PEER LISTENER TRAINING MANUAL

GULF OF MEXICO EDITION

Sea Grant Mississippi-Alabama

AltaPointe Health Systems

Coastal Family Health Center

Baldwin County Mental Health Center · Building Community · Since 1973

National Oceanic and Atmospheric Administration · NOAA · U.S. Department of Commerce

Acknowledgments

This workshop and its materials were originally prepared by the Prince William Sound Regional Citizens' Advisory Council (PWSRCAC) with Dr. Steven Picou of the University of South Alabama to develop a peer listener network in Alaskan communities. The Prince William Sound Regional Citizens' Advisory Council (www.pwsrcac.org/about/history.html) was formed after the *Exxon Valdez* oil spill in 1989 to provide a voice for communities affected by oil industry decisions in Prince William Sound, Gulf of Alaska, Cook Inlet, and down to the Kodiak Archipelago. The council is an independent non-profit organization whose mission is to promote environmentally safe operation of the Alyeska Pipeline Service Company's Valdez Marine Terminal and the associated oil tankers that call there.

The original version of this manual can be found as an appendix to the document titled, *Coping with Technological Disasters: A User-Friendly Guidebook,* which was published by the PWSRCAC in 2004. These training materials have been adapted for the Gulf of Mexico region with the help and support of the partners listed below. (See **Appendix A** for a complete list of contributors.)

- Alta Pointe Health Systems
- Auburn University
- Baldwin County Mental Health Center
- Coastal Family Health Center
- Mississippi-Alabama Sea Grant Consortium
- National Oceanic and Atmospheric Administration (NOAA) Gulf Coast Services Center

Suggested citation:

Picou, J.S., Prince William Sound Regional Citizens' Advisory Committee (PWSRCSC), Gulf of Mexico Peer Listener Training Manual Team. 2011. Peer Listener Training Manual: Gulf of Mexico Edition. MASGP-11-006.

Disclaimer

This workshop and its materials are designed for educational purposes only. The workshop and its materials do not render medical advice or professional services. The information provided here is not intended to be used for the purposes of diagnosing or treating a medical or psychiatric illness or as a substitute for professional care. It is not designed to replace the advice and counsel of a doctor, mental health professional or other health care provider.

Table of Contents

List of Tables

List of Figures

The Peer Listener Training Program

Introduction

In recent years, the Gulf Coast area has been affected by both natural and man-made disasters repeatedly, including Hurricane Ivan, Hurricane Katrina, Hurricane Rita, Hurricane Ike and the Deepwater Horizon Oil Spill. In experiencing these disasters, there have been a range of ecological, economic and emotional impacts on the communities of the area.

Research on rural communities and disaster effects has shown that many of the people who are affected by disasters are reluctant to use traditional mental health services, particularly when the disaster is man-made. Furthermore, traditional mental health services may not be effective at dealing with the long-term effects of disaster. However, one alternative treatment that has been found to be particularly effective is peer counseling. Peer networks have been established in other communities to help communities and individuals recover.

Peer listeners can provide a number of services to the community. Through special training in listening skills, anger management, depression and other family problems, peer listeners have a unique opportunity to assist their family and friends with ongoing concerns. A peer listener may merely serve as an available ear or may assist in problem solving or referral to more formal sources of support. Talking with someone who truly knows you and your community can be beneficial in helping an individual feel understood.

Since peer counselors are members of the community, they are more likely to be trusted and truly do have a greater understanding of the effects of the disaster. In addition, peer counselors know the people in the community who are in need, as well as the available community resources. By combining these individuals with training in crisis intervention and counseling, they are highly suited to intervene on a number of levels.

In many communities, peer listeners have served a number of functions. They may work with local church or community groups as a resource for persons in need. Or, they may work directly with mental health agencies as additional sources of support. Finally, they may be available informally to family and friends, as someone who will listen and may be able to offer some direction.

While intended to deal with the long-term effects of oil spills and other disasters, this network will remain in the community as an ongoing resource and would be in place should future disasters occur.

Photo courtesy of Melissa Schneider/Mississippi-Alabama Sea Grant Consortium

Section 1: Understanding Disasters and Mental Health

> ***Disaster: an event with a relatively sudden and identifiable onset that is caused by external or environmental factors and is associated with adverse effects on a group of individuals.***
>
> ***Disasters alter day-to-day activities of a community and threaten community survival.***

Recent Disasters in the Gulf

BP Deepwater Horizon Oil Spill (2010): An explosion on the Deepwater Horizon MC252 drilling platform occurred on April 20, 2010. The rig sank into the Gulf of Mexico, and the resulting spill lasted for three months. The full extent of the damage from the spill is unknown at this time; however, a Natural Resource Damage Assessment (NRDA) is being conducted to help determine the type and amount of restoration needed to compensate the public for harm to natural resources as a result of the spill (NOAA, 2010).

Hurricane Ike (2008): Ike's storm surge devastated the Bolivar Peninsula of Texas. Surge, winds and flooding from heavy rains caused widespread damage in other portions of southeastern Texas, western Louisiana and Arkansas. Twenty people were killed in these areas, with 34 others still missing. Property damage from Hurricane Ike is estimated at $19.3 billion (National Hurricane Center, 2010).

Hurricane Rita (2005): Rita produced considerable rainfall over large portions of Louisiana, Mississippi and eastern Texas and spawned an estimated 90 tornadoes over the southern United States.

Devastating storm surge flooding and wind damage occurred in southwestern Louisiana and extreme southeastern Texas, with some surge damage also occurring in the Florida Keys. Rita was responsible for seven deaths and caused damage

estimated at $10 billion in the United States (National Hurricane Center, 2010).

Hurricane Katrina (2005): Katrina caused catastrophic damage in southeastern Louisiana and southern Mississippi. Storm surge along the Mississippi coast caused total destruction of many structures, with the surge damage extending several miles inland. Similar damage occurred in portions of southeastern Louisiana southeast of New Orleans. The surge overtopped and breached levees in the New Orleans metropolitan area, resulting in the inundation of much of the city and its eastern suburbs. Wind damage from Katrina extended well inland into northern Mississippi and Alabama.

Katrina is responsible for approximately 1,200 reported deaths, including about 1,000 in Louisiana and 200 in Mississippi. It is the costliest United States hurricane on record, with damage estimated at $75 billion in the New Orleans area and along the Mississippi coast (National Hurricane Center, 2010).

Hurricane Ivan (2004): Ivan made landfall as a major hurricane with sustained winds of near 120 m.p.h. just west of Gulf Shores, Alabama, and later made a secondary landfall in the Central Gulf as a tropical storm.

Ivan produced more than 100 tornadoes and heavy rains across much of the southeastern United States. It is responsible for 25 deaths, and the damage estimated is nearly $14.2 billion in the U.S. (National Hurricane Center, 2010).

Long-term Effects of Disasters

A number of researchers have suggested that disasters typically produce only transitory effects, and few will develop ongoing psychological problems as a result of a single disaster; however, studies demonstrate that long-term effects are found.

Research on Long-term Effects

The effects and symptoms of a disaster typically decrease over the first several years, post-disaster; symptom persistence beyond two years is primarily associated with man-made disasters.

Decreased trust, suspiciousness and anger, sense of loss of control, relationship problems, somatic complaints and increased visits to medical and mental health facilities are examples of symptoms associated with the long-term effects of disasters.

Examples of long-term effects associated with well-known disasters are listed below. For more information about these events and a partial list of disaster research, please **see Appendix E**.

Buffalo Creek Flood (1972)

Two years after the dam collapse, 44% of survivors had probable Post Traumatic Stress Disorder (PTSD), and 28% reported PTSD 14 years after the collapse (Green, 1990).

Three Mile Island (1979)

Although there was no actual physical harm to individuals, there was a significant, long-term increase in rates of depression, anxiety, hostility and somatization.

Mount St. Helens (1980)

During the two years following the eruption, 13% of men and 27% of women highly exposed to the eruption were diagnosed with depression, anxiety disorders or PTSD (Shore, 1986).

Exxon Valdez Oil Spill (1989)

While short-term recovery focused on ecological and economic concerns, over time more diffuse effects on the community were noted with the loss of economic base. Joblessness and extended litigation led to anger, depression, alienation and a loss of trust. These emotions led to an increase in job problems, family problems and personal problems.

Table 1

A Classification of Disasters

	Technological or "Human-Caused" Disasters	Natural Disasters
Non-Toxic	• Dam collapse • Airplane crash • Explosion	• Hurricane • Tornado • Flood • Earthquake
Toxic	• Oil spill • Toxic chemical spill • Radiation leak • Toxic waste	• Radon • Gas contamination • Natural-Technological scenarios

From: Erikson, K. 1994. *A New Species of Trouble: Exploration in Disasters, Trauma and Community.* New York: W.W. Norton

Table 2

Characteristics of Different Classes of Disasters

Technological or "Human-caused" Disasters	Natural Disasters
• No warning	• May involve some warning time
• Rarely one "low point"	• Recognizable "low point" during worst part of disaster
• Potentially more difficult to define loss	• Defined loss of life and property
• Degree of victimization and harm hard to perceive	• Blame extends from God to man with most anger associated with recovery and agencies involved in recovery
• Suffering often not acknowledged	• Usually positive community response in the aftermath with community bonding in efforts to rebuild
• Long-term effects more common	• Primarily short-term psychological effects

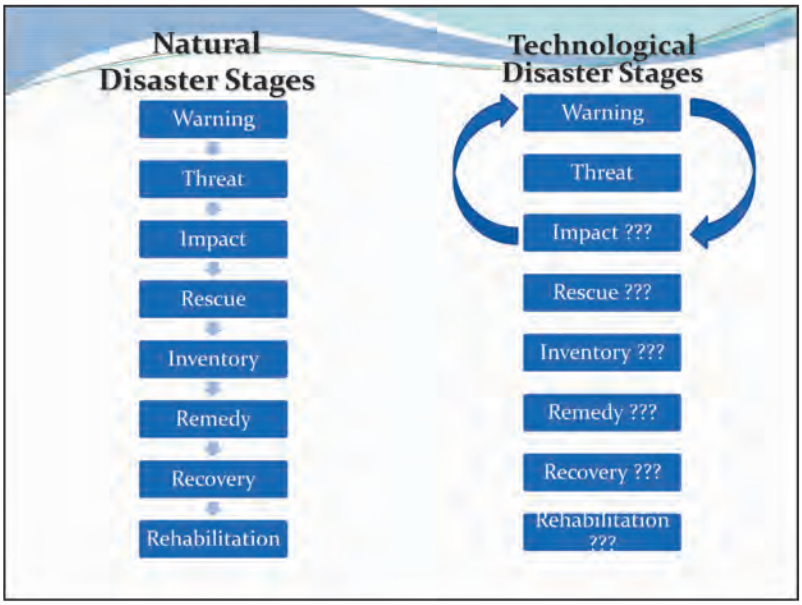
Table 3

Stages of Disaster Response

<table>
<tr><th></th><th>Pre-Disaster Preparation</th><th>Disaster Response</th><th>Post-Disaster Recovery</th></tr>
<tr><td rowspan="4">For Communities</td><td>Reduce vulnerability
Building codes
Regulations
Insurance</td><td rowspan="4">Immediate response to disaster
Evacuation
Search and rescue
Triage</td><td rowspan="2">Community agencies provide services to deal with disaster</td></tr>
<tr><td>Public education about disaster preparedness</td></tr>
<tr><td>Drills with public safety and health workers</td><td>Media coverage influences relief</td></tr>
<tr><td>Warnings of imminent disasters</td><td>Relief and aid often don’t match greatest needs</td></tr>
<tr><td rowspan="4">For Individuals</td><td rowspan="4">Tendency to underestimate likelihood of disaster, even with warnings</td><td>Majority of people cope well during actual crisis</td><td>Stress levels from increased demands and change in routines</td></tr>
<tr><td>Minimal severe psychological reactions</td><td>Most individuals have increased debt</td></tr>
<tr><td rowspan="2">People helping one another and working together</td><td>Avoiding dependency and resisting role of victim</td></tr>
<tr><td>“Hidden” stressors from temporary housing, lost leisure time, children out of school, lack of good information, need to talk</td></tr>
</table>

Figure 1

Stages of Natural and Technological Disasters



S.R. Couch, 1996. "Environmental Contamination, Community Transformation and the Centrulia Mine Fire" in J.K. Mitchell (ed.) *The Long Road to Recovery*. Tokyo: UN Press.

Figure 2

Stages of Technological Disasters

Picou, J.S., D.L. Brunsma and D. Overfelt, 2010. "Katrina as Paradigm Shift: Reflections on Disaster Research in the Twenty-First Century." In D.L. Brunsma, D. Overfelt, and J.S. Picou (eds.), *The Sociology of Katrina: Perspectives on a Modern Catastrophe (2nd ed.)*. pp. 1–21. Lanham, MD: Rowman and Littlefield Publishers, Inc.

With technological disasters, there is a repetitive nature, as new threats and warnings continue to emerge throughout different stages.

Psychological Effects of Disasters

Factors Affecting Recovery

- The individual's personal experiences in the disaster
- Level of resource loss (shelter, food, money, sense of control, trust in others and/or role identifications)
- The individual's prior level of mental functioning
- The degree to which one has to rebuild life
- Demographics
    - Lower incomes and larger families – associated with more emotional problems
    - Male vs. female – women found to have more symptoms than men
    - Age and marital status
- Type of disaster
- Disasters not associated with a single community
- Speed of onset of disaster

Short-term Psychological Effects

- There is little systematic research on immediate short-term effects due to their assumed transient nature.
- Acute stress disorder symptoms include dissociation, numbing, reduced awareness, and re-experiencing anxiety, avoidance and arousal.
- Other common short-term effects include sleep difficulties, irritability and difficulty concentrating.

Long-term Psychological Effects

- Persistence beyond two years is primarily associated with technological disasters.
- The emergence of stress-producing factors such as recreancy, litigation, health risks and uncertainty exacerbate long-term effects.
- Most social and psychological impacts, such as Post Traumatic Stress Disorder, are delayed for as long as 10 years.

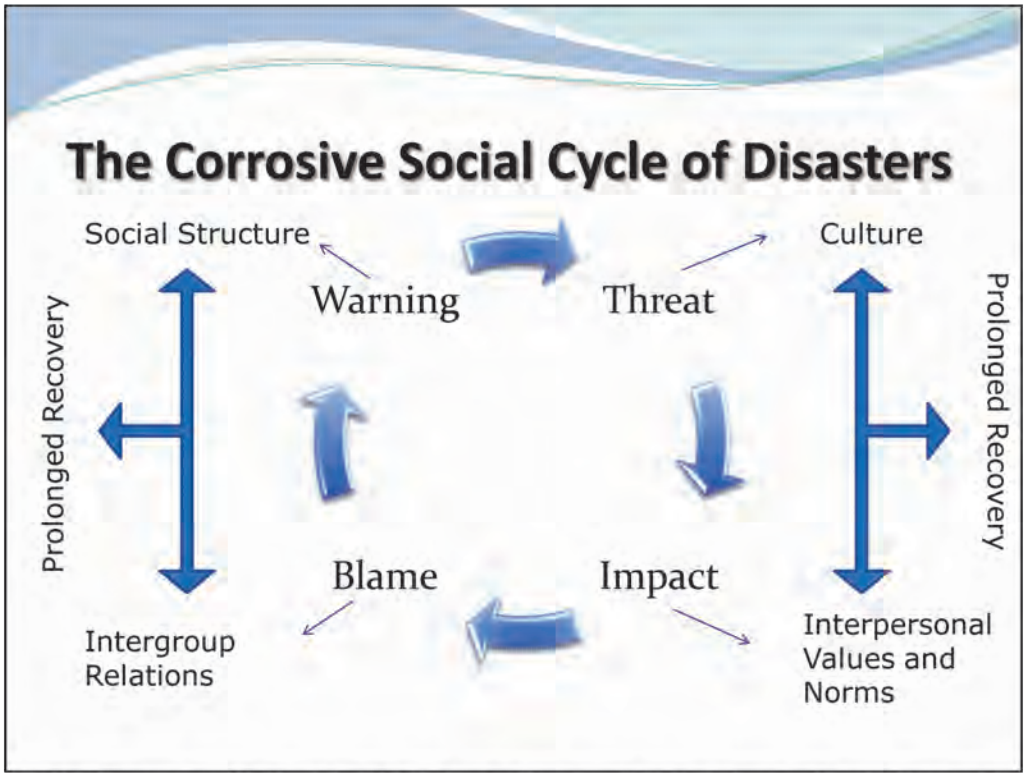
Phases of Psychological Recovery

1. Heroic Phase – Victims show strong emotions and altruistic reactions.
2. Honeymoon Phase (3–6 months) – Victims show energy and optimism in reconstructing lives based on promises and help from different agencies.
3. Disillusionment Phase (1 month to 1–2 years) – Victims deal with the frustration of failed help.
4. Reconstruction Phase – Individuals rebuild their own lives and community.

Photo courtesy of Melissa Schneider/Mississippi-Alabama Sea Grant Consortium

Figure 3

The Corrosive Social Cycle of Disasters



Picou, J.S., D.L. Brunsma, and D. Overfelt, 2010. "Katrina as Paradigm Shift: Reflections on Disaster Research in the Twenty-First Century." In D.L. Brunsma, D. Overfelt, and J.S. Picou (Eds.), *The Sociology of Katrina: Perspectives on a Modern Catastrophe (2nd ed.)*. pp. 1–21. Lanham, MD: Rowman and Littlefield Publishers, Inc.

Technological disasters can often lead to the development of corrosive communities. Corrosive communities will have dysfunctional effects (Freudenberg, 1991):

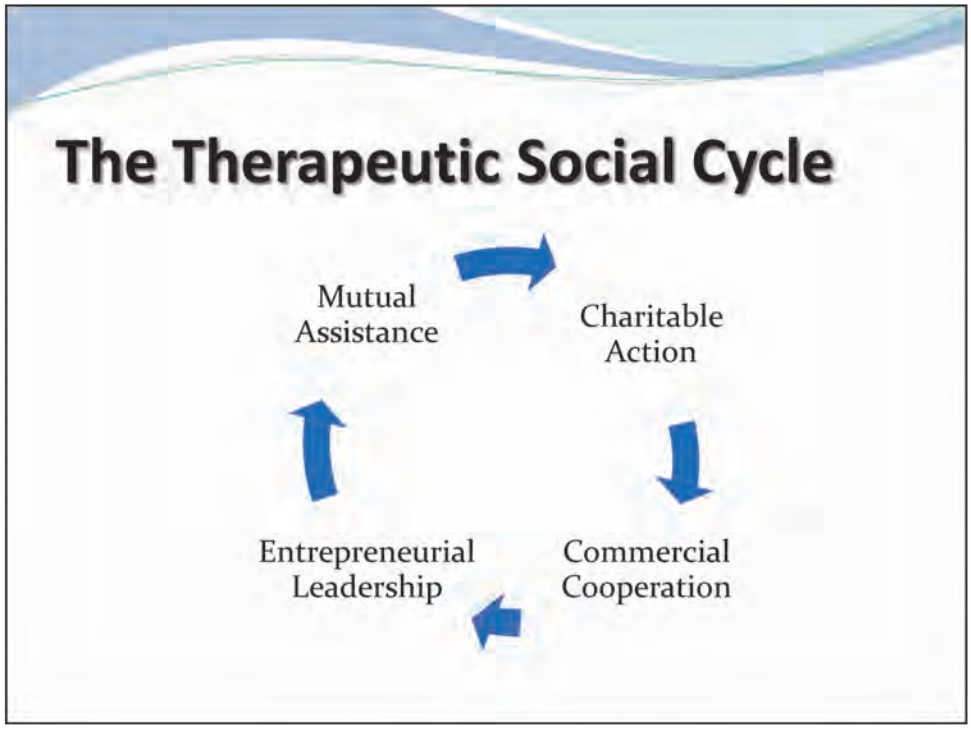
- The breakdown of social relationships,
- The fragmentation of community groups,
- Increased family conflict,
- The use of self-isolation as a primary coping strategy,
- Lack of sympathy from non-victims leading to guilt and resentment,
- Declining support capabilities of local mental health programs, and
- Patterns of continuing deterioration of community culture and organization.

The goal to overcoming or avoiding a corrosive community cycle is to work towards establishing therapeutic communities. These communities have a socially integrative effect after disasters characterized by these behaviors:

- An outpouring of altruistic feelings and behavior,
- Sympathetic behavior of non-victims, which helps compensate for the sorrow and stress many community members are experiencing, and
- Abundance of personal warmth and direct help.

Figure 4

The Therapeutic Social Cycle



Chamlee-Wright, Emily. 2006. *After the Storm: Social Capital Regrouping in the Wake of Hurricane Katrina*. Global Prosperity Initiative. Arlington, VA: Mercatus Center, George Mason University.

ACTIVITY: Identifying Disaster Impacts

Using your experiences, your observations and the experiences of others you know, choose two different types of disasters (e.g., oil spill, hurricane, death in the family, divorce, abuse, etc.) and write down the impacts these events have had on individuals and communities using the worksheet below. Then, when given instruction, share this information on the corresponding flip charts posted around the room.

Scenario 1: Impacts on Individuals	Scenario 1: Impacts on Communities
Scenario 2: Impacts on Individuals	Scenario 2: Impacts on Communities

Section 2: Building Peer Listening Skills

Formal Sources of Support

Following a disaster, formal sources of support are available to help those in the community with mental health, occupational questions and financial needs. Formal sources include individuals and agencies designed to provide support, such as churches and mental health agencies.

However, disaster victims do not always seek formal support services for various reasons. Some do not seek help as they do not perceive themselves, nor wish to be labeled, as “mentally ill.” This may be especially true within certain cultural groups. Additionally, in rural communities, formal support services are often very limited and may not be as accessible.

Following a disaster, formal support systems may also be overburdened, and professional staff may experience burn out as there is an increased need for services.

Types of Formal Support

Mental Health

- Individual therapy
- Group therapy
- Treatment programs
- Crisis intervention
- Hospitalization
- Self-help groups

Occupational/Financial

- Loan services
- Government programs
- Employment services

Informal Sources of Support

Social Support

Social support comes from a network of friends and neighbors who support us through good times and bad. A "social support system" includes people who live and work with us, people we share ideas and feelings with, people who celebrate successes with us and people who bring us up when we are feeling down.

Many people who survive a disaster experience a strong desire to separate from others. They withdraw, even from the people they are closest to, as even a casual question of how someone is doing can be difficult to answer. But ongoing avoidance of family, friends and strangers makes everything harder for everyone. Overcoming the tendency to isolate takes real strength and discipline.

Research shows that people who see being able to ask for help as a strength come through disasters stronger and healthier than those who view seeking help as a weakness. As a peer listener, you will be providing support to people who seek it, but more importantly, you can be a source of support to those who are uncomfortable asking for it.

Peer Listening

A peer-listener network can serve as an informal support service for community members, particularly for those individuals who are reluctant to use formal support networks.

As a peer listener, you will be providing support to people who are seeking support, but more importantly, you can be a source of support to those who are uncomfortable asking for it.

What's So Great About Listening?

While many people use the terms peer counselor and peer listener interchangeably, we chose the term peer listener for your role to *emphasize the importance of listening over counseling.* While certainly part of your role is to help people, in this next session we will be discussing how listening is the therapist/counselor's best tool.

The greatest temptation for most of us is to become anxious about "straightening people out, fixing them up and sending them in the right direction." Two of the cornerstone philosophies of counseling to remember are that there are no "quick fixes" and the goal is one of understanding, not changing.

In our anxiety to do something to people to make them different, we can become side-tracked into focusing on problems instead of people. The solution, then, becomes the goal of our interchange, rather than focusing on the issues and their meaning for the individual.

People who seek out peer listeners will most likely be looking for some sort of change. While the urge will be to solve their problem, listening will serve to help you understand them and to help them understand themselves.

If in listening to your peers, you can, with caring and empathy, reflect back to them their feelings and decode for them their messages, they will begin to see their situation more clearly and hear the messages from their own hearts. If you can listen in an accepting and non-judgmental manner, you provide for them a safe environment in which they can explore

*The term "**peer listening**" emphasizes the importance of listening over counseling.*

other sides of themselves that they may not have explored alone. And further, by listening and accepting, you allow them to find the strength within themselves to develop the best solution for their problem.

Communication connects people. We need to feel that whoever listens to us is nonjudgmental, empathetic and compassionate. We need to feel that the listener is focused completely on our dialogue. In this connection between speaker and listener, we need to feel trust and safety.

In any crisis situation, communicating our feelings to another is an important step to healing and coping. In fact, research has shown that people who are able to talk about their problems in a trusting situation have fewer physical and emotional symptoms. Effective communication can break barriers and open channels of hope. We all need a sense of inclusion, respect and acknowledgement—particularly in difficult times. As you learn to listen actively and speak clearly, you create important links in the helping and healing process.

Trust is created when people feel they are not being judged.

What Peer Listeners Do:

- Peer listeners can be a key component to recovery from trauma by being someone to talk to.
- Peer listeners are trained in communication skills.
- Peer listeners can serve as liaisons between disaster survivors and community resources.
- Peer listeners assure confidentiality and trust.

Peer Listeners Are:

- Genuine – real in their relationships, without façade or front
- Empathetic – feeling with another
- Caring in a non-possessive way
- Accepting without imposing conditions or judgments
- Willing to let others have the responsibility for their own growth and change
- Aware of their own limitations, their strengths and weaknesses
- Willing to learn new skills to listen better and help more effectively
- Committed to their personal growth and the well-being of their own families
- Aware of the importance of “connecting conversations” for a strong community

How to Be a Peer Listener:

- Be there for others
- Listen and watch
- Review your communication skills
- Normalize feelings and behaviors
- Take care of yourself

Nonverbal Issues

When peer listening, what is not being said can be as important as the content that is being shared. Consider how the following non-verbal factors can impact the experience of a peer-listening session.

1) Pay attention to the physical environment

- Choose a quiet, private setting.
- Be sensitive to distractions in the setting or individual distractions.

2) Respect personal boundaries

- Find the right distance for discussions so that personal space is respected.
    - 0 to 18 inches is an intimate distance.
    - Up to 4 feet is personal distance.
    - Up to 12 feet is a social distance.
    - Greater than 12 feet is public distance.

3) Be aware of body language

- Body language can serve as emotional cues.
- Consider your own body language, as well as the message being sent by the other person.
- Note that some body language can be interpreted differently.

Table 4

Non-Verbal Indicators of Emotion

Emotional Cue	Body Language
Anxiety	• Cold or clammy hands • Perspiring • Shallow breathing • Tightened muscles • Altering interpersonal distance • Side view
Anger or opposition	• Tightened jaw • Arms folded across chest • Intense eye contact • Tightened muscles • Clenched fists • Side view
Depression or helplessness	• Hunched shoulders
Lack of trust	• Side view
Boredom	• Foot jiggling, leg swinging, finger tapping, knuckle cracking • Yawning, nodding off • Eating, gum chewing, smoking • Playing with objects, playing with hair • Shifting positions • Reading, watching TV
Distracted	• Rummaging through things • Playing with clothing, hair, other objects • Scratching • Interrupting • Tapping fingers or pencil, clicking pens • Eating, drinking, smoking

Verbal Prompts

Recognizing Personality Traits

Different personalities require different types of response. Peer listeners must be able to recognize different personalities and be able to adapt communication methods to best facilitate discussions.

Table 5

Recognizing and Responding to Personality Traits

Personality Trait	How to Recognize Trait	How to Respond to an Individual with Trait
Dominant	• Assertive • Task-focused • Tell-oriented • Independent • Dominating	• Get to business • Stay on topic • Focus on results
Analytical	• Logical • Detail-oriented • Systematic • Indecisive • Detached from feelings	• Be on time • Be prepared • Be factual and logical • Follow up in writing
Expressive	• Spontaneous • Creative • Expresses emotions • Risk-oriented • Persuasive	• Praise them • Paraphrase • Focus on big picture • Socialize
Amiable	• Soft-spoken • Team-oriented • Emotional • Cooperative • Dependable	• Be genuine • Be patient • Be relaxed • Invite conversation • Offer assurance

Table 6

Levels of Communication

Level	Description
Level 1: Small Talk	• This type of communication serves the purpose of breaking the ice and/or establishing a mutual interest on an equalizing topic.
Level 2: Catharsis	• This type of communication often includes venting feelings and sharing problems or frustrations. • Someone with an intense need or who is expressing emotions needs a listener with empathy who will just listen, nod, say "I see" and not jump in with advice or criticism.
Level 3: Exchange of Information	• This type of communication provides information or "advice" to help solve a problem.
Level 4: Persuasion	• This type of communication attempts to influence someone to alter their emotions or plan of action.

Listening Skills

Following Skills

Following skills are used to break the ice, using conversational small talk. They are useful during transition phases, for paraphrasing and summarizing, and to reflect feelings. Following skills let the listener know that you understand. These are very useful in Level 1 conversation. They include:

- Door openers
- Minimal encouragers
- Infrequent questions
- Attentive silence

Example phrases include:

- “I see.”
- “Uh huh.”
- “I know what you mean.”

Reflecting and Prompting Questions

Reflecting and prompting questions rephrase the message to clarify and ensure understanding. These communication techniques encourage people to express their own feelings.

- Use open questions and avoid “yes/no” questions.
- Limit “why” questions, which may lead to defensiveness.
- Avoid loaded questions that cast judgment.
- Ask questions to explore alternatives and resources without giving advice.
- Use questions to recognize feelings.

Example phrases include:

- “You seem frustrated with that.”
- “I am hearing….”
- “How did that make you feel?”
- “What options are you considering?”
- “Can you say more?”

Common Response Styles

Evaluating/Advising Responses

These types of responses make a judgment about the relative goodness, appropriateness, effectiveness or rightness of the sender's problem or give advice and imply what the sender ought to or should do.

General rule: NOT FOR PEER LISTENERS TO USE; avoid in early stages, and always use with extreme caution.

Examples: *What I think what you should do is… You shouldn't get so upset about… You should learn to… You're not thinking straight... You're acting foolishly.*

Impact on sender:

- May feel threatened and defensive
- May feel listener assumes their judgment is superior
- Reinforces feelings of inferiority and low self-worth

Interpreting/Analyzing Responses

These responses offer psychological insights on feelings and behaviors, pointing out hidden reasons why the sender behaves as he/she does. These responses communicate the real meaning of the problem and the intent behind the sender's behavior.

Avoid using these phrases:

- *What I think you should do is…*
- *You shouldn't get so upset about…*
- *You should learn to…*
- *What's wrong with you…*

They make people feel defensive.

General rule: Better to lead them towards finding their own interpretations than to offer advice; avoid in early stages; spend more time listening.

Examples: *What's wrong with you is… Your problem is… You believe that… The reason you're saying that is… You're thinking that way because…*

Impact on sender: May feel defensive and afraid that future thoughts and feelings will be analyzed.

Supporting/Reassuring Responses

These types of responses indicate the listener's support and concern for the sender's feelings.

General rule: Do not provide false reassurance; do reassure your availability to help.

Examples: *You'll feel better. It's not so bad. Give him a chance, he'll come around. Things could be worse. Don't give up.*

Impact on sender: May be received as support or may be received as a lack of understanding or criticism of feelings

Probing/Questioning Responses

These types of responses reflect a desire for more information to better understand the problem.

General rule: Ask open questions, but avoid "why."

Use phrases like these instead:

- *Why do you think that's so?*
- *How do you feel when….?*
- *What I hear you saying is…..*

These responses let people know you are trying to understand them.

Examples: *Why do you think that's so? Why do you feel so… Why didn't you… What kind of a plan do you have to… How do you feel when…*

Impact on sender: Open questions encourage people to share more thoughts and feelings and encourage greater self-exploration.

Understanding/Paraphrasing Responses

These responses indicate an intent to understand the sender's thoughts and feelings and paraphrases what the sender has said in the receiver's own words.

General rule: USE THESE RESPONSES FREQUENTLY!

Examples: *You're so upset about… Sometimes you're so angry you feel like… When you feel ___, it is difficult to… You're really down… You feel happiest when...*

Impact on sender: Lets senders know that you have heard them and are actively trying to understand; lets senders hear their own thoughts and feelings for further clarification and understanding.

Summary Suggestions for Communication

1. Stop talking. You can't listen while you are talking.

2. Get rid of distractions. Avoid “fiddling” with things. Get away from unnecessary noise such as TV or radio. Make your surroundings as free of distractions as possible.

3. Be interested and show it. Genuine concern and a lively curiosity encourage others to speak freely. Interest also sharpens your attention and builds on itself.

4. Tune in to the other person. Try to understand his or her viewpoint, assumptions, needs and system of beliefs.

5. Concentrate on the message. Focus your attention on the person’s ideas and feelings related to the subject. Listen to how it is said. The person’s attitudes and emotional reactions may express as much or more meaning than the words that are spoken. Try to keep your personal feelings or biases about the individual from influencing what he/she is trying to say in this instance.

6. Look for the main ideas. Avoid being distracted by details. Focus on the key issue. You may have to dig to find it.

7. Watch for feelings. Often people talk to “get something off their chests.” Feelings, not facts, may be the main message.

8. Be sure to give feedback and check out what you think the speaker means and wants. Remember that you will be interpreting the person’s feelings and statements based on your experience, values, viewpoint and prejudices. Our convictions and emotions filter—even distort—what we hear.

9. Look at the other person. Let him/her know that you are listening. Maintain eye contact. Smile, nod or grunt as appropriate. This signals the speaker that you are with them.

10. Notice non-verbal language. The face, the eyes, the hands all help to convey messages. A shrug, a smile, a nervous laugh, gestures, facial expressions and body positions speak volumes. Start to read them. And be sure to check out your interpretation of these non-verbal messages just as you do the verbal ones.

11. Hold your fire. Avoid hasty judgment. Don't jump to conclusions regarding the situation or what the person wants. Hear the speaker out. Plan your response only after you are certain that you have gotten the whole message out.

12. Give the other person the benefit of the doubt. We often enter conversations with our minds already made up, at least partially, on the basis of past experience. Prejudgments can shut out new messages.

13. Get feedback. Make certain you're really listening. Ask a question. Confirm with the speaker what he or she actually said.

14. Leave your personal emotions aside. Try to keep your unrelated worries, fears or problems out of the situation. They will prevent you from empathizing and truly listening.

15. Share responsibility for communication. You, the listener, have an important role. When you don't understand, ask for clarification. Don't give up too soon or interrupt needlessly. Give the speaker time to express what he/she has to say.

16. Work at listening. Hearing is passive; our nervous system does the work. Listening is active; it takes mental effort and attention.

ACTIVITY: Peer Listening Practice

Break up into groups of three and have each group member select to be either a peer listener, a speaker or an observer.

In the time allowed, the peer listener will engage the speaker in discussing his/her personal experiences and resulting impacts from the BP Deepwater Horizon Oil Spill or any other trauma or disaster. Example scenarios (in addition to the oil spill) include a recent death, divorce, having to move, being bullied, loss of a job, abuse, etc. Feel free to use one of these examples or choose an event from your own experience.

The observer will provide feedback at the end of the given time on how the peer listener did, noting in particular the types of responses and non-verbal communication traits used during the exercise.

Next, the group will rotate roles and repeat two additional times, with feedback at the conclusion of each round.

Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Section 3: Recognizing Common Symptoms

Factors Affecting At-Risk Populations

Certain portions of any population are more at risk for developing common symptoms after a disaster, and those with more risk are likely to be impacted in different ways over time.

Before an event takes place, those with a past history of emotional problems are more at risk. During a disaster, those who are exposed to more acute trauma have increased risk. After an event, multiple triggers can contribute to or amplify a person's symptoms.

These stressors can include the disruption to the community, the economic losses, the uncertainty of ecosystem impacts and/or the loss of faith in government or other institutions who are unable to adequately help.

Within each population group, symptoms can range from panic, to depression, to fatigue, to ambiguous loss, to frustration.

These at-risk populations may vary by communication styles and personalities, culture and age.

Cultural Differences

Peer listeners must have extreme cultural sensitivity and try to learn more about the ways that cultures interact with one another, but also of the expected norms within each cultural background they will be working with. Many cultures may have a stigma with mental health, so creating a relationship of trust using more informal methods of support can be a great help.

Children

- The majority of disaster research on children demonstrates that children's reactions are influenced by their parents' reactions. Therefore, if a child's parents are severely distressed, children can be expected to have similar symptoms.
- Parents and teachers often underestimate the degree of stress experienced by children.
- Girls tend to show more psychopathology than boys.
- Symptoms are often related to the degree of morbidity and/or perceived threat.

Table 7

Symptoms in Children by Age

Preschool Age	Elementary and Adolescent Ages
• Repetitive play and drawings • Crying and irritability • Thumb-sucking • Fear	• Headaches and physical complaints • Depression • Fear • Confusion and poor concentration • Decreased school performance • Fighting • Withdrawing from peers

Elderly

While the elderly have vulnerabilities such as poor physical health, isolation, fixed income and higher rates of preexisting mental disorders, they do have possible strengths in their longer-term perspectives and potential prior experience with disasters.

- The elderly are often more resilient and less anxious post-disaster.
- They are more concerned with loss of exterior items and house damage, whereas younger individuals more concerned with loss of personal belongings.

- The elderly have less use of insurance.
- Elderly individuals have more positive ratings of emotional and physical health than younger individuals.

Common Symptoms

The following common symptoms are seen across all segments of the population following a disaster, in various degrees.

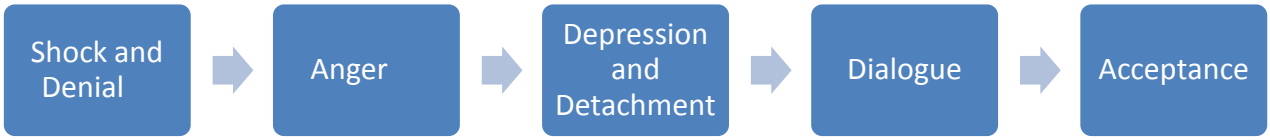
- Anger
- Depression
- Post Traumatic Stress Disorder (PTSD)
- Suicide
- Ambiguous loss and unresolved grief
- Abuse

ANGER

> ***an-ger*** *(ang'ger) n. 1. A feeling of extreme displeasure, hostility, indignation, or exasperation toward someone, or something; rage; wrath; ire. 2. Obs. Trouble; pain; affliction.*
>
> *Merriam-Webster Dictionary*

Anger is one of the most common emotional reactions following disaster and may be nearly universally experienced by those affected. Research has shown that even years after a disaster, individuals are often angry with the government or other institutions for their management of the post-disaster phase. Even in situations in which no one is to blame for a disaster, others may be held responsible for how they responded to the disaster.

Anger is also a normal part of the grief response, which is common after any significant loss.



Anger is an emotion that is neither right nor wrong, but rather an expression of your feelings. Feelings are not wrong, whereas how one expresses feelings can be destructive. Thus, anger can serve both positive and negative functions.

Table 8

Functions of Anger

Anger's Positive Functions	Anger's Negative Functions
Can be an energizer that may help us deal with conflict	Can disrupt our thoughts and actions, making it harder to think clearly and evaluate options
Can help us express tension and communicate negative feelings to others	May be a way to defend ourselves when not needed
Gives us information about people and situations	May prevent us from recognizing feelings
Can lead us to a feeling of control	Can lead us to aggression or impulsive acts

Blame and Anger

Blame and anger often go together. Blaming may stem from a need to understand and control a difficult situation by identifying someone or something as the cause of the problem.

Who Is to Blame?

- Blaming the victim: Attempt to explain and justify that there is a reason bad things are happening to others.
- Blaming ourselves: Can lead to depression.
- Blaming others
  - Can result in anger.
  - May be justified when someone is to blame for actions that hurt us, either intentionally or unintentionally.
- Displaced anger when we blame each other and/or those closest to us occurs either because there is no one to blame or the people or institutions to blame are unreachable.

Part of working through anger and blame is to let go of justified feelings, not because the source of anger has been vindicated, but because we no longer want to let anger control our lives and create greater harm.

Using Peer Listening Skills to Address Anger

- **Use active listening.**
- **Show empathy.** Listen for understanding; imagine how that person is feeling and why they feel justified in that feeling.
- **Reflection.** Communicate your understanding through non-verbal gestures, encouragers and paraphrasing.
- **Summarizing.** Reflect back to the individual your understanding of what they are saying.
- **Avoid saying anything that implies guilt or blame.**

Table 9

Responding to Anger

Phrases to Use	Phrases NOT to Use
• What I hear you really saying is... • It seems to me what you're saying is... • The real meaning behind what you're saying is... • The important points seem to be...	• I know how you feel. • You've got to get on with your life. • It was God's will. • You shouldn't think or talk about it. • Why didn't you…

Guidelines for Managing Anger

1. **Use problem solving.** Identify a problem, who is involved and how your values relate to the problem and then brainstorm and evaluate possible solutions.
2. **Calm down.** Take a deep breath; go on a short walk; give yourself time to think.
3. **Keep a positive attitude and an open mind.**
4. **Be a good listener.** Take time to hear what others are saying.
5. **Use "I" messages.** Use statements beginning with "I" instead of "you" to express needs and wants and reduce defensiveness and feelings of blame.

Changing Perceptions

Anger is a function not only of actions, but also of **reactions.** We cannot control what happens, but we can control how we choose to think about things. A simple way of remembering how to manage anger and change perceptions is to examine the ABCs of a situation:

A – antecedent – the event that triggers our emotions

B – behavior – our behavior/thoughts about the event

C – consequences – our emotions

Watch for Common Distorted Cognitions

- **Overpersonalization**
  - I am responsible for all bad things and failures, and things are done intentionally to harm me.
- **Overgeneralization**
  - If it is true in one case, it will be true and can be applied in any case that is similar.
- **Awfulizing**
  - Always thinking the worst is most likely to happen to you.

- **Black/white thinking**
  - Everything is either one extreme or another.
- **Selective Abstraction**
  - Focusing exclusively on the negative and that which validates or confirms your negative emotions.

Depression

Everyone occasionally feels sad, usually as a fleeting emotion. According to the National Institute for Mental Health, when a person has a depressive disorder, it interferes with daily life and normal functioning and causes pain for both the person with the disorder and those closest to him or her. Depression is a common but serious illness, and most who experience it need treatment to get better.

Facts about Depression

- Depressive disorders affect approximately 9.5% of the U.S. population age 18 and older in a given year.
- Major depression often follows severe, stressful events. Between 10–25% of women and 5–12% of men will experience major depression at some time in their life.
- Risk of major depression is higher if you've had previous episodes or if you have relatives with a history of depression
- Without treatment, over 50% of those with symptoms of depression will continue to have symptoms for longer than a year(Kessler, 2005)

Signs and Symptoms

- Frequent depressed mood
- Crying
- Decreased interest in things
- Change in appetite/weight (increase or decrease)
- Difficulty sleeping or sleeping too much

- Feeling slowed down
- Loss of energy, chronically tired
- Low self-esteem, self-blame
- Poor attention/concentration
- Suicidal thoughts or thoughts of death
- Hopelessness

Helping the Depressed Person

- Encourage participation in activities that once gave pleasure.
- Offer emotional support individually and/or in a support group setting.
- Engage the depressed person in conversation and listen carefully.
- Do not deny feelings expressed, accuse the depressed person of faking illness or laziness or expect him/her to "snap out of it."
- Point out realities and offer hope.
- Help the individual get appropriate diagnosis and treatment.
    - Suggest to the depressed individual that he or she see a counselor.
    - Assist the individual in making an appointment and/or going for the appointment.
    - Encourage him or her to comply and continue with treatment.
- Enlist others to help you assist the depressed person.
- Listen to your own instincts.
- Let a professional know if something the depressed person said is bothering you or seems unusual.

Treatment for Depression

- Counseling that focuses on changing thinking and increasing pleasurable activities seems to be best.
- Self-help books can be effective for mild depression.
- Medications are effective for many.
- It may take several weeks to show improvement.
- Medication benefits are best when combined with counseling.

- Hospitalization is recommended if there is severe functional impairment or high suicide risk.

Post Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder is a disabling anxiety disorder associated with traumatic events. It is caused by an intense fear of serious harm and re-experiencing the event and results in chronic distress.

PTSD Symptoms

Re-Experiencing Symptoms

- Recurrent, intrusive memories
- Nightmares
- Flashbacks
- Intense distress when reminded of the event
- Physiological reactions to reminders

Avoidance Symptoms

- Avoiding thoughts and feelings about trauma
- Avoiding reminders of the trauma
- Loss of memory for events related to the trauma
- Decreased interest in activities
- Feelings of detachment from others
- Restricted feelings
- Sense of foreshortened future, pessimistic outlook

Arousal Symptoms

- Sleep difficulties
- Irritability and anger
- Difficulty concentrating

- Hyper vigilance
- Easily startled

Peer Listener Strategies for Helping Someone with PTSD

- **Listen**
  - Do not give advice or make judgments.
  - Share the joys of success.
  - Share the pain and frustration of failure.
- **Provide emotional support**
  - Offer unconditional support of people who are in a difficult situation.
  - Do not have to be in total agreement with what they are doing.
- **Provide physical support**
  - Provide physical help with childcare, eldercare or chores.
  - Help meet demands of seasonal pressures.
- **Use affirming skills**
  - Appreciate the skills others possess and the work they do.
  - Affirmation of work skills from people who work in the same field.
  - Affirmation of personal skills from anyone who is respected and trusted.
- **Provide challenge**
  - Need challenge to avoid the risk of stagnation.
  - Need others who will question if the best approach is being taken to overcome obstacles.
  - Cut through emotions to arrive at a more rational decision.
- **Playing**
  - Need to be surrounded by people who can have fun.
  - Humor and play can help gain a new and fresh perspective on situations.

Suicide

Common Predictors of Suicide

- Depression or other mental disorder
  - Improvement in depression often precedes suicide
- Alcohol or other substance abuse
- Suicidal ideation, talk, preparation
  - 80–95% of people who attempt and complete suicide give warning signs
- Prior suicide attempts
- Lethal methods
- Isolation, living alone, loss of support
- Hopelessness, cognitive rigidity
- Being an older white male
- Modeling, history of suicide in the family
- Economic or work problems
- Marital problems, family pathology
- Stress and stressful events
- Anger, aggression, irritability
- Physical illness

Assessing Lethality of Suicide Risk

1. **Referral for treatment**

   ANYONE INDICATING SUICIDAL THOUGHTS SHOULD BE REFERRED FOR PROFESSIONAL TREATMENT.

   If there is not an immediate risk, you can give them information and then follow-up to see if they made contact. If the individual is a current risk, he or she should be referred immediately for treatment **(See page 50 for referral information)**.

Remember, in suicide situations there is **NO CONFIDENTIALITY.** Serious concerns about suicide should NOT be kept confidential!

2. **Ask the person.**

   "Sometimes when people are having problems like yours, they think about hurting themselves. Is this happening with you?"

   "That's quite a load for one person to carry. Has it made you think about hurting yourself?"

3. **Ask about plans.**

   "Tell me what you would do."

   "Do you have a plan to hurt yourself?" "What were you planning to do?"

4. **Ask about means.**

   "Do you have a gun/pills/poison (or whatever they would use)?"

5. **No Harm Agreement**

   Will they give you an unconditional agreement not to harm themselves?

   Have them say (and sign), “No matter what, I will not harm myself, by accident or on purpose.”

Ambiguous Loss and Unresolved Grief

Types of ambiguous loss

- Physical presence and psychological absence
- Physical absence and psychological presence
- Relentless stress of unknown future and not knowing what will be lost
- Confusion as to what has happened to me and why
- The loss of personal and family dreams (Boss, 1999).

Addressing Ambiguous Loss

- Never push too much for closure when a person's loss is ambiguous.
- Human connections are severed, so it is important to establish "connecting conversations" or the social construction of a "psychological family."
- Try to create a sense of relational coherence and facilitate faith in agency.
- Encourage comfort or fun with ambiguity.
- Help others to rethink power and control and reframe the notion of "special person."
- Encourage optimism and share success of experience.
- Help to reconstruct hope.
- Help shift the issue of "justice" from the courts to living a healthy and productive relational life.
- Develop personal, family and community pride by helping others.
- Encourage accepting what is unavoidable and the maintenance of spirituality.

Abuse

Alcohol and Substance Abuse

Facts about alcoholism

- Between 13–23% of people will have an alcohol problem at some time in their lifetime.
- Men are five times more likely than women to have an alcohol problem.
- Alcohol abuse is a factor in many suicides, homicides and criminal behavior and is a leading cause of physical problems resulting in hospitalization.
- Alcohol abuse is associated with increased rates of child abuse.

Warning signs of alcohol abuse

- Pattern of increased use
- Secretive drinking

- Drinking in the morning
- Tremors or shakes when not drinking
- Daily drinking
- Social or occupational impairment
- Drinking in high-risk situations

Patterns of alcohol abuse

Chronic drinking: With chronic drinking, the individual drinks large amounts every day until intoxicated, plans his or her life around drinking and social and occupational impairment is evident.

Social alcoholic: A social alcoholic is an individual who drinks primarily evenings and/or weekends, with minimal cravings, and work is not usually affected.

Binge drinking: A binge drinker has periods of abstention from alcohol followed by periodic binges. During a binge, the individual may be intoxicated for days.

Treatment for substance abuse

Alcoholics Anonymous (AA): 12- step support group that encourages complete abstinence.

Detoxification: A medically supervised withdrawal from alcohol; necessary to prevent Delirium Tremens (DTs) in heavy, chronic or binge drinkers.

Inpatient treatment: Generally follows AA model, with inclusion of relapse prevention, education and medication, if necessary. Also includes a heavy emphasis on group support.

Outpatient treatment: Programs generally are similar to inpatient care and can be as effective as inpatient if the individual has adequate support and can abstain in an unsupervised setting.

Domestic Violence

Domestic violence increases during and following disasters and can happen to any type of woman.

Table 10

Examples of Domestic Violence

Physical Violence	Examples include slapping, hitting, kicking, punching, choking, shoving, beating, throwing things, locking out, restraining and other acts designed to injure, hurt, endanger or cause physical pain.
Emotional Abuse	Examples include acts intended to shame, insult, ridicule, embarrass, demean, belittle or mentally hurt another person. Calling names such as fat, lazy or stupid; withholding money, affection or attention; forbidding someone to work, handle money or see family; or threatening to abandon or take children away are other examples of emotional abuse.
Sexual Abuse	Examples include forcing someone to have sex when they don't want to; forcing them to engage in sex acts they do not like; forcing them to have sex with others or watch others; and forcing reproductive decisions against the individual's desires.

Characteristics of the Abused Woman

While research does not identify any "typical" patterns of abused women, certain characteristics are associated with women who stay in abusive relationships for long periods. These include:

- low self-esteem
- abusive family of origin
- alcohol or drug abuse
- passivity in relationships
- dependency
- high need for affection, attention and approval
- traditional female gender role

Table 11

Signs of Abuse

Signs of Physical Abuse	**Behavioral Signs of Sexual Abuse**
• Extensive bruises and/or burns • Inconsistent explanations for injury • Withdrawal or fearfulness • Disliking or shrinking of physical contact • Acting out • Accident proneness • Exhibiting less mature behavior	• Depression, withdrawal and/or isolation from peers • Chronic discipline problems at school, increase in physical complaints, inappropriate sexual acting-out • Sudden change in attitude or personality, poor self-image • Reports of severe nightmares or exaggerated fears • Regressive behavior • Not wanting to go home or clinging to non-abusive parent

Note: There is no behavior that is totally indicative of sexual abuse, nor does the absence of signs mean abuse has not occurred. If you suspect that a child is being abused or neglected, refer to local child welfare authorities for further investigation.

Treatment for Domestic Violence

- Referral for treatment for the abuser, either individual or group
- Victim referral to a shelter, if needed, with individual counseling
- Children may also need short-term counseling

ACTIVITY: How Would You Handle This?

Work in small groups to review the list of scenarios and answer the questions below.

What if a friend is talking to you and starts to tell you about:

- Being a victim of domestic violence,
- Living with an alcoholic,
- Being a victim of child abuse,
- PTSD from serving in Afghanistan or
- Having suicidal thoughts.

What should you do?

What should you avoid doing?

Think about what you will do when you have to listen to painful experiences of another. How will you feel?

Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Section 4: Seeking and Providing Support

As a peer listener, you are offering help by providing people in need with an opportunity to help them work through their feelings, find alternatives and become ready to act.

There may be times when your role as peer listener is not enough and a referral is needed to help align your friend with further help from another agency, organization or professional.

Guide your friend in considering courses of action or resources for help. If your friend's needs fit your skills, perhaps you can help. Quite often the problem can't be solved by you or the person you are helping. In these situations, it is best to refer the person to someone else or to a group who can offer more specific assistance. This may be professional help (legal, financial, emotion or spiritual) or perhaps a support group or a supportive person.

Do not hesitate to admit that you don't know how to solve the problem. Just be willing to help the person find someone who might know. As you make the referral, remind your friend that you do care. You care enough to want the best possible help or service for that person.

Your most important gift to your peers is your listening, your acceptance and your sincere interest in them. To know you are not alone gives courage.

Referrals

When to Make a Referral

1. When you're in over your head
2. When you feel persistently uncomfortable
3. When you believe that improvement is "impossible" or the situation is "hopeless"
4. When the person you visit with says, "nothing is helping" or what you provide the person isn't helping
5. There is an obvious change in speech and/or appearance
6. The person continues to be so emotional he or she can't communicate
7. There is ongoing deterioration of life (social and physical)
8. All the person discusses are physical complaints
9. There is a sudden onset of memory confusion
10. You see signs/know of substance abuse
11. Hallucinations, delusions or severe pathology
12. Threats of self-harm or harm to others
13. Aggression and abuse (verbal and physical)
14. If the situation seems horrible or unbearable
15. **Most importantly, if you're unsure, then refer!**

Preparing for Referrals

Before you decide it's too difficult to get your friend to seek help, remember that your encouragement is important. Without your support, your friend may not seek needed professional advice.

The following are some tips that should help you as you confront a friend you're concerned about and encourage him or her to seek professional help.

1. Plan a Caring Confrontation

If possible, try to talk with your friend when there is neither rush nor distraction. Use phrases such as “I've been worried about…” or “I'm bringing this up because I really care about you.”

2. Protect Privacy

Find private space and make sure there are no interruptions while you are talking. Sensitivity to your friend's privacy communicates trust, respect and sincerity.

3. Discuss Specific Behaviors

Prior to the caring confrontation, list the behaviors you've seen your friend exhibit that concern you. Your list might include withdrawal, anger, self-destructive action, depression, lack of sleep or loss of appetite.

4. Ask What Your Friend Thinks and Feels

Being confronted with an emotionally painful problem is stressful. Initially, your friend may feel confused, frightened, embarrassed or defensive. It may be hard for him or her to respond to your concerns. Ask your friend about his or her feelings about the problem, and then be a good listener. Check for understanding, and support any attempts your friend makes to respond to the concerns you've voiced.

5. Understand Possible Barriers and Offer Alternatives

Before you approach your friend about the problems, understand what barriers may be keeping him or her from seeking professional help and be able to offer suggestions to help overcome these barriers. Being a good listener is especially helpful in identifying and understanding what barriers are keeping your friend from seeking help.

Possible barriers may include:

- Not wanting to be labeled as *mentally ill, crazy* or *psychotic* for seeking professional help.

- Not realizing that counselors work with individuals struggling with personal problems similar to their own, and not knowing what to expect.
- Feeling they can't afford the consultation fees or transportation costs.
- Having personal fears, anxiety and vulnerability about confronting a problem and accepting counseling to change the problem.

6. Locate Possible Community Resources

Before talking with your friend, you also need to know what community resources are available. Making the first contact often is the most difficult part of getting help. Offer to call a counselor for your friend or go with him to the first appointment. You can also leave the name number of a good counselor with your friend. Then your friend can call when he or she is ready

7. Continue to Be Supportive

No matter how much you prepare for your first caring confrontation, you still may not be able to convince your friend to seek professional help. Don't be discouraged!

You have taken an important first step in helping your friend. You have confronted him or her about the problem, and you have shown that someone cares. Continue to offer support and encouragement. It may take much time and effort to get your friend to seek help.

Independent Referrals

If the person or family is unwilling to make the contact or if there is some danger if action is not taken, you should take the initiative and begin the process for an independent referral.

1. Call the agency and ask to speak with the intake worker, if available.
2. Identify yourself and your relationship with the person or family.
3. State what you think the person's or family's needs are, noting whether they are depressed, suicidal, needs food or fuel, needs legal advice, etc.

4. Ask the agency what follow-up action they will take and what, if anything, you can do.

Support for Peer Listeners

A good peer listener also has to take care of himself or herself! In working with others in the community, the peer listener can develop compassion fatigue and need personal stress management. Coping skills can help manage stress and often help the peer listener personally.

Coping Skills

- Physical exercise, walking
- Good sleep
- Healthy food
- Humor and laughter
- Relaxation, body massage
- Breathing exercises, stretching, yoga
- Talk to a friend
- Vacation
- Hobbies

Conclusions

These materials have presented information on how to be a peer listener to help communities following a disaster be therapeutic communities rather than corrosive communities.

A peer listener:

- Will provide a key component to recovery from trauma by being someone to talk to, without coming up with the solutions to the problems of others,
- Is trained in communication skills,
- Can serve as a liaison between disaster survivors and community resources,
- Assures confidentiality and trust,
- Will be there for others,
- Listens and watches,
- Normalizes feelings and behaviors, and
- Takes care of him/herself.

For additional information to assist you as a peer listener following this training, visit the **Peer Listening website of the Mississippi-Alabama Sea Grant Consortium at**

http://masgc.org/peerlistening

This website will continue to provide updated information on peer listening efforts in the Gulf of Mexico, while also providing contacts for local resources and other helpful documentation to assist with your efforts.

References

Boss, Pauline. 1999. *Ambiguous Loss: Learning to Live With Unresolved Grief.* Cambridge, England: Harvard University Press.

Chamlee-Wright, Emily. 2006. *After the Storm: Social Capital Regrouping in the Wake of Hurricane Katrina*. Global Prosperity Initiative. Arlington, VA: Mercatus Center, George Mason University.

Couch, Stephen R. 1996. "Environmental Contamination, Community Transformation and the Centralia Mine Fire: Toward a Stage Model for Industrial Contamination." Pp. 60–85 in *Community Response to Industrial Disasters*, edited by James K. Mitchell. New York: United Nations University Press.

Erikson, K. T. 1994. *A New Species of Trouble*. New York: Norton.

Freudenburg, W. R. and T. R. Jones. 1991. "Attitudes and Stress in the Presence of Technological Risk: A Test of the Supreme Court Hypothesis." *Social Forces.* 69(4):1143–1168.

Green, Bonnie L.; Grace, Mary C.; Lindy, Jacob D.; Gleser, Goldine C.; et al. 1990. "Buffalo Creek Survivors in the Second Decade: Comparison with Unexposed and Nonlitigant Groups." *Journal of Applied Social Psychology*. Vol 20(13, Pt 1):1033-1050.

Kessler RC, Chiu WT, Demler O, Walters EE. 2005. "Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)." *Archives of General Psychiatry.* 62(6):617-27.

Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. 2005. "Lifetime Prevalence and Age-of-onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R)." *Archives of General Psychiatry*. 62(6):593-602.

National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling. 2011. *Deep Water: The Gulf Disaster and the Future of Offshore Drilling – Report to the President*. Retrieved February 4. 2011 from http://www.oilspillcommission.gov/final-report.

National Oceanic and Atmospheric Adminstration. 2010. *NOAA's Oil Spill Response: Assessment and Restoration* [Fact Sheet]. Retrieved from February 4, 2011, from http://www.noaa.gov/factsheets/new%20version/noaa_assessment_restoration.pdf.

National Hurricane Center. 2010. *Hurricane History*. Retrieved February 4, 2011, from http://www.nhc.noaa.gov/HAW2/english/history.shtml.

Picou, J.S. 2009. Disaster recovery as translational applied sociology: Transforming chronic community distress. *Humboldt Journal of Social Relations* 32(1):123-157.

Picou, J. S. 2009. When the Solution Becomes the Problem: The Impacts of Adversarial Litigation on Survivors of the Exxon Valdez Oil Spill. *University of St. Thomas Law Journal* (7) 1 Fall: 68-94.

Picou, J.S., D. L. Brunsma, and D. Overfelt. 2010. "Katrina as Paradigm Shift: Reflections on Disaster Research in the Twenty-First Century." In D.L. Brunsma, D. Overfelt, and J.S. Picou (Eds.), *The Sociology of Katrina: Perspectives on a Modern Catastrophe (2nd ed.)*. (pp. 1–21). Lanham, MD: Rowman and Littlefield Publishers, Inc.

Picou, J.S., C. Formichella, B.K. Marshall, and C. Arata. 2009. *Community impacts of the* Exxon Valdez *oil spill: A synthesis and elaboration of social science research.* Pp. 278-310 in Stephen R. Braund and Jack Kruse (ed.), Synthesis: Three decades of research on socioeconomic effects related to offshore petroleum development in coastal Alaska. MMS OCS Study 2009-006. Chapter 9.

Picou, J.S. and K. Hudson. 2010. "Hurricane Katrina and Mental Health: A Research Note on Mississippi Gulf Coast Residents." *Sociological Inquiry*. 80 (3). 513-524.

Prince William Sound Regional Citizens' Advisory Council. 2004. *Coping with Technological Disasters: A User-Friendly Guidebook.* Retrieved February 4, 2011, from www.pwsrcac.org.

Prince William Sound Regional Citizens' Advisory Council. 2004. *Coping with Technological Disasters: Appendices*. Retrieved February 4, 2011, from www.pwsrcsc.org.

Shore, James H.; Tatum, Ellie L.; Vollmer, William M. 1986. "Psychiatric reactions to disaster: The Mount St. Helens experience." *The American Journal of Psychiatry*. Vol 143(5):590-595.

Appendix A

Contributors to the Peer Listening Manual: Gulf of Mexico Edition

Megan Griggs
Clinical Director
Adult Outpatient Services
Alta Pointe
251-662-7304
mgriggs@altapointe.org

Carol Mann
Director of Public Relations
Alta Pointe
251-662-7317
cmann@altapointe.org

Janet Langley
Assistant Clinical Director
Adult Outpatient Services
Alta Pointe
251-639-2310
jlangley@altapointe.org

Robin Riggins
Executive Director
Baldwin County Mental Health Center
251-990-4211
rriggins@bcmhcal.com

Bethany Lohr
Licensed Clinical Psychologist
University of the South
931-273-8162
drbethanylohr@gmail.com

Ellen Abell
Extension Specialist & Assistant Professor
Auburn University
334-844-4480
abellel@auburn.edu

Susan Wingard
Baldwin County Extension Coordinator
Alabama Cooperative Extension System
251-937-7176
wingasf@aces.edu

Kay Daneault
Executive Director
Mental Health Association of Mississippi
228-385-1119
228-297-2503 (cell)
kay@msmentalhealth.org

Debby Traughber
Mental Health Coordinator
Coastal Family Health Center
228-234-5531
dtraughber@coastalfamilyhealth.org

Shawn Hicks
Outreach Coordinator
Coastal Family Health Center
228-234-5584 (cell)
shicks@coastalfamilyhealth.org

Kristy Ellenberg
Ellenberg Associates, Inc.
803-261-6656 (cell)
ktellenberg@earthlink.net

Tracie Sempier
Coastal Storms Outreach Coordinator
Mississippi-Alabama Sea Grant Consortium
228-818-8829
tracie.sempier@usm.edu

Ann Weaver
Program Training Specialist
NOAA Gulf Coast Services Center
228-688-2061
228-239-4788 (cell)
ann.weaver@noaa.gov

Marian Hanisko
Coastal Management Specialist
IMSG/NOAA Gulf Coast Services Center
228-818-8840 (M,W,F)
228-688-2837 (T,Th)
marian.hanisko@noaa.gov

LaDon Swann
Director
Mississippi-Alabama Sea Grant Consortium
Auburn University Marine Extension & Research Center
228-818-8842
251-648-5877 (cell)

J. Steven Picou
Professor of Sociology
Department of Sociology, Anthropology & Social Work
University of South Alabama
www.stevenpicou.com
251-460-6347
spicou@usouthal.edu

Jody A. Thompson
Auburn University Marine Extension & Research Center
251-438-5690
jody.thompson@auburn.edu

Melissa Schneider
Communications Coordinator
Mississippi-Alabama Sea Grant Consortium
228-818-8838
melissa.schneider@usm.edu

Tania G. Bayne
Therapist
Coastal Family Health Center
MS Gulf Coast Children's Health Project
228-234-6414 (cell)
tbayne@coastalfamilyhealth.org

Appendix B

Confidentiality

You will generally need to spend time building trust with someone before they are willing to talk with you about sensitive issues. Remember that trust is not given but earned.

Confidentiality plays a big role in earning trust, and is an important part of being a peer listener. Because confidentiality can mean different things to different people, confidentiality expectations for the peer listener are given below:

- Personal and financial information of others is **NEVER** discussed among friends, family or acquaintances.
- Personal and financial information of others is never discussed in public.
- Names of those with whom you work are shared only with your supervisor.
- Personal files or case notes of those with whom you work should be stored in a safe place not accessible to others. You and your supervisor must decide on the location of the safe place and who will have access to it.
- No participants shall be referred to other agencies without their consent.
- When you are not sure how to handle a particular situation, discuss it only with your supervisor or agency contact.
- When you need to use general information for reports, omit names of participants.

Exceptions to Confidentiality

When someone threatens physical harm to himself or herself or another individual, you need to let that person know that you **cannot** keep that information to yourself; try to get his or her permission to contact a mental health provider, minister, sheriff or other professional. If you cannot obtain consent, let the person know you must seek help on your own initiative.

Violating the confidentiality agreement between you and those people with whom you work can destroy any trust you have established or progress you've made. It

can hurt both your reputation and the reputation of your sponsoring agency. Please take these confidentiality expectations seriously!

Peer listeners need to be clear themselves about their own principles and ability to maintain confidentiality. You must inform your clients about how you will maintain confidentiality; do not assume that they will know without you telling them.

If for some reason you need to talk to another person about the client, such as a family doctor or parent, be sure to get the client's permission—in writing is best.

Prior to talking to someone about the client, discuss with them what you will say and be sure that they are comfortable with the level of information you are providing. Do not provide unnecessary information when talking or writing about a client, whether you are talking to the family doctor, the school principal, an employer, etc. Get to the point and report only what is essential and relevant.

If you have a peer or consultant to whom you turn for help and/or from whom you receive training, inform your clients that you have this support. Do not ever put yourself into situations where you cannot turn for help. Assure the client that this is normal practice for you and that you will maintain appropriate confidentiality.

Appendix C

Training Materials

Peer Listener Training Description

Introduction

The Peer Listener Training Program is designed to train local residents with basic knowledge to provide help to the disaster-impacted communities. A peer listener acts as an advisor, friend and referral agent for individuals within a community that may not desire to seek professional services, or may not know that help is available.

Community leaders should consider the following:

- Peer Listener Training should be conducted by qualified local mental health professionals when possible, or non-local mental health professionals when necessary.
- Peer listeners should be individuals within a community who are highly trusted, dependable and discreet resident volunteers. They should be representative of all cultural, ethnic and age groups within the impacted community.
- Community leaders should continually follow up with peer listeners to receive feedback and provide additional training and referral organizations when required.
- Local mental health professionals and community support organizations may be an excellent resource to supplement certain training sessions.

Participants in the training workshop will receive a copy of the Peer Listener Training Manual, which is a resource that each trained listener will be able to refer back to upon training completion. The manual contains information on:

1) Understanding Disasters and Mental Health
2) Building Peer Listening Skills
3) Recognizing Common Symptoms
4) Seeking and Providing Support

The training and the manual are designed not only for volunteers, but also to provide support and assistance to peer listeners themselves, who are also part of the impacted community.

Peer Listening Training Workshop Agenda

Welcome, Overview and Introductions
Provide an introduction of workshop, its objectives and the participants.

Section 1: Understanding Disasters and Mental Health
Participants will be able to distinguish the impacts of natural and technological (human-caused) disasters on communities and individuals.

Break

Section 2: Building Peer Listening Skills
Participants will learn about and practice effective peer listening and communication skills.

Section 3: Recognizing Common Symptoms
Participants will learn about common symptoms and concerns, such as anger, depression, post traumatic stress disorder, suicide, grief and abuse, how to recognize such concerns and how to use peer-listening skills to react to them.

Section 4: Seeking and Providing Support
Participants will learn about when, where and how to make referrals and will discuss how peer listeners take care of themselves.

Conclusions & Evaluations

Adjourn

For additional materials and information, visit the Peer Listening Website:

http://masgc.org/peerlistening

Peer Listening Process Agenda

4-Hour Session

Time	Objective	Supplies/Notes

00:00—00:20	**Welcome, Overview and Introductions**
	• Welcome
	• Introduction of workshop: purpose, background, partners, objectives
	• Logistics: Facilities, breaks, materials
	  ○ Add note that in practicing applications of the materials participants will be asked to share their experiences and perceptions of impacts in their communities. May want to add a ground rule of confidentiality to make everyone more comfortable sharing in this way.
	• Introduction of trainers
	• Introduction of participants
	  ○ Briefly go around the room for introductions by name, organization/community
		PowerPoint, laptop, projector
		Sign in sheet
		Name tents/badges
		Manuals

00:20—1:30	**Understanding Disasters and Mental Health**
	Participants will be able to distinguish the impacts of natural and technological (human- caused) disasters on communities and individuals
	
	• Define disasters and give case studies from disasters historically (15)
	• Distinguish natural, manmade/technological, and/or na-tech disasters and human responses to each (15)
	• Individual and small group discussion of responses seen in communities and individuals from Katrina to Deep Horizon
	  ○ Set up 4 flip charts around the room, each with a different title at the top: Katrina—impacts seen on individuals; Katrina—impacts seen in communities; BP—impacts seen on individuals; BP—impacts seen on communities
	  ○ Have worksheet in manual dividing page into 4 quadrants with same titles as flip chart stations. Give time to reflect and individually make notes for all 4 questions on worksheet (5)
	  ○ Count off participants into 4 groups and send each group to a different flip chart. In
		Flip charts, labeled as noted and markers
		Worksheet in manual
		
		Activity will help build local application into the training and build on experiences of those in the room. Can also be used as a reference to link back to during later portions of the training where common

	small groups, write answers on flip charts, without repeats, and rotate through all 4 stations (3 mins x 4 stations, plus process time =15 minutes) ○ Discuss outcomes from different stations—similarities/differences/how does it compare to other analysis of natural vs. tech disasters(20)	symptoms are discussed—show issues that may need to be more highlighted than others. Also gets participants comfortable sharing with each other.
1:30—1:45	**Break**	
1:45—2:45	**Building Peer Listening Skills** Participants will learn about and practice effective peer listening and communication skills. • Review the importance of peer listening and its effectiveness. (5) • Present information on communication and listening skills with demonstrations of good and bad techniques (15) • Active Listening Activity: Divide participants into groups with 3 members each (can have some with 4). Explain that the exercise will be repeated 3 times so that each person can take on different roles: listener, talker and the observer. To practice peer listening, they will first practice with each other. Ask participants to draw on their own experiences and be comfortable sharing information (address need for confidentiality for this exercise). For each round, 6 minutes to discuss their own experiences or experiences of others they know impacted by Katrina and/or BP Oil Spill (or to discuss a difficult time in his/her life). Listeners will be asked to listen and use skills just discussed. Observers can use worksheet in manual to track how listener is doing and provide feedback at end of each session (3 x 6 minutes, plus, 3 x 2 minutes of feedback, plus set-up explanation time = 25 • Group discussion on what some listeners did well, and what was difficult about being in the role of the listener (15)	Break could be moved until after presentation of materials in this section and before active listening activity Worksheet for observer role
2:45—3:35	**Recognizing Common Symptoms** Participants will learn about common symptoms and concerns, (such as anger, depression, post traumatic stress disorder, suicide, grief and abuse), how to recognize to such concerns and how to use peer-listening skills to react to them.	Worksheets with scenarios

	• Presentation of common concerns, with possible emphasis on areas noted more prevalently in earlier activities and discussions (30 minutes) • ACTIVITY: What would you say or do? Prepare worksheet for manual of 3-4 different situations/mock conversations, and ask participants to work in small groups writing suggested responses (10) • Class discussion of scenarios in worksheet (10)	
3:35—3:50	**Seeking and Providing Support** Participants will learn about when, where and how to make referrals. • Presentation of materials	Probably could use more time here, but done as lecture only
3:50—4:00	**Conclusions & Evaluations** • Reiterate objectives for the day and how these skills can help build "Therapeutic Communities" following disasters. • Activity: ○ Crumpled Paper Feedback: Ask participants to write down one way you will use materials and information from this training on slip of paper. Have them crumple paper into a ball and throw them around the room. Ask each participant to read at least 3 answers and then throw all to center of the room. • Participants fill out course evaluations	From timing standpoint this activity could be optional, but make sure question is included on formal evaluation to have participants consider application of skills learned.
4:00	**Adjourn**	

Peer Listening Process Agenda

Two 2.5-Hour Sessions

Session/Time	Objective	Supplies/Notes

Session 1
00:00—00:20
	Welcome, Overview and Introductions
	• Welcome
	• Introduction of workshop: purpose, background, partners, objectives
	• Logistics: Facilities, materials, relationship of part 1 & part 2 of materials
	  ○ Add note that in practicing applications of the materials participants will be asked to share their experiences and perceptions of impacts in their communities. May want to add a ground rule of confidentiality to make everyone more comfortable sharing in this way.
	• Introduction of trainers
	• Introduction of participants
	  ○ Briefly go around the room for introductions by name, organization/community
		PowerPoint, laptop, projector
		Sign in sheet
		Name tents/badges
		Manuals

Session 1
00:20—1:30
	Understanding Disasters and Mental Health
	Participants will be able to distinguish the impacts of natural and technological (human- caused) disasters on communities and individuals
	
	• Define disasters and give case studies from disasters historically (15)
	• Distinguish natural, manmade/technological, and/or na-tech disasters and human responses to each (15)
	• Individual and small group discussion of responses seen in communities and individuals from Katrina to Deep Horizon
	  ○ Set up 4 flip charts around the room, each with a different title at the top: Katrina—impacts seen on individuals; Katrina—impacts seen in communities; BP—impacts seen on individuals; BP—impacts seen on communities
	  ○ Have worksheet in manual dividing page into 4 quadrants with same titles as flip chart stations. Give time to reflect and individually make notes for all 4 questions on worksheet (5)
	  ○ Count off participants into 4 groups and
		Flip charts, labeled as noted and markers
		
		Activity will help build local application into the training and build on experiences of those in the room. Can also be used as a reference to link back to during later portions of the training where common symptoms are discussed—show

	send each group to a different flip chart. In small groups, write answers on flip charts, without repeats, and rotate through all 4 stations (3 mins x 4 stations, plus process time =15 minutes) ○ Discuss outcomes from different stations—similarities/differences/how does it compare to other analysis of natural vs. tech disasters(20)	issues that may need to be more highlighted than others. Also gets participants comfortable sharing with each other.
Session 1 1:30—2:22	**Building Peer Listening Skills** Participants will learn about and practice effective peer listening and communication skills. • Review the importance of peer listening and its effectiveness. (5) • Present information on communication and listening skills with demonstrations of good and bad techniques (15) • Active Listening Activity: Divide participants into groups with 3 members each (can have some with 4). Explain that the exercise will be repeated 3 times so that each person can take on different roles: listener, talker and the observer. To practice peer listening, they will first practice with each other. Ask participants to draw on their own experiences and be comfortable sharing information (address need for confidentiality for this exercise). For each round, 5 minutes to discuss their own experiences or experiences of others they know impacted by Katrina and/or BP Oil Spill (or to discuss a difficult time in his/her life). Listeners will be asked to listen and use skills just discussed. Observers can use worksheet in manual to track how listener is doing and provide feedback at end of each session (3 x 5 minutes, plus, 3 x 2 minutes of feedback, plus set-up explanation time = 22 • Group discussion on what some listeners did well, and what was difficult about being in the role of the listener (10)	
Session 1 2:22—2:30	**Next Steps & Conclusions** • Relate how tonight's information will relate to and be built upon by part 2 session, with reminders of when that session will be held, how to sign up. • Participants fill out evaluation.	
Session 2 0:00—00:25	**Welcome, Introductions, Review of Session 1 and Overview of Tonight** • Welcome	

	• Introduction of workshop: purpose, background, partners, objectives • Logistics: Facilities, materials, relationship of part 1 & part 2 of materials • Introduction of trainers • Introduction of participants Briefly go around the room for introductions by name, organization/community. Ask them to share any way they have used any skills or information from session 1 since prior session.	
Session 2 00:25—00:50	**Peer Listening Skills Review Exercise** Participants will practice active listening and communication skills. *Participants work in pairs in answering question of biggest change seen in community since BP/Katrina OR what personally causes stress in your life. Repeat so that role of listener and role of speaker are rotated. Give opportunity for quick feedback after each round. (5 mins x 2 + 1 min feedback x 2) Large group discussion of listening techniques that worked well (10)	
Session 2 00:50—01:50	**Recognizing Common Symptoms** Participants will learn about common symptoms and concerns, (such as anger, depression, post traumatic stress disorder, suicide, grief and abuse), how to recognize to such concerns and how to use peer-listening skills to react to them. • Presentation of common concerns, with possible emphasis on areas noted more prevalently in earlier activities and discussions (30 minutes) • ACTIVITY: What would you say or do? Prepare worksheet for manual of 3-4 different situations/mock conversations, and ask participants to work in small groups writing suggested responses (10) • Class discussion of scenarios in worksheet (15)	
Session 2 1:50—2:20	**Seeking and Providing Support** Participants will learn about when, where and how to make referrals. • Presentation of materials	
2:20—2:30	**Conclusions & Evaluations** • Reiterate objectives for the day and how these skills can help build Therapeutic Communities • Activity: o Crumpled Paper Feedback: Ask	From timing

	participants to write down one way you will use materials and information from this training on slip of paper. Have them crumple paper into a ball and throw them around the room. Ask each participant to read at least 3 answers and then throw all to center of the room. • Participants fill out course evaluations	standpoint this activity could be optional, but make sure question is included on evaluation to have participants consider application of skills learned.
2:30	**Adjourn**	

Peer Listening Training Workshop Evaluation Form

Training Location	
Training Date	
Training Host	
Participant's Name	
Participant's Organization	

1) Would you recommend that we include people from organizations similar to yours for future peer listening trainings?

Yes ☐ No ☐ Cannot Rate ☐

2) Have you ever participated in similar training(s)?

Yes ☐ No ☐ Cannot Rate ☐

If yes, then what training(s)?

3) How do you plan to use this training? Please include the type of people you might encounter and where you would most likely work with them (e.g., club house, church, etc.).

4) Please circle the number that best describes your level of satisfaction with this training.

How satisfied were you with the content of the training?

Very Unsatisfied 1 2 3 4 5 Very Satisfied

How satisfied were you with the way the information was presented?

Very Unsatisfied 1 2 3 4 5 Very Satisfied

After participating in this training how qualified do you think you are to be a peer listener?

Very Unqualified 1 2 3 4 5 Very Qualified

5) Please list up to three people (name, organization, and email information) you think should be invited to future peer listening trainings.

1)_____

2)_____

3)_____

6) What was the most beneficial aspect of this training and why?

7) What was least useful to you and why?

8) Would you be interested in participating in follow-up in-service (professional development) opportunities for peer listeners?

Yes ☐ No ☐ Cannot Rate ☐

If so, please suggest methods you would choose for in-service.

9) Please provide any other comments.

Thank you for your time and participation.

Appendix D

Bibliography

ANGER

Anger, the Misunderstood Emotion. Carol Tavris

Angry all the time. Ron-Potter-Efron

I.A.M.: A common sense guide to coping with anger. Melvyn L. Fein

Managing Anger. Mitchell H. Messer, Roman Coronado-Bogdaniak, Linda J. Dillon

The Anger Workbook. Lorraine Bilodeau

ANXIETY AND PTSD

Anxiety, Phobias, and Panic. Reneau Z. Peurifoy

I Can't Get Over It: A handbook for trauma survivors. Aphrodite Matsakis

The Anxiety and Phobia Workbook. Edmund J. Bourne

DEPRESSION

Living without Depression & Manic Depression. Mary Ellen Copeland

Overcoming Depression. Demitri Papolos and Janice Papolos

The Depression Workbook. Mary Ellen Copeland

The Good News About Depression. Mark S. Gold

The Feeling Good Handbook. David D. Burns

FAMILY ISSUES

A Couple's Guide to Communication. John Mordecai Gottman

Breaking Free from Domestic Violence. Jerry Brinegar

Children and Trauma. Cynthia Monahon

Parenting your Teenager. David Elkind

Playful Parenting. Denise Chapman Weston and Mark Weston

The Good Marriage. Judith S. Wallerstein & Sandra Blakeslee

The Verbally Abusive Relationship. Patricia Evans

Violent No More. Michael Paymar

SUBSTANCE ABUSE

Getting Started in A.A. Hamilton B.

Sober but Stuck. Dan F.

When A.A. Doesn't Work For You. Albert Ellis and Emmett Velten

Appendix E

Historical Disaster Research

Buffalo Creek Flood (1972)

Erikson, K.T. 1976. Disaster at Buffalo Creek: Loss of communality at Buffalo Creek. *American Journal of Psychiatry, 133,* 302–305.

Erikson, K.T. 1976. *Everything in its path: Destruction of community in the Buffalo Creek flood.* New York: Simon and Schuster.

Gleser, G.C., Green, B.L., and Winget, C.N. 1981. *Prolonged psychological effects of a disaster: A Study of Buffalo Creek.* New York: Academic Press.

Rangell, L. 1976. Discussion of the Buffalo Creek disaster: The course of psychic trauma. *American Journal of Psychiatry, 133,* 313–316.

Mount St. Helens (1980)

Adams, P.R. and Adams, G.R. 1984. Mount St. Helen's ashfall: Evidence for a disaster stress reaction. *American Psychologist, 39,* 252–260.

Buist, A.S., Martin, T.R., Shore, J.H., Butler, J., and Lybarger, J.A. 1986. The development of a multidisciplinary plan for evaluation of the long-term health effects of the Mount St. Helens eruption. *American Journal of Public Health, 76* (Suppl.), 39–44.

Leik, R.K., Leik, S.A., Ekker, K., and Gifford, G.A. 1982. *Under the threat of Mount St. Helens: A study of chronic family stress.* Minneapolis: University of Minnesota, Family Study Center.

Three Mile Island (1979)

Bromet, E. and Dunn, L. 1981. Mental health of mothers nine months after the Three Mile Island accident. *The Urban and Social Change Review, 14,* 12–15.

Bromet, E.J., Hough, L., and Connell, M. 1984. Mental health of children near the Three Mile Island reactor. *Journal of Preventive Psychiatry, 2,* 275–301.

Bromet, E.J., Parkinson, D., Schulberg, H., Dunn, L., and Gondek, P. 1982. Mental health of residents near the Three Mile Island reactor: A comparative study of selected groups. *Journal of Preventive Psychiatry, 1,* 225–276.

Bromet, E., Schulberg H.C., Dunn, L., and Gondek, P. 1980. *Three Mile Island: Mental health findings.* Rockville, MD: National Institute of Mental Health.

Collins, D.L., Baum, A., and Singer, J.E. 1983. Coping with chronic stress at Three Mile Island: Psychological and biomedical evidence. *Health Psychology, 2,* 149–166.

Cornely, P. and Bromet, E. 1986. Prevalence of behavior problems in three-year-old children living near Three Mile Island: A comparative analysis. *Journal of Child Psychology and Psychiatry, 27,* 489–498.

Houts, P. 1989. *The Three Mile Island Crisis: Psychological, Social, and Economic Impacts on the Surrounding Population.* University Park, PA: Pennsylvania State University Press.

Exxon Valdez Oil Spill (1989)

Gilson, T. 1989. Impacts of an Environmental Disaster on a Small Local Government: The Valdez, Alaska Oil Spill. *Government Finance Review*. June 27–29.

Cohen, M.J. 1995. Technological Disasters and Natural Resource Damage Assessment: An Evaluation of the *Exxon Valdez* Oil Spill. *Land Economics* 71:65–82.

Cohen, M.J. 1993b. *Economic Aspects of Technological Accidents: An Evaluation of the Exxon Valdez Oil Spill on Southcentral Alaska.* Ph.D. dissertation, University of Pennsylvania.

Cohen, M.J. 1993a. The Economic Impact of an Environmental Accident: A Time Series Analysis of the *Exxon Valdez* Oil Spill in Southcentral Alaska. *Sociological Spectrum* 13:35–63.

Davidson, A. 1990. *In the Wake of the Exxon Valdez: The Devastating Impact of the Alaska Oil Spill.* San Francisco: Sierra Club Books.

Dyer, C.L. 1993. Tradition Loss as Secondary Disaster: Long-Term Cultural Impacts of the *Exxon Valdez* Oil Spill. *Sociological Spectrum* 13(1):65–88.

Dyer, C.L., Gill, D.A. and Picou, J.S. 1992. Social Disruption and the *Valdez* Oil Spill: Alaskan Natives in a Natural Resource Community. *Sociological Spectrum* 12(2):105–126.

Gill, D.A. 1994. "Environmental Disaster and Fishery Co-Management in a Natural Resource Community: Impacts of the *Exxon Valdez* Oil Spill." Pp. 207-235 in C.L. Dyer and J.R.McGoodwin (eds.) *Folk Management in the World Fisheries: Implications for Fishery Managers.* Boulder, CO: University of Colorado Press.

Harrald, J.R., Cohn, R. and Wallace, W.A. 1992. We Were Always Re-Organizing...: Some Crisis Management Implications of the *Exxon Valdez* Oil Spill. *Industrial Crisis Quarterly* 6(3):197–217.

Keeble, J. 1991. *Out of the Channel: The Exxon Valdez Oil Spill in Prince William Sound.* New York: Harper Collins Publishers.

Klein, C.E. 1990. The Disaster of 'Disaster Response': The *Exxon Valdez* Oil Spill, Alaska, 1989. Paper presented at the annual meeting of the *Society for Applied Anthropology*, York, England.

Picou, J.S. and Gill, D.A. 1996. The *Exxon Valdez* Oil Spill and Chronic Psychological Stress. Pp. 879-893 in F. Rice, R. Spies, D. Wolfe, and B. Wright (eds). *Proceedings of the EVOS Symposium.*American Fisheries Symposium 18.

Picou, J.S. and Rosebrook, D.R. 1993. Technological Accident, Community Class-action Litigation and Scientific Damage Assessment: A Case Study of Court-Ordered Research. *Sociological Spectrum* 13(1):117–138.

Piper, E. 1993. *The Exxon Valdez Oil Spill: Final Report, State of Alaska Response.* Anchorage, AK: Alaska Department of Environmental Conservation.

Tierney, K.J. and Quarantelli, E.L. 1992. Social Aspects of the *Exxon Valdez* Oil Spill. *Industrial Crisis Quarterly* 6(3):167–173.

Tyler, L. 1992. Ecological Disaster and Rhetorical Response: Exxon's Communications in the Wake of the Valdez Oil Spill. *Journal of Business and Technical Communication* 6(2):149–171.