



## Disaster mental health: Ethical issues for counselors

**D**isaster mental health (DMH) is a widely recognized and essential component of comprehensive disaster response. DMH workers provide psychosocial support for disaster survivors and first responders while working within multidisciplinary emergency response teams. The purpose of DMH is to recognize the impact of disasters on survivors, responders, communities and affected individuals, and to apply supportive interventions.

Working alongside first responders, disaster relief volunteers, community decision-makers and faith-based leaders, DMH work differs dramatically from traditional clinical settings. DMH is designed to establish a human connection in a nonintrusive manner, address immediate and ongoing safety needs, provide physical and emotional comfort, offer practical assistance and foster short- and long-term adaptive functioning. Interventions may include linking impacted individuals to basic resources and providing outreach, psychoeducation, psychological first aid, crisis counseling, information and referral.

Differing from traditional crisis response, DMH interventions are tailored to address survivors' pragmatic needs. DMH responders know that stress reactions are natural and present in myriad ways across physiological, cognitive, behavioral, emotional and spiritual domains (for more, see the book *Disaster Mental Health: Theory and Practice* by James Halpern and Mary Tramontin). Over the past two decades, work within the crisis and trauma realm has seen a gradual shift in focus from adverse emotional reactions to approaches that emphasize resilience and posttraumatic

growth. Given outcome research on individual and community resilience following disaster, DMH workers assume resilience, as opposed to pathology, and provide practical assistance versus traditional psychotherapeutic approaches.

Literally meaning "ill-starred event," the term *disaster* is grounded in the idea of being unforeseen and out of one's control. Thus, in the immediate aftermath of disasters, DMH workers are faced with unique ethical challenges. This article will outline these challenges and provide recommendations for counselors as a foundation for understanding the ethics that surround DMH work.

### Professional competence

Central to the fulfillment of ethical standards is the mandate in the 2014 *ACA Code of Ethics* that professionals do not practice outside of their area of expertise. Thus, receipt of training prior to a deployment and supervision during each deployment are essential. Training specific to DMH work is required because it prepares mental health professionals to provide for and respond to the psychological needs of people across the continuum of disaster preparedness, response and recovery. Counselors cannot assume that the application of traditional counseling skills is sufficient. Traditional skills, while helpful, are not transferable to DMH without specialized training.

Counselors must also understand that each emergency management or humanitarian aid organization will have a required training protocol. Regardless of prior trainings, certifications or licensure, counselors must comply with these requirements. An invitation to deploy is also always necessary. All

assignments require an invitation from a local or national humanitarian aid organization authorized to serve the affected community.

### Informed consent

The tenet of informed consent, per the *ACA Code of Ethics*, says that clients have the right to information about the counselor and the counseling process and the right to choose whether they wish to enter into counseling. However, informed consent differs in disaster response.

DMH is not an ongoing counseling relationship, and the interventions, although based in helping skills, are not traditional counseling. Only when DMH professionals are engaged in counseling services or crisis intervention work, such as discussing psychological reactions to a disaster event, are they mandated to obtain informed consent. Often, no written consent is required. Typically, the informed consent process is verbal, meaning that DMH workers identify themselves and their part within the response team, highlighting their role in responding to the practical and psychoeducational needs of survivors.

Although disaster organizations have varied requirements, DMH workers should seek permission from survivors to share their information with other organizations or to advocate on their behalf. Disaster survivors in need of housing resources or clothing may need DMH workers to share their names and locations with another provider. Although DMH workers typically assist survivors in accessing resources on their own, there are instances in which advocacy on behalf of survivors is needed. Thus, verbal consent is warranted.



### Records and documentation

Standard A.1.b. of the *ACA Code of Ethics* describes how counselors create, secure and maintain records needed for service provision. In the context of DMH, documentation is unique to the organization in which the counselor is working.

The American Red Cross has forms to assist with performing triage, obtaining resources, documenting client case information and releasing confidential information. Conversely, the Federal Emergency Management Agency/Substance Abuse and Mental Health Services Administration Crisis Counseling Program documents services such as crisis counseling encounters (e.g., risk level, event reactions, referral), group encounters (e.g., public education) and weekly tallies of contacts and materials distributed.

One ethical consideration, similar to traditional counseling practice, is ensuring that client information remains confidential and that only authorized individuals can access the records created during DMH service provision. Although paperwork requirements vary depending on the response agency employed, documentation is usually completed after contact. It is also possible that DMH records may be cumulative, rather than individual, and include only information related to stress reactions or follow-up needs.

### Confidentiality

As just described, confidentiality is a vital part of ethical DMH work. However, given the settings of most DMH deployments — for example, short-term disaster relief shelters, community centers, churches and schools — traditional approaches to maintaining confidentiality often are not feasible. It is important to remind survivors of risks to confidentiality and then work to minimize those risks.

One example is the likelihood of people nearby in a crowded area overhearing a conversation between a DMH counselor and a survivor. Minimizing this risk could involve informing the survivor of this possibility and then finding another place where the survivor feels comfortable talking. Generally, DMH workers must understand that confidentiality cannot be guaranteed despite earnest attempts to maintain it.

### Duty to warn

As is also the case with traditional counseling, the ethical mandate to keep information confidential does not apply in situations of serious and foreseeable harm or when legal requirements demand release. DMH workers may encounter individuals who are at risk for suicide, homicide or other harmful behaviors (e.g., nonsuicidal self-injury, substance abuse). Workers must be able to attend to these immediate crisis needs, know whom

to consult with and refer the survivor for additional support services.

Counselors are strongly advised to know the rules regarding confidentiality and informed consent specific to their deployment organization. They should also not assume, given the constraints of informed consent and confidentiality, that they are not responsible for informing survivors of their duty to report.

### Developmental and cultural considerations

In all counseling interventions, professional counselors must attend to cultural and developmental aspects of their clients. As appropriate to DMH services, cultural and developmental considerations such as age, race, expressed gender, language, religion, national or social origin, disability status, marital or family status and affectional orientation are considered. All services rendered must be developmentally and culturally appropriate.

Counselors who are unsure about how to work with a specific survivor population should seek supervision or consultation within their operation. DMH counselors need to be cognizant of language or interpreter needs and use providers with language skills or interpreter services (e.g., language phone lines) as needed. DMH supervisors must also be knowledgeable of these issues when providing supervision and guidance to DMH professionals.

DMH workers should be aware that when providing DMH services, they must help anyone they encounter. As with professional counseling work, counselors engaged in DMH work may not discriminate or make values-based referrals. Workers should be mindful that any contact they have with a survivor may be the only contact that individual has with a mental health professional.

### **Boundaries and advocacy**

The potential for boundary extensions is ever present in the DMH realm. Most DMH work is local. Thus, the possibility of a DMH worker responding to an event, such as an apartment fire, that has occurred within his or her own community should be expected. The ability to recognize this challenge from an ethical standpoint and respond in an appropriate, ethical manner is key.

Boundaries may be extended as DMH workers attend to survivors' needs. This could include providing services in a private residence or doing a follow-up visit in a hospital. Weighing the benefits and risks of extending boundaries is imperative, while always keeping in mind that disaster response work is fraught with time and resource limitations.

As is evident in attending to developmental and cultural needs, DMH work frequently involves client and systems advocacy. Examples include assisting survivors in filling out paperwork to obtain assistance or working with organizations to ensure that the process to apply for monetary assistance is efficient and culturally appropriate.

### **Personal values**

Emotions often run high after a disaster, and strongly held beliefs are routinely expressed by survivors. DMH workers may experience this following a terrorist event (e.g., survivors making statements about the alleged perpetrator's background) or natural disaster (e.g., survivors expressing their feelings regarding government response). DMH workers will often hear survivors question their faith (e.g., "Why would God do this?").

As with traditional counseling services, DMH workers need to be aware of their own personal values and beliefs and not impose their belief systems on survivors. Process groups and supervision can

help increase DMH workers' awareness around these issues, ensure ethical service provision and assist with self-care. Survivors may ask for a worker's opinion about sensitive topics (e.g., gun control, equality of support services). Thus, DMH workers must know how to respond in a way that supports the survivor while avoiding values imposition. DMH workers should also be familiar with local resources, such as spiritual care workers or faith leaders, who are available to assist survivors.

### **Termination and referral**

Because DMH work is a short-term intervention, termination, transfer and referral are significant ethical considerations. DMH workers must have the ability to manage short-term relationships inherent to DMH work. For instance, they must be able to transfer a survivor to another worker while avoiding feelings of abandonment. If a DMH worker's shift has come to an end, he or she may need to introduce the survivor to another DMH worker.

In longer-term deployments, there are often needs that exceed the deployment time frame. Thus, DMH workers should attempt to provide long-term information, referrals and resources to survivors. Regarding referral, there may be situations in which survivors have ongoing psychological needs that exceed normal disaster reactions. Knowing how to handle these referrals and the protocols of the responding agency is imperative.

### **Conclusion**

In the wake of a catastrophic natural or human-caused disaster, ethical obligations can present DMH professionals with an enormous amount of uncertainty. Counseling professionals need to understand the inherent ethical challenges of DMH work and seek training prior to becoming involved in this work.

Counselors interested in becoming a DMH responder can go through the American Red Cross ([redcross.org/become-a-disaster-mental-health-volunteer](http://redcross.org/become-a-disaster-mental-health-volunteer)) or another local emergency response organization. Organizations that provide training, but not deployment services, include the National Center for PTSD and the National Child Traumatic Stress Network. The National Center for PTSD offers free online trainings related to

psychological first aid (see <http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp>), and the National Child Traumatic Stress Network offers trainings that help counselors understand the unique needs of children and adolescents in the wake of disaster (see [learn.nctsn.org](http://learn.nctsn.org)). The American Counseling Association also has a webpage dedicated to helping counselors who serve individuals and communities impacted by traumatic events (see [counseling.org/knowledge-center/trauma-disaster#disaster](http://counseling.org/knowledge-center/trauma-disaster#disaster)). ♦

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