



European Guideline for Target Group oriented
psychosocial aftercare-Implementation

Target Group Intervention Program Manual IV

Rehabilitation of Stress Response Syndromes in the Aftermath of Disaster

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Literature about Target Group Intervention Program (TGIP)

Translations of the manual in German and Spanish are available at www.eutopa-info.eu

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Further information about the TGIP in association with psycho-social aftercare for victims of terrorist attacks and for soldiers after foreign assignments are available at:

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1. Introduction

1.1 Functioning and disability after disaster

The criteria for Posttraumatic Stress Disorder (PTSD) which were determined at the inclusion of the diagnosis in the DSM-III (1980) are based on the observation that an experience of catastrophic nature can elicit the symptom triad of intrusions, avoidance and hyperarousal in a portion of those affected. Since then, numerous publications in professional journals have appeared that measure the epidemiology, prevention and treatment progress based on the degree of symptom intensity. A general consensus has emerged concluding that the successful treatment of stress response syndromes can be demonstrated by the recession of the symptoms. Until now, disability associated with stress response syndromes play a minor role.

At the Center for Psychotraumatology at Alexianer Krefeld GmbH, Germany, we have been able to observe the phenomenology and symptoms of numerous patients across all age groups suffering from a simple or complex PTSD. The symptoms of our patients provide us with limited information regarding the level of their functioning in work, family, and social life. It has been our experience that to be able to make an adequate indication regarding outpatient, part-time inpatient or full-time inpatient treatment, additional criteria beyond the symptoms must be considered. Aside from the functional level, the social context of the patient has to be given special consideration.

We have empirical data that shows that psychosocial factors play a fundamental role both as risk factors for the development of PTSD as well as prognosis factors for therapeutic success. Our research regarding the inter-validation of the Kölner Risikoindex (Cologne Risk Index) in conformance with several meta-analyses (Ozer et al., 2003) has shown that the lack of a social support system is a major risk factor for the development of PTSD (Bering et al, 2009; Bering, 2011). Our studies on the catamnesis of our patients have shown that the mobilisation of social resources determines the success of the treatment in a fundamental way (Köhler & Bering, 2011).

We know that after large-scale catastrophes, the majority of those affected develop an acute stress disorder that diminishes after a few weeks (NATO & OTAN, 2008). The ascertainment of the pathology during this timeframe is thus not a valid indicator for the prognosis of the duration of the stress reaction (Bryant, 2003). For this, we have to look for additional models that may be sufficient to predict the development of chronic mental disorders after e.g. disaster or other critical incidents. Recent research has shown that risk factors have a higher prognostic validity than the symptom load of German soldiers deployed from their mission in

Afghanistan (Dunker, 2009). However, disability may be a good candidate for prognostic screening in early intervention programs. Furthermore, components of disability may be a risk factor for late onset PTSD and an unsatisfying therapy outcome.

Hence, we ascertain that in our interaction with the patients at our center, we put a much higher emphasis on the psychosocial effects of PTSD than is embodied in the diagnostic manual pertaining to the DSM or ICD. Due to this, we see the necessity of developing a functional approach in the field of psychotraumatology, which would deal with the interaction between stress responses, the development of symptoms, and the development of a disability in the level of functioning. Moreover, different vocational groups such as psychiatrists, psychologists, nurses, physiotherapists, social workers and ergotherapists are part of our center's therapeutic team. However, the DSM or ICD does not provide us with a common interdisciplinary language that describes patient status in terms of functioning, participation and environmental factors.

The International Classification of Disability, Health and Functioning (ICF; WHO, 2001) could be an instrument with which the psychosocial effects of PTSD and complex PTSD may better be recorded in the future. Over this, the ICF terminology may serve as a common framework for different vocational groups to describe the status and outcome of treatment and rehabilitation. The upcoming redefinition of PTSD in the DSM-V also allows for the possibility of placing a stronger emphasis on the psychosocial consequences of stress disorders.

This manual of the Target Group Intervention Program (TGIP) adapts the TGIP to the concept of the ICF. Disability and health, central concepts based on the ICF, will serve as a framework for the disability management of stress response syndromes. This TGIP-Rehabilitation Manual takes into account that the ICF has been approved from all European member countries.

1.2 Promotion of Functioning & Rehabilitation

In the booklets I-III we have pointed out that the identification of the high-risk group for chronic psychological disorders is one main objective in the aftermath of disaster. The paradigm of functioning may be useful as a predictor for chronic stress syndromes and it might be useful to introduce the concepts of rehabilitation for those in treatment because of disabilities. Figure 1 shows that survivors of disaster may need rehabilitation programs that include back to work programs and improve functioning in interpersonal interaction, self-care, domestic life and participation in community, social and civil life. For this impairment, limitations and restrictions in terms of the ICF have to be identified early and the terminology of the ICF should serve as a basic framework for rehabilitation objectives. In order to provide tools that are sufficient to measure functioning and disability Q-FIS-SR was designed. In order to under-

stand the construction of Q-FIS-SR, we introduce and give an overview of the implementation of the ICF in Europe.

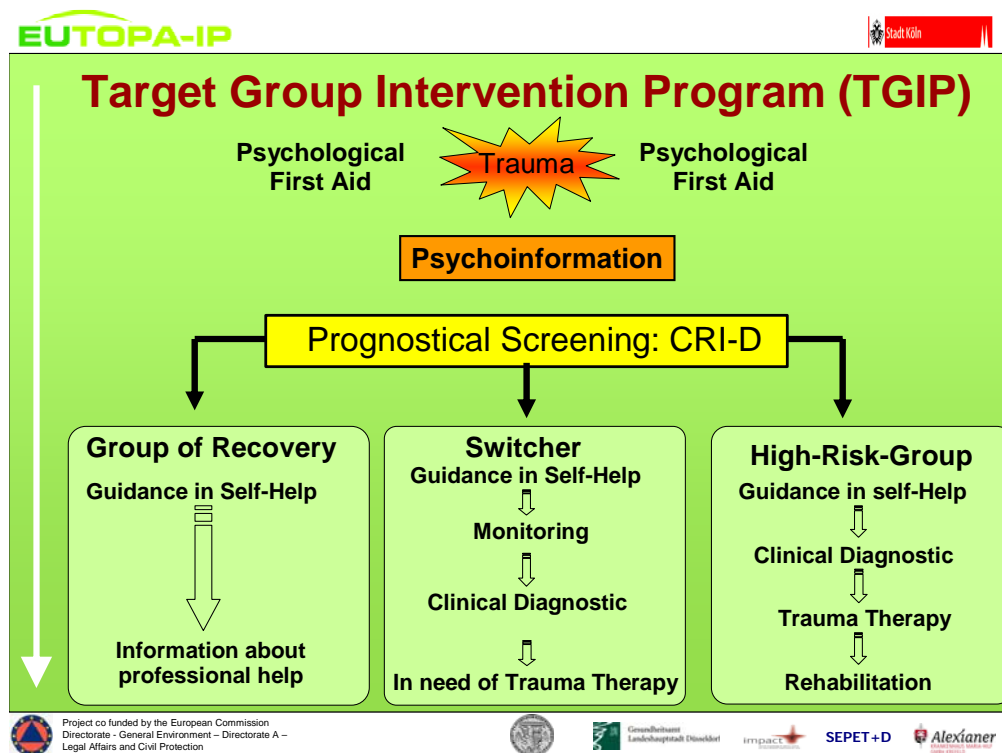


Figure 1: Target Group Intervention Program. Different measures of the TGIP are shown. In case of disabilities in activity and participation (e.g. work and social life), rehabilitation might be indicated after trauma therapy.

2. The International Classification of Functioning, Disability and Health

2.1 Definition

The ICF, endorsed in 2001 by the WHO, is a new classification system based on a biopsychosocial model (as opposed to the traditional biomedical found in the ICD-10), which understands functioning as an interaction between the health condition and surrounding factors/influences (personal, social and environmental). It is important to understand that the ICF is not meant to stand alone or replace the ICD-10. Rather, the ICF is described as a “second language” with which to assess health and disability. Broadly speaking, it can be said that the ICD-10 classifies disease, whereas the ICF classifies health. This is one of the central aspects of the ICF: it aims to emphasize the available resources of the patient, hence moving away from the traditional “deficit approach in medicine” (Lollar & Simeonsson, 2005, p. 324). The Director General of the WHO put it this way: “Together, the two [ICF and ICD] provide us with exceptionally broad and yet accurate tools to understand the health of a po-

pulation and how the individual and his or her environment interact to hinder or promote a life lived to its full potential” (Brundtland, 2002).

The structure of the ICF can be described as hierarchical and divided into two main parts: (1) Functioning and Disability and (2) Contextual Factors. Functioning and Disability consists of two components: (a) Body Systems (Function and Structure) and (b) Activities and Participation. The Contextual Factors also consist of two components: (a) Environmental and (b) Personal. (For an overview, see Figure 2).

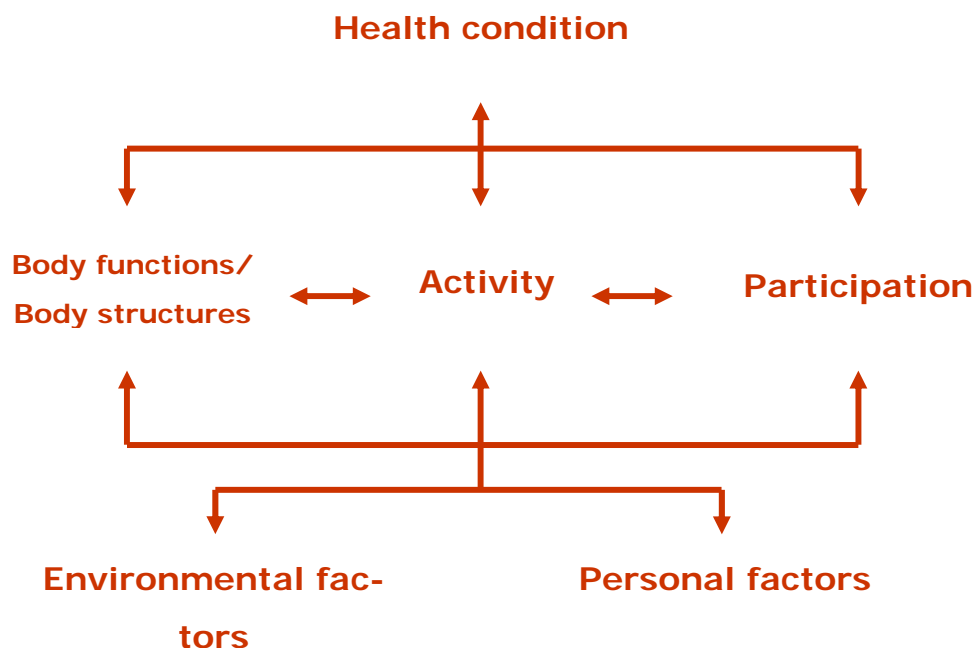


Figure 2: Components of the ICF

The WHO (2007) defines these components as follows: Body functions are “physiological functions of body systems” (p.9) (including psychological functions), whereas body structures are defined as “anatomical parts of the body, such as organs, limbs and their components” (p.9). Activity is understood as the “execution of a task or action by an individual, whereas participation is the involvement in a life situation” (p.9). Regarding the contextual factors, environmental factors are described as “physical, social and attitudinal environments in which people live and conduct their lives” (p. 9) and personal factors are described as “the particular background of an individual life and living, and comprise features of the individual that are not part of a health condition or health state” (p.15). Each component consists of a certain number of hierarchal organized codes that represent that component.

The ICF codes are complete only if applied with a qualifier, which shows how severely a certain area is impaired. The qualifier is added as a number (ranging from 0 = fully functioning/no impairment to 4 = not functioning at all/completely impaired) at the end of an item

code (i.e. xxx.2). For the description of environmental factors, the qualifier can be used to depict the item as having a negative impact on the individual, i.e. being a barrier to the individual's well-being, or as having a positive impact on the individual, i.e. promoting his or her well-being. This is done by adding a "+" or "-" in front of the qualifier (i.e. e115+3).

Possibly the most important contribution of this new classification system is the official notion that human functioning is based on interactions between a variety of factors. While health experts have always been aware of this fact it is now "officially" recognized through the ICF, no longer making it possible to overlook the fact that "the environment often affects the person with a physical impairment more than the actual physical condition" (Lollar & Simeonson, 2005). While the individual factors still play an important role, the notion that the patient is sick and has problems functioning that are due solely to personal factors is being replaced by a more holistic and comprehensive view of the person—not just as an individual, but as a member of society. The ICF finally shows how inappropriate it is to take a person out of the context in which he lives, and view him solely as an isolated being.

This approach also shifts the responsibility for the disability from the individual to all of society: the members of the immediate family, teachers, the community and finally professional health specialists, institutions and the laws and legislation passed by politicians. To a certain extent, this fact applies in particular to mental health disorders: For too long, individuals with mental health disorders have been labeled as "crazy". The ICF challenges society to take responsibility, since the disability of an individual and the amelioration or degradation of his or her state lies not primarily in his or her own hands, but in the hands of society. With the introduction of the ICF, the official framework has been set for every citizen to acknowledge the role he or she plays in the disabilities of his fellow men.

2.2 Implementation of the ICF: Status quo

The ICF is currently in the middle of an intensive transfer and implementation process in many countries. This chapter aims to give a brief review of the implementation process regarding mental health disorders.

2.2.1 The implementation of the ICF into legislation and health systems

Projects based on the ICF are currently underway in 74 countries (Ustun et al., 2003). Mbo-goni (2003) reviewed the extent to which the ICF (and formerly, the International Classification of Impairment, Disability and Handicap (ICIDH)) was being applied internationally. While past surveys conducted in developing countries did not use ICIDH/ICF definitions internationally, more recent surveys showed that they were being applied.

In the United States, several important steps have been taken towards an implementation of the ICF into the health system: The US Office for Personnel Management used the ICF to revise the form that employees use to identify themselves as having a disability (Bruyère, 2005). Furthermore, the National Committee on Vital and Health Statistics has recommended that the ICF be used as a tool for reporting functional status. The Department of Health and Human Services reviewed national surveys and organized the items relating to disability factors and functioning according to the ICF classification system (Bruyère et al., 2005).

In Europe, the EUTOPA project (Schedlich et al., 2008), which includes countries such as Germany, Spain, the Netherlands and the Czech Republic, has been of importance in implementing the ICF in the field of psychosocial care in the aftermath of disaster.

Regarding its place in the German legal and health systems, several points can be made: The ICF has been taken up in legislation and regulations of the German healthcare system, and insurance companies have begun to include the ICF on their rehabilitation application forms. Furthermore, the new German Social Code is based on the ICF. The importance and the potential of the ICF are not only reflected within German laws, but also in the everyday work with patients and in all types of documentation. All guidelines and general recommendations within the context of rehabilitation have been adjusted to the ICF (Ewert & Stucki, 2007).

2.2.2 The implementation of the ICF into clinical mental health setting

Regarding the implementation of the ICF for mental health disorders, several important steps are being taken. The development of the “Procedural Manual and Guide for a Standardized Application of the ICF” and the development of the DSM-V (Kennedy, 2003) are already underway. To facilitate the application of the ICF, the American Psychological Association (APA), together with the WHO, is creating the “Procedural Manual and Guide for a Standardized Application of the ICF”, a clinical manual that provides guidelines and tools to apply the various concepts and items of the ICF in a reliable, valid and user-friendly way.

Several aspects of the DSM-IV are already under revision as the DSM-V is being developed, including the GAF on the fifth axis. This revision offers many opportunities to include concepts of the ICF and “rethink how the concept of functioning and disability fit into the diagnostic criteria of mental disorders” (Kennedy, 2003). Areas in which the ICF could play an important role are the coding of environmental factors on Axis IV and the disability criterion in Axis I, and again regarding functioning on Axis V. Undoubtedly, working to refine the DSM-IV will “likely involve consultation with the ICF” (Kennedy, 2003). On the other hand, it will provide an opportunity to refine sections of the ICF, particularly the Environmental Factors (Kennedy, 2003).

Important outcomes related to the implementation of the ICF include the development of “core sets”. Core sets are a “generally-agreed-upon” list of ICF categories for a certain disability (Cieza et al., 2004a), aiming to simplify the application of the ICF. In the field of mental health disorders, core sets have been developed for depression (Cieza et al., 2004b), and are currently being developed for bipolar disorder (Vieta et al., 2007). The ICF core set for depression consists of a “comprehensive core set” with 121 categories (for a multi-professional description of patients) and a “brief core set” of 31 categories (for clinical studies and research).

The development of ICF core sets is an international collaboration project among the “ICF Research Branch in Cooperation with the WHO Collaborating Center for the Family of International Classifications in Germany (at DIMDI)”, the World Health Organization and many other international organizations such as the International Society for Physical and Rehabilitation Medicine. ICF core sets for 22 health conditions have been developed so far, and two are currently under development (<http://www.ICF-research-branch.org>). Parallel to this international collaboration there have been other initiatives with the aim of developing core sets based on the ICF, which have followed different methodological approaches. One of these initiatives refers to psychiatric patients and is presented in the following paragraphs.

Two projects conducted in Germany relative to the implementation of the ICF into a clinical everyday setting are worth mentioning, and are also of international value: The development of a Mini-ICF-Rating for Mental Disorders (Linden & Baron, 2005) and the development of a core set for the rehabilitation of psychiatric patients, which was implemented in an exemplary manner rehabilitation center “Haueser am Latterbach” (Grundmann, 2005).

The Mini-ICF-Rating for Mental Disorders is a short observer rating instrument for the assessment of disabilities and was first used at the rehabilitation clinic “Seehof” to test patients who suffer from affective disorders, personality disorders, and neurotic, stress-related and somatoform disorders. A significant inter-rater congruence as well as significant correlations with psychopathology, motivation to work and duration of the inability to work was obtained. Due to the positive results of this initial study that demonstrated the reliability, validity, practicality, and economic viability of this rating instrument, the further development of the Mini-ICF could be an important step for the implementation of the ICF for mental disorders.

A second core-set has been developed for psychiatric rehabilitation and was implemented at the rehabilitative setting “Haueser am Latterbach”. A Delphi method was used to decide on the 146 items ultimately chosen. Three main assessment methods were used to assess and rate the items chosen to be included in the core sets: direct dialogue with the patient, behavior observation and psychometric tests such as the SCL-90-R. The integration of the ICF into the rehabilitation program was facilitated by using the Rehab-Cycle Model, a four-step approach of assessment, assignment, intervention and evaluation (Grundmann et al., 2005).

The results obtained here show this core set to allow for a satisfactory depiction of the functional health of the patients. A high acceptance rate throughout all occupational groups was found and the relatively simple and non-judgmental language simplified the communication with the patients. Furthermore, the rehabilitation management was described as transparent and easily comprehensible. Further research can be based on the results achieved here (Grundmann et al., 2005).

Naturally, the implementation of this relatively new classification system must still be optimized. Extensive training for the actual application of the ICF is necessary, as is the development of more core sets and further research on opportunities to apply the ICF in the daily routines of rehabilitation. All-in-all, it can be said that efforts thus far seem very promising and the implementation of the ICF is off to a good start (Bruyère et al., 2005).

2.2.3 ICF in disaster management

Effects of disasters are an overwhelming change of environmental factors. Crisis intervention programs intervene on the psychosocial level and less on the biomedical. ICF describes resources as well as disabilities. Limitation of activity and participation are promising candidates for prognostic screening. ICF is a multi-professional language for rehabilitation that serves as a framework for mid- and long-term intervention. Different vocational groups have different objectives and responsibilities in the case of disaster. While mental health professionals play a secondary role in an acute traumatic event, uniformed services are directly involved. For this they have to be trained to serve psychological first aid. They are mainly responsible for technical support in disaster situations and create an environment that facilitates the supply of medical help and provide first aid support, such as shelters, electricity, water, etc. In a secondary role, they might mobilize psychosocial support in terms of contact to relatives and further professional help. Once the acute phase is over, measures like psychoinformation, communication in the community, and guidance in self-help are of main importance. Beside the risk factors mentioned in the Cologne Risk Index, the individual pattern of environmental factors and first signs disabilities might be observed. For this, we have to be aware of the different occasional groups maybe responsible to identify body functions and structures, limitations of activity and participation, as well as facilitators and barrier factors of environmental factors. For example, mental health professionals might evaluate body functions and structure. Activities and participation like learning and employing knowledge, general task and defense, communication, mobility, self-care, domestic life, interpersonal interaction and relationships, major life areas, and community, social and civic life might be identified by social workers, peers including peers of uniformed, services as well as volunteers. The initial assessment of the disaster's consequences includes how the disaster af-

fects the relationships of survivors, attitudes, as well as services, policies and others. Q-FIS-SR was created to provide a tool to all vocational groups who are involved in the disaster and those involved in the process of psychosocial care. For this Q-FIS-SR will be introduced in the next chapter.

3. Questionnaire- Functioning and Disabilities - Stress Response (Q-FIS-SR)

In EUTOPA the Cologne Risk Index-Disaster (CRI-D) was developed to differentiate the target groups self-healers, switchers and high-risk individuals after disaster caused by stress response to disaster. An online version of the CRI-D was implemented on www.eutopa-info.eu and performed in four languages. This was done by means of empirical results in field studies and meta-analysis on risk factors for developing long-term clinical symptoms after potential psycho-traumatic experiences. EUTOPA-IP emphasizes the need of medical and occupational rehabilitation of a subgroup of the survivors and uniformed services after disaster. For this, we have supplemented the CRI-D with a psychometric instrument that monitors functioning and disabilities of survivors and uniformed services in the aftermath of disaster. This questionnaire is called the Questionnaire of Disabilities and Functioning on Stress Response (Q-FIS-SR). This questionnaire is based on the ICF categories down to the second and third level classification.

Figure 3 shows the structure of the ICF with the parts “functioning and disabilities” and “contextual factors”. We have identified components, domains and chapters which are accentual to identify functioning and disabilities, as well as contextual factors for survivors and uniformed services after disaster. Figure 3 shows that the categories in the chapter b1 and single categories in the chapter b1 to b6 help mental health professionals standardize functioning and disabilities caused by stress responses. However, in the early phase other vocational groups other than mental health professionals, such as uniformed services, psychological first-aid workers are on the scene. Later social workers and trained volunteers might be involved in the psychosocial care. These vocational groups can be trained to be experts in classifying the limitations of activities and participations. The environmental factors might also be documented by all vocational groups involved in a disaster situation.

The structure of categories is visualized in figure 4. Twenty-seven categories of body functioning are identified. Most of them characterize impairment of mental functioning like emotional, cognitive, sleep, thought and perceptual impairment. The categories b117, b122, b126, b130, b140, b143, b144, b147, b152, b156, b160 and b164 are useful for this. These categories characterize general psychopathology. Peritraumatic dissociation (PD) is de-

scribed by the categories b110, b114, b1800, b1801 and b1802. Beside the impairment of mental functioning, other categories might be impaired. For this, we have chosen categories that describe impairment of general body function like pain, heart, urogenital, respiration and digestive functioning. The categories b280, b310, b410, b420, b440, b510, b515, b620, b640 and b650 are important for this.

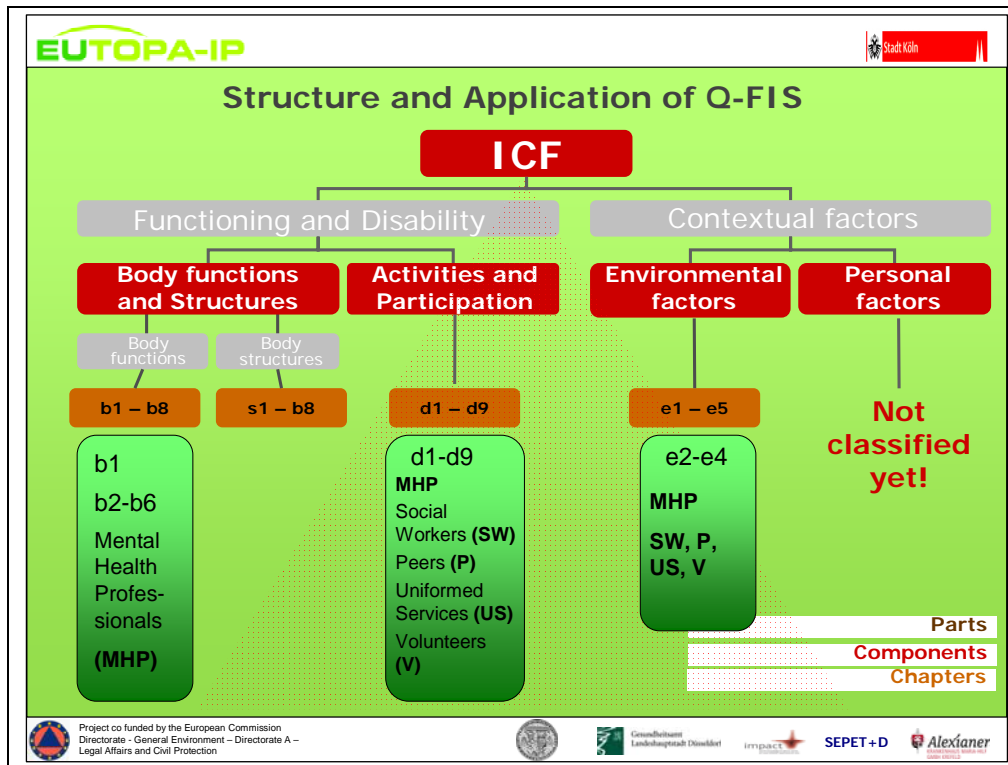


Figure 3: The structure of the ICF with the parts functioning and disabilities and contextual factors.

The main difference to other approaches is that the Q-FIS-SR describes limitations of activities and participation. For this we have chosen categories from the chapters d1 (learning and applying knowledge), d2 (general tasks and demands), d4 (mobility), d5 (self-care), d6 (domestic life), d7 (interpersonal interactions and relationships), d8 (major life areas), and d9 (community, social and civic life). All-in-all 28 categories are included to describe limitations in the field of psychosocial performance. Q-FIS-SR uses 13 categories to describe facilitators and barriers in the components e2 (natural environment and man-made changes to the environment), e3 (support and relationships), e4 (attitudes of environmental factors) and e5 (services, systems and policies). Please note that environmental factors might be facilitating or barrier factors.

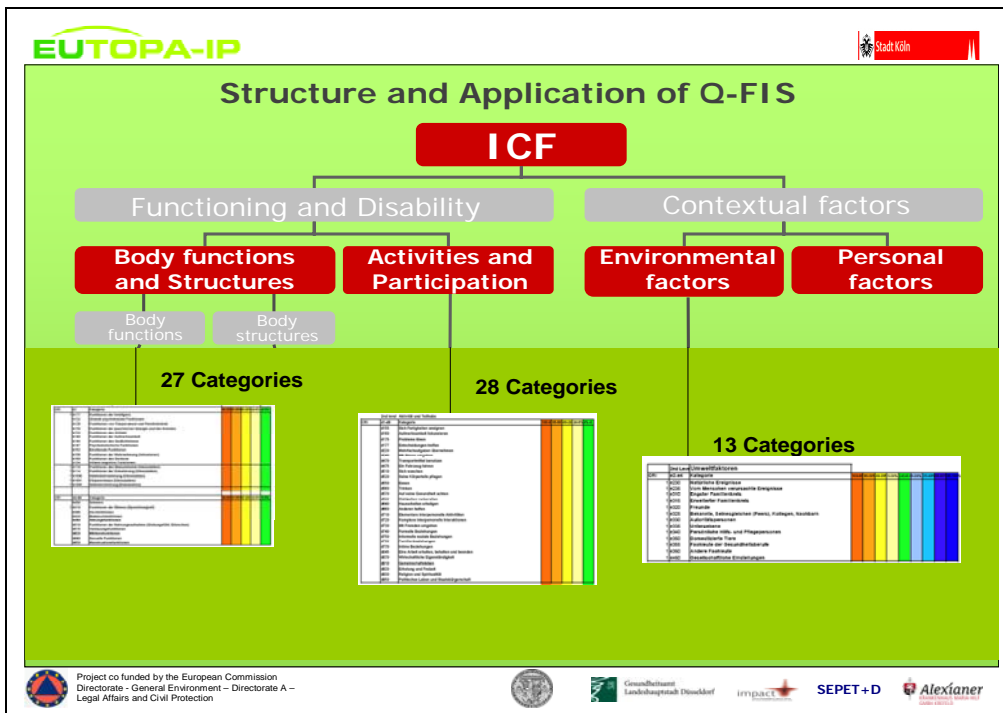


Figure 4: Categories of Q-FIS-SR. Categories are demonstrated according to body functions, activities and participation, as well as environmental factors. Overall, the Q-FIS-SR operates with 68 categories.

To explain how Q-FIS-SR works in practice we refer to a case report in the following chapter.

4. Exemplary application of Q-FIS-SR: A case study

4.1 Case Study ICF Uniformed Services

Mr. Williams, a fire fighter, was on duty when a huge traffic accident with 52 cars occurred on the highway. They were informed by the emergency system and accompanied by medical doctors they arrived at the scene of the accident. Mr. Williams was involved in cutting open the cars to free the casualties. He witnessed a couple die that was sitting in the front seat of a car and were squeezed by the motor block. After 24 hours, the fire brigade were finally able to leave the scene of the accident. When he came home, he felt strange with symptoms of derealisation and depersonalisation. He felt supported by his family but recently he was criticized by his superiors and invalidated by his colleagues. The first four weeks he was able to work regularly but later he began to feel symptoms of avoidance and denial and was not able to go on working without being anxious that a similar accident could happen again. He decided to visit his general physician who diagnosed him with instable blood pressure regulation. No physical reason was found for paroxysmal feelings of general pain in the body. He became unable to work.

In terms of the ICF, Mr. Williams developed impairment of mental functioning. This causes limitations in his working capacities and family life. Limitations resulting from the conflicts with a superior made it worse. His family, however, supported him. Mr. Williams joined a rehabilitation program. The first part of the program was a trauma therapy based on a psychodynamic cognitive model. The second part of the rehabilitation was a return-to-work program. Evaluation was documented based on the Q-FIS-SR.

4.2 Application of Q-FIS-SR

To apply the Q-FIS-SR we distinguish between body functions, activity and participation as well as environmental factors. In terms of the TGIP model Mr. Williams was identified as belonging to the risk group according to the risk profile of the CRI-D. He participated in a psychoinformation session and a peer recommended Mr. Williams to refer to a mental health professional. In terms of figure 5, the Q-FIS-SR was used to document impairment of body functions (b1, b2-b6), limitations of activity and participation (d1-d9), and environmental factors (e1-e5).

Table 1: Categories of Q-FIS and Case report Mr. Williams

Body Functions					Activity and Participation					Environmental Factors														
b/GP	1	2	3	4	C	d	1	2	3	4	C	e	4	3	2	1	0	1	2	3	4	C		
b/GP	Imp. of general psychopath.					d185	Acquiring skills					e230	Natural events											1
B117	Intellectual functions				1	d180	Focusing attention					e235	Human-caused events	■	■	■								1
B122	Global psychosocial functions	■	■		1	d175	Solving problems					e310	Immediate family							■	■			1
B128	Temp. & personality functions	■	■			d177	Making decisions	■	■			e315	Extended family											1
B130	Energy and drive functions	■	■			d220	Undertaking multiple tasks	■	■			e320	Friends							■	■			1
B140	Attention functions	■	■			d240	Handling stress	■	■			e325	Others **											1
B134	Sleep	■	■			d470	Using transportation	■	■			e330	People in authority position											1
B144	Memory functions	■	■			d475	Driving	■	■			e335	People in subordinate positions											1
B147	Psychomotor functions	■	■			d510	Washing oneself	■	■			e340	Care providers and assistants											1
B152	Emotional functions	■	■			d520	Caring for body parts					e350	Domesticated animals											1
B156	Percept. functions/ Intrusions	■	■			d560	Eating					e355	Health professionals											1
B180	Thought functions	■	■			d560	Drinking					e360	Other professionals							■				1
B164	Higher-level cognitive functions	■	■			d570	Looking after one's health					e480	Societal attitudes											1
B/PD	Peritraumatic dissociation					d830	Preparing meals																	
B110	Consciousness functions	■	■		1	d840	Doing housework																	
B114	Orientation functions	■	■		1	d880	Assisting others																	
B1800	Experience of self	■	■		1	d710	Basic interspers. interactions			■														
B1801	Body image	■	■		1	d720	Complex interspers. interactions			■														
B1802	Experience of time	■	■		1	d730	Relating with strangers			■														
b/GBF	Imp. General body function					d740	Formal relationships																	
b280	Sensation of pain	■	■			d760	Informal social relationships																	
b310	Voice functions/ Speechless	■	■		1	d780	Family relationships																	
b410	Heart functions	■	■			d770	Intimate relationships																	
b420	Blood pressure functions	■	■			d845	Job Activity and Participation *																	
b440	Respiration functions	■	■			d870	Economic self-sufficiency			■														
b510	Ingestion functions	■	■			d910	Community life																	
b515	Digestive functions	■	■			d920	Recreation and leisure																	
b620	Urination functions	■	■			d930	Religion and spirituality																	
b640	Sexual functions	■	■			d960	Political life and citizenship																	
b650	Menstruation functions	■	■																					

Figure 5: Classifying functioning and disabilities in terms of Q-FIS-SR. Categories of Q-FIS-SR are demonstrated according to body functions, activities and participation, as well as environmental factors. The qualifiers are demonstrated from *.1 to *.4 (blue: disabilities of functioning; yellow: disabilities of activity and participation). Environmental facilitators (green: *.+1 to *.+4) and barriers (red: *. -1 to *. -4) are visualized.

Q-FIS-SR measures three types of body functions important in the field of psychotraumatology. First, impairment of general psychopathology (b/GP) is described. Mr. Williams developed an impairment of global psychosocial function. He became depressed, and his drive and energy was impaired. He suffered from sleep disturbances and recurring thoughts about the disaster. Peritraumatically he experienced dissociative symptoms like impairment of con-

consciousness functions, derealisation, depersonalisation self-experience and body image. Beside this he saw his general physician because of instable blood pressure regulation, speechlessness and general pain. The Q-FIS-SR describes typical limitations in activity and participation. He developed limitations on decision making, multi-tasking and handling stress, particularly at work. He was impulsive in his interpersonal interactions. He felt supported by his family but unsupported by superiors and his team. The mental health professional qualified this Q-FIS-SR profile according to the following schema, which is based on the ICF.

- 0 NO problem (none, absent, negligible,...)
- 1 MILD problem (slight, low,...)
- 2 MODERATE problem (medium, fair...)
- 3 SEVERE problem (high, extreme,...)
- 4 COMPLETE problem (total,...)

This schema is valid for the part one of the ICF “functioning and disability” which include the components of body function and structure and the component of activity and participation. However, environmental factors may be facilitators or barrier factors. According to the ICF following schema is valid for the contextual factors.

0 NO facilitator	0 NO barrier
+1 MILD facilitator	1 MILD barrier
+2 MODERATE facilitator	2 MODERATE barrier
+3 SEVERE facilitator	3 SEVERE barrier
+4 COMPLETE facilitator	4 COMPLETE barrier

To visualize the qualification of the Q-FIS-SR uses classification bars. The profile of impairments, limitations, restrictions and resources can be identified (Fig. 5) at a glance.

5. Rehabilitation in Target Group Intervention Program

5.1 Rehabilitation in TGIP

Figure 1 shows the different measures that are of main importance for counselling and treatment of survivors and uniformed services affected by a disaster. In the case of Mr. Williams a chronic stress response syndrome, such as posttraumatic stress disorder (PTSD) caused the Q-FIS-SR profile described above. To show how the rehabilitation process works we introduce the rehab-cycle. On the one hand treatment and rehabilitation are two different measures in the mid-and long-term interventions of the TGIP; on the other hand treatment and rehabilitation overlaps. Objectives of rehabilitation have to be defined and integrated in the rehab-cycle. Treatment encompasses special techniques like CBT, EMDR, or psychodynamic approaches. Rehabilitation includes all measures of different vocational groups that are helpful to improve participation in family life, social life and work. These different vocational groups may be mental health professionals, social workers, physiotherapists, and case managers in rehabilitation.

5.2 Rehab-Cycle

Figure 6 shows the rehabilitation cycle which consists of an assessment, an assignment, an intervention and evaluation of the outcome. In the case of Mr. Williams an assessment was conducted by history taking, psychometric diagnostic and standardised interviews according to the DSM and ICD. Over this Q-FIS-SR was applied to understand the patients needs in terms of life quality and needs. Mr Williams assigned for rehabilitation. According to the rehabilitation objectives an intervention plan was created. The rehabilitation objectives had following outline:

1. Improvement of mental function like emotional regulation, sleep, intrusions and concentration.
2. Improvement of general body functioning like reduction of pain, speechlessness and instability of blood pressure regulation.
3. Improvement of participation in Learning and applying knowledge, general tasks and demands and specially interpersonal interactions and relationships.
4. A major goal of the rehabilitation is an improvement of the working situation and relation to superiors.

The intervention plan was created according to these objectives. This intervention plan consists of a trauma therapy. Often trauma therapy is effective to improve mental functioning (goal 1). To reduce pain physiotherapy like myoreflextherapy might be helpsom. A medica-

tion might be helpful to reduce depressive symptoms and improve sleeping functions. To improve activity and participation different vocational groups are important. Beside mental health professionals, ergotherapists, physiotherapists and social workers are specially trained to rehabilitate learning skills, mobility and interpersonal functioning. Back-to-work programs are helpful when contextual factors at work appear to be barrier factors for rehabilitation. A rehabilitation manager might be helpful to overcome these difficulties. This back to work program consists mediation with superiors, readaptation to his working place and a step by step model of working hours. The therapy and the rehabilitation are evaluated using the Q-FIS-SR assessment sheet. According to the qualifier the ICF evaluation is displayed according to the progress in the trauma therapy and the return-to work program (chapter 6). While the peritraumatic dissociation stays constant most categories of mental and general body functioning improved. The rehabilitation program was useful to reduce some of the limitations in activity and participation. Most crucial the mediation with the superiors helped. For a period of 2 month Mr. Williams withdraw from the scene and worked at the fire brigade office. Step by step he came back to his former working place. However, under special circumstances he felt disabled.

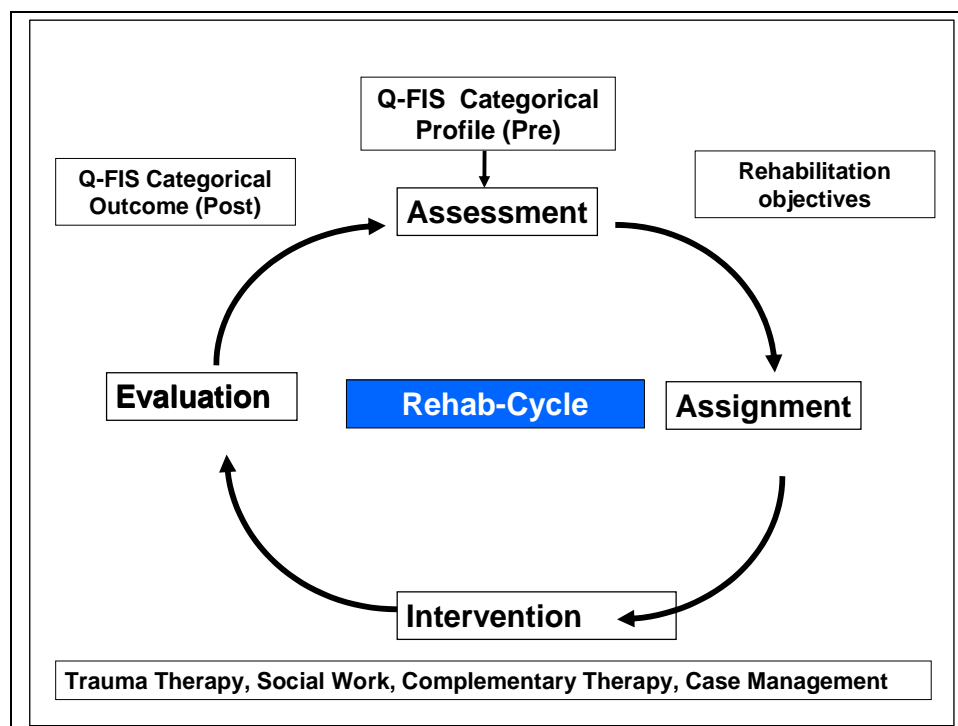


Figure 6: Rehab-Cycle. The Q-FIS-SR is used to determine the ICF category profile. According to this Q-FIS-SR profile the rehabilitation objectives are formulated. Interventions are planned for different vocational groups. Rehabilitation outcome is measured by Q-FIS-SR.

6. Return-to-work programs

The occupational performance of employees is what keeps a healthy society running. The objective of disability management is to safeguard this performance: Companies retain valuable knowledge; individuals maintain their standard of living; and the burden on social systems is eased. A limitation in the ability to work is a major societal problem in different European countries. For this return-to-work programs are part of the legal framework in many European countries. The idea is to link the TGIP to return-to-work program that are part of the existing disability.

In Germany, the SGB IX is crucial for the integration of medical and occupational rehabilitation and relevant for return-to-work programs for e.g. uniformed services. For this e.g. the “Betriebliches Wiedereingliederungsmanagement, § 84 SGB IX”, serves as a legal framework. Our model points out how the TGIP can be linked to existing return-to-work programs in different areas.

7. Discussion

Current guidelines like NATO & OTAN, TENTS, IMPACT and the booklets I, II, III of the TGIP program do not provide ideas about the rehabilitation process. However, we know that, besides the development of symptoms, survivors and uniformed services after disaster may develop stress response syndromes with several problems in functioning, which creates the necessity of disability management. However, concepts of how functional problems or disabilities may be measured are lacking and may serve as the basis for the rehabilitation process. This booklet explains that a rehabilitation measure should follow trauma therapy—most likely in overlap—and that the assignment for return-to-work programs are necessary to reach sufficient results in rehabilitation of employment capacity and psychosocial competences in family life and community life. We have shown that the Q-FIS-SR may serve as a supplement to the Cologne Risk Index to validate additional risk factors on the functional level. Through this, the Q-FIS-SR may serve as a baseline of a disability analysis in the beginning of the rehabilitation process. In addition to the categories of mental functioning, other categories of general health functioning like pain, cardiovascular system, digesting system and muscle system create an understanding of how this may influence the activity and participation in different areas of health status. So far we have shown that these limitations can be expressed by the Q-FIS-SR. Theoretically, the rehab-cycle can be used to measure disability to qualify the disability in parallel to the rehabilitation process and serve as an evaluation system. However, this process of case formulation, application of Q-FIS-SR, and the evaluation of the rehabilitation process would supplement current systems, which are mostly

focused on symptom treatment and symptom control. Further work is needed to establish rehabilitation for uniformed services and survivors after disaster. Currently, the social code in the different European countries differs so that a general conclusion on the framework of all European countries is currently impossible.

At the EUTOPA-IP Conference in Cologne in April 2011, delegates discussed the approach of the ICF. We asked about the implementation of the ICF in Europe, the use of the ICF in rehabilitation process, the need to develop ICF core sets and the pros and cons of this approach.

The working groups came to following conclusions:

- The main effect of disaster is dramatic and sudden, and goes along with an unexpected change of environmental factors. The PTSD model in ICD and DSM does not express the interaction between personal, social and environmental factors. We need a second language to describe the environmental, social and personal effects of disaster from the perspective of environmental factors.
- The ICF is a heuristic model that goes far beyond description on the symptom-diagnosis level. Regardless of the purpose of the ICF, the advantages and limitations are not yet fully known and far from being implemented in the healthcare systems all over Europe. For many delegates, the ICF seems to be too laborious for day-to-day work. Some health professionals prefer a far more individual approach when working with patients and think that even the ICD and DSM are too restrictive.
- Implementation of such a complex system as the ICF may take an entire decade. And then it might be questionable if it is still state-of-the-art. However, the ICF constitutes second language in terms of a tool for different vocational groups (medical doctors, psychotherapists, social workers, physiotherapists, etc.) and helps set common goals for the treatment.

The delegates discussed the extent to which the ICF is implemented in their home country.

- The ICF is implemented by law in Germany. The Dutch Department of Health intends to implement it by law. It is in use in other countries like the UK, Spain, Portugal, mostly in physical or neurological rehabilitation. There is no general implementation so far.
- Beyond this, the ICF was not implemented in clinical practice at all and very little is known about it, although it might be considered useful. Careful consideration should be given on how the ICF can be implemented, as it might create resistance in clinicians.

- Because reduction of symptoms does not necessarily mean an amelioration of disabilities, the functional approach of the ICF was taken for granted by all participants.

The delegates came to the following general conclusion:

The ICF covers the entire field of medicine and includes over 1424 Codes. For this reason, the ICF is not practical for use in the field of psychosocial care after disaster. Core sets for stress response syndromes like the Q-FIS-SR may be practical for use in the aftermath of disaster for stress response and recovery.

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Appendix

Table 1: Categories of Q-FIS and Case report Mr. Williams

Body Functions						Activity and Participation						Environmental Factors												
b/GP		1	2	3	4	C		1	2	3	4	C		4	3	2	1	0	1	2	3	4	C	
b/GP	Imp. of general psychopath.						d155	Acquiring skills						e230	Natural events									1
B117	Intellectual functions					1	d160	Focusing attention						e235	Human-caused events	■	■	■						1
B122	Global psychosocial functions	■	■	■		1	d175	Solving problems						e310	Immediate family					■	■			1
B126	Temp. & personality functions	■	■				d177	Making decisions	■	■				e315	Extended family					■	■			1
B130	Energy and drive functions	■	■				d220	Undertaking multiple tasks	■	■	■			e320	Friends					■	■			1
B140	Attention functions						d240	Handling stress	■	■	■			e325	Others **					■	■			1
B134	Sleep	■	■				d470	Using transportation	■	■	■			e330	People in authority position			■	■					1
B144	Memory functions						d475	Driving						e335	People in subordinate positions			■	■					1
B147	Psychomotor functions	■	■				d510	Washing oneself	■	■				e340	Care providers and assistants									1
B152	Emotional functions	■					d520	Caring for body parts						e350	Domesticated animals									1
B156	Percept. functions/ Intrusions	■					d550	Eating						e355	Health professionals									1
B160	Thought functions						d560	Drinking						e360	Other professionals						■			1
B164	Higher-level cognitive functions						d570	Looking after one's health						e460	Societal attitudes									1
B/PD	Peritraumatic dissociation	■	■	■			d630	Preparing meals																
B110	Consciousness functions	■	■	■		1	d640	Doing housework																
B114	Orientation functions	■	■	■		1	d660	Assisting others																
B1800	Experience of self	■	■	■		1	d710	Basic interpers. interactions	■	■														
B1801	Body image					1	d720	Complex interpers. interactions																
B1802	Experience of time					1	d730	Relating with strangers	■	■	■													
b/GBF	Imp. General body function	■	■	■			d740	Formal relationships																
b280	Sensation of pain	■	■				d750	Informal social relationships																
b310	Voice functions/ Speechless	■	■			1	d760	Family relationships																
b410	Heart functions	■	■				d770	Intimate relationships																
b420	Blood pressure functions						d845	Job Activity and Participation *																
b440	Respiration functions	■	■				d870	Economic self-sufficiency	■	■														
b510	Ingestion functions						d910	Community life																
b515	Digestive functions						d920	Recreation and leisure																
b620	Urination functions						d930	Religion and spirituality																
b640	Sexual functions						d950	Political life and citizenship																
b650	Menstruation functions																							

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Table 2: Questionnaire on Functioning and Disabilities-Stress Response (Q-FIS-SR)

Body Functions		1	2	3	4	C	Activity and Participation					1	2	3	4	C	Environmental Factors																										
4	3	2	1	0	1	2	3	4	C																																		
b/GP	Imp. of general psychopath.						d155	Acquiring skills								e230	Natural events																										
B117	Intellectual functions						d160	Focusing attention								e235	Human-caused events																										
B122	Global psychosocial functions						d175	Solving problems								e310	Immediate family																										
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B156	Percept. functions/ Intrusions						d550	Eating								e355	Health professionals																										
B160	Thought functions						d560	Drinking								e360	Other professionals																										
B164	Higher-level cognitive functions						d570	Looking after one's health								e460	Societal attitudes																										
B/PD	Peritraumatic dissociation						d630	Preparing meals																																			
B110	Consciousness functions						d640	Doing housework																																			
B114	Orientation functions						d660	Assisting others																																			
B1800	Experience of self						d710	Basic interpers.interactions																																			
B1801	Body image						d720	Complex interpers. interactions																																			
B1802	Experience of time						d730	Relating with strangers																																			
b/GBF	Imp. General body function						d740	Formal relationships																																			
b280	Sensation of pain						d750	Informal social relationships																																			
b310	Voice functions/ Speechless						d760	Family relationships																																			
b410	Heart functions						d770	Intimate relationships																																			
b420	Blood pressure functions						d845	Job Activity and Participation *																																			
b440	Respiration functions						d870	Economic self-sufficiency																																			
b510	Ingestion functions						d910	Community life																																			
b515	Digestive functions						d920	Recreation and leisure																																			
b620	Urination functions						d930	Religion and spirituality																																			
b640	Sexual functions						d950	Political life and citizenship																																			
b650	Menstruation functions																																										

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