiologist from Stanford wanted to see her right away. At the hospital, the doctors explained the urgency. On a CT scan, the radiologist had detected a mass under her armpit. It looked like an enlarged lymph node, a telltale sign of breast cancer.

A decade earlier, she had battled the disease on the other side. But this was a brand-new malignancy and not a recurrence of the old tumor, which has lower survival rates. This was like starting from square one, a brand-new battle. Klor felt so lucky that she let out a whoop when the doctor informed her that only one lymph node was implicated and the disease was contained.

The knitting needle through her heart had actually saved her life, her doctors said. If she hadn't gone to the ER—if she hadn't been screened with all those machines—the tumor probably wouldn't have been detected until it had grown and spread. Klor believes she's one of the luckiest people in the world. I didn't die from the knitting needle, she remembers thinking, So I'm not going to die from cancer.

Klor spent most of the year undergoing surgery, chemo and radiation. On every single trip to the doctor, she was accompanied by family or friends. During that time, she also managed to finish a quilt, knit shrugs, scarves and shawls, and watch her daughter grow up fast. Klor suffered plenty from the treatments, but she also discovered something she didn't know about herself. She had always struggled with a sensitive nature; at times, she had been vulnerable to depression. Physically, she wasn't very tough either. "I really have surprised myself," she says about her experience, adding, "I didn't think I had this kind of strength."

The blunt reality of survival is this: too many people perish when they shouldn't. They morph into marble instead of taking decisive action. Exploring this phenomenon is the main focus of Dr. John Leach, one of the world's leading experts on survival psychology. He has lived for more than 20 years in England's Lake District, where he teaches an advanced course in survival psychology at Lancaster University.

In November 1987, Leach was changing trains one night in London at the King's Cross Underground station, a sprawling hub that throbs with more than 30,000 passengers during rush hour. He noticed the "thickest, greasiest, most cloying smoke I've ever seen." At first, it didn't make sense. There were no flames—just acrid smoke like the kind that belches from a ship's funnel. Almost without thinking, he found his way up to ground level and hurried to the exit.

Today, more than 21 years later, most of the memories have faded, but Leach can still smell the foul smoke and hear the wail of a uniformed railway worker: "There are people dying down there." For some inexplicable reason, as the fire spread, trains kept on arriving in the station. Meanwhile, aboveground, officials unwittingly directed passengers onto escalators that carried them straight into the flames. Many commuters followed their routines despite the smoke and fire. They marched right into the disaster, almost oblivious to the crush of people trying to escape—some actually in flames. Thirty-one people perished in the King's Cross fire, and incredibly, the Underground staff never sprayed a single fire extinguisher or spilled a drop of water on the fire.

Leach has a name for this syndrome. It's called the "incredulity response." People simply don't believe what they're seeing. So they go about their business, engaging in what's known as "normalcy bias." They act as if everything is OK and underestimate the seriousness of danger. Some experts call this "analysis paralysis." People lose their ability to make decisions.

In any emergency, people divide into three categories, Leach says. First, there are the survivors like the 155 people on US Airways Flight 1549, who manage to save themselves in the worst situations. Second, there are unavoidable fatalities: people who never have a chance, like so many of the 200,000 people in Southeast Asia who were swept away by the tsunami of 2004. Third, there are victims who should have lived but perished unnecessarily.

After examining countless disasters and categorizing the ways people respond to life-threatening situations, Leach came up with what might be called the theory of 10-80-10. First, around 10 percent of us will handle a crisis in a relatively calm and rational state of mind. The top 10 percent are leaders, like a few passengers on the US Airways flight who took charge and guided others off the plane.

Leach says the vast majority of us—around 80 percent—fall into the second category. In a crisis, most will "quite simply be stunned and bewildered." We'll find that our "reasoning is significantly impaired and that thinking is difficult." We'll behave in "a reflexive, almost automatic or mechanical manner." We'll sweat. We'll feel sick, lethargic, numb. Our hearts may race. And we'll experience "perceptual narrowing" or tunnel vision. We'll barely hear people around us. It's OK—it's not necessarily fatal—and it doesn't last forever. The key is to recover quickly from brain lock or analysis paralysis, shake off the shock and figure out what to do.

The last group—the final 10 percent—is the one you definitely want to avoid in an emergency. Simply put, the third band does the wrong thing. They behave inappropriately and often counterproductively. In plain terms, they freak out and can't pull themselves together. And they often don't survive.

Prof. Richard Wiseman can tell if you're lucky or unlucky just by handing you a newspaper and asking you to count the number of photographs in its pages. Some folks finish the job in a few seconds while others need a couple of minutes to tally all the pictures. The reason for the difference isn't that some people are better counters than others. Rather, the secret lies on page two of the newspaper where Wiseman has inserted a huge message in one-inch letters:

STOP COUNTING—THERE ARE 43 PHOTOGRAPHS IN THIS NEWSPAPER.

Believe it or not, many people actually miss this enormous headline in the paper. They're too busy counting photos to notice. The giant message isn't a trick. There really are 43 pictures in the paper. Professor Wiseman has found that if you see the announcement right away, you tend to be a lucky person open to random opportunities. By contrast, if you don't spot it, you're usually an unlucky person more likely to miss out on fortuitous possibilities.

Psychologists call this "inattentional blindness"—we don't notice things when we don't pay real attention. One of the most famous studies of inattentional blindness was conducted by Daniel Simons and Christopher Chabris in the elevator lobby of the 15th floor of the Harvard psychology department. One team of players wearing white shirts and another group dressed in black tossed two orange basketballs back and forth. Subjects were asked to watch a video of this ball-passing exercise and count the number of passes made by players dressed in white. After 45 seconds in one version of the video, a woman in a full gorilla costume walks right through the scene. The hairy ape is clearly visible crossing the screen for five seconds. Remarkably, 56 percent didn't even notice the gorilla right in the middle of the action. In another video, the gorilla stops, faces the camera, pounds her chest and then marches off. The action lasts nine seconds, but again only 50 percent spotted the furry interloper.

How is it possible to miss the gorilla? And what does it tell us about survival? Professor Simons now teaches psychology at the University of Illinois at Urbana-Champaign. The main lesson and surprise of the gorilla experiment, he tells me, is how easy it is to miss something as obvious as a gorilla. "Distinctive and unusual objects do not automatically capture our attention," he says. Many other studies have demonstrated that it's difficult—if not impossible—to be aware of everything going on around you, or even right in front of you. One reason is that your eyes see in high resolution only within around two degrees of your focal point. In other words, no matter how good your eyesight, the vast majority of your surroundings are essentially out of focus. To understand, try holding your arm out in front of you and making the thumbs-up sign. The sliver of the world that you see in high resolution is only about as wide as your thumbnail. If you focus, say, on your cuticle, you'll immediately notice how the detail in your peripheral vision drops off dramatically.

The gorilla experiment is important, Simons says, because it shocks you into realizing how little of your environment you consciously perceive, especially if you're very focused on a specific task. Once you've gained this insight, Simons believes, you can start opening yourself up to all the possibilities that you may be missing. In everyday life, Simons recognizes there's no guarantee he'll notice a gorilla or cement truck coming right at him. This awareness has changed the way he interacts with the world. Especially when he's driving, he's more alert to potentially disastrous events, and he intentionally devotes attention to those dangers instead of assuming they'll immediately capture his eye.

When it comes to spotting hairy apes and red-light runners, Wiseman believes there's another important factor at work, too. Neuroticism is a personality trait of people who tend to be anxious, tense and sensitive to stress, he explains. In the gorilla experiment, people with high levels of neuroticism are very serious and intense about their assignment to count the number of basketball passes. People with low levels are calmer and less sensitive to stress. According to Wiseman, lucky people usually are more laid-back and open to life's possibilities—like giant headlines in his newspaper experiment—while unlucky people are more uptight, nervous and closed off.

If you want to test yourself, take a quick look at this domain name sometimes used by stress researchers: www.opportunityisnowhere.com.

What do you see? For many people, the web site seems discouraging: opportunity is nowhere. But others see the exact opposite: opportunity is now here. When it comes to hidden messages, lucky people perceive more of the world around them. "It is not that they expect to find certain opportunities, but rather that they notice them when they come across them," Wiseman writes in his book "The Luck Factor." This ability (or talent) "has a significant, and positive, effect on their lives."

Wiseman, who holds Britain's only professorship in the public understanding of psychology, at the University of Hertfordshire, has devoted a decade to exploring the secrets of serendipity. He discovered that some people actually do have all the luck, while others are a "magnet for ill fortune."

"Luck is not a magical ability or a gift from the gods," Wiseman writes. "Instead, it is a state of mind—a way of thinking and behaving." Above all, he insists that we have far more control over our lives—and our luck—than we realize. Going back to the Italian Renaissance philosopher Niccolò Machiavelli, great thinkers and writers have argued that 50 percent or more of what happens in life is determined entirely by chance (or Fortuna, the Roman goddess of fortune). Wiseman says no way. He believes that only 10 percent of life is purely random. The remaining 90 percent is "actually defined by the way you think." In other words, your attitude and behavior determine nine tenths of what happens in your life. Wiseman has concluded that there are four reasons why good things happen to certain people.

First, lucky people frequently happen upon chance opportunities. "Being in the right place at the right time is actually all about being in the right state of mind," Wiseman writes. As his newspaper experiment shows, lucky people are more open and receptive to unexpected possibilities. They tend to be more relaxed about life, and they operate with a heightened awareness of the world around them. Quite simply, they spot and seize upon openings that other people simply miss. They also tend to be more social and maintain what Wiseman calls a "network of luck." Most of us know around 300 people on a first-name basis. According to Wiseman, that means you're only two handshakes away from 90,000 people who could bring chance opportunities into your life.

Second, lucky people listen to their hunches and make good decisions without really knowing why. Unlucky people, by contrast, tend to make unsuccessful decisions and trust the wrong people. "My interviews suggested that lucky people's gut feelings and hunches tended to pay off time and time again," Wiseman writes. "In contrast, unlucky people often ignore their intuition and regret their decision." In survival, this kind of instinct can make all the difference.

Third, lucky people persevere in the face of failure and have an uncanny knack for making their wishes come true. They're convinced that life's most unpredictable events will "consistently work out for them." Their world is "bright and rosy," Wiseman writes, while unlucky people expect that things will always go wrong. Their world is "bleak and black." When Wiseman gives lucky and unlucky people a puzzle that is actually impossible to solve, the reactions are very telling. "More than 60 percent of unlucky people said that they thought the puzzle was impossible, compared to just 30 percent of lucky people. As in so many areas of their lives, the unlucky people gave up before they even started."

Fourth, lucky people have a special ability to turn bad luck into good fortune. Of all four defining factors involved in luck, Wiseman believes this one plays the most important role in survival. Wiseman's conclusion echoes the work of Dr. Al Siebert, one of America's foremost authorities on survival psychology. After more than 40 years investigating what he calls "the survivor personality," Siebert believes, "life's best survivors not only cope well, they often turn potential disaster into a lucky development."

So in the end, what does it take to survive life's inevitable challenges? Clearly, no single theory can encompass every situation. No common denominator applies to every person or struggle. In some cases, the cosmic coin toss determines everything. Alzheimer's patients don't pick their DNA. Trauma victims don't choose the drunk drivers careening through the streets. Still, survival isn't entirely out of your hands. In fact, you control much more of your destiny than you may imagine. Above all, your mindset makes the difference. You can take care of yourself, pay attention to your surroundings and even count the rows to the emergency exit on an airplane. You can make your own luck in the worst situations. You can pray, too, if it suits you. There are as many ways into the Survivors Club as there are personalities.

Sherwood is a journalist, author and executive director of TheSurvivorsClub.org. This article is adapted from his new book, The Survivors Club: The Secrets and Science That Could Save Your Life (Grand Central Publishing, January 2009).

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