EUTOPA

European Network for Psycho-Social Aftercare in Case of Disaster

Target Group Intervention Programme
Manual II

Manual for target group intervention within the scope of major losses and disasters

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The manual for target group intervention within the scope of major losses and disasters has been developed in the course of the project „European Guideline for Target group Oriented Psychosocial Aftercare in Cases of Disaster (EUTOPA)“, which is sponsored by the European Union.

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Preface

The manual for target group intervention within the scope of major losses and disasters (booklet II) was developed in the course of the project „European Guideline for Target group Oriented Psychosocial Aftercare in Cases of Disaster (EUTOPA)“, which is sponsored by the European Union. The main question of the project is: According to current research, what kind of crisis intervention measures have proven to decrease the risk of victims developing stress disorders following major loss situations? In this connection, the workgroup adopts the approach that identifying survivors who are at a high risk of developing a chronic stress disorder through so-called “screenings” is essential for psychosocial aftercare.

By Screening we mean a combination of various survey parameters. Risk factors for developing a post-traumatic stress disorder as well as surveying the severity of symptoms are among these parameters. The screening works in the sense of a switch stand in the scope of the overall concept of target group intervention (TGI).

In our manuals (I to III) we have adapted the conception to the requirement profile of international major loss situations. The focus of manual I is on a basic element of TGIP. It deals with theoretical and practical background for implementing the Cologne Risk Index, which is adapted for a checklist to measure the victims’ risk-profile. The manual at hand contains the modules for target group intervention and differentiated measures in the context of establishing target groups. In manual III we present a manualised form of trauma-based psychoeducation. Our concept is based on the opinion that process-orientation and identifying risk groups is instrumental to the implementation of a crisis intervention programme. In the past, we developed this concept for different types of situations. We have developed this concept for various types of situations in the past. Along with PLOT and EUTOPA we aim to implement the concept in a European context while using the Internet. For this we have created the websites www.eutopa-info.eu and www.plot-info.eu. The manual is written with professional helpers in mind and supposed to show this target group the possibilities and limitations of the method.

Literature on Target Group Intervention Programme (TGIP)

Translations of the manual in English, French, Spanish and German are available at

www.eutopa-info.eu

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

www.ikpp-bundeswehr.de

www.plot-info.eu

1. Introduction

In the recent decades, there has been a marked increase in natural disasters as well as major losses caused by technical failure or terrorism (e.g. natural disasters: www.emdat.com). Major losses mean that many people directly or indirectly affected, as well as who were their families, victims, bereaved persons, witnesses, the affected community and relief units need to be cared for. Aside from the medical treatment of those injured, the necessity of acute, midterm and long-term care has been increasingly recognized and advanced in the past 15 years.. The need to incorporate psychosocial emergency care of those affected from the beginning is uncontested among experts. This topic is also finding increasing recognition in our neighbouring European countries.

According to the definition criteria of the Norris workgroup (2002), a disaster is characterised by three key features: (1) a sudden beginning, (2) the collective experience and being collectively affected by the disaster, and (3) a collectively great degree of threat and destruction. By definition, this distinguishes disasters from enduring stress, e.g. war (cf. Piper, 2005). After a disaster

- a large number of people are affected directly and indirectly,
- a large number of people need medical treatment and psychosocial support,
- there are great physical, social and mental challenge
- regional emergency medical services - including emergency psychosocial capacities - do not suffice,
- various occupation groups are involved and need to be coordinated (emergency medical services, physicians, and management, and psychologists, fire brigade, police, military, ministers, psychotherapists, etc.),

catches up with us with each major loss. The general conditions of from 9/11 in New York to the terrorist attacks in Madrid 2003 and London 2004, flood disasters and the tsunami 2004/2005 have repeatedly demanded a great deal of flexibility in order to rise to the demands of a disaster.. Each event develops its own dynamic and requires a great deal of commitment, creativity, flexibility and resilience from helpers.. Experiences must be integrated and concepts need to be revised after each disaster.. "The heterogeneity of traumatic events and their aftermath defies any specific guidelines, and there is a need for flexibility of interventions and adaptations to specific circumstances." (Hobfoll et al., 2007, 284)

- central leadership and organisational structures for acute as well as mid- and long-term care are necessary,
- the required assistance is highly complex,
- capacities for mid- and long-term care are usually overstrained; resources may have been destroyed,,
- security in one's own surrounding might not exist anymore; entire areas or regions are affected and
- trust in public officials is put to the test and easily upset..

Experience continues to prove that the realisation of developed concepts, strategies and guidelines is difficult and we have no way of preparing for every possible event. The unpredictable reality

In the actual case of a disaster, mid- and long-term stress reactions must be expected in victims, their families and rescue workers.. In this case it is the collective challenge of all professional helpers to ameliorate suffering, and support victims and help them return to their normal lives.
The European Community promotes research projects that deal with the conceptualisation of psychosocial emergency care and prevention of long-term psychological consequences to victims of disasters. Conceptual work and networking on a European level is necessary, as disasters cannot be limited to European borders.

Thus the project "European Guideline for Target-Group oriented Psychosocial Aftercare in Cases of Disaster - EUTOPA", that was promoted by the Department of the European Community Environment, is focused on the optimisation of psychosocial care in case of disasters. Under the coordination of the bureau of international affairs of the city of Cologne, an international research network cooperates: the Cologne university's Institute for Clinical Psychology and Psychological Diagnostics (IKPPD), the Centre for Psychotraumatology in Krefeld, the Impact foundation in Amsterdam, Netherlands as well as the Spanish Society of Psychotraumatology and Dissociation (SEPET+D) in Madrid, Spain.

This cooperation aims to identify gaps in coverage and further conceptual development of existing concepts that can be put to practice in European countries. If we want to sensibly integrate crisis intervention programmes in emergency aid, we are dependent on minimum standards that consider the course of the process of stress disorders. The main question here is: According to current research, which crisis intervention measures have proven useful in acute, mid- and long-term aftercare in order to curtail the risk of post-disaster stress disorders?

Uncertainty concerning effectiveness and goal orientation is evident in the conception and empirical examination of crisis intervention measures as well as acute, mid- and long-term aftercare (cf. Bering, 2005; Bering et al., 2006). "No evidence-based consensus has been reached to date with regard to effective interventions for use in the acute and the mid-term post mass trauma phases." (Gersons & Olff, 2005 in Hobfoll et al., 2007, 284). EUTOPA comprises of suggestions how to proceed in order to optimise and assure the quality of crisis interventions and preventive measures.

One of the contributions of the Institute for Clinical Psychology and Psychological Diagnostics (IKPPD) and the Centre for Psychotraumatology at the Alexianer hospital in Krefeld within the EUTOPA project is the adaptation of the Target Group Intervention Programme (TGIP) to the situation type and dynamic of process for victims of disasters. TGIP focuses on individual mid- and long-term aftercare measures and aims to connect to early intervention concepts as seamlessly as possible. For a differentiated presentation of current empiric standards regarding acute and early intervention, we refer to the manual „Multidisciplinary Guideline-Early Interventions after disasters, terrorism and other shocking events“ by our project partner in the Netherlands (Stitchting Impact, 2007; www.eutopa-info.eu).

With regards to content, the question arises for the adaptation which measures are efficient at which point in time of the potentially traumatic process (Fischer & Riedesser, 2003) during and after a disaster. It is beyond dispute that people in an existentially threatening and impairing situation need support. The goal of efficient psychosocial aftercare measures must also be the minimisation of the development of stress disorders due to trauma in the sense of a successful secondary prevention. The prevention of a posttraumatic stress disorder (PTSD) was mainly aimed for and surveyed in the past. Today's state of knowledge, however, is that the impact of stress after a potentially traumatic experience is clearly more complex, so that an empirical focus on PTSD does not do the scope of stress reactions justice. Acute stress reaction (ICD: F 43.0), Adjustment disorder (ICD: F 43.2), and Posttraumatic stress disorder (PTSD - ICD-10: F 43.1) are some of the psychological impairments, along with comorbid disorders in cases of long-term progresses (e. g. depression, anxiety- or somatisation disorders as well as addictions).

Chapter II of the manual TGIP in Cases of Disaster begins with an introduction to different levels of target group oriented intervention measures.

2. Measures of target group intervention in the scope of psychosocial aftercare after major losses and disasters

Target group intervention (TGI) is considered a secondary preventive concept of individual psychosocial aftercare. Its purpose is to prevent the development of long-term stress disorders following critical incidents. Planning an intervention strategy in the scope of TGI in cases of major losses is geared to the procedures of TGI with victims of violence (Fischer et al., 1999) and soldiers of the German armed forces (Bering et al., 2003) and is adjusted to the logistic and structural conditions of major losses. The fundamental differences between the concept of TGI and other early intervention concepts are::

1. a screening instrument developed for the sole purpose of early detection of persons at risk (Cologne Risk Index - KRI, see Manual I) and

2. the distinction between risk-independent and risk-dependent intervention measures

Early detection of factors that promote the development of a stress disorder plays a key role in this concept.. In order to assess the risk, an appropriate questionnaire, i.e. a checklist, that enables prognostic inferences to the coping progress (cp. Bering et al. 2008, chapter I). After assessing each risk profile, individually customised interventions can be suggested and initiated.

We refer to the concept of customised intervention measures as Target Group Intervention (TGI) (Bering et al., 2000a; Bering et al. 2001b; Bering et al., 2003; Schedlich et al., 2003), whereas we distinguish between measures that are offered regardless of the individual risk

profile of persons concerned and measures that are customised to the individual risk profile.

We assume that the early detection of risk persons using the KRI and the customisation of intervention measures enable an economical planning, that can guarantee the ideal support of even large numbers of affected persons and low staffing.

It is emphasised that the reaction to extremely stressful experiences should not be viewed as pathological or as the pre-stage to pathology. Many people temporarily suffer from normal stress reactions and mainly need support in re-establishing resources and returning to normalcy, not traditional diagnostic procedures or clinical treatment (Hobfoll et al., 2007).

The basis of planning interventions for individual psychosocial aftercare is

1. the orientation on the time criterion, to the process model of traumatic stress, and
2. the orientation on the risk profile of affected persons, risk evaluation using the KRI (cp. Bering et al., 2008, Band I)

The phaseal boundary is difficult with many disasters and the event of large numbers of injured persons because of the continuous violence, sustained shock and lack of aid. Furthermore it is often difficult to create a clear boundary between an acute situation and a post-situation period; as a result, acute measures may overlap with intermediate-term aftercare.

The risk profile for developing a stress disorder can only be assessed within the course of the process. So the question arises, at what point in time should which promising intervention measure be implemented? Furthermore the question arises as to which interventions are appropriate for the different contrast groups. In order to find answers to these questions, the axis of time in fig. 1 has been divided into the acute phase (A), the transition phase (B) and the impact phase (C). Moreover, the standard modules of target group intervention (see fig. 1) have been divided into risk-dependent and risk-independent modules of target group intervention (see fig. 2).

In case of major losses and disasters, there are three condition criteria that influence the respective planning of intervention and that are distinctive to TGI:

1. At what point in time of the traumatic process does the intervention come into action?
2. Under what network conditions is TGI implemented?
3. How many people are affected by a critical incident?

The number of affected persons and the availability of professional helpers are pivotal to the setting (individual or group setting) and the extent of help possibilities. The objective is to offer adequate help to as many affected persons as possible in order to prevent long-term disorders, while making ideal use of staff capacities. The psychosocial aftercare for relief workers must be optimised as well, in order to prevent psychological after-effects and sustain work capability.

It is necessary and sensible to provide a target group oriented intervention strategy so that affected persons as well as relief units are neither over- nor under-accommodated with supportive measures.

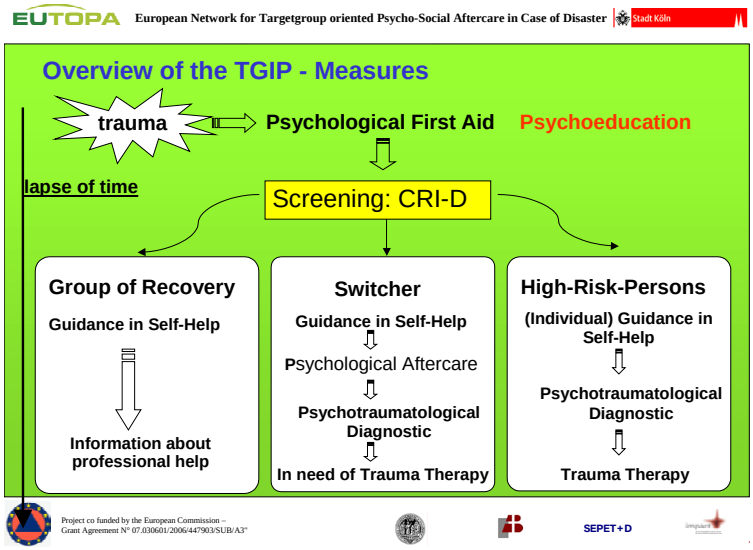

Figure 1: Standard flow chart of target group intervention
The type of intervention is dependent upon the course of the process. Acute care is central to phase A. Phase B describes the length of time between shock and early impact. Psychoeducation and screening with the Cologne Risk Index are at the centre of phase B. Phase C leads into the graduated planning of intervention for the self-recovery, switch and risk group. (from Bering et al., 2003)

The acute care of affected persons through primary safeguarding and psychological first aid are among the risk-independent measures (phase A). Only after the shock phase has subsided can psychoeducative information that is geared towards the KRI, among other things, be implemented. Discussion of the results and brief counselling conclude the passage into the early impact phase (B).

Monitoring, continuative diagnostics, individual counselling, family counselling and acute trauma therapy are among the risk-independent intervention modules. These interventions are allocated to phase C on the time base. Thus the helper orients their choice of intervention by the time base and the victim's risk profile. Therefore we must disassociate ourselves from the somatological paradigm of emergency medicine, so that accessible diagnostics (psychological triage) at the place of the incident and in immediate hospital treatment respectively would be possible. While the training of emergency physicians and paramedics aims to enable them to recognize and administer life-saving interventions at the place of the incident, if possible, therapists and first aiders must be able to survey the complete course of process and prevent the chronification of a stress disorder during a psychosocial crisis intervention programme. The somatic paradigm of emergency medicine thus cannot be translated to crisis intervention programmes one-to-one.

In the following we will specify the intervention modules of target group intervention programme in order to characterize it more precisely.

Interventions during the acute traumatic situation, the impact phase and in the traumatic process go by the motto: As much as necessary, as little as possible.

In planning an intervention, it is important to distinguish between basic prevention measures for all persons affected and tiered measure that depend on the individual risk profile. In content the emphases vary depending on the point in time of the intervention, i.e. whether interventions are offered in the context of the acute situation, the impact phase or the traumatic process. The planning of the intervention in the context of TGI is described in the following chronological order, whereas we distinguish between risk-dependent and risk-independent measures.

Target group intervention measures for affected persons	
Risk-independent measures	**Risk-dependent measures**
1. Acute care	1. Monitoring
2. Psychological acute care	2. Continuing diagnostics
4. Psychoeducation/information	3. Individual counselling
4. Screening with the KRI-D	4. Acute trauma therapy (e.g. MPTT)
5. Instructions for self-help	5. Family counselling
6. Discussion of results and individual counselling	

Fig.2: Risk-dependent and risk-independent measure in the context of TGI

Before tiered, risk-dependent interventions become effective, basic psychologically relevant measures, aside from medical treatment, must be implemented within the scope of secondary prevention. acute care of those affected by providing primary safety and psychological first aid are among these measure. Furthermore psychoeducation and screening with the KRI-Bw, discussion of the results, brief counselling and instructions for self-help should be implemented no earlier than after the initial shock phase has worn off.

2.1 Risk-independent measure in TGI

2.1.1 Acute care

In the acute situation and immediately thereafter, independently of their risk profile the following measures belong to the primary care of those affected:

- Medical treatment
- Safeguarding and protection for those affected
- Seeing to it that all primary needs (thirst, hunger, warmth, hygiene) are met
- Distancing from the place where the event happened
- Information about the event (cause, extent)

- Information on the whereabouts of family members
- enabling getting in touch with other family members
- grief support
- information about continuative help
- offers to talk

Medical care is always a priority when dealing with major losses. Acute psychological care, however, is a key part of care and effects the way victims deal with what they have experienced positively. Rebuilding relative safety and primary care as well as clear information are in the foreground. Another paramount concern during this stage is the recreation of social connections (Hobfoll et al., 2007). Information is an existential human necessity - to know whether loved ones are unharmed and well. Transparency and to an extent knowing the reasons for courses of action (medical measures, necessary separation of families during medical treatment, shelter possibilities, contacts) are helpful in order to counteract the loss of control. Questions that those affected have about the situation are not ignored but answered to the best knowledge and correctly, since the victims have a pronounced desire to know as much as possible at this time. Information must be presented in a brief and clear manner since the intake capacity is extremely limited in the shock situation.

Transparency and calming attention are internalised positively in this situation (Bengel, 2007; Lasogga & Gasch, 2000). Further measures, such as psychoeducation and in depth instructions for self-help etc. are not indicated at this early time and are not promising for lasting preventive effects (vgl. Bäumker & Bering, 2003).p

2.1.2 Psychosocial support measures in the latency phase and after (phase B and C)

Following the acute situation, those affected often have necessities regarding the safeguarding of their daily life and material resources, as well as safeguarding the social network, depending on the situational context. Providing appropriate counselling and support opportunities (e.g. regarding financial support, legal clarification, finding missing persons) and help with dealing with public authorities and giving those affected the information about these opportunities is of main concern here.. Depending on the detraction to the person's context of life, this support can be necessary over a long period of time (months to years). Victims of terrorist attacks, for example, frequently need support with legal actions against the terrorist for a long time. In extreme cases these legal actions can go on for decades, like after the bombing in Bologna in 1981. Disputes over monetary compensation, e.g. after technical disasters, are also often linked to long preliminary proceedings..

Funeral services and commemoration services also need to be organized and supported. Affected persons might eventually need support in creating a memorial.

Ensuring the above-mentioned support as seamlessly as possible is one of the goals of the concept of psychosocial aftercare after disasters.

The psychological aftercare measures mentioned in the following text focus on individual secondary preventive support in dealing with traumatic experiences and the reduction of stress disorders, as well as the prevention of long-term stress disorders.

After the initial shock reaction has subsided, initial psychoeducative, informative measures can be implemented. If psychoeducation is not possible at this time, e.g. due to deployment issues, medical or personnel reasons, it can be offered at any later point in the course of the traumatic progress as well. More specific descriptions of content and implementation of psychoeducational measures can be found in volume III (cp. Zurek et al., 2008, Band III).

Subsequent to psychoeducation, screening with the KRI-D is implemented in order to get a differentiated assessment of the individual risk profile. Depending on the result of the KRI assessment, those affected are assigned to the groups of self-recovery, switchers or risk persons. The assignment of affected persons to the risk groups depending on the level of points in the risk index is the basis for target-oriented, continuative intervention. The results of the assessment are **always** and **only** disclosed in individual contact. A differentiated description of the KRI for use in case of a disaster can be found in volume I (cp. Bering et al. 2008, Band I).

2.1.3 Information and brief counselling after screening with the *Cologne Risk Index Disaster*

After the screening with the KRI, which ideally should be conducted in individual contact, e.g. in a counselling session, each affected person's personal risk profile and prognosis is discussed with them in **individual contact (!)**. Personal contact allows the counsellor a brief explanation of potential risk and protective factors, assessing individual resources and needs during the post-expositional time and a first impression of trauma-compensatory strategies.. Depending on the time available, those affected are able to talk about their traumatising experience in an individual setting. The counsellor however should avoid an emotional immersion into this context and intervene in a resource-oriented way and advise on where to find further contact. In particular arranging counselling possibilities on a needs-basis, e.g. legal and administrative aid, trauma counselling and / or trauma psychotherapy is of key importance here. All three groups (self-recovery, switchers, risk persons) are pointed to sensible courses of dealing with their experiences during the latency phase, like talking to others about their experiences and finding rest and retreat in order to support the healing process.
Discussing and explaining in detail necessary and possible support opportunities is essential to brief counselling. Transparency regarding possible and potentially necessary actions can have higher compliance as a result in the long run.

If this has not been done already, affected persons should be given "pocket cards" with essential information at the end of the individual contact. These cards should contain contact numbers and addresses they can turn to if need be. Necessary contacts to professional help can also be initiated jointly with the affected person.

Brief counselling of persons in the self-recovery group
Indicators of an adverse course of processing and professional help options are explained. Further contact after a time period of 2 to 4 weeks is offered.

Brief counselling of switchers
Switchers are pointed to sensible behaviour patterns, e.g. talking with others, finding rest and retreat, doing sports, etc. Furthermore the switchers are particularly sensitised to additional stress factors during the latency phase that could lead to an advanced progress, e.g. additional stressful experiences, social or administrative problems, familial or financial troubles. Indications for an adverse progress of processing the experience are explained. Further contact with the switchers during the latency phase is scheduled.

Brief counselling of risk persons
Risk persons are advised that, due to biographical and/or situational factors, it might be more difficult for them to process the stressful experience without support. Like the self-recovery and switcher group, they are pointed to sensible behaviour patterns during the latency phase and self-help options. Beyond that, further counselling appointments that should take place in a time period that enables monitoring and accompanying the progress (at least once a week) are scheduled if possible.

An overview of the contents of brief counselling

- Notification of the individual risk profile
- Exploring resources and trauma-compensatory strategies
- Advising sensible behaviour patterns during the latency phase
- Pointing to self-help literature
- Sensitisation to adverse progresses
- Introduction to (professional) support and contact possibilities
- Initialisation of necessary support contacts (e.g. legal and administrative aids, financial aids, counselling, trauma psychotherapy)

2.1.4 Instructions for self-help

Another action that is offered to persons belonging to the self-recovery group, the switcher group as well as the risk group is the instruction for self-help. The affected persons are shown distancing and self-calming techniques that they can use to control and reduce traumatic material. Among these are distancing exercises (e.g. distraction by arithmetic, seeing-hearing-feeling), imaginative techniques (e.g. light-

energy-technique, safe inner place, inner helper), relaxation exercises and information about stress reducing habits (Fischer, 2003; Reddemann 2001). These techniques support the natural coping process and promote the transition to the recovery phase. With these exercises persons affected can have the experience that they are able to influence their emotions and thoughts. The possibility of cognitive and emotional control counteracts the traumatic experience of loss of control and helplessness. Experience shows that affected persons can utilise the offered techniques in a variably positive way. It makes sense to offer a large variety of techniques so that each person can chose those that are most useful and "fitting" to their personal preferences. Because the possibility to use these techniques is often limited due to time restrictions, pointing to the self-help brochures is especially important. In the brochures, affected persons can find a broad spectrum of exercises that they can try and chose according to their individual preferences.

The techniques can be shown in an individual or group setting. For risk persons, the risk of being flooded with traumatic material, especially during imaginative exercises, cannot be excluded. Should the techniques be offered in a group, risk persons should be monitored closely and have been introduced to some techniques for self-calming in previous individual contact. It is especially important to include relief units in group offers, since the integration and support of in a group of colleagues can be used as a protective factor..

2.2 Risk-independent, target group oriented intervention measures

After the acute care, psychoeducation/ information, screening, brief counselling and instruction for self-help the offered measures of support differ depending on the individual risk profile (cp. fig. 1).

Active monitoring and support, psychotraumatological diagnostics and acute trauma therapy can be offered..

Active monitoring and support:

Active support can be in form of contact by phone or in person. By recognizing additional stress factors, the risk of chronification of symptoms can be assessed in time and acute trauma therapy can be initiated if needed.

Diagnostics:

In order to assess the individual process of dealing with trauma, diagnosis instruments can be used to establish the traumatic process as well as treatment options. Extensive diagnostics should only be made and evaluated by professionals, since previous knowledge and experience in the subject of psychotraumatology are imperatively necessary. Trauma diagnostics and an extensive anamnesis as well as a series of trauma diagnostic procedures are used to survey the extent of previous traumatisations and the development of symptoms.

Psychotherapy

Trauma psychotherapy is already indicated for the risk group during the latency phase. In the context of international research, cognitive behaviour therapy is the preferred method (Nice-Guideline, 2005, Impact, 2007, Hobfoll et al, 2007). However, we

have also had achieved positive results with psychodynamic methods (Horowitz, 1976, Fischer, 2000) particularly as there is a multi-disciplinary approach to trauma confrontation.

2.2.1 Target group intervention for the self-recovery group

If a person has been assigned to the group of self-recovery, it is very likely they will not develop a resulting symptomology even if they develop symptoms like hyper arousal, avoidance or intrusions at first. For this group the offered supportive measures during the processing can suffice. In any case it is helpful to sensitise the affected persons to pathogenetic progressive forms and point them to support offers. Further contact after two to three weeks - personal or by phone - can be offered. Potentially adverse progressive forms and additional stresses can be determined and further support offered if necessary.

2.2.2 Target group intervention for switchers

Affected persons that have been assigned to the group of switchers often display the risk of a chronic progress if further stresses occur after the event, for example lack of social support, unjustified accusations, legal disputes or further traumatisation. For this reason these persons need an extensive after care in the sense of active monitoring and support. Direct contact during the time of traumatic impact and thereafter enable the assessment of possible risk potentiation. Continuative intervention, such as counselling or acute trauma therapy, can be offered early on in the case of progressive development.

Regular contact in the weeks and months after the event, whether by phone or in person of a counsellor for psychotraumatology or trauma psychotherapist, should be arranged in a counselling interview. Establishing contact *always* takes place through the person's counsellor or another professional, since the avoidance tendencies immanent to trauma and possibly depression, minimisation and denial can be prevented through actively contacting the affected person.. It is advisable to agree upon concrete appointments for contact by phone or in person. This conveys a sense of safety and can mean a psychological "anchor" the affected person. If appointments are not kept, it is incumbent upon the person concerned to actively seek contact and to give an explanation to why they did not keep the appointment. Only this way can pathogenetic denial and retreat tendencies be recognized and intercepted early on.

The frequency of contact varies depending on the assessment of the risk of a progressive development. The more a person is at risk, the closer contact should be kept.. This way, arranging an appointment after a month can suffice if the person's own and social resources are good, however, appointments should be made biweekly with persons at risk.

If the progress "leans" towards chronification in the process of the traumatic impact, be this by an increase in stressful circumstances or because of a lack of social and/ or personal resources, continuative measures are necessary.

Differentiated clinical diagnostics can establish whether a PTSD or other psychotraumatological disorder has developed. To prevent a chronification, acute trauma therapy should be recommended in any case. It is advisable to recommend that those close to the affected person are involved in counselling and treatment in order to strengthen one of the essential protective factors, social support.

2.2.3 Target group intervention for the risk group

If persons were assigned to the risk group, continuative measures should be implemented directly. Persons at risk should receive support from psychotherapists and psychiatric therapists.. Aside from substantiated psychotraumatological diagnostics, extensive individual counselling should be given at any rate in several appointments. In the acute or early impact phase, the emphasis lies on strengthening resources and the ability to distance oneself from traumatic contents. The individual trauma compensatory mechanisms should be established and strengthened and techniques for self-stabilisation should be related. Only at a later point of the traumatic process should a focal acute trauma therapy with explorative elements be carried out..

3. Structural implementation – The problem defined and the solution statement

The project EUTOPA focuses on supporting victims of disasters, their families and bereaved as well as the training of relief organisations that are involved in the immediate and long-term after care of the victims. According to the results of customised psychotraumatology, the graduated measures of target group intervention within the EUTOPA project are adapted to the needs of the specific target group while considering the aftercare possibilities in the various European countries.. The EU aspires to optimise the measures of the involved relief organisations by increasing transparency. In order to guarantee a substantiated aftercare of victims, broad training of the involved professional groups is necessary.

The key activity of the EUTOPA project partners is to optimise the intermediate and long-term aftercare of victims of disasters in a way that enables time sensitive and efficient support in cases of major loss. In our contribution this particularly pertains to continuative individual interventions, such as screening, psychoeducation, instructions for self-help, needs-oriented counselling as well as target group differentiated psychotrauma counselling and trauma psychotherapy.

In terms of implementing measures subsequent to the acute phase, especially deliberations concerning the structural integration of intermediate and long-term aftercare is relevant and a basic difficulty of the aftercare of victims must be discussed: the repeatedly occurring difficulties of interfaces and the necessity of optimising the transition from acute care into intermediate and long-term aftercare.

Experience in major losses has shown that there is frequently a large contingent of helpers at the site of a disaster that offer psychological support to the victims. So in the immediate situation, support - not judging its quality - is often present in excess. The coordination of those helping, the integration of psychosocial supporters into existing structures of danger defence, the cooperation between various professional groups and relief organisations as well as the transition into continuative providence frequently presents a difficult challenge. Accordingly, one work group within the expert conferences taking place within the EUTOPA project (direction: Orengo, Schedlich, Vymetal) focuses on the interface difficulty and the formulation of solution approaches. According to experts, the consequences of lacking coordination and integration of the various professional groups and structural networks can be summarised as follows::

- Overprovision and with that the overburdening of victims onsite.
- Decreased acceptance of psychosocial support and relief workers by victims and the public.
- Undersupply or problematic gabs in the supply to victims due to lacking coordination of resources, lacking communication, knowledge and integration of the structures of danger defence.
- Uncertainty, helplessness and anger on the part of victims - the experiencing of yet another loss of control.
- Loss of trust in political authorities.

(Results of the first expert workshop, Cologne, November 2007; Orengo, Schedlich, Vymetal, www.eutopa-info.eu)

In order to ensure the differentiated and needs-oriented care of those affected, structured deliberations on the integration and coordination of the psychosocial emergency care (PSEC) must be made..

Psychosocial emergency care (PSNV) stands for the total structure of preventive as well as short, intermediate and long-term psychosocial and supportive measures in the context of stressful emergencies i.e. operations. PSEC contains the *offers* (e.g. aftercare of relief workers, bereavement counselling, crisis intervention, psychological first aid, counselling, therapy, etc.) as well as the *offerors*, whose forms of organisation and structures as well as legal provisions in the individual countries. Greater goals of psychosocial emergency care are:

- making adequate support and help available to help affected groups and individuals process their experiences,
- prevention and early detection of psychosocial stress effects after emergencies as well as
- the appropriate treatment of stress disorders and, regarding relief workers, psychological stress related after deployments. (cp. Helmerichs, 2007)

To support the transition from acute into intermediate aftercare, the immediate supply of written information at the site of the event as well as the offer to contact persons whose address has been recorded

at a later time are helpful measures. One possible solution to the optimisation of intermediate and long-term offers that is also represented by many European experts and that is formulated in the EPP is installation of a **central coordination centre** in the countries with primarily network-oriented tasks. Comprehensively, specially trained and qualified structures of offers should be collected so that these may be accessed quickly. The installation of a coordination point belongs to the preparation for an emergency and should be included in conceptual deliberations. On a European level, mutual interfaces must be identified in order to bundle European initiatives of nationwide psychosocial care after major losses and make existing resources available beyond borders.

In case of a disaster, **regional contact points** for the population must be established, where affected persons can find unbureaucratic support quickly and find out information about continuative means of support. Regional contact points and the central point coordination centre should be closely linked in order to utilise the - often to few - available resources ideally.. It is essential that aside from informing affected persons about continuative help on site, they are informed about aftercare possibilities comprehensively and multilingually via the media. This is the only way to ensure that the information reaches all potentially affected (e.g. unharmed persons that were able to leave the site quickly and are not registered). Ideally multi-disciplinary personnel should be available (counsellors for legal, social and financial questions, psychotrauma counsellors, and psychotherapists in order to cover the complex needs of affected persons.
In order to improve the cooperation, coordination and integration of the involved government and non-government relief organisations, regular **workgroup meetings** with representatives of the relief organisations involved should be conducted on a state level as well as on a European level.

An essential part of quality assurance in psychosocial emergency care in case of major losses and disasters is the development of **minimum standards of training** the involved professional groups. This ranges from the psychosocial qualification of relief workers, acute helpers (e.g. emergency pastoral care personnel, emergency psychologists, crisis intervention teams), the personnel working crisis lines up to psychotrauma counsellors and trauma psychotherapists.. That way, the risk-independent measures of TGIP during individual intermediate and long-term aftercare, for example, do not have to be implemented by emergency psychologists or psychotherapists, but it requires the additional qualification to administer psychosocial counselling resp. psychotrauma counselling. Clinical diagnostics in the case of switchers or persons at risk and trauma psychotherapy can only be conducted by clinical psychologists and medical specialists (cp. also Blank und Helmerichs, 2008)

Measures for the structural optimisation of intermediate and long-term psychosocial aftercare in case of disaster

- Setting up a **central coordination centre** in the countries with primarily network-oriented tasks and the gathering of qualified aid offers for intermediate and long-term aftercare as well.
- **Setting up regional contact points** for the population, along with the provision of multi-disciplinary support offers that should preferably be availably over the time of several months to a year.
- Repeated **information** about contact possibilities and opportunities to get help **via public media.**
- Use of **Internet portals to distribute information**
- regular **workgroup meetings** with representatives of the organisations involved in order to improve the cooperation, coordination, differentiation of tasks and agree on resources
- **Development of minimum standards of qualified training** of the professional groups involved, on the level of the respective requirements profile.
- Preferably previous **clarification** of **costs being covered** by municipalities, communities, countries, etc.

4. Measures of target group intervention to prevent psychological long term disorders persons affected by disasters - Summary

If we reference the structural considerations on optimising the transition from acute into intermediate care and the measures of TGIP to the currently formulated effect-principles by Hobfoll et al. (2007), we can summarise: especially the extensive information about the situation, the traumatic process as well as the possibilities of continuative help in the frame of psychoeducational measures support the strengthening of the sense of relative security, promotes trauma-compensatory competencies as well as cognitive control functions and thus reassurance and self-efficacy. The instruction for self-help is also geared towards the promotion of self-efficacy. In psychodynamic counselling and trauma psychotherapy, the aim is to work towards strengthening the trauma-compensatory schemes and control functions, while the discrepancy of the experience of threat and the compensation capacities as well as the personal importance of the experience is distinguished. The provision of continuative help options always contains a social offer as well, aside from the appreciation of the experience, the opportunity of making

contact and social integration, which has also been established as a main principle of effect. The experience of unconsciousness and loss of control can be put into perspective, self-efficacy strengthened and the experience of isolation can be counteracted. The affected person's image of self and world can be appropriated to the experience of the situation and modified in the course of processing. Processes of integration of a modified image of self and world, regaining a scope of action and experience and the experience of social and institutional assistance support the regaining of hope and focus on the future.

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