Massachusetts Behavioral Health Disaster Responder Participant Reference Guide

September 2006

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TABLE OF CONTENTS

INTRODUCTION 4
What is the purpose of this reference guide? 5
What is the MA Behavioral Health Disaster Response System? 6
MA Disaster Timeline 9
How is the National Incident Management System used in MA? 12
What is the Incident Command System? 13
How is behavioral health disaster response defined? 14
What are the principles that guide behavioral health disaster responses? 15

HUMAN IMPACT OF DISASTERS 16
What actually constitutes a disaster? 17
What are some differences between human-caused and natural disasters? 18
What are some of the common reactions to disasters? 20
What should I know about each stage of disaster? 21

UNDERSTANDING BEHAVIORAL HEALTH DISASTER RESPONSE 24
What is the difference between a behavioral health disaster response and mental health? 25
What important skills do I need to set the groundwork for BHDR? 27
What factors must I consider in order to properly screen and assess disaster survivors? ... 30

INTERVENTION: GOALS OF BHDR 31
What are the goals of behavioral health disaster response with adults? 32
What interventions best meet the needs of children in different age groups? 34
What are the goals of behavioral health disaster response with children? 36

POPULATIONS WITH SPECIAL NEEDS 38
What are the goals of behavioral health disaster responsing with different ethnic groups? . 39
What role does culture and ethnic identity play in behavioral health disaster responses? ... 40
What are some considerations for providing BHDR with different ethnic groups? 43
How can I develop cultural competence as a BHDR? 46
What are the goals of a behavioral health disaster response with older adults? 47
What are some common reactions and suggestions for interventions with older adults? 50
What are goals of behavioral health disaster response with people with mental illness? 51

STRESS MANAGEMENT FOR THE BHDR 53
What are the rewards and challenges of BHDR? 54
What are the signs and symptoms of compassion fatigue? 55
What are some strategies for stress management at a disaster site? 56
How do I incorporate stress management into my daily life? 58

JOINING THE MASSACHUSETTS BHDR TEAM 59
How do I join? 60
Behavioral Health Disaster Responder Data Form 61
In what situations might I be deployed? 62
What should I consider prior to being deployed? 62
How will I get deployed? 63
What will I do at a site? 64
MA Department of Mental Health BHDR roles & responsibilities 64
BHDR Training Contributors 66
Glossary 68
Acronyms 72
Internet Sites 73

APPENDIX A: QUICK TIP SHEETS 74
MA BHDR Deployment Quick Review 75
Alcohol, Medication, and Drug Use After Disaster 76
Brief Tips about Self-Care and Self-Help Following Disasters 77
Tips For Relaxation 79
What You May Experience 80
Helping Children After a Disaster 81
Connecting With Others I. 83
Connecting With Others II. 84

APPENDIX B: READING FOR BEHAVIORAL HEALTH DISASTER RESPONDERS 86
Phases of Traumatic Stress Reactions in a Disaster 87
Treating Survivors in the Acute Aftermath of Traumatic Events 90
Psychosocial Resources in the Aftermath of Natural and Human-Caused Disasters 100
Developing Cultural Competence in Disaster Mental Health Programs 105
Disasters and Substance Abuse or Dependence 109
PTSD in Children and Adolescents 111
PTSD and the Family 115
Managing Grief after Disaster 119
Anniversary Reactions to a Traumatic Event: 128

I N T R O D U C T I O N

"No disaster is ever the same."
~Louise Carcione

WHAT IS THE PURPOSE OF THIS REFERENCE GUIDE?

The Behavioral Health Disaster Responders Course was designed to prepare participants to become skilled members of the Massachusetts volunteer behavioral health disaster response team. Under the auspices of the Department of Mental Health and the Department of Public Health, skilled behavioral health disaster responders provide an indispensable service to victims, families, emergency responders, and other community members.

This reference guide is intended as a refresher guide for The Behavioral Health Disaster Responders Course participant. Included in this reference guide are:

- The Behavioral Health Disaster Responder's role defined and the principles that guide Behavioral Health Disaster Response work
- Basic disaster concepts
- The operational guidelines of disaster work, including an outline of the Incident Command Structure, Federal Emergency Management Agency, and the Massachusetts Behavioral Health Disaster Program
- The human impact of disaster and standard disaster reactions
- Evidence-based, best-practices including intervention strategies and techniques to be employed in the after of a disaster
- Specific interventions to match the needs of a culturally diverse populations and the needs of specific at-risk groups
- The stressors inherent in disaster work for the behavioral health responder and how to reduce the effects of these stressors

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WHAT IS THE MASSACHUSETTS BEHAVIORAL HEALTH DISASTER RESPONSE SYSTEM?

Massachusetts Department of Mental Health

As the state mental health authority, The Massachusetts Department of Mental Health (DMH) promotes mental health through early intervention, treatment, education, policy and regulation so that all residents of the Commonwealth may live full and productive lives. For many years, the primary mission of the Massachusetts Department of Mental Health (DMH) is to provide services to citizens with long-term or serious mental illness, and research the causes of mental illness. DMH is also informed by Massachusetts General Lay, Chapter 19, to "*take cognizance of all matters affecting the mental health of the citizens of the Commonwealth".* In accordance, DMH has the infrastructure in place to provide emergency and disaster crisis counseling to the general public during times of President or Governor-declared states of emergency, or other local, regional, or statewide catastrophic events.

DMH supports the Massachusetts Department of Public Health, American Red Cross, and the Massachusetts Emergency Management Agency (MEMA) with the coordination of resources, training, and operations in the delivery of disaster response services to citizens of the Commonwealth (pursuant to the Massachusetts Comprehensive Emergency Management Plan and Executive Order 144). In addition to large-scale disasters, DMH may also deploy crisis counselors, called Behavioral Health Disaster Responders, to respond to "major local emergencies" such as fires and traumatic fatalities in schools and communities. When DMH coordinates and deploys crisis counseling services, they are provided on a volunteer basis to the community for the acute phases of an emergency event.

The Department of Mental Health maintains an organizational structure that allows for a timely and appropriate response to statewide, regional, or local emergencies. This structure consists of:

- A Director of Emergency Management, Statewide Emergency Management Coordinator, and six Area Emergency Management Coordinators, who are based regionally across the state. The Area Emergency Coordinators themselves have a back-up coordinator in each area. A DMH Emergency Management Coordinator will be on-site where Behavioral Health Disaster Responders are deployed.

- A cadre of Behavioral Health Disaster Responders on a statewide emergency call-up roster.

- Partnership with other disaster mental health stakeholders to allow coordination and sharing of resources during disaster response.

- DMH provides a staff member as part of the Massachusetts Emergency Management Team (MEMT) to the Statewide Emergency Operations Center for Level IV emergency events. A representative of DMH also sits on the MEMT throughout the year for drills and trainings, and the Department acts as the lead support agency for the Department of Public Health for the State's Health and Medical Function of the State's Comprehensive Emergency Management Plan (CEMP), when activated.

Massachusetts Department of Public Health

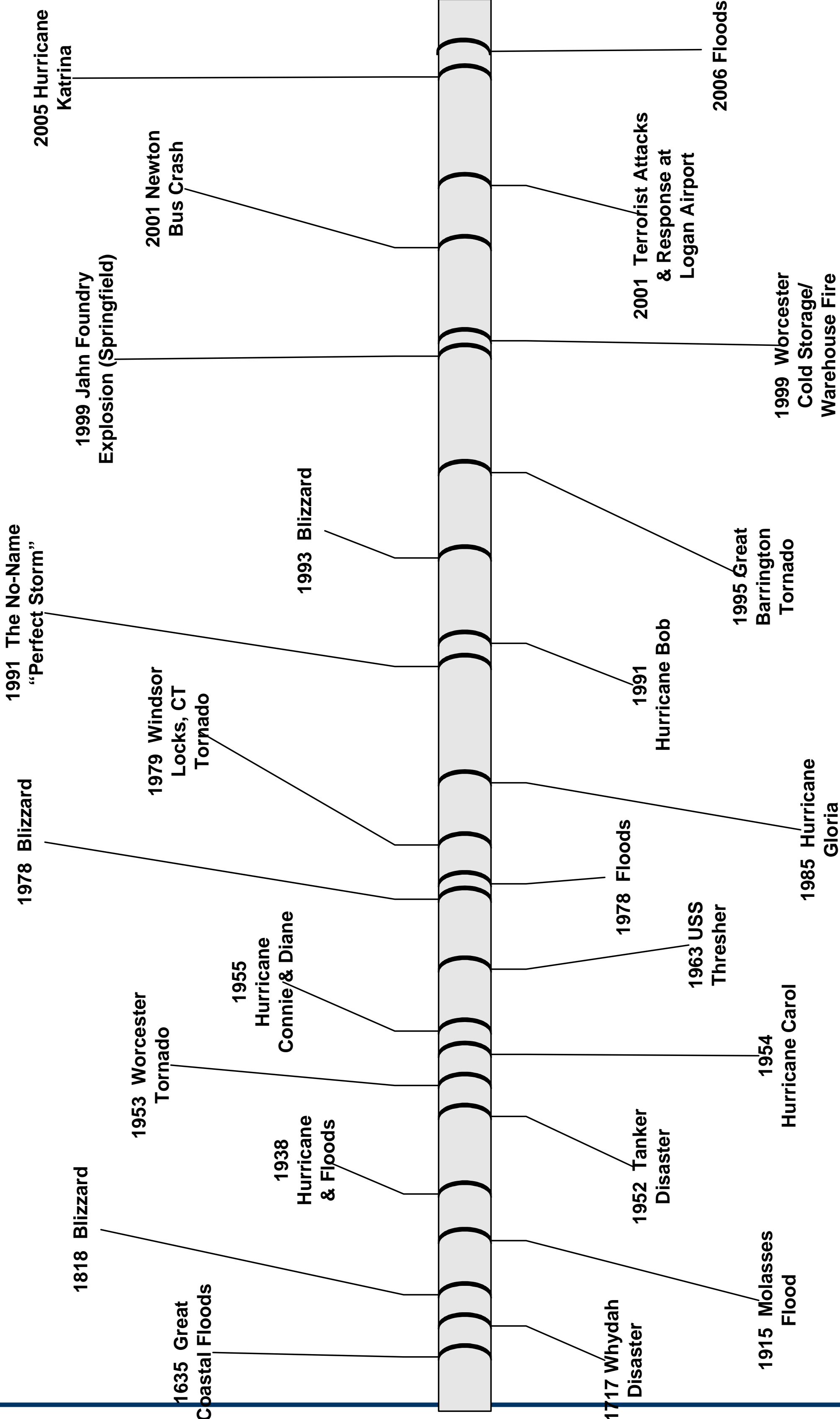
In February 2002, the Massachusetts Department of Public Health (DPH) received increased federal funding form the U.S. Health Resources and Services Administration's National Bioterrorism Hospital Preparedness Program and the U.S Centers for Disease Control and Prevention's Public Health Preparedness and Response for Bioterrorism Program. The overall objective of this funding was to enhance the public health preparedness efforts in Massachusetts. Included in the objectives was a mandate to "enhance the networking capacity and training of health care professionals to be able to recognize, treat and coordinate care related to the behavioral health consequences of bioterrorism or other public health emergencies".

To accomplish these objectives, DPH created a Center for Emergency Preparedness (CEP) and the CEP has partnered with the Massachusetts Department of Mental Health and DPH's Bureaus of Substance Abuse Services to develop a comprehensive behavioral health disaster response plan for residents of the Commonwealth of Massachusetts.

Bureau of Substance Abuse Services

The Bureau of Substance Abuse Services (BSAS) is the single state authority in charge of overseeing substance abuse prevention and treatment services in the Commonwealth. Through a collaboration with DMH, BSAS works as part of the CEP to coordinate the Behavioral Health Disaster Response for Massachusetts. Specifically, the BSAS All-Hazards Coordinator works with the DMH Emergency Management Director to develop and facilitate trainings and tools to recruit and deploy volunteer crisis counselors. In the event of an emergency or disaster, the BSAS Regional Managers, who oversee the work of substance abuse service providers, work with the All-Hazards Coordinator and the DMH Area Emergency Coordinators, who oversee the work of crisis counselors on-site, to allocate local/area substance abuse services as needed.

Massachusetts Disaster Timeline



DISASTER TIMELINE FOR THE STATE OF MASSACHUSETTS

- **August 1635: Great Coastal Hurricane** (the first recorded hurricane in New England)
- **April 26, 1717: The Whydah**, a former slave ship, was captained by Sam Bellamy who successfully plundered the New England coast for years, ran aground on Cape Cod during a harsh storm. Out of a crew of 146, only 2 men survived.
- **March 11-14, 1888: Blizzard**. This storm dumped 30 - 50 inches of snow in the region In Boston, where the snow mixed with rain, the city was covered with 9 inches of heavy wet slush
- **August 1918: Influenza outbreak** at Camp Devens, MA. This second wave of influenza broke out in Boston with remarkable speed, but both the city and the state of MA fooled themselves as to the epidemic's seriousness. On August 27, the first case reported to sick-bay on the Navy's Commonwealth Pier. Within two weeks, 2,000 officers and men of the First Naval District had the flu.
- **January 15, 1919: Molasses Flood**. Fermentation, a sudden rise in temperature, and an inadequate tank containing two million gallons of molasses exploded, flooding the streets of Boston and killing 21 people.
- **1936: Spring Floods**. Flooding caused $133 million in damage, killed 24 people and made 77,000 homeless. Mills and factories in Lawrence, Haverhill and Lowell, MA. were severely damaged. Over 80 bridges in Maine required reconstruction and a large portion of downtown Hartford, CT was submerged.
- **September 21, 1938: Hurricane and Floods**. The Hurricane of 1938 struck on September 21, 1938, with wind gusts up to 138 mph. 700 people were killed and 2,000 injured. More than $400 million in damages (1938 dollars) resulted from this and affected every New England state
- **February 1952:** Two 520' T-2 **tankers** broke in half within 40 miles of each other. The tankers were east of Cape Cod in a raging storm with 70-knot winds and 60-foot seas. The *Pendleton* out of Baton Rouge, LA, bound for Boston, MA, carrying kerosene and heating oil broke apart at dawn. The *Fort Mercer*, also carrying kerosene, and bound for Portland, ME, began to break apart later that morning about 8:00AM. The Coast Guard was able to rescue 70 of the 84 crew members.
- **July 9, 1953: Worcester Tornado**. The tornado hit Worcester at 5:08 p.m. Within one minute more than 90 people were dead and over 1,300 injured. Damage estimates were placed in excess of $52 million .
- **August 31, 1954: Hurricane Carol**. Hurricane Carol killed 66 people, injured several thousand, and left many locations in CT, RI, and southeastern MA in shambles. The storm also left several hundred homeless in southern RI, and was a major economic blow to the RI beach tourist industry. Carol had produced

destruction from Long Island to Canada, with RI, CT, and southeastern MA suffering the greatest destruction. Losses were nearly $500 million.

- **August 1955: Hurricane Connie** (4-6 inches of rain) and Hurricane Diane (20 inches of rain) within a week of each other producing major flooding. While these hurricanes affected the entire Atlantic coast from NC through MA, CT suffered the most damage. Of the 180 lives that were lost, 77 were in CT. Of the 680 million dollars in property damage, over 350 million dollars occurred in Connecticut. Over 200 dams in New England suffered partial to total failure. Many of these were in the area immediately south of Worcester, in the Thames and Blackstone headwaters.
- **April 10, 1963: USS Thresher** disaster off the coast of Cape Cod where 129 men died when the submarine imploded.
- **February 10, 1978: Blizzard**. The blizzard of '78 dumped 24 to 38 inches of the white stuff immobilizing the infrastructure and blocking major interstate highways. Thousands of motorists abandoned their automobiles on the highways and in some areas upwards of 2 weeks were required to clear the snow
- **June 1978: Floods** resulted from the February 6 and 7 "Blizzard of 1978." This storm formed in the Carolinas and moved northward along the Atlantic seaboard. The storm produced record amounts of snow and hurricane-force winds. Record tidal flooding occurred from Boston, MA, northward to Portland, ME. Total economic losses from the storm, including damages directly caused by the storm and costs of snow removal, approached $1 billion.
- **October 3, 1979: Tornado in Windsor Locks, CT**. This twister lasted only about 45-60 seconds, but managed to kill 3 people, injure over 300, destroy 40 homes and cause $300 million in property damage.
- **September 27, 1985: Hurricane Gloria**. Gloria was responsible for a total of eight deaths in the US. Two persons were killed in CT, two were killed in RI, and one each in NY and NH. It is estimated that 1 hour after the storm 2.2 million people were without electricity in the Northeastern US (Tavett). Hurricane Gloria produced one of the largest single power losses in the US up to that time: 683,000 lost power in NY, 669,000 in CT, 237,000 in NJ, 174,000 in RI, 124,000 in MD, 84,000 in MA, and 56,000 in VA. More than 200,000 persons evacuated the low lying areas on Long Island, and in NJ, MD, VA, DE, CT, RI, and southeastern MA. Total damage is estimated at $900-million in 1986.
- **October 29-31, 1991: The No-Name "Perfect Storm".** A low pressure system, high pressure system, and fading hurricane collided over the Atlantic Ocean, creating what became known as *The Perfect Storm*. This tempest slammed the eastern US, causing hundreds of millions of dollars in damage. 10 people tragically lost their lives due to the storm. About 100 homes along the Massachusetts coast were completely destroyed by The Perfect Storm. Seven counties in MA were declared Federal Disaster Areas.

- **1991: Hurricane Bob**. The number of fatalities reported as a direct result of Hurricane Bob stands at 17. Several of those killed were struck by tree limbs. A person photographing a motel roof blowing off in Provincetown, was killed when they were struck by flying debris. At least two deaths occurred on boats during the hurricane - one in eastern CT and one in MA. The regional power companies estimated that 2.1 million people lost power for more than 24-hours due to the hurricane. Total property damage is estimated at $900 million dollars.
- **March 1993: Blizzard**. The "Blizzard of the Century" ravaged the southern mid-Atlantic states from AL to MA, accompanied in other states by severe weather disturbances such as tornadoes, thunderstorms, and floods. Snow fell at rates between an inch and two inches an hour in some areas, and many locations experienced record-breaking snowfalls and record snow depths.
- **May 29, 1995: Tornado in Great Barrington, MA**. This tornado, with winds in excess of 200 mph, killed 3 people, injured 23 and caused an estimated $25 million in damage
- **February 25, 1999: Jahn Foundry explosion in Springfield**. Resulting in the deaths of three workers and serious injuries to nine others. Jahn Foundry Corp. was cited with forty safety and health violations and fined $148,500.
- **December 3, 1999: Worcester Cold Storage and Warehouse Fire**. An empty warehouse caught fire, but quickly enveloped 6 fire fighters inside, who were unable to make it out alive. It took six days to extinguish the blaze, eight to locate the remains of all six men
- **April 27, 2001: Newton Bus Crash**. A tour bus carrying sleeping middle school music students from Newton, MA, skidded off a highway off-ramp and flipped on its side early Friday, killing four children and injuring more than 30 people.
- **September 11, 2001: Terrorist Attacks** and Response at Logan Airport. In addition to the large-scale events that affected the nation as a whole, American Airlines Flight 11 (92 people on board) and United Airlines Flight 175 (65 people on board) originated from Logan Airport and were involved in the terrorist attacks of September 11th.
- **August 25-29, 2005: Hurricane Katrina**-MA response. 235 people were evacuated from the Gulf Coast Region to Otis Air force Base following the hurricane. Additionally, it is estimated that approximately1,500 people came to MA voluntarily
- **May 6, 2006: Floods** – The floods of May 2006 were the worst the Commonwealth has seen in over 70 years. Many communities saw 17 inches of rain in less than one week. Fourteen emergency shelters were opened in Middlesex and Essex Counties and over 5,000 residents were forced to evacuate.

HOW IS THE NATIONAL INCIDENT MANAGEMENT SYSTEM USED IN MA?

When you are deployed to a disaster as a Behavioral Health Disaster Responder you will be working under the National Incident Management System (NIMS) framework. NIMS is a comprehensive, national approach to incident management that is applicable at all jurisdictional levels and across functional disciplines.

Emergencies occur every day somewhere in the United States. These emergencies are large and small and range from fires to hazardous materials incidents to natural and human-caused disasters. Each incident requires a response. Whether from different departments within the same jurisdiction, from mutual aid partners, or from State and Federal agencies, responders need to be able to work together, communicate with each other, and depend on each other.

The events of September 11, 2001 have underscored the need for and importance of national standards for incident operations, incident communications, personnel qualifications, resource management, and information management and supporting technology. To provide standards for domestic incident response, President Bush signed Homeland Security Presidential Directive-5 (HSPD-5). HSPD-5 authorized the Secretary of Homeland Security to develop the National Incident Management System.

NIMS provides a interoperability and compatibility among all responders by balancing flexibility and standardization:

- NIMS provides a flexible framework that facilitates government and private entities at all levels working together to manage domestic incidents. This flexibility applies to all phases of incident management, regardless of cause, size, location, or complexity

- NIMS provides a set of standardized organizational structures, as well as requirements for processes, procedures, and systems designed to improve interoperability

NIMS is comprised of several components that work together as a system to provide a national framework for preparing for, preventing, responding to, and recovering from domestic incidents. These components include:

- Command and management
- Preparedness
- Resource management
- Communications and information management
- Supporting technologies
- Ongoing management and maintenance

WHAT IS THE INCIDENT COMMAND SYSTEM?

An integral part of the National Incident Management System is the Incident Command System (ICS). ICS is a standard, on-scene, all-hazard incident management concept. ICS is a proven system that is used widely for incident management by firefighters, rescuers, emergency medical teams, and hazardous materials teams. ICS represents organizational best practices and has become the standard for incident management across the country.

ICS is also interdisciplinary and organizationally flexible to meet the needs of incidents of any kind, size or level of complexity. Using ICS, personnel from a variety of agencies can meld rapidly into a common management structure. When you are deployed as a Behavioral Health Disaster Responder the DMH Emergency Coordinator on-site will familiarize you with the Incident Command System for that disaster.

ICS has several features that make it well suited to managing incidents. These features include:

- Common terminology
- Organizational resources
- Manageable span of control
- Organizational facilities
- Use of position titles
- Reliance on an Incident Action Plan
- Integrated communications
- Accountability

To gain an understanding of the NIMS and ICS structures you will be required to take the NIMS training to become a Behavioral Health Disaster Responder. On September 30, 2005, Governor Romney issued Executive Order 469, designating the National Incident Management System as the Commonwealth's Incident Management Standard.

This Executive Order directs all first responders and personnel working in the Commonwealth to be certified in NIMS/ICS in order to participate in emergency/disaster rescue and recovery efforts. As such, DMH/DPH is adopting the successful completion of NIMS-700 or ICS-100 as a standard for which a Behavioral Health Disaster Responder can be activated and deployed as a crisis responder for the State of Massachusetts.

Due to the importance that our nation has placed on emergency responders having an understanding and working knowledge of both NIMS and ICS, Massachusetts has adopted the requirement that all new Behavioral Health Disaster Responders become NIMS 700 certified to complete their training. Obtaining certification is free of charge and can be completed in a self-study program on-line through the FEMA. A Behavioral Health Disaster Responder is not considered to be active for deployment until NIMS 700 certification is achieved.

HOW IS BEHAVIORAL HEALTH DISASTER RESPONSE DEFINED?

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes crisis counseling as an intervention whose goal is to "…assist individuals in coping with the psychological aftermath of the disaster, mitigate additional stress or harm, and to promote the development of coping strategies that individuals may be able to call upon in the future. While always cognizant of those with special needs, "the thrust of …crisis counseling…has been to serve people responding normally to an abnormal experience." Crisis counseling supports "short-term interventions with individuals and groups experiencing psychological sequelae to large-scale disasters. These interventions involve the counseling goals of assisting disaster survivors in reviewing their options, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors recover to their pre-disaster level of functioning…crisis counseling draws upon the assumption that the individual is capable of resuming a productive and fulfilling life following the disaster experience if given support, assistance, and information at a time and in a manner appropriate to his or her experience, education, developmental stage, and culture."

The term Behavioral Health Disaster Response is synonymous with crisis counseling and is the term used by the Massachusetts Behavioral Health Disaster Program. Volunteers under the Massachusetts Program are called Behavioral Health Disaster Responders (BHDR).

Adapted from SAMHSA CCP-PG02

WHAT ARE THE PRINCIPLES THAT GUIDE BEHAVIORAL HEALTH DISASTER RESPONSES?

The following principles have been defined by the Substance Abuse and Mental Health Services Administration and guide the provision of behavioral health response following disasters.

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma-individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Most people do not see themselves as needing mental health services following disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more practical than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active, genuine interest, and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

HUMAN IMPACT OF DISASTERS

"When trauma strikes our basic beliefs and assumptions are shattered and our path to healing is in defining a new normal…"
~Linda Daniels, PsyD

WHAT ACTUALLY CONSTITUTES A DISASTER?

Simply stated, a disaster is “a tragic event that disrupts the normal routine of life, causing suffering, loss of life and/or property.” Disasters are characterized in a number of ways, but in behavioral health research the consensus is that disasters fall in either one or two types; natural and human-caused.

Natural disasters include earthquakes, hurricanes, floods and mudslides, fires and firestorms, tidal waves, tornadoes and so forth.

Human-caused disasters include transportation accidents, major power outages, nuclear reactor accidents, bombings of populated areas and attacks on significant pieces of physical infrastructure, mass casualty suicide-bombing, mass shootings, and deployments of chemical, biological, or radiological weapons.

In natural disasters, the causal agent is seen as beyond human control and without evil intent. For some, accepting mass destruction as “an act of God” is easier, whereas for others it can be more difficult. The world can temporarily seem to become unsafe with its potential for random, uncontrollable and devastating events (Yates, 1998).

In human-caused disasters such as bombings and other acts of terrorism, technological accidents, or airline crashes, survivors grapple with acts of deliberate human violence and human error. The perception that the event was preventable, the sense of betrayal by a fellow human(s), the externally focused blame and anger, and possible years of litigation are all associated with an extended and often volatile recovery period.

In reality, there is interplay between natural and human factors (Green & Solomon, 1995) and survivors experience reactions consistent with each dimension as they struggle with causal attributions. For example, emotional damage from the natural event of flooding may be increased due to human factors such as inadequate planning, cumbersome governmental policies, or faulty warning systems. Likewise, an aircraft accident, for instance, may result from an interaction of poor weather conditions and pilot error.

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT ARE SOME DIFFERENCES BETWEEN HUMAN-CAUSED AND NATURAL DISASTERS?

The chart below compares human-caused and natural disasters along several important dimensions. The differences in how disasters are perceived, based on cause, is important to understand and will help shape the behavioral health disaster response.

Comparison of Mass Violent Victimization and Natural Disaster

Dimension	Mass Violent Victimization	Natural Disasters
Examples	• Mass Riot • Hostage taking • Terrorist bomb • Arson • Bioterrorism • Mass Shooting • Aircraft hijacking	• Hurricane • Earthquake • Tornado • Flood • Drought • Wildfire • Volcanic eruption
Causation	• Include evil human intent, deliberate sociopolitical act, human cruelty, revenge, hate or bias against a group, mental illness.	• Is an act of nature; severity of impact may result from interaction between natural forces and human error or actions.
Appraisal of Event	• Event seems incomprehensible, senseless • Some view as uncontrollable and unpredictable, others view as preventable • Social order has been violated	• Expectations defined by disaster type • Awe expressed about power and destruction of nature • Disasters with warnings increase sense of predictability and controllability • Recurring disasters pose ongoing threat
Psychological Impact	• Life threat, mass casualties, exposure to trauma, and prolonged recovery effort result in significant physical and emotional effects • There are higher rates of Post-Traumatic stress Disorder (PTSD), depression, anxiety and traumatic bereavement that can last for a longer period of time	• Property loss and damage are primary impacts, so reactions relate to losses, relocation, financial stress, and daily hassles • Disaster traumatic stress typically resolves over 18 months, with lower rates of diagnosable disorders unless high number of fatalities and serious injuries
Subjective Experience	• Victims are suddenly caught unaware in a dangerous, life-threatening situation. May experience terror, fear, horror, helplessness, and sense of betrayal and violation. • Resulting distrust, fear of people, or being "out in the world" may cause withdrawal and isolation. • Outrage, blaming the individual or group responsible, desire for revenge, and demand for justice are common.	• Separation from family members, evacuation, lack of warning, life threat, trauma, and loss of irreplaceable property and homes contribute to disaster stress reactions. • Anger and blame expressed toward agencies and individuals responsible for prevention, mitigation, and disaster relief.
World View/Basic Assumptions	• Assumptions about humanity are shattered; individuals no longer feel that the world is secure, just, and orderly. • Survivors confronted with the reality that	• Spiritual beliefs may be shaken (e.g., "How could God cause this destruction?"). • Loss of security

Dimension	Mass Violent Victimization	Natural Disasters
	evil things can happen to good people. • People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.	• People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.
Stigmatization of Victims	• Some survivors may come to feel humiliation, responsibility for others' deaths, survivor guilt, self-blame, and unworthy of assistance, thus assigning stigma to themselves. • The larger community, associates, friends, and even family may distance themselves to avoid confronting the idea that crime victimization can happen to anyone. • Well-meaning loved ones may urge victims and bereaved to "move on," causing them to feel rejected and wrong for continuing to suffer. • Hate crimes reinforce the discrimination and stigma that targeted groups already experience.	• Disasters tend to have greater impact on people with fewer economic resources due to living in lower-cost, structurally vulnerable residences in higher-risk areas. • Survivors from cultural, racial, and ethnic groups; single parent families; people with disabilities; and the elderly on fixed incomes experience greater barriers to recovery causing double jeopardy and potential stigma.
Phases of Response and Reconstruction	• Impact • Outcry • Disbelief • Interaction with the criminal justice system; local, state, federal agencies, etc. • Working-through process • Coming to terms with realities and losses • Reconstruction	• Warning, threat • Impact • Rescue and heroism • Honeymoon • Interaction with disaster relief and recovery • Disillusionment • Coming to terms with realities and losses • Reconstruction
Media	• The media shows more interest in events of greater horror and psychological impact. • Excessive and repeated media exposure puts people at risk for secondary traumatization. • Risk of violation of privacy.	• Short-term media interest fosters sense in community that "the rest of the world has moved on". • Media coverage can result in violations of privacy; there is a need to protect children, victims, and families from traumatizing exposure.
Secondary Injury	• Victims' needs may conflict with necessary steps in criminal justice process. • Steps required to obtain crime victim compensation and benefits can seem confusing, frustrating, bureaucratic, and dehumanizing and trigger feelings of helplessness. • Bias-crime victims may suffer prejudice and blame. • Victims may feel that the punishment is inadequate in comparison to the crime	• Disaster relief and assistance agencies and bureaucratic procedures can be seen as inefficient, fraught with hassles, impersonal. • Disillusionment can set in when the gap between losses, needs, and available resources is realized. • Victims rarely feel that they have been "made whole" through relief efforts."

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT ARE SOME OF THE COMMON PHYSICAL, EMOTIONAL, COGNITIVE, AND BEHAVIORAL REACTIONS TO DISASTERS?

While reactions to disasters may vary between individuals, there are common reactions that are normal reactions to the abnormal event. Sometimes these stress reactions appear immediately following the disaster; in some cases, they are delayed for a few hours, a few days, weeks, or even months. These stress reactions may be categorized as physical, emotional, cognitive, and behavioral symptoms. The following table describes common reactions to trauma:

Physical Reactions	Emotional Reactions
• Faintness, dizziness • Hot or cold sensations in body • Tightness in throat, stomach, or chest • Agitation, nervousness, hyper-arousal • Fatigue and exhaustion • Gastrointestinal distress and nausea • Appetite decrease or increase • Headaches • Exacerbation of pre-existing health conditions	• Shock, disbelief, numbness • Anxiety, fear, worry about safety • Sadness, grief • Helplessness, powerlessness • Vulnerability • Dissociation (disconnected, dream-like) • Anger, rage, desire for revenge • Irritability, short temper • Hopelessness and despair • Blame of self and/or others • Unpredictable mood swings
Cognitive Reactions	**Behavioral Reactions**
• Confusion and disorientation • Poor concentration and memory problems • Impaired thinking and decision making • Complete or partial amnesia • Repeated flashbacks, intrusive thoughts and images • Obsessive self-criticism and self-doubts • Preoccupation with protecting loved ones • Questioning of prior belief system	• Sleep disturbances and nightmares • Jumpiness, easily startled/ • Hypervigilance, scanning for danger • Crying and tearfulness for no apparent reason • Conflicts with family and coworkers • Avoidance of reminders of trauma • Inability to express feelings • Isolation or withdrawal from others • Increased use of alcohol or drugs

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT SHOULD I KNOW ABOUT EACH STAGE OF DISASTER IN ORDER TO PROVIDE THE APPROPRIATE BEHAVIORAL HEALTH RESPONSE?

Exposure to stressors related to the immediate aftermath of a disaster and subsequent stressors often challenges our assumptions about life and creates a disconnect between pre and post-trauma beliefs, but the intensity of this distress usually subside with time. Experts agree that the amount of time it takes people to recover depends both on what happened to them and the meaning they give to the event. Prior research into terrorist events and disasters has shown that reactions to these events may be categorized into different phases. As a Behavioral Health Disaster Responder you may be deployed to work with survivors at different phases of disaster.

Impact Phase

Most people respond appropriately during the impact of a disaster and react to protect their own lives and the lives of others. This is a natural and basic reaction. A range of such behaviors can occur, and these may also need to be dealt with and understood in the post disaster period. After the fact, people may judge their actions during the disaster as not having fulfilled their own or others' expectations of themselves.

During the impact phase, some people respond in a way that is disorganized and stunned, and they may not be able to respond appropriately to protect themselves. Such disorganized or apathetic behavior may be transient or may extend into the post disaster period, that people may be found wandering helpless in the devastation afterwards. These reactions may reflect cognitive distortions in response to the severe disaster stressors and may for some indicate a level of dissociation.

Several stressors may occur during impact, which may subsequently have consequences for the person:

- Threat to life and encounter with death
- Feelings of helplessness and powerlessness
- Loss (e.g., loved ones, home, possessions)
- Dislocation (i.e., separation from loved ones, home, familiar settings, neighborhood, community)
- Feeling responsible (e.g., feeling as though could have done more)
- Inescapable horror (e.g., being trapped or tortured)

- Human malevolence (It s particularly difficult to cope with a disaster if it is seen as the result of deliberate human factors).

Recoil & Rescue: Immediate Post-Disaster Phase
This is the phase where there is recoil from the impact and the initial rescue activities commence. Initial mental-health effects may appear (e.g., people show confusion, are stunned, or demonstrate high anxiety levels). Emotional reactions will be variable and depend on the individual's perceptions and experience of the different stressor elements noted earlier. Necessary activities of the rescue phase may delay these reactions, and they may appear more, as the recovery processes get under way. Reactions may include:

- Numbness
- Denial or shock
- Flashbacks and nightmares
- Grief reactions to loss
- Anger
- Despair and sadness
- Hopelessness

Conversely, relief and survival may lead to feelings of elation, which may be difficult to accept in the face of the destruction the disaster has wrought.

Recovery Phase
The recovery phase is the prolonged period of adjustment or return to equilibrium that the community and individuals must go through. It commences as rescue is completed and individuals and communities face the task of bringing their lives and activities back to normal. Much will depend on the extent of devastation and destruction that has occurred as well as injuries and lives lost (Raphael, 1993).

This phase may be associated with a honeymoon phase deriving from the altruistic and therapeutic community response immediately following the disaster. A disillusionment phase may soon follow when the disaster is no longer on the front pages of newspapers, organized support starts to be withdrawn, and the realities of losses, bureaucratic constraints, and changes wrought by the disaster must be faced and resolved (Raphael, 1993).

During the stage of acute danger the priority for all is basic safety and survival. Once this is relatively secured, other needs emerge that are both existential and psychological. And once manifest, these needs are typically left frustrated and unfulfilled for a prolonged period of time. Many times, through the media, retribution, or continued violence, the community 8in question is exposed to further traumatic events.

It is particularly important to remember that emotional needs may be very significant, especially for those who have been severely affected. They may only start to appear during this phase. People may also be hesitant to express distress, concern, or dissatisfaction, feeling they should be grateful for the aid given or because they

have suffered less than others have. It should be noted that sometimes emotional reactions may present as physical health symptoms, such as sleep disturbance, indigestion, and fatigue, or they may present as social effects such as relationship or work difficulties.

Success in working through all of these phases enables the individual to return to levels of functioning comparable to the pre-disaster period. Although survivors may cycle back and forth between the disillusionment and coming to terms phases, most people will begin to put their lives back together in new ways. At some level, they will always grieve for what they lost, but most will find themselves over time mending and growing to meet new challenges.

Adapted from: Phases of Traumatic Stress Reactions in a Disaster, National Center for PTSD.

UNDERSTANDING BEHAVIORAL HEALTH DISASTER RESPONSE

"Never let your need to help exceed the client's need for help."
~James Munroe, EdD

WHAT IS THE DIFFERENCE BETWEEN A BEHAVIORAL HEALTH DISASTER RESPONSE AND MENTAL HEALTH TREATMENT?

While training as a mental health or substance abuse clinician is important to understanding the human impact of trauma, it is equally important to understand the counseling skills that are specific to disaster response. As some of the skills and training will overlap, there are aspects of behavioral health disaster response that are very different from the provision of traditional mental health and substance abuse services. The following helps to illustrate the differences and highlights the goals of behavioral health disaster response.

What is Behavioral Health Disaster Response?

Behavioral Health Disaster Response is focused on short-term interventions with individuals and groups experiencing the psychological impact of large-scale disasters. These interventions involve the counseling goals of assisting disaster survivors in understanding their current situation and reactions; reviewing their options; providing emotional support; and encouraging linkages with other individuals and agencies that may help survivors recover to their pre-disaster level of functioning. In effect, the goal of behavioral health disaster response is to assist individuals in coping with the psychological aftermath of the disaster, mitigate additional stress(ors) or psychological harm, and to promote the development of coping strategies that individuals may be able to call upon in the future.

What is Mental Health Treatment?

In contrast to the behavioral health disaster response services, mental health treatment (as typically defined within the mental health community) implies the provision of assistance to individuals for an existing pathological condition or disorder. In this context, an evaluation and/or psychological testing are completed by a licensed mental health professional. The evaluation is followed by the assignment of a diagnosis consistent with the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association or other similar diagnostic tool. Typically, the mental health professional and client will then discuss various treatment options and agree to certain interventions and treatment goals. Common interventions include using numerous approaches for the treatment of mental disorders (e.g., interpersonal, cognitive-behavioral, psychodynamic, humanistic, etc.), personality reconstruction, development of insight into a wide variety of historical and current life experiences, and resolution of unconscious conflicts. During treatment, the provider maintains a documented treatment plan and record.

The next chart provides a basic description of the ***key*** differences between traditional mental health services and behavioral health disaster response. These differences influence the way services are provided.

Behavioral Health Disaster Response	"Traditional" Mental Health Practice
• Is primarily community-based. • Focuses on assessment of strengths, adaptation of existing coping skills and development of new ones. • Seeks to restore people to pre-disaster levels of functioning. • Accepts content at face value. • Validates the appropriateness of reactions to the event and its aftermath and normalizes the experience. • Has a psycho-educational focus.	• Is often office-based. • Focuses on diagnosis and treatment of a mental illness. • Attempts to impact the baseline of personality and functioning. • Examines content. • Encourages insight into past life experiences and their influence on current problems. • Has a psychotherapeutic focus.

Use of Mental Health and Substance Abuse Professionals as Behavioral Health Disaster Responders

Training and experience as a mental health or substance abuse professional in the traditional system does not guarantee that an individual will be an effective crisis counselor. While there are many examples of mental health and substance abuse professionals who have functioned exceptionally well as crisis counselors, there are also numerous examples of situations where this has not been the case. The most effective professionals serving on crisis counseling teams have the following characteristics:

- They can assimilate a revised conceptualization of mental health and substance abuse services that is often different than their training and traditional function (e.g. lack of diagnosis, interventions in very non-traditional settings, role ambiguity).

- They are comfortable working with paraprofessionals or trained nonprofessionals.

- They are able to incorporate crisis counseling principles and practice into the theoretical construct that usually guides their practice.

In addition, you do not necessarily need to be a Mental Health or Substance Abuse provider to become a Behavioral Health Disaster Responder. Our volunteer system, in accordance with the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and nationally recognized evidence informed best practices, acknowledges that paraprofessionals and trained natural helpers can be just as effective in most instances in providing crisis response.

Adapted from: Emergency Mental Health and Traumatic Stress: Crisis Counseling and mental Health Treatment Similarities and Differences. www.mentalhealth.samhsa.gov

WHAT IMPORTANT SKILLS DO I NEED TO SET THE GROUNDWORK FOR BEHAVIORAL HEALTH DISASTER RESPONSE?

Behavioral health disaster counseling involves establishing rapport, listening and guiding survivors. Survivors typically benefit from both talking about their disaster experiences and being assisted with problem solving and referral to social and community resources. The following basic behavioral disaster response counseling skills are the foundation for work with survivors of disaster.

Establishing Contact

The first contact with a survivor is important. When the initial contact is made with respect and compassion it can establish an effective helping relationship and increase the person's receptiveness to further help. Do not assume that people will respond to your assistance with immediate positive reactions. It may take time for some survivors or bereaved persons to feel some degree of safety, confidence and trust. If an individual declines your offer of help, respect his/her decision and indicate when and where Behavioral Health Disaster Responders will be available later on.

Introduce yourself by first name, identify yourself as a Behavioral Health Disaster Responder, and describe your role. Ask for permission to talk to them, and explain your objective of finding out whether there is anything you can do to make things easier, or helping with ways to help themselves feel better. Address adults using there last name, unless given permission to do otherwise.

Building Rapport

Rapport refers to the feelings of interest and understanding that develop when genuine concern is shown. Conveying respect and being nonjudgmental are necessary ingredients for building rapport. Survivors respond when Behavioral Health Disaster Responders offer a compassionate presence.

Maintaining a Calm Presence

People take their cue from how others are reacting. By demonstrating calmness and clear thinking, you can help survivors feel that they can rely on you. Others may follow your lead in remaining focused, even if they do not feel calm, safe, effective, or even hopeful. Behavioral Health Disaster Responders often model the sense of hope that affected persons cannot always feel while they are still attempting to deal with what happened and current pressing concerns.

Active Listening

Behavioral Health Disaster Responders listen most effectively when they take in information through their ears, eyes, and "extrasensory radar" to better understand the survivor's situation and needs. Some tips for listening are:

- ***Allow silence***- Silence gives the survivor time to reflect and become aware of feelings. Silence can prompt the survivor to elaborate. Simply "being with" the survivor and their experience is supportive.

- ***Attend nonverbally***- Eye contact, head nodding, and caring facial expressions let the survivor know that the worker is in tune with them.

- ***Paraphrase***- When the Behavioral Health Disaster Responder repeats portions of what the survivor has said, understanding, interest, and empathy are conveyed. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the survivor know that he or she is being heard. Good lead-ins are: "So you are saying that…" or "I have heard you say that…is that correct?"

- ***Reflect feelings***- The Behavioral Health Disaster Responder may notice that the survivor's tone of voice or nonverbal gestures suggests anger, sadness, or fear. Possible responses are, "You sound angry, scared etc., does that fit for you?" This helps the survivor identify and articulate his or her emotions.

- ***Allow expression of emotions***- Expressing intense emotions through tears or angry venting is an important part of healing; it often helps the survivor work through feelings so that he or she can better engage in constructive problem solving. Behavioral Health Disaster Responders should remain relaxed, breathe, and let the survivor know that it is OK to feel.

Responding to the Survivor's Needs
Behavioral Health Disaster Responders can feel the understandable impulse to help in every way possible when confronted with the seemingly overwhelming needs of a survivor. However, the Behavioral Health Disaster Responder must respond to the individual needs of the survivor and ensure that their own need to help does not overshadow the survivor's need for help.

- **Example:** A New Orleans evacuee and guest at Camp Edwards following Hurricane Katrina commented on the desire of volunteers to help at times when there were more volunteers than there was need. " You didn't want to tell them you didn't need anything, because they looked so disappointed. You'd try to think of a mission to send them on like to get a pair of tweezers. I think I have eight pairs of tweezers."

It is critical that the Behavioral Health Disaster Responder monitor their own internal reactions and judgments while assessing a survivors needs. Use caution not to become over involved and do too much for the survivor. This is usually not in the best interest of the survivor. When survivors are empowered to solve their own problems, they feel more capable, competent, and able to tackle the next challenge. Behavioral Health Disaster Responders should clearly understand the scope of their

role in the disaster relief effort and recognize that empowering survivors is different from doing for them.

Maintaining Flexibility

It is critical for Behavioral Health Disaster Responders to be flexible and able to work in an unpredictable environment. When you are deployed to a disaster you will be working under the incident command system and may be assigned a number of different roles from performing mental health/substance abuse assessments to providing concrete services like food and water. Every role is equally important and you must be willing to accept the assignment asked of you as well as maintain the flexibility to change course as needed.

Adapted from: Emergency Mental Health and Traumatic Stress: Crisis Counseling and mental Health Treatment Similarities and Differences. www.mentalhealth.samhsa.gov & National Child Traumatic Stress Network and National Center for PTSD, Psychological First Aid: Field Operations Guide, September 2005.

WHAT FACTORS MUST I CONSIDER IN ORDER TO PROPERLY SCREEN AND ASSESS DISASTER SURVIVORS?

The following factors influence the survivor's reactions, coping, and recovery process following a disaster and will assist the BHDR in initial screening and needs assessment.

Screening & Assessment Checklist	
• Trauma and loss exposure	• Prior coping with major stressors
• Presence of risk/resiliency factors	• Availability of social support
• Current psychological distress	• Current pressing concerns

Survivor's experiences are, in part, shaped by their cultural, ethnic, and racial backgrounds. Understanding an individual or community's cultural background along with educational, socioeconomic level, age group, and religious beliefs will assist you in assessing the needs of survivors and guide you in providing culturally competent services. Behavioral Health Disaster Responders should be mindful of the following when assessing the needs of ***all*** survivors.

Cultural Response Checklist
• Meanings associated with current disaster and emergency response
• Beliefs and practices regarding death, burial, mourning, trauma, and healing
• Trauma and violence in country of origin and within United States
• Views about mental health providers
• Professional courtesy (e.g., greetings, who to talk to first, who is "family")

It is also important to be aware of the phase of trauma the individual or community may be in during the assessment phase. Each phase of trauma necessitates a unique approach. The following checklist will assist the Behavioral Health Disaster Responder in properly assessing each individual survivor.

Trauma Phase Response Checklist
Heroic Phase: Current social/financial/housing, etc. resources; level of anxiety, fear, sense of control.
Honeymoon Phase: Level of willingness to discuss traumatic event; problem-solving capacity
Disillusionment Phase: Intensity of frustration, anger, discouragement, depression; level of ability to cope with and advocate for changes in recovery system.
Recovery Phase: Level of hope for the future and planning for future; acceptance of disaster and individual's belief that s/he is a survivor.

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

INTERVENTION : GOALS OF BEHAVIORAL HEALTH DISASTER RESPONSE

"What is a problem before a disaster will likely be much worse after a disaster."
~Kermit A. Crawford, Ph.D.

WHAT ARE THE GOALS OF BEHAVIROAL HEALTH DISASTER RESPONSE WITH ADULTS?

It is important to remember that most survivors of disasters are normal, well-functioning people who are struggling with the disruption and loss caused by the disaster. The goals of crisis intervention involve helping survivors regain some sense of control over their immediate situations and re-establish rational problem-solving and decision-making abilities. Crisis intervention typically involves four components: (1) promote safety and security; (2) identify current priority needs; (3) assess functioning and coping; (4) provide reassurance, normalization, psycho-education, and practical assistance.

Promote Safety and Security

- "May I get you something to drink?"
- "Are you feeling comfortable/safe here?"

Survivors need to feel protected from threat and danger. If the survivor does not feel safe or comfortable, the Behavioral Health Disaster Responders **priority** is to facilitate safety. Doing things that are active (rather than passive waiting), practical (using available resources), and familiar can increase a sense of control over the situation.

Identify Current Priority Needs, Problems, and Possible Solutions

- "What do you need right now?"
- "Describe the most urgent problem you are facing right now.
- "Do you need any medications that you currently don't have?"
- "Who might be able to help you?"

Selecting and successfully addressing one solvable problem as most immediate can help bring back a sense of control and capability. Existing sources of assistance among friends, family, health care providers, or community resources may be helpful. One role of the Behavioral Health Disaster Responder is to assist with accessing resources when needed.

Assess Functioning and Coping

Discussion of individual disaster experiences must be carefully tailored to the person's situation and coping style. For example, for those who are highly distressed, talking in much detail about their disaster experience and expressing related emotions might promote further destabilization. With these individuals, provide reassurance and comfort and move on with problem solving if the person is able to. For other survivors, detailed verbalization of their traumatic experience can facilitate some reality-based acceptance that, in turn, can contribute to appropriate problem solving.

- “How are you doing?”
- “How do you feel you are coping?”
- “How have you coped with stressful life events in the past?”
- “Who has been a support to you in the past?”

Exposure to trauma and post-disaster adversities can exacerbate ongoing substance use, cause relapse of past substance abuse, or lead to new abuse. Information about this may be elicited with questions like:

- “Do you tend to use alcohol, prescription medications, or drugs as a way to cope with stress?”
- “Have you had any problems in the past with alcohol or drug use?”

Through observation, asking questions, and reviewing the magnitude of the survivor’s problems and losses, the Behavioral Health Disaster Responder develops an impression of the survivor’s capacity to address current challenges. Based on this assessment, the worker may make referrals, point out coping strengths, and facilitate the survivor’s engagement with social supports. The Behavioral Health Disaster Responder also may seek consultation from a supervisor.

Provide Reassurance, Normalization, Psycho-education, and Practical Assistance

Support, ****reassurance***, acknowledgment, and normalization of feelings and reactions occur throughout the intervention.

- “These are normal reactions to a disaster”
- “It is understandable that you feel this way”

It is important that the survivor feel the response provided by the Behavioral Health Disaster Responder is both personal and individual. BHDR’s must pay close attention to the individual’s experience and style and not offer ***“canned” responses***. Psycho-education should address the particular reactions mentioned by the survivor. Practical assistance may involve helping to arrange childcare, making a phone call, or obtaining critical information.

****NOTE: Statements like: “You are lucky to be alive.” “It could have been worse.” “My sister/friend/uncle/ neighbor, etc. was in a similar situation…” etc are NOT RECOMMENDED!***

Adapted from: U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT INTERVENTIONS BEST MEET THE NEEDS OF CHILDREN IN DIFFERENT AGE GROUPS?

Children rely on the stability and predictability of their environment and the availability of dependable caretakers to maintain a sense of safety and wellbeing. In the wake of a disaster much of what is familiar to a child may be disrupted including their home, school, or possibly separation from family members, caretakers, and pets. In understanding a child's reaction to a disaster, it is necessary to consider the child's stage of psychological development as well as the level of their exposure to the trauma and their prior life context. The following table identifies common behavioral, physical, and emotion symptoms children may experience following a disaster. This table also offers some intervention options that may be used by Behavioral Health Disaster Responders in the wake of a disaster and some interventions that may be discussed with parents for the days, weeks and months following a disaster.

Age 1-5
Behavioral Symptoms: clinging to parents to familiar adults; helplessness and passive behavior; resumption of bed wetting or thumb sucking; fears of dark; avoidance of sleeping alone; increased crying
Physical Symptoms: loss of appetite; stomach aches; nausea; sleep problems; nightmares; speech difficulties; tics
Emotional Symptoms: anxiety; generalized fear; irritability; angry outbursts; sadness; withdrawal
Intervention Options: give verbal reassurance and physical comfort; clarify misconceptions repeatedly; provide comforting bedtime routines; help with labels for emotions; avoid unnecessary separations; permit child to sleep in parents' room temporarily; demystify reminders; encourage expression regarding losses; monitor media exposure; encourage expression through play activities

Age 6-11
Behavioral Symptoms: decline in school performance; school avoidance; aggressive behavior at home or school; hyperactive or silly behavior; whining, clinging, acting like a younger child; Increased competition with younger siblings for parents' attention; traumatic play and reenactments
Physical Symptoms: change in appetite; headaches; stomach aches; sleep disturbances and nightmares; somatic complaints and death; self blame; guilt
Emotional Symptoms: fear of feelings; withdrawal from friends, familiar activities; reminders triggering fears; angry outbursts; preoccupation with crime, criminals, safety
Intervention Options: give additional attention and consideration; relax expectations of performance at home and at school temporarily; set gentle but firm limits for acting out behavior; provide structured but undemanding home chores and rehabilitation activities; encourage verbal and play expression of thoughts and feelings; listen to child's repeated retelling of traumatic event; clarify child's

distortions and misconceptions; Identify and assist with reminders; develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, identifying at-risk children

Age 12-18
Behavioral Symptoms: decline in academic performance; rebellion at home or school; decline in previous responsible behavior; agitation or decrease in energy level, apathy; delinquent behavior; risk-taking behavior; social withdrawal; abrupt shift in relationships
Physical Symptoms: appetite changes; headaches; gastrointestinal problems; skin eruptions; complaints of vague aches and pains; sleep disorders
Emotional Symptoms: loss of interest in peer social activities; sadness or depression; anxiety and fearfulness about safety; resistance to authority; feelings of inadequacy and helplessness; guilt, self-blame, shame and self-consciousness; desire for revenge
Intervention Options: give additional attention and consideration; relax expectations of performance at school and home temporarily; encourage discussion of experience of trauma with peers, significant adults; avoid insistence on discussion of feelings with parents; address impulse to recklessness; link behavior and feelings to event; encourage physical activities; encourage resumption of social activities, athletics, clubs, etc.; encourage participation in community events; develop school programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers

Adapted from: Emergency Mental Health and Traumatic Stress: Crisis Counseling and mental Health Treatment Similarities and Differences. www.mentalhealth.samhsa.gov

WHAT ARE THE GOALS OF BEHAVIORAL HEALTH DISASTER RESPONSE WITH CHILDREN AND HOW BEST CAN I MEET THEM?

The goal of behavioral health disaster response is to assist children in:

- Regaining a sense of safety and security
- Depending on developmental stage, gaining an understanding and acceptance of the events that have occurred
- Appropriately identify and express reactions
- Grieve and effectively cope with traumatic stress
- Resume age-appropriate roles and activities

Immediate interventions with children include:

- Physical comforting
- Rest
- Respond in a way that is consistent with the child's level of development
- Sit or crouch at a child's eye level
- Help children verbalize their feelings, concerns and questions; provide simple labels for common emotional reactions (e.g. mad, sad, scared, worried). Match the children's language to help you connect with them, and to help them to feel understood and to understand themselves. Do not increase their level of distress by using extreme words like "terrified" or "horrified".
- Repeated concrete explanations of what happened and what is going to happen
- Repeated assurances that they are safe and secure
- Access to materials to draw or play
- Opportunities to verbalize feelings and questions
- Snacks for nurturance
- Blankets for warmth and nesting

Play Areas

Play areas for children often are set up adjacent to or within family gathering settings. Opportunities for quiet play, structured activities, and more active play can be provided for children of different ages and interests. Providing a setting and structure for play gives children an opportunity to release energy, allow a distraction from the trauma, and gives parents some respite. Older children and adolescents can be helpful in encouraging the younger children to participate. Children may have suggestions of songs to sing or classroom games that they have played at school during recess. Several activities can be done with only paper and pencil:

- Tic-tac-toe
- Making paper airplanes and throwing them at a target such as an empty wastebasket
- Group drawing: have children sit in a circle; the first child begins a drawing. After 10 seconds, that child passes the drawing to the child on their right.

- Continue until everyone has added to the drawing. Then show the group the final picture.

Teach Children Breathing Exercises

Deep breathing can help children to reduce feelings of over-arousal and physical tension. Lead a child through a breathing exercise:

1. "Let's practice a different way of breathing that can help calm our bodies down.
2. Put one hand on your stomach, like this (demonstrate).
3. Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this (demonstrate).
4. Then, we will breathe out through our mouths. When we breath out, our stomachs are going to suck in and up like this (demonstrate).
5. We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe our really slowly.
6. Let's try it together. Great job!
7. Make a game of it: blow bubbles with a bubble wand and dish soap; blow bubbles with chewing gum; blow paper wads or cotton balls across the table; ell a story where the child helps you imitate a character that is taking deep breaths (i.e., the three little pigs).

Adapted from: National Child Traumatic Stress Network and National Center for PTSD, Psychological First Aid: Field Operations Guide, September 2005.

POPULATIONS WITH SPECIAL NEEDS: ADDITIONAL CONSIDERATIONS AND INTERVENTIONS

"Listen with your heart and not only your professional ear."
~Mari Bennasar, Psy.D.

WHAT ARE THE GOALS OF CRISIS COUNSELING WITH DIFFERENT ETHNIC GROUPS?

Behavioral Health Disaster Responders must respond specifically and sensitively to the various cultural groups affected by a disaster. In many disasters, ethnic and racial minority groups may be especially hard hit because of socioeconomic conditions that force the community to live in low income, sub-standard housing that is particularly vulnerable to destruction. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values often contribute to disaster outreach programs' difficulty in establishing access and acceptance.

Cultural diversity includes social class, gender, race, sexual identity, and ethnicity. Each family or individual receiving disaster mental health services should be viewed within the context of their cultural/ethnic/racial/sexual identity group and their experience of being a part of that group. The degree and nature of acculturation is also extremely relevant, in that bicultural influences are manifested by variation within each group.

To be culturally sensitive and provide appropriate services, Behavioral Health Disaster Responders must be aware of their own values, attitudes, and prejudices (we all have them); be committed to learning about cultural differences; and be flexible, creative, and respectful in our intervention and outreach approaches.

WHAT ROLE DOES CULTURE AND ETHNIC IDENTITY PLAY IN BEHAVIORAL HEALTH DISASTER RESPONSES?

Culture is a vehicle through which individuals learn the resilience that is essential in overcoming adversity. Unfortunately, when physical, social, daily rituals, and environments become disrupted following a disaster, life for all becomes chaotic. Behavioral Health Disaster Responders can help in mitigating these disruptions by assisting survivors in reestablishing cultural customs and social networks. To do so, it is important for the Behavioral Health Disaster Responder to have a basic understanding of the role of culture, race, and ethnic identity that may play out in a disaster. The following definitions will help the BHDR in understanding (and therefore be better prepared) to respond in a culturally sensitive manner to those affected by a disaster.

According to SAMSHA, "ETHNICITY" refers to a common heritage of a particular group. Elements of a shared heritage include history, language, and rituals." In contrast, many view "RACE" as consisting of physical characteristics such as hair and skin color. However, such a "biological construct" does not fully define the scope and depth of ethnicity. In fact, ethnicity may overlap with race. For example, ethnic groups like Cubans and Peruvians include people of different races. As such, race is widely viewed as a social construct. "CULTURE refers to the *shared* attributes of a group of people and is broadly defined as a *common heritage or learned set of beliefs, norms and values.*

Therefore, race and ethnicity *should not* be equated with culture since different people may belong to the same culture regardless of their race and ethnicity. Simply stated, In fact, culture is as applicable to groups of whites, such as Irish Americans or gay and lesbian Americans, as it is to racial and ethnic groups. For instance, people who have shared religious or political beliefs are characteristics of a culture. It is also important to note that culture <u>can</u> change. For example immigrants from other countries come with their norms, beliefs, and values. However, through acculturation, some of these immigrants will take on some of the characteristics of United States culture and visa versa.

Given the essential role culture plays in daily life it is understandable that culture is extremely important during disastrous times. Behavioral Health Disaster responding is at its best when survivors from different cultures receive help that is in line with their cultural beliefs.

In addition to the distinctions between race, ethnicity, and culture, the Behavioral Health Disaster Responder should also keep the following three interrelated dynamics in mind when attempting to provide culturally sensitive assistance: "***the importance of community***; ***racism and discrimination; and social and economic inequality***."

Community often is extremely important to racial and ethnic groups, because communities provide an especially strong social support. As mentioned earlier, support networks are important for survivors following a disaster. These natural support networks operate to help members of the network to overcome daily stressors and called upon in times of crisis. However, following a disaster, all members of the social network may be negatively affected, rendering the survivors unsupported during this period. Moreover, "its smaller size may render the group more fragile following a disaster. In fact, "groups such as refugees, having previously experienced destruction of their social support system, the destruction of a second support system may be particularly difficult." (Beiser, 1990; Van der Veer, 1995). Behavioral Health Disaster Responders therefore should be mindful of the importance of helping to re-establish such natural support networks and that helping friends and extended families is as important as helping the individual survivor.

Racism and Discrimination is experienced by many ethnic groups including Native Americans, African Americans, Latinos, and Japanese and Chinese Americans. Resultantly, these groups may distrust offers of outside help and/or may be unfamiliar with the mechanisms for receiving assistance following a traumatic event.

Social and Economic Inequality: In many instances, ethnic and racial groups may be especially hard hit because of socioeconomic conditions that may have forced the community to live in low income; sub-standard housing that is particularly vulnerable to destruction. In addition, social and economic inequality exists *among and within* different ethnic and racial groups as a disproportionate of minorities live in poverty while, at the same time, "some subgroups of Asian Americans, for example, have prospered and others remain at low socioeconomic levels." Of course, with poverty comes greater relative material loss. On the other hand, given the resilience shown in light of racism/discrimination and social/economic inequality, these same groups may show stronger coping skills than members of the dominant culture.

In addition to community, racism/discrimination, and social/economic inequality, the following dimensions should also be considered when the Behavioral Health Disaster Responder is offering disaster response assistance.

Help seeking behavior; customs and traditions in loss and trauma; and natural support networks should all be considered in providing behavioral health disaster response assistance when working with difficult cultures. For instance, in many cultures, survivors may *seek help* from their community leaders, families, places of worship, and friends rather than state, local, federal or private sector systems. Thus, building rapport and trust with such survivors is critical to the behavioral health disaster response effectiveness.

Customs and traditions related to loss following a disaster are culture-specific. Religious and cultural beliefs may dictate the survivor's perception of the underlying cause of the disaster. For example, numerous cultures believe that disasters have

spiritual connotations and therefore receiving external help is counter to this belief. Instead, healing is borne out of cultural-specific customs and traditions. Faith healers, local herbalists and other traditional healers may play a critical role in the survivor's recovery. It is therefore helpful for Behavioral Health Disaster Responders to "understand the concepts of integrated body, mind and spirit when they provide disaster crisis counseling services to diverse populations. [The Behavioral Health Disaster Responder] should be able to integrate traditional methods into service delivery." (de Monchy, 1981). In addition, various cultural groups express grief in numerous ways. For example, while in American Culture grief is often viewed as time-limited, for other cultures, extended grief periods are seen as indicative of the level of honor bestowed upon the deceased.

In summary, Behavioral Health Disaster Responders should respond specifically and sensitively to the various cultural groups affected by a disaster. Language barriers, suspicion of governmental programs due to prior experiences, rejection of outside interference or assistance, and differing cultural values are often contributors to the responder's difficulty in establishing access and acceptance. Finally, the Behavioral Health Disaster Responder must also be aware of their own values, attitudes, and prejudices (we all have them); be committed to learning about cultural differences; and be flexible, creative, and respectful in our intervention and outreach approaches.

(This section is largely adapted from the SAMSHA publication entitled Developing Cultural Competence in Disaster Mental Health Program; SMA03-3828) by Jean Athey, Ph.D., and Jean Moody-Williams, Ph.D., under Contract No. 99M00619401D with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Portland Ridley was a contributing author and also served as the Government Project Officer. Susan R. Farrer, M.A., was the content editor of the guide).

WHAT ARE SOME CONSIDERATIONS FOR PROVIDING BEHAVIORAL HEALTH DISASTER RESPONSES WITH DIFFERENT CULTURAL, RACIAL, AND ETHNIC GROUPS?

In order to provide culturally sensitive and appropriate services, several considerations for the Behavioral Health Disaster Responder when **establishing contact** with various ethnic, racial and cultural groups are provided below:

Communication: Both verbal and nonverbal communication can be barriers to providing effective disaster crisis counseling when survivors and workers are from different cultures. Culture influences how people express their feelings as well as what feelings are appropriate to express in a given situation. The inability to communicate can make both parties feel alienated and helpless.

Personal Space: "Personal space" is the area that immediately surrounds a person, including the objects within that space. Although spatial requirements may vary from person to person, they tend to be similar among people in a given cultural group (Watson, 1980). A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive. Such clues may include, for example, moving the chair back or stepping closer.

Social Organization*:* Beliefs, values, and attitudes are learned and reinforced through social organizations, such as family, kinships, tribes, and political, economic, and religious groups. Understanding these influences will enable the disaster crisis counselor to more accurately assess a survivor's reaction to disaster. A survivor's answers to seemingly trivial questions about hobbies and social activities can lead to insight into his or her life before the disaster.

Time*:* An understanding of how people from different cultures view time can help avoid misunderstandings and miscommunication. In addition to having different interpretations of the overall concept of time, members of different cultures view "clock time"—that is, intervals and specific durations—differently. Social time may be measured in terms of "dinner time," "worship time," and "harvest time." Time perceptions may be altered during a disaster. Crisis counselors acting with a sense of urgency may be tempted to set timeframes that are not meaningful or realistic to a survivor.

Environmental Control*:* A belief that events occur because of some external factor—luck, chance, fate, will of God, or the control of others—may affect the way in which a survivor responds to disaster and the types of assistance needed. Survivors who feel that events and recovery are out of their control may be pessimistic regarding counseling efforts. In contrast, individuals who perceive that their own behavior can affect events may be more willing to act (Rotter, 1966). Disaster crisis counselors need to understand beliefs related to environmental control because such beliefs will affect survivors' behavior.

Language/degree of fluency in English and literacy: Cultural sensitivity is conveyed when information is translated into primary languages and/or available in non-written When informational brochures, pamphlets, manuals and other material intended for use with individuals who speak a different language from English, these materials should be translated and back-translated for accuracy with the target group. When English is a person's second language, emotions are frequently experienced and expressed in their language of origin. Use of trained translators, especially with mental health backgrounds, is preferable to family or neighbors because of issues of privacy and confidentiality.

Immigration experience and status: The number of generations and years in the U.S., degree of acculturation, and citizenship status are relevant to consider when defining outreach strategies. Also, war, living conditions, and trauma in the country of origin as well as conditions of immigration may impact coping with the current disaster.

Family values: Determine who is included in the "family." Often, elders and extended family members are considered part of the family unit and form the primary avenue of support. Learn who the family decision-makers are, the relative roles of women and men, parents and children, and of the older generation.

Cultural values and traditions: Cultural groups have considerable variation regarding views of loss, death, grieving, property, home, rebuilding, religion, spiritual practices, mental health, healers, and helping. The disaster itself may be viewed as punishment, an act of God or other deity, or the result of another event or action.

Practical Suggestions

- Learn from local leaders, social service workers, and community members from the cultural group about values, family norms, traditions, community politics, etc., ideally before a disaster strikes.

- Involve mental health staff and community outreach workers who are bilingual and bicultural whenever possible. Involve trusted community members to enhance credibility.

- Allow time and devote energy to gaining acceptance, be wary of aligning your efforts with agency/organizations that are mistrusted by the communities you're trying to reach. Take advantage of association with valued and accepted organizations.

- Be dependable, non-judgmental, genuine, respectful, well informed, and credible to the community. Listen for verbal and non-verbal cues and modify efforts accordingly.

- Determine most appropriate and acceptable ways to introduce yourself and define your program and services to be culturally sensitive.
- Recognize cultural variation in expression of emotions, manifestation, and description of psychological symptoms, mental health problems, and view of "counseling."
- Provide community education information in multiple languages and via radio, TV, and church announcements if there is low literacy level.
- Focus on problem-solving and concrete solutions. Be action-oriented and empower clients through education and skill building.
- Assist in eliminating barriers to help: interpret facts, policies, and procedures; and, provide advocacy and resource assistance in dealing with barriers.

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

HOW CAN I DEVELOP CULTURAL COMPETENCE AS A BEHAVIORAL HEALTH DISASTER RESPONDER?

The following highlights the attributes, knowledge, and skills necessary in developing cultural competence. The committed Behavioral Health Disaster Responder should continuously strive to acquire or enhance these key features.

Personal Attributes

- Genuineness, empathy, and a capacity to respond flexibly to a range of possible solutions
- Acceptance and awareness of cultural differences and cross-cultural dynamics
- Willingness to work with survivors of different cultures
- Ability to articulate one's own values, stereotypes, and biases and to identify how they may accommodate or conflict with the needs of culturally diverse disaster survivors
- Openness to learning about the cultures of diverse groups

Knowledge

- History, tradition, values, artistic expressions of culturally diverse disaster survivors
- Help-seeking behaviors, informal helping supports, and natural healing practices of survivors of various cultures
- Role of language, speech patterns, and communication styles in culturally distinct communities
- Psychosocial stressors relevant to diverse groups (e.g., migration, acculturation stress, legal and illegal discriminatory patterns, racism, and socioeconomic status)
- Community resources (agencies, informal helping networks) and their availability for special populations

Skills

- Ability to discuss cultural issues and to respond to culturally-based cues
- Ability to assess the meaning of culture for the disaster survivor
- Ability to interview and assess survivors on the basis of their personal, psychological, social, cultural, political, or spiritual models

(From Jean Athey, Ph.D., and Jean Moody-Williams, Ph.D., under Contract No. 99M00619401D with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Portland Ridley was a contributing author and also served as the Government Project Officer. Susan R. Farrer, M.A., was the content editor of the guide)

WHAT ARE THE GOALS OF A BEHAVIORAL HEALTH DISASTER RESPONSE WITH OLDER ADULTS?

Older adults may experience reactions to trauma that are unique to their stage in the life cycle. The experience accrued over a lifetime can provide older people with tools to cope with the losses, changes, and painful emotions associated with disaster. They may have successfully adjusted to deaths of family members and friends, or to losses of physical abilities, life roles, and employment. However, when older adults have not adequately adjusted to prior losses and/or have health problems or are physically frail their experience of the disaster may be greatly influenced by these factors. A sudden, threatening, traumatic event can evoke extremely heightened feelings of fear, helplessness, and vulnerability for these survivors. Sudden evacuations or moves can be disorienting and confusing for older adults. In addition, cognitive decline may make it more difficult for older persons to understand evacuation instructions or emergency assistance information.

Special concerns for older adults- Behavioral Health Disaster Responders should be extremely mindful of the following special considerations of older adults following disaster.

Reluctance to evacuate - Research shows that older adults are less likely to heed warnings, may delay evacuation, or resist leaving their homes during disasters. Disaster planning and preparedness is especially critical with this group

Vulnerable housing - Due to limited income, some older adults may live in housing situations that are susceptible to disasters due to the location and age of buildings.

Fear of institutionalization - Many older adults fear that if their diminished physical or emotional capabilities are revealed, they will risk loss of independence or institutionalization. They may under-report the full extent of their problems and needs.

Multiple losses - An older person may have lost their income, job, home, loved ones, and/or physical capabilities prior to the disaster. For some, these prior losses may build coping strength and resilience. For others, these losses compound each other. Disasters sometimes provide a final blow that makes recovery especially difficult.

Significance of losses - As a result of a disaster, irreplaceable possessions such as photograph albums, mementos, valued items, or sacred objects passed on through generations may be destroyed. Pets or gardens developed over years may be lost. The special meaning of these losses must be recognized to assist grieving.

Sensory deprivation - An older person’s sense of smell, touch, vision, and hearing may be less acute than the general population. As a result, they may feel especially

anxious about leaving familiar surroundings. They may not be able to hear what is said in a noisy environment or may be more apt to eat spoiled food.

Chronic health conditions - Higher percentages of older persons have chronic illnesses that may worsen with the stress of a disaster, particularly when recovery extends over months. Arthritis may prevent an older person from standing in line for long periods of time. Problems with thinking and memory may affect the person's ability to remember or process information.

Medications - Older adults are more likely to be taking medication that need to be replaced quickly following disaster. Medications may cause problems with confusion and memory, or cause a greater susceptibility to problems such as dehydration.

Hyper/hypothermia vulnerability - Older persons are often more susceptible to the effects of heat and cold. This becomes critical in disasters when furnaces and air conditioning may be unavailable.

Transfer and relocation trauma - Frail adults who are dislocated without use of proper procedures may suffer illness or even death. Relocation to unfamiliar surroundings and loss of community may result in depression and disorientation.

Delayed response syndrome - Older persons may not react as fast to a situation as younger persons. In disasters, this may mean that deadlines for applications or eligibility timelines may need to be extended.

Mobility impairment or limitation - Older persons may not be able to use automobiles or have access to public or private transportation. This may limit the opportunity to relocate, go to shelters, Disaster Recovery Centers, or to obtain food, water, or medication when necessary.

Financial limitation - Because some older adults live on fixed incomes, they can't take out a loan to fully repair their homes. They are unable to "start over" due to lack of money and time, as is more possible for younger people.

Isolation - Some older adults have limited social support systems and are not associated with local senior centers or churches. Their isolation may contribute to not learning about available resources. They may not have access to help with clean up or repairs. Disaster outreach efforts should prioritize reaching theses individuals.

Crime victimization - Con artists target older people, particularly after a disaster. These issues need to be addressed in shelters, housing arrangements, and when contractors are being selected to repair homes.

Bureaucracy unfamiliarity - Older adults often have not had experience working through bureaucratic systems. This is especially true for those who had a spouse who dealt with these areas.

"Handout" stigma - Many older persons will not use services that have the connotation of being a "handout." They may need to be convinced that disaster services are available as a government service that their taxes have purchased.

Mental health stigma - Older persons may feel ashamed because they experience mental health problems, or they may be unfamiliar with counseling as a form of support. Psychological stress may be manifested in physical symptoms, which some find more acceptable. Mental health services should emphasize "support", "talking", and "assisting with resources", and de-emphasizing diagnosis of psychopathology.

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT ARE SOME COMMON REACTIONS AND SUGGESTIONS FOR INTERVENTIONS WITH OLDER ADULTS?

The following chart outlines commons reactions and suggestions for intervention:

Age: Older Adults
Behavioral Symptoms: withdrawal and isolation; reluctance to leave home; mobility limitations; relocation adjustment problems
Physical Symptoms: worsening of chronic illnesses; sleep disorders; memory problems; somatic symptoms; susceptible to hypo and hyperthermia; physical and sensory limitations interfering with recovery
Emotional Symptoms: depression; despair about losses; apathy; confusion; suspicion; agitation, anger; fears of institutionalization; anxiety with unfamiliar surroundings; embarrassment about receiving "hand outs"
Intervention Options: provide strong and persistent verbal reassurance; provide orienting information; ensure that physical needs are addressed (water, food, warmth); use multiple assessment methods as problems may be underreported; assist with reconnecting with family and support systems; assist in obtaining medical and financial assistance; encourage discussion of traumatic experiences, losses, and expression of emotions; provide crime victim assistance

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT ARE GOALS OF BEHAVIORAL HEALTH DISASTER RESPONSE WITH PEOPLE WITH SEVERE MENTAL ILLNESS?

Along with the reactions from disasters that many people experience, those with severe mental illnesses (SMI) may be at an increased risk for distress, especially posttraumatic stress symptoms.

Multiple studies have shown that people with SMI are more likely than other people to experience trauma, with over 90% reporting exposure to at least one traumatic event in their lifetime. Moreover, most people with SMI experience multiple traumatic events. These studies have focused primarily on interpersonal trauma, including sexual and physical assault in childhood and adulthood.

While no studies have examined the specific effects of disaster-related stressors, there is accumulating evidence that, following extremely stressful life events, people with SMI are more likely to develop PTSD than people without SMI. Other studies show that approximately 30% to 40% of people with SMI currently have PTSD. This is 20 to 30 times the rate for people without SMI. The reason for this increased rate is not fully understood.

However, it is probably due to a combination of factors including increased risk for victimization (especially interpersonal victimization). People with SMI are also often more exposed to violence and risky situations including living on the streets and in homeless shelters and engaging in drug abuse. The increased rate of PTSD in people with SMI also may be due to an increased vulnerability to stress, which may be related to their primary psychiatric disorder.

Extremely stressful events can exacerbate preexisting PTSD symptoms. People with SMI who have preexisting PTSD in addition to their psychotic disorder or mood disorder may experience an increase in their PTSD symptoms in much the same way that other people with PTSD may. This might include (1) having more upsetting memories and nightmares about past stressful experiences, (2) increased fear and avoidance of thoughts, feelings, and things related to the trauma, or (3) increased problems with sleep, concentration, and being more alert for signs of danger. Given the high rates of PTSD among people with SMI, there may be a lot of people at risk for such an exacerbation of posttraumatic symptoms.

On the other hand, several studies have shown that people with severe psychiatric disorders, whether hospitalized or outpatient, ***are not*** necessarily prone to greater distress following a disaster. For example, persons with SMI exposed to the Three Mile Island nuclear accident did not suffer greater anxiety and depressive episodes than similar psychiatric patients who lived in an area that was not exposed to the accident. Also, people with schizophrenia that were in hospitals in Israel during the Gulf War showed no greater war-related distress than people from the community who were similar to the patients in terms of age, gender, education, and marital status. Yet, the findings from these studies contrast the results of the studies

reported above that found people with SMI had a strong risk for developing PTSD, especially following interpersonal traumas. ***This difference*** may be due to the nature of the stressor or to other factors such as sample size differences or assessment differences. These discrepancies, however, point to the need for better information about how people with SMI, both hospitalized and outpatient, respond to disasters.

The following suggestions may enhance the Behavioral Health Disaster Responder's ability to work effectively with this population:

- Behavioral Health Disaster Responders may want to make additional support and services available if it appears that a person with SMI is experiencing increased distress.

- Given the high rates of PTSD among this population, routine assessment for PTSD is recommended. If a person with SMI is experiencing posttraumatic symptoms, it is especially important to assess for PTSD. Similarly, if a person experiences an exacerbation of symptoms of their primary psychiatric disorder, increased problems with functioning, or increased substance use, it also may be appropriate to assess for PTSD. Despite the high rates of PTSD in the SMI population, PTSD is not often considered and documented as a comorbid diagnosis by clinicians.

- Effective treatments for PTSD are available and are presently being developed and tested by clinicians and people with SMI. Preliminary data suggest that talking about traumatic events with clinicians familiar with trauma does not exacerbate SMI symptoms. However, given the early stage of treatment development, clinicians familiar with trauma may still wish to consult a trauma specialist when working with an SMI client who is experiencing symptom exacerbation due to recent trauma.

(Adapted from National Center for PTSD Fact Sheet By Kay Jankowski, Ph.D. and Jessica Hamblen, Ph.D.).

STRESS MANAGEMENT FOR THE BEHAVIORAL HEALTH DISASTER RESPONDER

"In extraordinary times, remember to do the ordinary."
~Olivia Moorehead-Slaughter, Ph.D.

WHAT ARE THE REWARDS AND CHALLENGES OF BEHAVIORAL HEALTH DISASTER RESPONSE?

Behavioral Health Disaster Responders often experience personal gratification by using their skills and training to assist people in need. The ability to be part of the disaster response team can be an antidote for feelings of vulnerability, powerlessness, and outrage commonly experienced by non-impacted community members following a disaster. Assisting people as they struggle to put their lives back together is fundamentally meaningful. Behavioral Health Disaster Responders learn about their own strengths and vulnerabilities. They may be reminded of the preciousness of human life and their significant relationships. Many workers have said their view of human nature has been changed through the community outpouring of kindness, generosity, and the power of simple gestures following a disaster.

While there are clearly long lasting positive benefits for the Behavioral Health Disaster Responder in offering help and witnessing courage and resilience in others it is also important to possess an awareness of and attention to the Behavioral Health Disaster Responder's level of stress. Behavioral Health Disaster Responders can be faced with a range of challenging stressors including devastating losses, deaths and injuries, destruction of property, and emotional pain of survivors that can touch the worker in powerful and personal ways and are at risk for experiencing compassion fatigue. Figley (1995) defined *compassion fatigue* as the natural consequent behaviors and emotions resulting from helping or wanting to help a traumatized or suffering person. Figley reminds us that "There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care." This normalization of compassion fatigue has provided the foundation for a proactive and responsible approach to addressing stress in Behavioral Health Disaster Responders. The Behavioral Health Disaster Responder working with both peers and supervisors can effectively manage stress and compassion fatigue through self-awareness and practicing good self-care.

Figley, C. R. (E.d) (2001). Treating Compassion Fatigue. Philadelphia: Brunner/Mazel.

WHAT ARE THE SIGNS AND SYMPTOMS OF COMPASSION FATIGUE?

Worker stress results from the interaction of three factors: (1) the amount of exposure to trauma; (2) environmental factors such as working conditions and management practices; and (3) individual factors including the worker's perceptions, personal coping and stress reduction practices, personality, and applicable training and experience. The following signs and symptoms of worker stress are commonly experienced by Behavioral Health Disaster Responders with limited job effects.

However, functioning is likely to be impaired when Behavioral Health Disaster Responders experience a number of stress reactions simultaneously and with moderate intensity. When this occurs it is helpful to take a break and utilize self-care strategies to help counteract stress effects.

Signs and Symptoms of Compassion Fatigue
Psychological & Emotional: feeling heroic, invulnerable, euphoric; denial about one's stress level; anxiety and fear; worry about safety of self and others; anger or irritability; Restlessness; sadness, grief, depression; distressing dreams; guilt; feeling overwhelmed, hopeless; feeling isolated, lost, or abandoned; Apathy; over-identification with survivors; feeling misunderstood or unappreciated
Cognitive: memory problems and forgetfulness; disorientation and confusion; slowness or difficulty in thinking, concentration, and comprehension; difficulty calculating, setting priorities, making decisions; limited attention span; loss of objectivity; inability to stop thinking about disaster
Behavioral: change in activity level; decreased efficiency and effectiveness; difficulty communicating; outbursts of anger, frequent arguments; inability to rest-change in eating habits; sleep disturbances; change in patterns of intimacy; change in job performance; periods of crying Increased use of alcohol, tobacco, or drugs; vigilance about safety or environment; blaming and criticizing others; proneness to accidents
Physical: increased heartbeat; increased blood pressure; upset stomach, nausea, diarrhea; change in appetite, weight loss or gain; sweating or chills; tremors or muscle twitching; muffled hearing; tunnel vision; feeling uncoordinated; headaches, soreness in muscles, back pain; feeling a lump in the throat; exaggerated startle response; fatigue that does not improve with sleep; decreased resistance to colds, flu, or infection; flare-up of allergies, asthma, or arthritis

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

WHAT ARE SOME STRATEGIES FOR STRESS MANAGEMENT AT A DISASTER SITE?

Stress management for Behavioral Health Disaster Responders is both the responsibility of the worker as well as the leadership team. The on-site management team will provide clear instruction and training, limit shifts to 12 hours, encourage breaks, rotate between high, mid, and low-stress tasks and check-in with workers periodically. The leadership team will also strive to reduce worker stress by including the following dimensions in the mental health response strategy:

- Effective management structure
- Clear purpose, goals, and training
- Functionally defined roles
- Administrative controls
- Debriefings
- Team support
- Plan for stress management

As each worker has his or her own pattern of stress responses, it is equally critical that Behavioral Health Disaster Responders strive to monitor their own level of stress and employ self-care strategies both on-site and off. It is also vital to think about how you normally respond to stress and monitor yourself on the work-site**.** It is normal to experience stress; the key thing to remember is that stress can be effectively managed. The following steps can be taken to manage stress at the worksite:

- Encourage and support coworkers.
- Recognize that not having enough to do or waiting are expected parts of being a Behavioral Health Disaster Responders.
- Eat regular nutritious meals and avoid excessive caffeine.
- Get enough sleep and rest.
- Take regular breaks.
- Use time off to decompress.
- Practice relaxation techniques such as deep breathing and gentle stretching.
- Talk to coworkers about your reactions to the work.
- Maintain a sense of humor.
- Stay in contact with your family and friends.
- Pace yourself between low and high-stress activities.

It is important to strive to maintain self-awareness to recognize the early warning signs for stress reactions. Key to achieving self-awareness is recognizing that one may not be able to always self-assess problematic stress reactions. Behavioral Health Disaster Responders should work together to monitor each other's stress reactions and feel comfortable providing and receiving feedback and suggestions from both coworkers and supervisors. Always seek consultation when necessary. Working at a disaster site poses challenges that you may not find in your everyday workplace, such as working with survivors in a non-structured setting. Understand the differences between professional helping relationships and friendships to help

maintain appropriate roles and boundaries. Be mindful that over-identification with or feeling overwhelmed by victims and families' grief may signal a need for support and consultation. On-site it is critical to be aware of personal vulnerabilities and emotional reactions and to remember the importance of team and supervisor support.

What are some strategies for managing stress after a disaster?

BHDRs may feel mixed emotions at the end of an assignment, regardless of the length of the assignment. While there may be some relief that the assignment has ended, there is often a sense of loss and letdown. Behavioral Health Disaster Responders may at times have difficulty making the transition back into everyday life and to their regular job. Remember it is best to gently rejoin life and to give yourself time to stop and reflect on the experience and how it changed you. The following stress management techniques may be helpful following an assignment:

- Continue to practice good self-care.
- Eat regular nutritious meals and avoid excessive caffeine.
- Practice relaxation techniques such as deep breathing, gentle stretching, and regular exercise.
- Reconnect with friends and family at your own pace.
- Decide who and how much you feel comfortable talking about your Behavioral Health Disaster Responders work.
- Consider participating in organized debriefing or operational critiques.
- Practice portion control with media exposure. Decide how much exposure to the media regarding this event is right for you.

US Department of Health and Human Services. A Guide to Managing Stress in Crisis Response Professionals. DHHS Pub. No. SMA 4113. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

HOW DO I INCORPORATE STRESS MANAGEMENT AND SELF CARE STRATEGIES INTO MY DAILY LIFE?

It is important for Behavioral Health Disaster Responders to incorporate stress management into their everyday lives. When stress management techniques are familiar and routine they are more naturally used when responding to a disaster. The following chart offers a number of suggestions for immediate and long-term stress management and self-care strategies.

Dimension	Immediate Response	Long-Term Response
Self-Awareness	• Early warning signs for stress reactions recognized and heeded • Acceptance that one may not be able to self-assess problematic stress reactions • Over-identification with or feeling overwhelmed by victims' and families' grief may result in avoiding discussing painful material • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue	• Exploration of motivations for helping • Understanding when "helping" is not being helpful • Understanding differences between professional helping and relationships and friendships • Examination of personal prejudices and stereotypes • Recognition of discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety which interferes with the capacity to "be" with clients • Recognition of over-identification with survivors resulting in loss of perspective and role
Balanced Lifestyle	• Nutritional eating and hydration, avoidance of excessive junk food, caffeine, alcohol, or tobacco • Adequate sleep an dress, especially on longer assignments • Physical exercise and gentle muscle stretching when possible • Contact/connection maintained with primary social supports	• Family and social connections maintained away from program • Exercise, recreational activities, hobbies, or spiritual pursuits maintained • Healthy nutritional habits pursued • Over-investment in work discouraged
Stress Reduction Strategies	• Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) • Using time off to "decompress" and "recharge" • Talking about emotions and reactions with coworkers during appropriate times	• Cognitive strategies employed (e.g., positive self-talk, restructuring distortions) • Relaxation techniques (e.g., yoga, meditation) • Pacing self between low and high-stress activities • Talking with coworkers, friends, family, or counselor about emotions and reactions

U.S. Department of Health and Human Services. Mental Health Response to Mass Violence and Terrorism: A Training Manual. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

JOINING THE MASSACHUSETTS BEHAVIORAL HEALTH DISASTER RESPONSE TEAM

"Through our continuous improvement approach to training, this Public/Private collaboration has attracted clinicians from around the Commonwealth to become behavioral health disaster responders."
~Stephen Moss

HOW DO I JOIN?

Step 1: Complete BHDR-101 and/or BHDR-202 training sessions.
Step 2: Complete the Behavioral Health Disaster Responder Data Form.
Step 3: Complete the National Incident Management System online training or an accredited ICS-100 class and obtain NIMS certification (or an ICS-100 certificate).

Training

The training program is offered in two 7.5-hour sessions. Day 1 of the training, called BHDR-101, provides an educational overview of crisis intervention, mobilization of the state system by DMH/DHP/MEMA, and unified response to disasters. Individuals who have little or no prior experience as crisis counselors must complete both training days to become certified as a Behavioral Health Disaster Responder. Individuals who have previous training as crisis counselors by the Massachusetts Department of Mental Health, FEMA, the Red Cross or another accredited agency, need only complete the second day of the training session, called BHDR-202. BHDR-202 is the skill-building, hands-on experiential day where new techniques and the personal experience of responders to past emergencies are shared for training purposes.

Behavioral Health Disaster Responder Data Form

If after completing BHDR-202 you decide that you are interested in becoming a volunteer crisis counselor, you will receive a Behavioral Health Disaster Responder Data form to fill out. This form will provide us with your contact, professional, and licensure information along with information about your experience and areas of expertise. We ask that you carefully consider all items covered during the training sessions and in the reference guide before registering, as we rely on our volunteers to assist us during emergencies.

National Incident Management System Online Training

The National Incident Management System integrates effective practices in emergency preparedness and response into a comprehensive national framework for incident management. The NIMS enables responders at all levels to work together more effectively to manage domestic incidents no matter what the cause, size, or complexity.

On September 30, 2005, Governor Romney issued Executive Order 469, designating the National Incident Management System as the Commonwealth's Incident Management Standard. This Executive Order directs all first responders and personnel working in the Commonwealth to be certified in NIMS/ICS in order to participate in emergency/disaster rescue and recovery efforts. As such, the Behavioral Health Disaster Responder Team (consisting of DMH and DPH representatives) is adopting the successful completion of NIMS-700 or ICS-100 as a standard for which a Behavioral Health Disaster Responder can be activated and deployed as a crisis responder for the State of Massachusetts.

The NIMS training can be found at: http://www.training.fema.gov/EMIWeb/IS/IS700.asp. The NIMS web site offers the choice of taking an interactive web-based course or reviewing the printable version of the IS-700 Self-Study guide. After completing one of the two, download the exam questions and take the final exam. After successful completion of the course you will receive a certificate in the mail.

BEHAVIORAL HEALTH DISASTER RESPONDER DATA FORM

Last Name:	**First Name:**
Please list all numbers of where you can be contacted (if there is a crisis): Home: Work: Cellular: Pager: Other:	**Date of Birth:**
What is your response availability? (check all that apply) ☐ 24/7 ☐ 8am-5pm (M-F) ☐ 5pm-9am ☐ Weekends only ☐ Other:	**What response areas are you able to work**? (check all that apply) ☐Home ☐Work ☐Statewide ☐Out of state ☐ Long-term recovery ☐Interpreter ONLY
Employer Name:	**Employment Address:**
Work Address:	**City:** **State:** **Zip:**
Work Phone:	**Geographic Area Of Work Address**: ☐Western ☐Central ☐North East ☐Metro Boston ☐South East ☐Out of State
Home Address:	**City:** **State:** **Zip:**
Primary Email:	**Secondary Email:**
Please list your Degree/Field Of Study:	**Please list your current Certifications:**

Are you currently licensed in Massachusetts? (MH, SA, or Medical) ☐Yes ☐No
If yes, answer all of the questions in this section.
License Type: ☐MD ☐PhD ☐EdD. ☐PsyD ☐RN ☐LICSW ☐LMHC ☐LCSW ☐CADAC
MA License No:
Additional Licenses (include license numbers):
NOTE: Your licenses will be checked with the Massachusetts Board of Licensure.

Do you have any additional clinical/professional specialties? (check all that apply)
☐Children ☐ Adolescence ☐ Adults ☐ Elderly ☐ Substance Abuse ☐ Dual Diagnosis
☐ Spiritual Care ☐ Medical Profession ☐ First Responders ☐ Disability ☐ Homelessness
☐ Severe Mental Illness ☐ Veterans ☐ Victims of Crime ☐ Domestic Violence ☐ Sexual Abuse/Assault
☐ Trauma/PTSD ☐ Group Counseling ☐ Multicultural Issues ☐ Other
☐ List any population that you prefer NOT to work with:
Additional Specialties or Comments:

Please check of any additional training you have completed: (check all that apply)
☐ American Red Cross Volunteer Training ☐ CISM/CISD Training ☐ NOVA Training
☐ American Red Cross Mental Health/Disaster Training
☐ Behavioral Health Disaster Response Training (BHDR) ☐ Psychological First Aid Training
☐ National Incident Management System (NIMS) ☐ Incident Command System (ICS)
☐ MASS Support Helpline Crisis Counselor (Licensed) ☐ Other Disaster Training:

Disaster Response Experience:
Please check of any additional training you have completed: (check all that apply)
☐ All Hazards Disaster Planning ☐ Bioterrorism ☐ CISM/CISD ☐ Crisis Counseling
☐ Crisis Counseling Trainer ☐ Cultural Competency ☐ Disaster Grant Programs ☐ Incident Command
☐ Leadership ☐ Man-made Disasters ☐ Natural Disasters ☐ Research ☐ Risk Communication
☐ Partnering/Organization/Relationship Building ☐ Special Populations ☐ Stress Management
☐ Substance Abuse ☐ Sustainability ☐ Traumatic Stress/PTSD ☐ Other Experience

Other Disaster Response Experience:

Please list any languages spoken / Please list any cultural affiliations you possess:

IN WHAT SITUATIONS MIGHT I BE DEPLOYED?

Upon completion of the BHDR-101 & BHDR-202 training courses, Behavioral Health Disaster Responder Data Form, and the NIMS on-line course you will be placed on the roster of Massachusetts Behavioral Health Disaster Crisis Response Team. You may be contacted to respond to one of the following situations. This list is not meant to be all inclusive but descriptive of the types of disaster emergency events a Behavioral Health Disaster Responder could be called upon to deliver for.

Situation A: Department of Mental Health or Department of Public Health emergencies, or Local Emergencies identified by MEMA, Red Cross or other local emergency response personnel. Local Emergencies include:

- Accidental Death
- Business Fire
- Fire
- Hepatitis A Clinics
- Medical Emergency
- Suicide
- Train, Bus or Auto Accident
- Violent Death
- Violent Act resulting in local deaths
- Influenza pandemic or other biological outbreak/pandemic event

Situation B*:* President-declared disaster or Governor-declared state of Emergency Response including:

- Bombing
- Earthquake
- Flood
- Hazardous Material Exposure
- Hostage Situation
- Hurricane
- Radiological Event
- Severe Thunderstorm
- Snow Storm
- Terrorist Attack
- Tornado
- Toxic Chemical Spill

WHAT SHOULD I CONSIDER PRIOR TO BEING DEPLOYED?

You will be working in a volunteer capacity and unless FEMA funds are allotted, your work will be unpaid. This is similar to the American Red Cross volunteer structure. When registering for this volunteer opportunity, you should ask yourself questions like: can you be available to be on-call and deployed 24/7 or do I have limitations to the time you can volunteer? You are responsible for making arrangements ahead of time with your workplace concerning coverage and payment arrangements. In addition, you should communicate any limitations you have around volunteering your time to DMH, either by reporting it on the Behavioral Health Disaster Responder Data From or to identified DMH representatives.

You will need your own transportation to travel to and from the designated disaster site or staging (meeting) area. You will need to consider if you willing to respond to disasters statewide or would you prefer to be deployed in specific regions? Once

reporting on-site, you will be working under the Incident Command Structure, referenced earlier in this guide, and will be reporting to the on-site DMH/Emergency Management Coordinator or authorized representative.

When you receive a call asking you to activate your Behavioral Health Disaster Responder volunteer status and deploy to a disaster site, think about whether the assignment is right for you to take at that time. You may want to take some time to consider the assignment and call back the Behavioral Health Disaster Responder Coordinator with your response. Things to consider are:

- Is the location safe for you to travel to?
- Is your own family/loved ones safe from harm if you are absent for a period of time?
- Do you have permission from your employer to take the assignment?
- Do you have a Family Disaster Plan in place?

HOW WILL I GET DEPLOYED?

You will receive a telephone call from either the DMH Statewide Emergency Management Coordinator (Central Office or an Area Emergency Management Coordinator). The coordinator will brief you on the situation and then ask you to report to the site.

Things to remember before leaving for the site:

- Address and directions to the site
- Name of the BHDR coordinator at the site
- Photo ID
- Copy of your professional license
- Comfortable shoes
- Change of clothing
- Water & portable food/snacks

WHAT WILL I DO AT A SITE?

- Report to the designated coordinator at the site and you will be briefed and assigned to assist, as and where needed.
- Be aware of the ICS structure and work in collaboration with your team.
- Work only your assigned shift (up to 12 hours).
- Maintain confidentiality concerning all emergency and disaster crisis counseling contacts.
- Follow site coordinator direction to record all pertinent data on DMH tracking forms, when required, and comply with all other protocols and service requirements, as requested.
- Practice self-care on the site. This may mean requesting to rotate between high and low stress assignments as needed, taking breaks, and peer support.
- Participate in the group debriefing prior to leaving the site.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH BEHAVIORAL HEALTH DISASTER RESPONDERS ROLES & RESPONSIBILITIES

Overview of Volunteer Duties

- Report for duty and provide services **only** when called upon to do so by person/organization in charge of the mental health/substance abuse deployment to the incident/disaster
- Upon arriving at a disaster response site: report to the person-in-charge of the behavioral health (mental health/substance abuse) coordination, present any identification requested, and follow all procedures governing the deployment assignment. This may include documentation (such as carrying your professional license, if applicable) requirements, pre-duty screening interviews, and attending a post-duty shift defusing session.
- Assist those affected by the disaster (victims, families of victims, first responders, and the larger community)
- Administer crisis intervention techniques including support, information, disaster crisis counseling, substance abuse services, outreach, and/or referral
- Focus on general support, concrete problem solving, and healthy coping mechanisms
- Provide information about the mental health/substance abuse response to disasters as needed to small and large groups
- Connect those affected to familial, community, health, and/or disaster relief support systems
- Respond to cultural variations in response to disaster
- Address the mental health/substance abuse needs of special populations
- Address the Cognitive, Behavioral, Affective and Somatic Responses to Disasters
- Address the counseling and support needs of first responders and other disaster workers

- Reports questions concerns and request to Behavioral Health Disaster Response team leader/DMH Emergency Management Coordinator or designated shift supervisor.

Task Responsibilities

- Understand the role of the Behavioral Health Disaster Responder in a disaster or major emergency event within the Incident Command System.
- Training in Specific Disaster Mental Health/Substance Abuse Techniques. This includes:
    - Recognize the need for Disaster Mental Health and Substance Abuse Services for individuals, groups, families and Disaster workers
    - Understand the Cognitive, Behavioral, Affective, and Somatic Responses to Disasters, including distinctions between disaster crisis/substance abuse counseling and traditional mental health/substance abuse services.
    - Understand basic principles of disaster mental health, including that in most disaster situations victims and families will largely be from the general population and not have the pre-existing mental health and substance abuse issues that many mental health/substance abuse professionals encounter in their usual practice.
    - Evaluate "distressed" and anxious individuals; identify need for further evaluation or referral to traditional mental health, substance abuse, and/or emergency psychiatric services for persons exhibiting high-risk symptoms or behaviors.
    - Provide a wide range of Disaster Mental Health/Substance Abuse services appropriate to people affected by the event
    - Provide referrals to appropriate follow up care as needed

BEHAVIORAL HEALTH DISASTER RESPONDER TRAINING CONTRIBUTORS

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GLOSSARY

Acculturation (SAMHSA Definition): The process by which an individual or group adopts the identity, customs, or values of another culture.

Competence (SAMHSA Definition): The capacity to function effectively.

Crisis Counseling Program (CCP): FEMA-funded grant program to provide crisis counseling to survivors of a disaster, within either a 60-day period or a 9-month period.

Crisis Counseling**:** A short-term intervention with individuals and groups experiencing psychological reactions to a major disaster and its aftermath. Crisis counseling assists people in understanding their current situation and reactions, reviewing their options, addressing their emotional support and linking with other individuals/agencies who may assist the disaster survivor. It is assumed that, unless there are contrary indications, the disaster survivor is capable of resuming a productive and fulfilling life following the disaster experience if given support, assistance, and information in a manner appropriate to the person's experience, education, developmental stage and ethnicity. Crisis counseling does not include treatment or medication for people with sever and persistent mental illnesses, substance abuse problems or developmental disabilities.

Cultural Competence (SAMHSA Definition): A set of values, behaviors, attitudes, and practices that enables an individual or organization to work effectively across cultures; the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals or families receiving services as well as of staff who are providing such services.

Culture (SAMHSA Definition): The shared attributes of a group of people; a common heritage or learned beliefs, norms, and values.

Disaster *(FEMA definition*): An occurrence of a severity and magnitude that normally results in deaths, injuries and property damage and that cannot be managed through the routine procedures and resources of government. It requires immediate, coordinated, and effective response by multiple government and private sector organizations to meet human needs and speed recovery.

Disaster Field Office (DFO): The office that is established in or near the designated area to support Federal and State response operations.

Disaster Recovery Center (DRC): A centralized location where individuals affected by a disaster can go to obtain information on disaster recovery assistance programs form various Federal, State, and local agencies, as well as volunteer organizations. Trained staff is also on hand to provide counseling and advice.

Disaster/Emergency: A disaster and an emergency can both be described as any natural or human-caused event, which threatens or causes excessive morbidity, mortality, and/or loss of property. Disaster and emergency are used interchangeably whenever a situation calls for a crisis response. However, emergencies can be handled with resources that are routinely available to the community. A disaster calls for a response and resources that exceed local capabilities.

Emergency Management (EM): The organized analysis, planning, decision-making, and assigning and coordinating of available resources, for the purpose of preparing for, responding to, or recovering from major community-wide emergencies and disasters.

Emergency Medical Services (EMS): Local medical response teams, usually rescue squads or local ambulance services that provide medical services during a disaster.

Emergency Operations Center (EOC): This is the nerve center of disaster response operation; a protected site from which government officials and emergency response personnel exercise direction and control in an emergency. The EOC is designed to be self sufficient for a reasonable amount of time, with provisions for electricity, water, sewage disposal, ventilation and security. The major functions of the EOC are information management, situation assessment, and resource allocation.

Essential Services Personnel: Positions providing service that must be maintained regardless of the emergency situation to ensure quality care. These positions include direct care in 24-7 programs, such as residential services; emergency services; medication delivery to clients; medical personnel, and maintenance/transportation personnel.

Ethnicity (SAMHSA Definition): The common heritage of a particular group of people; including shared language, rituals, and preferences for music and food.

Federal Emergency Management Agency (FEMA): Lead Federal agency in disaster response and recovery. Provides funding for crisis counseling grants to State mental health authorities following Presidential declared disasters through the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS).

Federally Declared Disasters: There are varying levels of disaster declaration. Federally declared disasters represent the highest level, and can be established only by formal declaration of the President of the United States. An event, real and/or perceived, receives Federal declaration when it is deemed to threaten the well-being of citizens, overwhelm the local and state ability to respond and/or recover, or affect Federally owned property or interests.

Incident Command System (ICS): An organized system of roles, responsibilities, and suggested operational guidelines used to manage and direct emergency operations at the scene of an incident.

Local Disaster: A local disaster is any event, real and/or perceived, which threatens the well being of citizens in one municipality. A local disaster is manageable by local officials without a need for outside resources.

Major Disasters: As defined under P.L. 93-288, a major disaster is any natural catastrophe, (including hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mud slide, snowstorm, or drought), or regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under this Act, that serves to supplement the efforts and available resources for States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.

Massachusetts Emergency Management Agency (MEMA): the state agency responsible for coordinating federal, state, local, voluntary and private resources during emergencies and disasters in the Commonwealth of Massachusetts.

Natural Helper (SAMHSA Definition): A person that may or may not hold a degree relating to counseling but possess strong intuitive skills, know how to relate well with others, possess good and common sense, and are good listeners.

Psychological First Aid: an evidence-informed modular approach for assisting children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. Psychological First Aid techniques are: consistent with research evidence on risk and resilience following trauma; applicable and practical in field settings; appropriate to developmental level across the lifespan; and culturally informed and adaptable.

Special Populations: A targeted group in a disaster-impacted community or area with needs that require specific attention. Many definitions of special populations exist, and as such the term “special populations” can become quite expansive. The Massachusetts Department of Public Health’s Center for Emergency Preparedness has developed the following working definition, meant not to exclude groups, but to

more easily facilitate discussion. Special populations can be thought of in two major groups:

- **Demographic Group:** This group includes demographically distinct populations or individuals whose demographic distinction may put them at risk of isolation during an emergency. Examples of demographically distinct populations may include racial minorities, ethnic minorities, populations with

  distinct cultural and linguistic needs, elders, children, refugees and immigrants, institutionalized individuals, homeless, etc.

- **Health Conditions Group:** This group includes individuals or populations with physical disabilities or other functional health impairments that at times may entail dependence on mechanical or technological equipment and also may be them at risk of isolation during an emergency. Examples of individuals with health conditions may include persons who are deaf or hard of hearing, visually impaired, uses a wheelchair, homebound, or have a mental health and/or substance abuse condition, etc.

State-Declared Disasters: A state-declared disaster is any even, real and/or perceived, which threatens the well-being of citizens in multiple cities, counties, regions, and/or overwhelms a local jurisdiction's ability to respond, or affects a state-owned property or interest.

ACRONYMS

ARC: American Red Cross

BHDR: Behavioral Health Disaster Responder or Response

DMH: Massachusetts Department of Mental Health

DPH: Massachusetts Department of Public Health

EOC: Emergency Operations Center

FEMA: Federal Emergency Management Agency

ICS: Incident Command Structure

MAESF: Massachusetts Emergency Support Functions

MEMA: Massachusetts Emergency Management Agency

MEMT: Massachusetts Emergency Management Team

NIMS: National Incident Management System

SAMHSA: Substance Abuse and Mental Health Services Administration

INTERNET SITES

Organization	Website
American Red Cross of Massachusetts Bay	www.bostonredcross.org
Center for Disease Control and Prevention	www.cds.gov
Center for Multicultural Mental Health, Boston University School of Medicine/Boston Medical Center	www.cmmh-cmtp.com
Federal Emergency Management Agency	www.fema.gov
Massachusetts Department of Mental Health	www.mass.gov/dmh
Massachusetts Department of Public Health	www.mass.gov/samh
Massachusetts Emergency Management Agency (MEMA):	www.mass.gov/mema
MassSupport:	www.mass.gov/samh
National Center for PTSD	www.ncptsd.va.gov
National Institute of Mental Health	www.nimh.nih.gov
Substance Abuse & Mental Health Services Administration	www.samhsa.gov
Substance Abuse & Mental Health Services Administration Disaster Technical Assistance Center	www.samhsa.gov/dtac
US Department of Homeland Security	www.dhs.gov or www.ready.gov

APPENDIX A

Quick Tip Sheets

MASSACHUSETTS BEHAVIORAL HEALTH DISASTER RESPONDER DEPLOYMENT QUICK-REVIEW

How will you be deployed?

You will receive a telephone call from either the DMH Central Office or an Area Emergency Management Coordinator. The coordinator will brief you on the situation and then ask you to report to the site.

Things to remember before leaving for the work-site:

- Address and directions to the site
- Name of the BHDR coordinator at the site
- Photo ID (license & ID-badge from your place of employment)
- Copy of your professional license
- Comfortable shoes
- Change of clothing
- Water & portable food/snacks
- Handy-pack (small pouch to carry keys, ID, etc.)

What will I do at the site?

- Report to the BHDR coordinator at the site and you will be briefed and assigned to assist, as and where needed.
- Be aware of the ICS structure and work in collaboration with your team.
- Work only your assigned shift (up to 12 hours).
- Maintain confidentiality concerning all emergency and disaster crisis counseling contacts.
- Follow site coordinator direction to record all pertinent data on DMH tracking forms, when required, and comply with all other protocols and service requirements, as requested.
- Practice self-care on the site. This may mean requesting to rotate between high and low stress assignments as needed, taking breaks, and peer support.
- Participate in the group debriefing prior to leaving the site.

Remember the goals of behavioral health disaster response:

- Promote safety and security
- Identify current priority needs
- Assess functioning and coping
- Provide reassurance, normalization, psycho-education, and practical assistance

A NATIONAL CENTER FOR PTSD FACT SHEET: ALCOHOL, MEDICATION, AND DRUG USE AFTER DISASTER

Some people increase their use of alcohol, prescription medications or other substances after a disaster. You may feel that using drugs and alcohol seem to help you escape bad feelings or physical symptoms related to stress responses (e.g., headaches, muscle tension). However, they can actually make these things worse in the long term because they interrupt natural sleep cycles, create health problems, interfere with relationships, and create potential dependence on the substance. If your use of alcohol or drugs has increased since the disaster or is causing problems for you, it is important for you to reduce your level of use or seek help in gaining control over your use.

Managing alcohol, medication, and drug use

- Pay attention to any change in your use of alcohol and/or drugs.
- Consult with a healthcare professional about safe ways to reduce anxiety, depression, muscle tension, and sleep difficulties.
- Correctly use prescription and over-the counter medications as indicated.
- If you find that you have greater difficulty controlling alcohol/substance use since the hurricane, seek support in doing so.
- Eat well, exercise, get enough sleep, and use your family and others for support.
- If you believe you have a problem with substance abuse, talk to your doctor or counselor about it.
- If you feel like using larger amounts of either prescribed or over-the-counter medications, consult a healthcare professional.

If you have had an alcohol, medication, or drug problem in the past

For people who have successfully stopped drinking or using drugs, experiencing a disaster can sometimes result in strong urges to drink or use again. Sometimes it can lead them to strengthen their commitment to recovery. Whatever your experience, it is important to consciously choose to stay in recovery.

- Increase your attendance at substance abuse support groups.
- Talk with family and friends about supporting you to avoid use of alcohol or substances.
- If you are receiving disaster crisis counseling, talk to your counselor about
- Your past alcohol or drug use.
- If you have a 12-Step sponsor or substance abuse counselor, talk to him or her about your situation.
- If you have been forced to move out of your local community, talk to disaster
- Ask workers about helping to locate nearby alcohol or drug recovery groups, or ask them to help organize a new support group.
- Increase your use other supports that have helped you avoid relapse in the past.

A NATIONAL CENTER FOR PTSD FACT SHEET: BRIEF TIPS ABOUT SELF-CARE AND SELF-HELP FOLLOWING DISASTERS

The emotional effects of terrorist attacks are felt by people everywhere: victims, bereaved family members, friends, rescue workers, emergency medical care providers, mental-health care providers, witnesses to the event, volunteers, members of the media, and citizens of the community, the effected country, and the world. Those who were at the scene of attack and those who lost loved ones will almost certainly have strong reactions. People who see or hear about attacks on TV may also have strong reactions.

Common reactions to traumatic events like terrorist attacks include feeling afraid, sad, horrified, helpless, angry, overwhelmed, confused, distracted, emotionally numb, or disoriented. People may also be bothered by nightmares or upsetting thoughts and images that come to mind. Young children may be upset, distracted, or feel out of sorts. These are normal reactions to very stressful events. With the help of family and friends, most people gradually feel better as time goes by.

What can people do to cope?

- Spend time with other people. Coping with stressful events is easier when people support each other.
- If it helps, talk about how you are feeling. Be willing to listen to others who need to talk about how they feel.
- Get back to your everyday routines. Familiar habits can be very comforting.
- Take time to grieve and cry if you need to. To feel better in the long run, you need to let these feelings out instead of pushing them away or hiding them.
- Ask for support and help from your family, friends, church, or other community resources. Join or develop support groups.
- Set small goals to tackle big problems. Take one thing at a time instead of trying to do everything at once.
- Eat healthy food and take time to walk, stretch, exercise, and relax, even if just for a few minutes at a time.
- Make sure you get enough rest and sleep. People often need more sleep than usual when they are very stressed.
- Do something that just feels good to you like taking a warm bath, taking a walk, sitting in the sun, or petting your cat or dog.
- If you are trying to do too much, try to cut back by putting off or giving up a few things that are not absolutely necessary.
- Find something positive you can do. Give blood. Donate money to help victims of the attack. Join efforts in your community to respond to this tragedy.
- Get away from the stress of the event sometimes. Turn off the TV news reports and distract yourself by doing something you enjoy.

What can adults do to help children cope?

- Let them know you understand their feelings.
- Tell them that they really are safe.
- Keep to your usual routines.
- Keep them from seeing too many frightening pictures of the events.
- Educate yourself about how to talk to children of different ages about trauma.
- When should a person seek more help?
- Sometimes people need extra help to deal with a traumatic event. People directly affected by this tragedy, young children, people who have been through other traumatic events, and people with emotional problems are more likely to need professional help. A person may need extra help coping if a month after the attack he or she:
- Still feels very upset or fearful most of the time
- Acts very differently compared to before the trauma
- Can't work or take care of kids or home
- Has important relationships that are continuing to get worse
- Uses drugs or drinks too much
- Feels jumpy or has nightmares a lot
- Still can't stop thinking about the attack
- Still can't enjoy life at all

A NATIONAL CENTER FOR PTSD FACT SHEET: TIPS FOR RELAXATION

Tension and anxiety are common after disasters. Unfortunately, they can make it more difficult to cope with the many things that must be done to recover. There is no easy solution to coping with post-disaster problems, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have energy for coping with life. These can include muscular relaxation exercises, breathing exercises, meditation, swimming, stretching, yoga, prayer, exercise, listening to quiet music, spending time in nature, and so on. Here are some basic breathing exercises that may help.

For Yourself:

- Inhale slowly (one-thousand one, one-thousand two, one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
- Silently and gently say to yourself, " My body if filled with calmness." Exhale slowly (one-thousand one; one-thousand two, one-thousand three) through your mouth and comfortably empty your lungs all the way down to your abdomen.
- Silently and gently say to yourself, "My body is releasing the tension."
- Repeat five times slowly and comfortably.
- Do this as many times a day as needed.

For Children:

- Lead a child through a breathing exercise:
    1. "Let's practice a different way of breathing that can help calm our bodies down.
    2. Put one hand on your stomach, like this (demonstrate).
    3. Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this (demonstrate).
    4. Then, we will breathe out through our mouths. When we breath out, our stomachs are going to suck in and up like this (demonstrate).
    5. We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe our really slowly.
    6. Let's try it together. Great job!
    7. Make a game of it: blow bubbles with a bubble wand and dish soap: blow bubbles with chewing gum; blow paper wads or cotton balls across the table; tell a story where the child helps you imitate a character who is taking deep breaths (i.e., the three little pigs)

A NATIONAL CENTER FOR PTSD FACT SHEET: WHAT YOU MAY EXPERIENCE

Intrusive Reactions

- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again (flashback)
- Avoidance and withdrawal reaction
- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being “on the lookout” for danger, startling easily, or being jumpy
- Irritability or outbursts of anger
- Difficulty falling or staying asleep, problems concentrating or paying attention

Trauma and loss reminders

- Places, people, sights, sounds, smells, and feelings that remind you of the disaster can bring on distressing mental images, thoughts, and emotional/physical reactions
- Common examples include: sudden loud noises, the smell of fire, sirens of ambulances, locations where you experienced the disaster, seeing people with disabilities, funerals, anniversaries of the disaster, and television/radio news about the disaster.

What Helps

- Talking to another person for support
- Engaging in positive distracting activities
- Getting adequate rest and eating healthy meals
- Trying to maintain a normal schedule
- Scheduling pleasant activities
- Taking breaks

What Doesn’t Help

- Using alcohol or drugs to cope
- Working too much
- Withdrawing from family or friends
- Anger or violence
- Overeating or failing to eat
- Not taking care of yourself

HELPING CHILDREN AFTER A DISASTER
From Facts for Families, American Academy of Child and Adolescent Psychiatry

A catastrophe such as an earthquake, hurricane, tornado, fire, flood, or violent acts is frightening to children and adults alike. It is important to explain the event in words the child can understand. Parents should also acknowledge the frightening parts of the disaster when talking with a child about it. Falsely minimizing the danger will not end a child's concerns. Several factors affect a child's response to

The way children see and understand their parents' responses are very important. Children are aware of their parents' worries most of the time, but they are particularly sensitive during a crisis. Parents should admit their concerns to their children, and also stress their abilities to cope with the disaster.

A child's reaction also depends on how much destruction and/or death he or she sees during and after the disaster. If a friend or family member has been killed or seriously injured, or if the child's school or home has been severely damaged, there is a greater chance that the child will experience difficulties.

A child's age affects how the child will respond to the disaster. For example, six-year-olds may show their worries by refusing to attend school, whereas adolescents may minimize their concerns, but argue more with parents and show a decline in school performance.

Following a disaster, people may develop Posttraumatic Stress Disorder (PTSD), which is psychological damage that can result from experiencing, witnessing, or participating in an overwhelmingly traumatic (frightening) event. Children with this disorder have repeated episodes in which they re-experience the traumatic event.
Children often relive the trauma through repetitive play. In young children, upsetting dreams of the traumatic event may change into nightmares of monsters, of rescuing others, or of threats to self or others. PTSD rarely appears during the trauma itself. Though its symptoms can occur soon after the event, the disorder often surfaces several months or even years later.

Parents should be alert to these changes in a child's behavior:

- Refusal to return to school and "clinging" behavior, including shadowing the mother or father around the house
- Persistent fears related to the catastrophe (such as fears about being permanently separated from parents)
- Sleep disturbances such as nightmares, screaming during sleep and bedwetting, persisting more than several days after the event
- Loss of concentration and irritability
- Startled easily, jumpy

- Behavior problems, for example, misbehaving in school or at home in ways that are not typical for the child
- Physical complaints (stomachaches, headaches, dizziness) for which a physical cause cannot be found
- Withdrawal from family and friends, sadness, listlessness, decreased activity, and preoccupation with the events of the disaster
- Professional advice or treatment for children affected by a disaster--especially those who have witnessed destruction, injury or death--can help prevent or minimize PTSD. Parents who are concerned about their children can ask their pediatrician or family doctor to refer them to a child and adolescent psychiatrist for an evaluation.

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Seeking Social Support

- Making contact with others can help reduce feelings of distress
- Children and adolescents can benefit from spending some time with other similar-age peers
- Connections can be with family, friends, or others who are coping with the same traumatic event

Social Support Options

- Spouse or partner
- Priest, Rabbi, or other clergy
- Support group
- Trusted family member
- Doctor or nurse
- Co-worker
- Close friend
- Crisis counselor or other counselor
- Pet

Do . . .

- Decide carefully whom to talk to
- Start by talking about practical things
- Ask others if it's a good time to talk
- Decide ahead of time what you want to discuss
- Let others know you need to talk or just to be with them
- Tell others you appreciate them listening
- Choose the right time and place
- Talk about painful thoughts and feelings when you're ready
- Tell others what you need or how they could help—one main thing that would help you right now

Don't . . .

- Keep quiet because you don't want to upset others
- Assume that others don't want to listen
- Keep quiet because you're worried about being a burden
- Wait until you're so stressed or exhausted that you can't fully benefit from help

Ways to Get Connected

- Calling friends or family on the phone
- Getting involved with a support group
- Increasing contact with existing acquaintances and friends
- Getting involved in community recovery activities
- Renewing or beginning involvement in church, synagogue, or other religious group activities

A NATIONAL CENTER FOR PTSD FACT SHEET: CONNECTING WITH OTHERS

Giving Social Support

You can help family members and friends cope with the disaster by spending time with them and listening carefully. Most people recover better when they feel connected and understood to others who care about them. Some people choose not to talk about their experiences very much, and others may need to discuss their experiences on numerous occasions. Talking about things that happened because of the disaster can help them seem less overwhelming. At times, just spending time with people one feels close to and accepted by, without having to talk, can feel best. Here are some things we know about giving social support to other people after disasters.

Reasons Why People May Avoid Social Support

- Not knowing what they need
- Not wanting to burden others
- Wanting to avoid thinking or feeling about the event
- Feeling embarrassed or "weak"
- Doubting it will be helpful, or that others won't understand
- Feeling that others will be disappointed or judgmental
- Feeling they will lose control
- Having tried to get help and felt that it wasn't there before
- Not knowing where to get help

Good Things to Do When Giving Support

- Show interest, attention, and care
- Show respect for individuals' reactions and ways of coping
- Talk about expectable reactions to disasters, and healthy coping
- Find an uninterrupted time and place to talk
- Acknowledge that this type of stress can take time to resolve
- Believe that the other is capable of recovery
- Be free of expectations or judgments
- Help brainstorm positive ways to deal with their reactions
- Offer to talk or spend time together as many times as is needed

Things That Interfere with Giving Support

- Rushing to tell someone that he or she will be okay or that they should just "get over it"
- Acting like someone is weak or exaggerating because he or she isn't coping as well as you are
- Discussing your own personal experiences without listening to the other person's story
- Giving advice without listening to the person's concerns or asking the person what works for him or her
- Stopping the person from talking about what is bothering them

- Telling them they were lucky it wasn't worse

When Your Support is Not Enough…

- Let the person know that experts think that avoidance and withdrawal are likely to increase distress, and social support helps recovery
- Encourage the other to talk with a counselor, clergy, or medical professional, and offer to accompany them
- Encourage the other to get involved in a support group with others who have similar experiences
- Enlist help from others in your social circle so that you all take part in supporting the other

APPENDIX B

Readings for Behavioral Health Disaster Responders

A NATIONAL CENTER FOR PTSD FACT SHEET
PHASES OF TRAUMATIC STRESS REACTIONS IN A DISASTER

Heroic Phase (Immediate aftermath to 1 Week)
The Heroic Phase is characterized by fear, confusion, shock, adrenalin rush, heroic acts by individuals and groups, and by people coming together. During the heroic phase, some people respond in a way that is disorganized and stunned, and they may not be able to respond appropriately to protect themselves. Such disorganized or apathetic behavior may be transient or may extend into the post disaster period, so that people may be found wandering helpless in the devastation afterwards. These reactions may reflect cognitive distortions in response to the severe disaster stressors and may for some indicate a level of dissociation.

Most people respond appropriately during the impact and in the immediate aftermath of disaster and react to protect their own lives and the lives of others. This is a natural and basic reaction. A range of such behaviors can occur, and these may also need to be dealt with and understood in the post disaster period. After the fact, people may judge their actions during the disaster as not having fulfilled their own or others' expectations of themselves.

Several stressors may occur during this phase, which may subsequently have consequences for the person:

- Threat to life and encounter with death
- Feelings of helplessness and powerlessness
- Loss (e.g., loved ones, home, possessions)
- Dislocation (i.e., separation from loved ones, home, familiar settings, neighborhood, community)
- Feeling responsible (e.g., feeling as though could have done more)
- Inescapable horror (e.g., being trapped or tortured)
- Human malevolence (It is particularly difficult to cope with a disaster if it is seen as the result of deliberate human actions.)

Additionally, individuals who have never had substance abuse problems are not likely to develop such problems. However research also indicates an increase in substance use during this phase. There is a greater likelihood that individuals in recovery or who are on the crest of problematic substance use are at increased risk, in the former case, relapse and/or, in the latter case, have a significant increase in use that may lead to impaired functioning.

Honeymoon Phase (1 Week to 6 Months)
This is the phase where there is recoil from the impact and the initial rescue activities commence. The Honeymoon Phase is characterized by the need to attend to basic needs in a chaotic environment, concerns over safety and security, unrealistic view of recovery and the sharing of resources. This period is also often

associated with altruistic and therapeutic community response immediately following the disaster. In this case relief and survival may lead to feelings of elation, which, concurrently, may be difficult to accept in the face of the destruction the disaster has wrought.

Initial behavioral health effects may appear (e.g., people show confusion, are stunned, or demonstrate high anxiety levels). Emotional reactions will be variable and depend on the individual's perceptions and experience of the different stressor elements noted earlier. Necessary activities of the rescue phase may delay these reactions, and they may appear more, as the recovery processes get under way. Reactions may include:

- Numbness
- Denial or shock
- Flashbacks and nightmares
- Grief reactions to loss
- Anger
- Despair
- Sadness
- Hopelessness

As mentioned in the Heroic Phase above, individuals who are "at risk" for substance use disorders may be at increase risk during this phase. There is a greater likelihood that individuals in recovery or who are on the crest of problematic substance use may have, in the former case, relapse and/or, in the latter case, have a significant increase risk of use that may lead to impaired functioning.

Disillusionment Phase (2 Months to 2 Years after disaster)
This phase is characterized by the stark realization of loss and the work to be done to recover what was lost. The reality of the disaster's impact on the individual's life often "sinks in" during this phase. The disillusionment phase also often occurs when the disaster is no longer on the front pages of newspapers, organized support is withdrawn, and the realities of losses, bureaucratic constraints, and other changes wrought by the disaster must be confronted and resolved (Raphael, 1986). The individual becomes more aware of community and local disaster "politics". ***The grieving process may continue especially if the individual suffered deep personal loss significant other or individual functioning).*** This is the period that family discord and issues of abuse emerge or re-ignite. Issues of substance abuse also become clearer during this phase, as does the needs for mental health and substance abuse interventions. During this phase survivors begin to feel more isolated and forgotten. For those still affected, many will feel setbacks in recovery and have impulses toward giving up. This is where survivors need their own recovery plan and where support in breaking tasks down to manageable doses is critical. Yet, this can also be a period of renewed commitment toward recovery.

Reconstruction/Recovery Phase: (May last for several years and ongoing)
The recovery phase is the prolonged period of individual and/or community adjustment or the return to equilibrium. It commences as rescue is completed and individuals in communities face the task of bringing their lives and activities back to

normal. Much will depend on the extent of devastation and destruction that has occurred as well as injuries and lives lost (Raphael, 1993).

It is during the recovery phases when needs move beyond basic safety and survival to, among others, existential and psychological needs. ***And once manifest, these needs are typically left frustrated and unfulfilled for a prolonged period of time. Many times, through the media, retribution, or continued violence, the community in question is exposed to further traumatic events.***

In the Reconstruction/Recovery Phase it is particularly important to remember that during this period emotional needs may be very significant, especially for those who have been severely affected. It is during this phase that issues of PTSD and substance use disorders typically become very clear. They may only start to appear during this phase. It should be noted that sometimes emotional reactions may present as physical health symptoms, such as sleep disturbance, indigestion, and fatigue, or they may present as social effects such as relationship or work difficulties.

At the same time, this phase is also often associated with the proverbial, “light at the end of the tunnel”. Individuals begin to put the disaster behind them. They experience a sense of empowerment.

A NATIONAL CENTER FOR PTSD FACT SHEET: TREATING SURVIVORS IN THE ACUTE AFTERMATH OF TRAUMATIC EVENTS

Summary
Treatment of survivors in the acute aftermath of traumatic events is complex. Survivor's concrete needs may be very urgent, secondary stressors may still be operating, expressions of distress are volatile and highly reactive to external realities, and symptoms expressed may not reflect psychopathology. Normal healing processes are already operating, and significant assistance is provided by natural supporters and healers (e.g., relatives, community leaders) and should not be interfered with. Professional helpers are often enduring significant stress themselves and do not operate in their usual environment. A treatment model, which favors knowledge of pathogenic processes over symptom recognition, is described.

Introduction

'Therapy' during the acute phase may be distinctive in the following ways:
* A *conceptual re-framing* is needed: at this phase one may still be handling the trauma, rather than treating a post-traumatic condition. Psychological rescue (or first aid) may be the proper term for some interventions.

- Along with symptoms, current sources of stress should be in the forefront of the clinical evaluation. Relocation, separation, or continuous threats (such as during political repression) are powerful modulators of behavior. Help at this stage may consist of mitigating the effect of concurrent stressors.
- The mental and physical conditions that follow traumatic events are extremely complex, unstable, and rapidly changing. Perception of the event may vary from one individual to the other, individuals may be suggestible and unusually reactive: they may be very responsive to the emotional tone of helpers, but also reactive to real or fantasized realities, such as rumors.
- Expressions of distress are often appropriate at this stage, and one should be very careful not to classify them as 'symptoms' in the sense of being indicative of a mental disorder. The appropriateness and the 'productiveness' of the early response are more important indicators of disorder than the intensity of the response.
- During rescue efforts, professionals and nonprofessionals may have similar roles (e.g., soothing, comforting, orienting, reassuring etc.). Nonprofessionals are available in larger numbers and include the survivor's natural supporters (e.g., relatives, peers) and other community members (nurses, volunteers, disaster area managers). These supporters may also be overwhelmed and distressed, and mental health professionals' roles may be to support and guide the supporters.
- Professionals may be induced to share another person's grief as part of the healing process. The degree to which they can do this may have important effects on their efficacy as helpers and on their own well-being.

Who should be treated by mental health specialists?
This dilemma has been approached in two systematic ways: The first was to provide specialized treatment to those identified as being ill (e.g., soldiers who ceased to function during combat because of stress responses). The second consisted of covering all those exposed by providing some kind of professional intervention, recently in the form of debriefing. This chapter proposes to help making such decisions by pointing to the following ideas:

- The dichotomous choice between treatment and no-treatment should be replaced by the notion of ‘depth of treatment'.
- The early and urgent needs of all should be addressed (yet, not necessarily by psychological interventions).
- Trauma survivors should be considered at risk for developing traumatic stress disorders.
- Specific risk factors should be evaluated, for each case on the basis of the existing literature.
- The survivors' progress towards recovery should be followed and clinical decisions made on the basis of observations over time (instead of symptoms at any particular point in time).
- Treatment should be provided in a context of continuity of care.

The nature of traumatic events
DSM IV definition sets an entry criterion for considering an event to be traumatic in the context of making a diagnosis of PTSD-that is, an event that is life-threatening and in which one responds with a specific subjective response. However, it is not a good-enough definition of a traumatic event in that it is nonspecific and does not address the mechanisms of mental traumatization.

Extreme events may traumatize people in many different ways.

Concrete elements of traumatic events that increase the risk for PTSD include:

- Threat to one's life or body integrity.
- Severe physical harm or injury.
- Intentional injury or harm.
- Exposure to the grotesque.
- Witnessing or learning of violence to loved ones.
- Causing death or severe harm to another.
- The severity of traumatic events is related to them being intense, inescapable, uncontrollable, and unexpected.

Traumatic events can also be defined as those exceeding the person's coping resources or breaking his or her protective defenses.

Traumatizing elements of events can include:

- Fear and threat.

Stress theory proposes that specific innate or acquired mechanisms control human responses to threat. Learning theory predicts that psychobiological responses to extreme threats will be re-experienced because associations are learned between the threatening event and cues present at the time of trauma. Further, through conditioned learning, avoidance of trauma reminders increases. The intensity of the threat, its perception by the individual, and the immediate bio-psychological response are important predictors of subsequent psychopathology. The degree of perceived control over events and over one's reaction is an important modulator of the effect of stress on the brain. Physiological stress (e.g., bleeding or dehydration) may further influence response to a stressor.

- Actual or symbolic loss.

Real and symbolic damage in the form of injury, separation or death of significant others, loss of property, destruction of social networks etc., result in feelings of loss and damage to esteem and identity. Loss and subsequent mental processing may be central to the development of PTSD. Suffering a loss not experienced by those around you can result in feelings of extreme alienation from others. E.g., after finding a close friend mortally wounded, an Israeli army officer described feeling "totally cut off from others. I was completely alone, detached from my own soldiers who suddenly became total strangers to me."

- Exposure to grotesque and disfigured human bodies.
- Emotional or physical pain of others, dehumanization, degradation, humiliation.

Exposure to the grotesque, extreme agony of others, human cruelty, dehumanization, degradation, and humiliation can shatter reassuring assumptions and damage defenses or coping mechanisms.

- Forced relocation.
- Separation from and/or lack of information about loved ones.

The cutting of comforting social ties can result in loneliness and social isolation.

- Damaging appraisals of survivor's behavior or response.

A stable narrative of the traumatic events and of one's own responses is formed and consolidated during the short period that follows trauma and shapes how the event will be remembered. Memories of a traumatic event can be influenced by social appraisals of behaviors during or following the event (e.g., shameful, virtuous, dishonorable, heroic, cowardly, etc.). Extreme social labels are often counter-productive because they make it harder for survivors to process the complexities and ambiguity of their own experience.

Phases of coping with traumatic stress

Responses in the days that follow trauma are characterized by being under stress, use of extreme defenses, (such as over control of emotions or dissociation), and a focus on physical and emotional survival.

A later period of reappraisal and reevaluation has the main psychological task of assimilation of events and their consequences. This period is characterized by intrusive recollections of the traumatic event. Both periods can be physically and psychologically demanding.

Coping styles vary from action prone to reflective and analytical, from emotionally expressive to reticent. Clinically, response style is not as ultimately important as the degree to which coping efforts are successful as defined by the survivor's ability to:

- Continue task-oriented activity
- Regulate emotion
- Sustain positive self value
- Maintain and enjoy rewarding interpersonal contacts

Symptoms expressed following trauma

Initial symptoms are varied, complex, and unstable. They can include exhaustion, stupefaction, sadness, anxiety, agitation, numbness, dissociation, disorientation, confusion, depression, physical arousal, and blunted affect.

Some responses are ‘normal' in the sense of affecting most survivors, being socially acceptable, psychologically effective, and self-limited.

Indicators of effective coping include: a low degree of distress (though this should not be confused with numbing or blunted affect); intrusive recollections that lead a survivor to recruit sympathy and help; upon repetition, the trauma narrative becomes richer, includes other elements, and takes on a reflective tone (e.g., "When I think about it now, I could have done worse."); nightmares change from mere repetition of the event to more remote renditions.

Indicators of more pathological responses include: continuous distress without periods of relative calm or rest; severe dissociation symptoms that continue following a return to safety; intense intrusive recollections that are fearfully avoided, experienced as a torment, or seriously interfere with sleep; extreme social withdrawal; the inability to think about rather than just emotionally experience the trauma.

Assessment and evaluation

Need to clarify what elements were traumatizing for the individual rather than imposing own assumptions or theory. Domains to assess and evaluate include:
Exposure to traumatizing elements includes death of loved ones, injury, relocation, loss of property, social network, previously held beliefs, cognitive schemata, identity,

honor, peace of mind, sense of continuity with previous life (e.g., "I'm not the same person any more.").

- Individual prior risk factors for traumatization; including prior psychological disorder, prior trauma exposure
- Presence of secondary physiological stressors; includes effects of injuries, pain, internal bleeding, dehydration, medical procedures
- Presence of secondary psychological stressors; includes police interrogation, media attention, prolonged relocation, continued separation and estrangement from family and friends, bewilderment, disorientation, uncertainty about safety of self and significant others, missing family members, continued lack of control over what is happening.

Questions to assess secondary psychological stressors include: Is the survivor secure and out of danger? Does he or she have enough control of what is happening? Are there major uncertainties in the present? Are negative events (or news) still expected?

Does the survivor have clear enough information about self and significant others? Has adequate human attention and warmth been given to the survivor? Has trust been established between survivors and helpers? Can the current conditions humiliate or dishonor the survivors?

Evolution of symptoms over time
This includes the quality, intensity, and development of early responses. Assess content and structure of trauma narrative as it evolves (including concrete descriptions, subjective appraisals, emotional responses) without pointing out inconsistencies or making interpretations. Notice whether narrative becomes richer, includes more elements, takes on a reflective tone.

- Coping efficacy: degree to which symptoms are tolerated by survivor or interfere with functioning.

Can the survivor continue task-oriented activity? How well organized, goal directed, and effective is such activity? Is the survivor overwhelmed by strong emotions most of the time? Can emotions be modulated when such modulation is required? Is the survivor inappropriately blaming himself or herself? Does the survivor generalize such accusations to his or her personality or self? How isolated, alienated, or withdrawn is the survivor? Does he seek the company of others or avoid it?

- Availability of healing resources; includes access to social support, nature of societal response.

Interventions

General principles

- Help providers must be tolerant of symptomatic behavior, strong emotions.
- Help providers must respect the survivor's ability to self-regulate and monitor his or her environment.
- Help providers must break the wall of mental isolation that can follow trauma exposure and must maintain continuity of care so that survivors do not begin to feel betrayed and re-isolate.
- Help providers must provide care that is tailored to the needs, capacities, and desires of survivors.
- The survivor must be able to properly utilize and enjoy what is offered. Stress responses may reduce such capacity.

Generic goals of early interventions

- To reduce psychobiological distress and the effects of secondary stressors.
- To treat specific symptoms when they interfere with normal healing processes.
- To assist the normal healing process by supporting the survivor and helpers, by seeing that such helpers are available, that families are evacuated together, etc.
- To follow progress by continued assessment of global coping efficacy.

Interventions in the different phases of the acute response

Peri-traumatic period

- Protect from further exposure to stress, contain the immediate physiological and psychological responses, and increase controllability of the event and of subsequent rescue efforts.
- Be aware of and responsive to survivor's comfort and dignity (e.g., by covering his or her body, avoiding intrusive looks of others and of the media).
- Reorient survivor within the rescuing environment; identify self and role.
- Continuously inform survivors about steps to be taken (e.g., evacuation to a hospital), medication given (e.g., morphine), and other information.
- Provide genuine information (including admitting lack of information) but avoid breaking bad news if possible.
- Maintain human contact with survivors throughout rescue efforts.
- Bring in natural helpers (e.g., relatives, friends) and support them with advice and information.
- If survivors have difficulty expressing their experience verbally, use other bodily and emotional channels are open for communication. e.g., comforting touch (with respect for gender and social boundaries), physical comforts (warmth, hot showers, clean clothes), favorite music, foods, books, and movies.
- Whenever possible, reconnect or evacuate survivors with their family and friends.

Addressing Early Responses

Early post-trauma interventions should aim to facilitate psychological recovery and disable progressive sensitization.

- Encourage survivors to verbalize and share their individual story with others.

While telling the story is stressful and rarely without strong emotion, it also creates an emotional bond that reduces the survivor's isolation.

- Expect oscillation between periods of extreme anguish and relative rest.
- Encourage grieving for losses and re-adaptation (new learning about self /others).
- Encourage survivors to express painful emotions (verbally, through art, music).
- Attempt to interrupt continuous distress.
- Encourage survivors to be with others.
- Encourage increased thinking about the trauma (rather just experiencing).
- Allow for specific recovery styles to develop in individuals and families (one may talk and another may be silent).
- Assess the strengths and the weakness of the survivor's immediate supporters.
- Explain meaning of symptoms and recovery process to survivors and their helpers.

Treating Emergent or Unremitting Symptoms Upon Return to Normal Activities

- Survivors may become more symptomatic as they prepare to leave the hospital.

Phobic responses, major depression, and acute PTSD may become evident because they start to interfere with normal tasks.

- If there are new or unremitting symptoms 4 or more weeks after return to a safe environment, survivor may require professional care.

Specific techniques

Crisis interventions and stress management

- These interventions attempt to stop the vicious circle of catastrophic appraisal and extreme distress, address survivors' perception that their reaction is abnormal or that they have totally lost their inner strength, move subjects from a stage of disarray to a stage of effective coping.
- Excessive distress is thought to impair effective problem solving, and coping.
- Steps of crisis interventions include 1. Appraising with the individual what specific elements in a given situation create intolerable distress. 2. Recognizing, legitimizing, and challenging the perceived totality of the situation. 3. Addressing efforts already made to solve the salient problem. 4. Assessing other ways of problem-solving, other resources, alternative plans of action (such as effective help-seeking, postponing efforts to find a solution, and focusing on alternative goals).

Treatment of combat stress reaction (CSR) within the military

- CSR has had dual goals of treating combat soldiers and reducing manpower loss due to psychological reactions.
- PIE model (proximity, immediacy, and expectations) focused on treating CSR casualties as near as possible to the frontline, as soon as possible, and with an expectation of recovery and return to duty.
- Effectiveness of PIE approach has not been confirmed by studies of CSR, and there is some evidence that it is not effective in preventing PTSD.
- Best approach may be to allow a natural selection process by which those who recover within the time allocated to staying in a frontline facility may go back to their previous role, while those with persistent reactions are evacuated to the rear.

Brief cognitive interventions

- 4 and 5 session Cognitive Behavioral Therapy (CBT) interventions administered weeks after trauma have been found to reduce rates of PTSD in samples of sexual assault, nonsexual assault, and accident victims.

Debriefing

- Semi-structured individual and group interventions are designed to alleviate initial distress and prevent the development of mental disorders following exposure to traumatic events through reviewing the facts, sharing emotions, validating individual experiences, learning coping skills, evaluating current symptoms, and preparing for future experience.
- Controlled studies of debriefing interventions have shown that most survivors perceived debriefing sessions as beneficial and satisfying and that the interventions significantly reduced concurrent distress and enhanced group cohesion.
- But in controlled studies of 4 different types of trauma survivors, one-session interventions were not effective in preventing PTSD and, in 2 of 4 studies, had negative long-term effects.
- The effects of debriefings in the context of continuous care have not been studied.

Pharmacological interventions

- Short-term administration of anxiolytics (i.e., benzodiazepines for 5 nights) to recent (between one and three weeks) trauma survivors was found to improve sleep and PTSD symptoms, but prolonged treatment by high potency benzodiazepines in recent trauma survivors (2 to 18 days following trauma) was associated with higher incidence of PTSD at six months.
- Pharmacological agents that interfere with learning (e.g., benzodiazepines) may prevent post-trauma adaptation. This argues against administering such drugs continuously to trauma survivors.

- Therefore, the use of sedatives in recent trauma survivors should have specific target (e.g., sleep, control of panic attacks) and should be time-limited.
- No studies have been conducted on effects of antidepressants in acute trauma victims.
- Other classes of drugs may prove useful, but no studies have yet been completed.

Effects on helpers

- Rescuers and helpers are also at risk for developing stress responses.
- Warning signs of burnout include excessive exposure, inability to disengage from work, irritability, inability to relax, difficulties communicating with others.
- Effects on rescuers can be reduced by: monitoring exposure to trauma, ordering and enforcing breaks and resting periods, providing relief replacement workers.
- Professional and lay helpers who help by listening to trauma survivors' distress and trauma stories need adequate preparation, support, and opportunities to ventilate and share their emotions.

Conclusions

There are multiple reasons why early interventions can be ineffective:

- PTSD has a complex etiology.
- The relative contribution of early and short interventions is necessarily small.
- Early responses to trauma are changeable and a mixture of normal and abnormal behavior.
- It is difficult to identify which persons are at risk for continued problems.
- It is difficult to conduct interventions in early aftermath of disastrous events.

What have been found to be effective are multiple sessions of CBT provided weeks (not days) following the trauma. However, in many cases, if the client cannot tolerate CBT, supportive counseling is in order until the client can tolerate the intensity of some aspects of brief CBT.

Effective treatment should be administered during the early posttraumatic period to symptomatic survivors.

Immediate contact can provide the survivor with an open door (or address) for continuous or later treatment and the ability to identify oneself as being in need of treatment.

Stages of early responses to traumatic events should follow this general framework:

1. Provide concrete help, food, warmth, and shelter.
2. Once out of concrete danger, soothe and reduce states of extreme emotion and increase controllability.
3. Assist survivors in the painful and repetitive re-appraisal of the trauma.
4. Treat specific syndromes such as acute stress disorder, depression, and other anxiety disorders.

Excerpted with permission, from a chapter written by Arieh Y. Shalev, M.D., Department of Psychiatry, Hadassah University Hospital, Jerusalem to appear in R. Yehuda (Ed.), *Treating Trauma Survivors with PTSD: Bridging the Gap Between Intervention Research and Practice.* Washington, DC: American Psychiatric Press.

A NATIONAL CENTER FOR PTSD FACT SHEET: PSYCHOSOCIAL RESOURCES IN THE AFTERMATH OF NATURAL AND HUMAN-CAUSED DISASTERS: A REVIEW OF THE EMPIRICAL LITERATURE, WITH IMPLICATIONS FOR INTERVENTION

Findings regarding psychosocial resources are organized by distinguishing between resources that are threatened by stress (vulnerable resources) and resources that emerge in response to stress (emergent resources). Emergent resources must be mobilized to replace or replenish the vulnerable ones. We first reviewed the evidence regarding the protection afforded by psychological and social resources, then the evidence regarding the potential for resource deterioration, then the evidence regarding resource mobilization in the aftermath of disasters.

Protection Afforded by Psychological Resources
Psychological resources such as coping efforts, self-efficacy, mastery, perceived control, self-esteem, hope, and optimism do protect disaster victims, as indicated by the following empirical results:

- ***Ways of coping*** influenced symptom outcomes in several studies, but the findings were not always consistent across them. Avoidance coping and blame assignment were consistently problematic, but other ways of coping were sometimes helpful and sometimes not.
- ***Beliefs about coping*** were far more important than ways of coping. What matters, apparently, is not how individuals actually cope but rather how they perceive their capabilities to cope.
- ***Self-efficacy, mastery, perceived control, self-esteem, hope, and optimism*** all are related positively, strongly, and consistently to mental health in both the short-term and long-term.

Protection Afforded by Social Resources
Social embeddedness, received social support, and perceived social support are all critical for disaster victims, as indicated by the following findings in the empirical research:

- ***Social embeddedness*** is the size, activeness, and closeness of the survivor's network-is related strongly and consistently to mental health.
- ***Received social support*** is the actual helping behavior that emerges in response to stress. Although it usually is related positively to mental health, the findings are not entirely consistent, in part because levels of help received are confounded with need. Received support is important primarily because it protects and replenishes other resources, such as perceived social support.
- ***Perceived social support*** is the most thoroughly researched social resource. With few exceptions, disaster survivors who subsequently believe that they are cared for by others and that help will be available if needed, fare better psychologically than disaster survivors who believe they are unloved and alone.

Resource Deterioration

The extent to which resources were lost may be the single most important thing to understand about a post disaster environment, as indicated by the following research:

- ***Global indices of resource loss*** show that the greater the amount of resource loss, regardless of the specific resources, the greater the psychological distress. Several studies have found such measures to be the strongest predictors of symptom outcomes.
- ***Psychological resources,*** such as optimistic biases and perceived control, occasionally have been found to decline after disasters.
- ***Social resources***, specifically social embeddedness and perceived social support, appear to be especially vulnerable to the effects of disasters. The reasons are many, including loss of network members through death and relocation and community-wide changes in social activities. An important feature of disasters is the likelihood that potential supporters are victims themselves. As a result, the need for support for all affected may surpass its availability, leaving social networks unable to provide necessary support.
- ***The Social Support Deterioration Model***, which has been tested across several disasters, indicates that declines in social support account for a large share of victims' subsequent declines in mental health. Attending to the social needs of disaster victims could go a long way toward protecting survivors from long-term adverse psychological consequences.
- ***Resource mobilization*** can help counteract the forces that engender resource deterioration. It is therefore critical to understand the processes that influence the receipt or mobilization of postdate social support.
- ***The Social Support Deterioration Deterrence Model***, an extension of the earlier deterioration model, shows that resource deterioration is *not* inevitable. When disaster victims receive too little help relative to their needs, their subsequent perceptions of social support deteriorate. However, when disaster victims receive help that is adequate relative to their needs, they maintain their expectations of support (and subsequent mental health).
- ***Families and friends*** are relied upon more often, and with greater subsequent comfort, than outsiders and professional sources of support.
- ***Emotional, informational, and tangible help*** are all important to disaster victims.
- ***The rule of relative needs***, which means that the most help should go to those who need it the most, is followed appropriately by most communities.
- ***The rule of relative advantage*** acknowledges that the distribution of post disaster help is not governed by need alone. Within communities, the amount of received support increases as network size, help seeking, comfort, and economic well-being increases. These rules operate at the macro- as well as micro-level. Post disaster "altruistic communities" are less likely to develop in a context of low resources than in a context of high resources. These communities are also less likely to develop after technological disasters than

after natural disasters. As far as we know, support mobilization has not been studied in the aftermath of mass violence.

- ***Sustaining helping activities may be more difficult than mobilizing them.*** In time, attentive media and other outsiders leave. Families and social networks become saturated with stories and shared feelings. Over time, fatigue, irritability, and scarcity of resources increase the potential for interpersonal conflict and social withdrawal. When support provisions are inadequate, inequitable, or too short-lived, the mobilization of support gives way to the deterioration of support.

Summary and Conclusions

Although the empirical data on resources is less extensive than the research on the overall impact of disasters or risk factors for adverse outcomes, it has grown tremendously in recent years. These data yield the following conclusions and recommendations:

- ***Naturally occurring psychosocial resources*** provide important protection against adverse symptom outcomes. Unfortunately, these same protective resources are themselves vulnerable to the impact of disasters and sometimes decline or deteriorate in strength. Fortunately, such deterioration is unlikely when post disaster support provisions are adequate, equitably distributed, and sufficiently lasting to meet survivors' needs.
- One limitation is that the data supporting this perspective emerged primarily from studies of natural disasters. Although some of the natural disasters studied have been quite serious***, it has not been established that naturally occurring resources are powerful enough to overcome the effects of the profound trauma that accompanies mass violence.*** It also has not been established that such resources and processes effectively protect survivors from PTSD, as most of the studies predicted levels of nonspecific distress. This is not to say that resources are not important in the context of mass violence, only that they have not been studied very much.
- We should educate survivors, and those who come into contact with them, that ***avoidance and blame assignment are rarely effective coping strategies***. Otherwise, however, the specific ways of coping matter much less than do people's perceptions of themselves as able to cope and control outcomes. It may be more important for disaster workers to reassure survivors that they do, in fact, have what it takes to meet the demands faced.
- ***A focus on self-efficacy*** does not mean that mental-health services are not needed but rather that such services should be delivered in a way that provides resources without threatening them. Some people are more likely to accept help for "problems in living" than to accept help for "mental-health problems." In exercising our good intentions to help victims, we must not inadvertently rob them of the very psychological resources they need to persevere over the long term.

- ***Naturally occurring social resources are particularly vital for disaster victims***. Professionals and outsiders are important sources of assistance when the level of need is high, but they must not and cannot supplant natural helping networks. People should *not* abandon their routine social activities because these keep people informed about the relative needs of network members, provide natural forums for sharing experiences, and preserve a sense of social embeddedness. It also might be helpful to educate individuals about the reasons why significant others may not always be able to provide them with the quality or quantity of interpersonal support they expect.

Implications for Intervention
A number of implications for intervention can be drawn from the above results. Whether directed toward the community, family, or individual, the emphasis for interventions should be on empowerment, meaning they should draw upon and build strengths, capabilities, and self-sufficiency.

Community-focused interventions for enhancing social resources will vary depending upon the disaster, the setting, and the culture. General recommendations are as follows:

- Collective grieving expresses solidarity and facilitates unity and collective action.
- Keep people in their natural groups if they must be relocated.
- Provide social activities for new communities that form because of displacement, especially if natural groups have not been retained.
- Group meetings in which participants brainstorm about various themes for rebuilding the community help survivors to recognize the reality of loss, to identify and discuss local problems, and to work together toward an achievable, specific goal.
- In order to emphasize inclusiveness, the above activities must reach out to people who might feel isolated or marginalized. Community members also might canvas the community to learn of others' needs.

Family-focused interventions are very important. Most people are most comfortable seeking and receiving help from family members, yet family members also are a significant source of strain and conflict. Disaster workers should search for effective ways to build and sustain support at the family level. The following are only a few general suggestions:

- Encourage families to talk together about their experiences, losses, and feelings.
- Encourage families to resume normal activities to the extent possible.
- Help families handle conflict appropriately so as to minimize negative encounters caused by the strain, fatigue, and irritability that often follow trauma.

Individual-focused interventions are costly and often unnecessary. They should be reserved for those persons who are most distressed, who had weak psychological and social resources to begin with, or who suffered particularly dire resource losses. If it is recalled that resources must be invested in order to acquire new ones, it will be understood that the people who need such services the most may be least likely to seek them. Outreach to such persons, and to the communities in which they are most likely to live is essential.

Clearly, resources matter in times of stress. The concepts of emergent and vulnerable resources may be helpful not only for organizing the research but for organizing information about a specific community's resources. A clear goal of intervention should be to help disaster-stricken communities plot strategies that increase the emergence of resources and decrease the vulnerability of resources. Providing the people within indigenous networks with the resources they need to help one another is (or should be) the primary objective of disaster mental-health policy. The ultimate task is to foster a mobilization of community support that will be powerful, inclusive, and that will last long enough to conquer the spiral of losses.

DEVELOPING CULTURAL COMPETENCE IN DISASTER MENTAL HEALTH PROGRAMS: GUIDING PRINCIPLES AND RECOMMENDATIONS (ADAPTED)

Culture and Disaster

Since it's founding, the United States has been a nation of diversity. In the years to come, fertility and mortality rates, immigration patterns, and age distributions within subgroups of the population will contribute to an increasingly diverse national population (Day, 1996). Data from the 2000 U.S. Census reveal that Hispanics have replaced African Americans as the second largest ethnic group after whites.[2] Because of higher birth and immigration rates, the Hispanic population is growing faster than any other ethnic minority group (DHHS, 2001). The population of Asian Americans is also growing and is projected to continue growth throughout the first half of the 21st century, primarily because of immigration (DHHS, 2001). As shown in Table 1-1, by 2010, Hispanic Americans will comprise 14.6 percent of the U.S. population, African Americans will comprise 12.5 percent, Asian Americans will comprise 4.8 percent, and Native Americans will comprise less than 1 percent (U.S. Department of Commerce, 2000).

These demographic changes have given the United States the benefits and richness of many cultures, languages, and histories. At the same time, the Nation's growing diversity has made it more important than ever for health and human service providers—including disaster mental health service providers—to recognize, understand, and respect the diversity found among cultural groups and subgroups. Service providers must find ways to tailor their services to individuals' and communities' cultural identities, languages, customs, traditions, beliefs, values, and social support systems. This recognition, understanding, respect, and tailoring of services to various cultures is the foundation of cultural competence.

Understanding Culture

Culture influences many aspects of our lives—from how we communicate and celebrate to how we perceive the world around us. Culture involves shared customs, values, social rules of behavior, rituals and traditions, and perceptions of human nature and natural events. Elements of culture are learned from others and may be passed down from generation to generation.

Many people equate race and ethnicity with culture; however, the terms "race" and "ethnicity" do not fully define the scope and breadth of culture. Race and ethnicity are indeed prominent elements of culture, but there are important distinctions between these terms. For example, many people think of "race" as a biological category and associate it with visible physical characteristics such as hair and skin color.

Physical features, however, do not reliably differentiate people of different races (DHHS, 2001). For this reason, race is widely used as a social category. Different cultures classify people into racial groups on the basis of a set of characteristics that are socially important (DHHS, 2001). Often, members of certain social or racial

groups are treated as inferior or superior or given unequal access to power and other resources (DHHS, 2001).

"Ethnicity" refers to a common heritage of a particular group. Elements of this shared heritage include history, language, rituals, and preferences for music and foods. Ethnicity may overlap with race when race is defined as a social category. For example, because Hispanics are an ethnicity, not a race, ethnic subgroups such as Cubans and Peruvians include people of different races (DHHS, 2001).

"Culture" refers to the shared attributes of a group of people. It is broadly defined as a common heritage or learned set of beliefs, norms, and values (DHHS, 2001). Culture is as applicable to groups of whites, such as Irish Americans or German Americans, as it is to racial and ethnic minorities (DHHS, 2001). People can share a culture, regardless of their race or ethnicity. For example, people who work for a particular organization, people who have a particular physical or mental limitation, or youth in a particular social group may share cultural attributes.

A culture can be defined by characteristics such as:

- National origin;
- Customs and traditions;
- Length of residency in the United States;
- Language;
- Age;
- Generation;
- Gender;
- Religious beliefs;
- Political beliefs;
- Sexual orientation;
- Perceptions of family and community;
- Perceptions of health, well-being, and disability;
- Physical ability or limitations;
- Socioeconomic status;
- Education level;
- Geographic location; and
- Family and household composition.

Culture changes continuously. For example, immigrants to the United States bring with them their own beliefs, norms, and values, but through the process of acculturation gradually learn and adopt selected elements of the dominant culture. An immigrant group may develop its own culture while becoming acculturated. At the same time, the dominant culture may change as a result of its interaction with the immigrant group (DHHS, 2001).

Diversity Among and Within Racial and Ethnic Minority Groups
Four racial and ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans—accounted for approximately 30 percent of the U.S. population in the year 2000 and are expected to account for nearly 40 percent of the U.S. population by 2025 (DHHS, 2001). Although there are important differences among these four groups, there also is broad diversity within each group. In other words, people who find

themselves in the same racial or ethnic group—either by census category or through self-identification—do not always have the same culture. Examples follow:

- American Indians and Alaska Natives may belong to more than 500 tribes, each of which has a different cultural tradition, language, and ancestry (DHHS, 2001).
- Asian Americans and Pacific Islanders may identify with any of 43 subgroups and speak any of 100 languages and dialects (DHHS, 2001).
- Hispanics may be of Mexican, Puerto Rican, Cuban, Central and South American, or other heritage (DHHS, 2001).

Furthermore, the broad category labels are imprecise (DHHS, 2001). For example, people who are indigenous to the Americas may be called Hispanic if they are from Mexico or American Indian if they are from the United States (DHHS, 2001). In addition, many people in a particular racial or ethnic minority group may identify more closely with other social groups than with the group to which they are assigned by definition (DHHS, 2001). Finally, many people identify with multiple cultures that may be associated with factors such as race, ethnicity, country of origin, primary language, immigration status, age, religion, sexual orientation, employment status, disability, geographic location, or socioeconomic status. Table 1-2 identifies Federal Government categories for race and ethnicity.

Recognizing the limitations of the traditional broad groupings, the U.S. Census Bureau revised the categories used to report race and ethnicity in the 2000 Census. For the first time, individuals could identify with more than one group (U.S. Office of Management and Budget, 2000). The U.S. Census Bureau anticipated that this change would result in approximately 63 categories of racial and ethnic identifications (DHHS, 2001).

Cultural Competence: Scope and Terminology

We use many terms to refer to concepts associated with cultural competence and with interactions between and among people of different cultures including "cultural diversity, cultural awareness, cultural sensitivity, multiculturalism, and transcultural services." Although the differences in the meanings of these terms may be subtle, they are extremely important. For example, the term "cultural awareness" suggests that it may be sufficient for one to be cognizant, observant, and conscious of similarities and differences among cultural groups (Goode et al., 2001).

"Cultural sensitivity," on the other hand, connotes the ability to empathize with and understand the needs and emotions of persons of one's own culture as well as those of others and to identify with emotional expressions and the problems, struggles, and joys of someone from another culture (Hernandez and Isaacs, 1998).

The term “cultural competence” suggests a broader concept than “cultural sensitivity” implies. As previously defined in this section, the word “culture” refers to the shared attributes—including beliefs, norms, and values—of a group of people (DHHS, 2001). The word “competence” implies the capacity to function effectively, both at the individual and organizational levels. “Competence” is associated with “culture” to emphasize that being aware of or sensitive to the differences between cultures is not sufficient. Instead, service providers must have the knowledge, skills, attitudes, policies, and structures needed to offer support and care that is responsive and tailored to the needs of culturally diverse population groups.

Many people and organizations have developed definitions of cultural competence. The following definition blends elements of definitions used by SAMHSA (DHHS, 2001), the Health Resources and Services Administration (DHHS), the Office of Minority Health (DHHS, 2000a), and definitions found in the literature (Bazron and Scallet, 1998; Cross et al., 1989; Denboba, 1993; Evans, 1995; Roberts et al.,1990; Taylor et al., 1998):

Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

The document was written by Jean Athey, Ph.D., and Jean Moody-Williams, Ph.D., under Contract No. 99M00619401D with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Portland Ridley was a contributing author and also served as the Government Project Officer. Susan R. Farrer, M.A., was the content editor of the guide.

A FACT SHEET FROM THE NATIONAL CENTER FOR PTSD: DISASTERS AND SUBSTANCE ABUSE OR DEPENDENCE

What are the rates of substance use following disasters?

The following findings from empirical disaster research summarize the issue of disasters and substance abuse or dependence.

- Rates of new onset alcohol dependence disorders after a disaster, assessed according to DSM criteria, range from 0% to 2%.
- Virtually no cases of new onset drug abuse emerged in any of the studies.
- Although there are rarely new onsets, the total current prevalence of diagnosed alcohol dependence disorders is approximately 8%. Individuals in select groups who had significant problems with alcohol before a disaster are likely to have problems with alcohol use after a disaster.
- Rates of self-reported problematic alcohol use are similar to the total prevalence (7% - 9%).
- Using alcohol occasionally as a way of coping is more common, about 15% on average. These rates range from 6% - 40%. The high rates occur among survivors with other psychological diagnoses.
- Unlike rates of most other diagnoses and problems, rates of alcohol abuse or dependence appear to be no higher in survivors of mass violence than in survivors of natural disasters.

What has research shown about substance use following disasters?
Four studies on the aftermath of the bombing of the Murrah Federal Building in Oklahoma City found only minimal increases in alcohol use, abuse, or dependence.

- North et al.[1] conducted diagnostic interviews with 192 highly exposed survivors and found no new onset substance use (alcohol or drug) disorders. This finding is striking in light of the high prevalence of other psychological disorders in the sample. For example, 34% had disaster-specific PTSD and 13% had new onsets of Major Depressive Disorder. Most of the survivors who used alcohol as a way of coping to a significant degree were those who were suffering from some other psychological disorder. That is, only 6% of respondents who did not meet criteria for a psychiatric disorder used alcohol to cope compared to 13% - 40% of persons who had one or more psychiatric diagnoses.
- Shariat et al.[2] surveyed 494 victims directly involved in a traumatic event about various medical problems. At a rate of 7%, alcohol use was among the least frequent problems. The most prevalent new medical conditions were auditory problems (32%), anxiety (28%), and depression (27%).
- Smith et al.[3] conducted a population survey of the Oklahoma City metropolitan area using Indianapolis as a control community. The rates of increased use of alcohol were approximately 2% and 1% in the two communities, respectively.

- In a study that has not yet been published, North[4] found a high lifetime rate (50%) of alcohol abuse/dependence among the firefighters who worked in Oklahoma City. Although none of these disorders began after the disaster, 25% continued to abuse alcohol after the disaster. Other studies of incidents of mass violence yielded similar results.
- After a shooting spree in a Texas cafeteria, North et al.[5] detected new onset alcohol use or dependence disorders in 4% of the men and 0% of the women. In contrast, the rates for new onset PTSD were 21% for men and 29% for women, and the rates for new onset depression were 5% for men and 8% for women. Fifteen percent of the sample said they sometimes used alcohol to cope with stress.
- North and her colleagues have studied a total of 10 disasters (including the two mentioned above) using the same methods and instruments. The remaining disasters spanned the range of mass violence (shooting sprees), technological disasters (plane crash), and natural disasters (tornado, firestorm, flood, earthquakes). Tallied across all studies, 8% of 811 adults met criteria for post disaster alcohol dependence, but the rate of new onset alcohol use disorders was only 1%. There were no new onset drug problems in any of the studies.

Although few researchers have data as directly relevant, other researchers have corroborated the findings that alcohol abuse is not a common reaction to disaster.

- After Hurricane Andrew, David et al.[6] assessed a sample of area residents. New onsets of PTSD (36%) and depression (30%) were common but alcohol dependence (2%) was not.
- Norris et al.[7] reported that 9% of their sample of victims of Hurricane Andrew "used alcohol or drugs to forget" at least sometimes, but of the 25 symptoms that were assessed, only one symptom was less prevalent.
- Bravo et al.[8] studied a large sample of victims of floods and mudslides in Puerto Rico and found no increase in symptoms of alcohol use, even within the most severely exposed group (predisaster = 0.9; postdisaster = 1.1). In a regression analysis that controlled for a number of important variables, exposure was correlated with depressive, somatic, and posttraumatic stress symptoms but not with alcohol use symptoms.

A NATIONAL CENTER FOR PTSD FACT SHEET: PTSD IN CHILDREN AND ADOLESCENTS

By Jessica Hamblen, Ph.D.

The diagnosis of Posttraumatic Stress Disorder (PTSD) was formally recognized as a psychiatric diagnosis in 1980. At that time, little was known about what PTSD looked like in children and adolescents. Today, we know children and adolescents are susceptible to developing PTSD, and we know that PTSD has different age-specific features. In addition, we are beginning to develop child-focused interventions. This fact sheet provides information regarding what events cause PTSD in children, how many children develop PTSD, risk factors associated with PTSD, what PTSD looks like in children, other effects of trauma on children, treatment for PTSD, and what you can do for your child.

What events cause PTSD in children?

A diagnosis of PTSD means that an individual experienced an event that involved a threat to one's own or another's life or physical integrity and that this person responded with intense fear, helplessness, or horror. There are a number of traumatic events that have been shown to cause PTSD in children and adolescents. Children and adolescents may be diagnosed with PTSD if they have survived natural and man made disasters such as floods; violent crimes such as kidnapping, rape or murder of a parent, sniper fire, and school shootings; motor vehicle accidents such as automobile and plane crashes; severe burns; exposure to community violence; war; peer suicide; and sexual and physical abuse.

How many children develop PTSD?

A few studies of the general population have been conducted that examine rates of exposure and PTSD in children and adolescents. Results from these studies indicate that 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children and adolescents who have experienced a trauma, 3 to 15% of girls and 1 to 6% of boys could be diagnosed with PTSD.

Rates of PTSD are much higher in children and adolescents recruited from at-risk samples. The rates of PTSD in these at-risk children and adolescents vary from 3 to 100%. For example, studies have shown that as many as 100% of children who witness a parental homicide or sexual assault develop PTSD. Similarly, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop PTSD.

What are the risk factors for PTSD?

There are three factors that have been shown to increase the likelihood that children will develop PTSD. These factors include the severity of the traumatic event, the parental reaction to the traumatic event, and the physical proximity to the traumatic event. In general, most studies find that children and adolescents who report

experiencing the most severe traumas also report the highest levels of PTSD symptoms. Family support and parental coping have also been shown to affect PTSD symptoms in children. Studies show that children and adolescents with greater family support and less parental distress have lower levels of PTSD symptoms. Finally, children and adolescents who are farther away from the traumatic event report less distress.

There are several other factors that affect the occurrence and severity of PTSD. Research suggests that interpersonal traumas such as rape and assault are more likely to result in PTSD than other types of traumas. Additionally, if an individual has experienced a number of traumatic events in the past, those experiences increase the risk of developing PTSD. In terms of gender, several studies suggest that girls are more likely than boys to develop PTSD. A few studies have examined the connection between ethnicity and PTSD. While some studies find that minorities report higher levels of PTSD symptoms, researchers have shown that this is due to other factors such as differences in levels of exposure. It is not clear how a child's age at the time of exposure to a traumatic event impacts the occurrence or severity of PTSD. While some studies find a relationship, others do not. Differences that do occur may be due to differences in the way PTSD is expressed in children and adolescents of different ages or developmental levels (see next section).

What does PTSD look like in children?
Researchers and clinicians are beginning to recognize that PTSD may not present itself in children the same way it does in adults (see What is PTSD? below). Criteria for PTSD now include age-specific features for some symptoms.

Very young children may present with few PTSD symptoms. This may be because eight of the PTSD symptoms require a verbal description of one's feelings and experiences. Instead, young children may report more generalized fears such as stranger or separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. These children may also display posttraumatic play in which they repeat themes of the trauma. In addition, children may lose an acquired developmental skill (such as toilet training) as a result of experiencing a traumatic event.

Clinical reports suggest that ***elementary school-aged children*** may not experience visual flashbacks or amnesia for aspects of the trauma. However, they do experience "time skew" and "omen formation," which are not typically seen in adults. Time skew refers to a child mis-sequencing trauma related events when recalling the memory. Omen formation is a belief that there were warning signs that predicted the trauma. As a result, children often believe that if they are alert enough, they will recognize warning signs and avoid future traumas. School-aged children also reportedly exhibit posttraumatic play or reenactment of the trauma in play, drawings,

or verbalizations. Posttraumatic play is different from reenactment in that posttraumatic play is a literal representation of the trauma, involves compulsively repeating some aspect of the trauma, and does not tend to relieve anxiety. An example of posttraumatic play is an increase in shooting games after exposure to a school shooting. Posttraumatic reenactment, on the other hand, is more flexible and involves behaviorally recreating aspects of the trauma (e.g., carrying a weapon after exposure to violence).

PTSD in ***adolescents*** may begin to more closely resemble PTSD in adults. However, there are a few features that have been shown to differ. As discussed above, children may engage in traumatic play following a trauma. Adolescents are more likely to engage in traumatic reenactment, in which they incorporate aspects of the trauma into their daily lives. In addition, adolescents are more likely than younger children or adults to exhibit impulsive and aggressive behaviors.

Besides PTSD, what are the other effects of trauma on children?
Besides PTSD, children and adolescents who have experienced traumatic events often exhibit other types of problems. Perhaps the best information available on the effects of traumas on children comes from a review of the literature on the effects of child sexual abuse. In this review, it was shown that sexually abused children often have problems with fear, anxiety, depression, anger and hostility, aggression, sexually inappropriate behavior, self-destructive behavior, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, and substance abuse. These problems are often seen in children and adolescents who have experienced other types of traumas as well. Children who have experienced traumas also often have relationship problems with peers and family members, problems with acting out, and problems with school performance.

Along with associated symptoms, there are a number of psychiatric disorders that are commonly found in children and adolescents who have been traumatized. One commonly co-occurring disorder is major depression. Other disorders include substance abuse; other anxiety disorders such as separation anxiety, panic disorder, and generalized anxiety disorder; and externalizing disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder.

How is PTSD treated in children and adolescents?
Although some children show a natural remission in PTSD symptoms over a period of a few months, a significant number of children continue to exhibit symptoms for years if untreated. Few treatment studies have examined which treatments are most effective for children and adolescents. A review of the adult treatment studies of PTSD shows that ***Cognitive-Behavioral Therapy (CBT)*** is the most effective approach. CBT for children generally includes the child directly discussing the traumatic event (exposure), anxiety management techniques such as relaxation and assertiveness training, and correction of inaccurate or distorted trauma related thoughts. Although there is some controversy regarding exposing children to the

events that scare them, exposure-based treatments seem to be most relevant when memories or reminders of the trauma distress the child. Children can be exposed gradually and taught relaxation so that they can learn to relax while recalling their experiences. Through this procedure, they learn that they do not have to be afraid of their memories. CBT also involves challenging children's false beliefs such as, "the world is totally unsafe." The majority of studies have found that it is safe and effective to use CBT for children with PTSD.

CBT is often accompanied by ***psycho-education*** and ***parental involvement***. Psycho-education is education about PTSD symptoms and their effects. It is as important for parents and caregivers to understand the effects of PTSD as it is for children. Research shows that the better parents cope with the trauma, and the more they support their children, the better their children will function. Therefore, it is important for parents to seek treatment for themselves in order to develop the necessary coping skills that will help their children.

Several other types of therapy have been suggested for PTSD in children and adolescents. ***Play therapy*** can be used to treat young children with PTSD who are not able to deal with the trauma more directly. The therapist uses games, drawings, and other techniques to help the children process their traumatic memories. ***Psychological first aid*** has been prescribed for children exposed to community violence and can be used in schools and traditional settings. Psychological first aid involves clarifying trauma related facts, normalizing the children's PTSD reactions, encouraging the expression of feelings, teaching problem solving skills, and referring the most symptomatic children for additional treatment. ***Twelve Step*** approaches have been prescribed for adolescents with substance abuse problems and PTSD. Another therapy, ***Eye Movement Desensitization and Reprocessing (EMDR)***, combines cognitive therapy with directed eye movements. While EMDR has been shown to be effective in treating both children and adults with PTSD, studies indicate that it is the cognitive intervention rather than the eye movements that accounts for the change. ***Medications*** have also been prescribed for some children with PTSD. However, due to the lack of research in this area, it is too early to evaluate the effectiveness of medication therapy.

Finally, ***specialized interventions*** may be necessary for children exhibiting particularly problematic behaviors or PTSD symptoms. For example, a specialized intervention might be required for inappropriate sexual behavior or extreme behavioral problems.

A NATIONAL CENTER FOR PTSD FACT SHEET: PTSD AND THE FAMILY

By Eve B. Carlson, Ph.D. and Joseph Ruzek, Ph.D.

How does PTSD affect family members?

Because the symptoms of PTSD and other trauma reactions change how a trauma survivor feels and acts, traumatic experiences that happen to one member of a family can affect everyone else in the family. When trauma reactions are severe and go on for some time without treatment, they can cause major problems in a family. This fact sheet will describe family members' reactions to the traumatic event and to the survivor's symptoms and behaviors.

It's no wonder that family members react to the fact that their loved one has gone through a trauma. It's upsetting when someone you care about goes through a terrible ordeal. And it's no wonder that people react to the way a traumatized family member feels and acts. Trauma symptoms can make a family member hard to get along with or cause him or her to withdraw from the rest of the family. It can be very difficult for everyone when these changes occur. Just as people have different reactions to traumatic experiences, families also react differently when a loved one is traumatized. In the section below, many different types of reactions are described. A family may experience many of these reactions, or only a few. All of the reactions described, however, are common in families who have had to deal with trauma.

Sympathy

One of the first reactions many family members have is sympathy for their loved one. People feel very sorry that someone they care about has had to suffer through a terrifying experience. And they feel sorry when the person continues to suffer from symptoms of PTSD and other trauma responses. It can be helpful for the person who has experienced the trauma to know that his or her family members sympathize with him or her, especially just after the traumatic event occurs.
Sympathy from family members can have a negative effect, though. When family members' sympathy leads them to "baby" a trauma survivor and have low expectations of him or her, it may send a message that the family doesn't believe the trauma survivor is strong enough to overcome the ordeal. For example, if a wife has so much sympathy for her husband that she doesn't expect him to work after a traumatic experience, the husband may think that she doesn't have any confidence in his ability to recover and go back to work.

Depression

One source of depression for family members can be the traumatic event itself. All traumas involve events where people suddenly find themselves in danger. When this happens in a situation or place where people are used to feeling safe, just knowing the event happened could cause a person to lose faith in the safety and predictability of life. For example, if a woman gets mugged in the parking lot of a neighborhood shopping center, her family may find they feel depressed by the idea that they are not really as safe as they thought they were, even in their own neighborhood.

It can also be very depressing when a traumatic event threatens a person's ideals about the world. For instance, if a man gets traumatized in combat by seeing someone tortured, it can be very depressing to know that people are capable of doing such cruel things to each other. Before the man was faced with that event, he may have been able to believe that people are basically good and kind.

Depression is also common among family members when the traumatized person acts in a way that causes feelings of pain or loss. There may be changes in family life when a member has PTSD or other symptoms after trauma. The traumatized person may feel too anxious to go out on family outings as he or she did in the past. The traumatized person may not be able to work because of PTSD symptoms. As a result, the family income may decrease and the family may be unable to buy things and do things the way they did before the traumatic event. A husband may feel unloved or abandoned when-because of her depression-his traumatized wife withdraws emotionally and avoids being intimate or sexual. Children whose father can't be in crowds because of combat trauma may feel hurt that their father won't come to see them play sports. When PTSD lasts for a long time, family members can begin to lose hope that their loved one or their family will ever get "back to normal."

Fear and Worry

Knowing that something terrible can happen "out of the blue" can make people very fearful. This is especially true when a family member feels unsafe and often reminds others about possible dangers. Very often, trauma survivors feel "on edge" and become preoccupied with trying to stay safe. They may want to get a guard dog, or put up security lights, or have weapons in the house in order to protect themselves and their family members. When one person in a family is very worried about safety, it can make everyone else feel unsafe too. However, something that helps one person feel safe-like a loaded weapon under the bed-may make another person feel unsafe.

Family members can also experience fear when the trauma survivor is angry or aggressive. As described above, trauma survivors can become angry and aggressive automatically if they feel they are in danger. Trauma survivors may also become angry and aggressive because they are frustrated that they have trauma symptoms, or because they learned to be aggressive as a way to protect themselves in the trauma situation. No matter what the reason for the anger and aggression, it naturally makes family members fearful.

Many trauma symptoms can cause family members to worry. A wife might worry that her traumatized husband who becomes angry and violent at the least provocation will be injured in a fight or get in trouble with the police. A daughter may worry that her mother will make herself ill by drinking heavily as a result of a traumatic event. A man's inability to keep a job because of trauma-related problems may cause his family to worry constantly about money and the future.

Avoidance

Just as trauma survivors are often afraid to address what happened to them, family members are frequently fearful of examining the traumatic event as well. Family members may want to avoid talking about the trauma or trauma-related problems, even with friends. People who have experienced trauma hope that if they don't talk about the problem, it will go away. People also don't wish to talk about the trauma with others because they are afraid that others won't understand or will judge them. Sometimes, if the traumatic event is one associated with shame, such as rape, family members may avoid talking about the event and its effects because of social "rules" that tell us it is inappropriate to talk about such things. Family members may also not discuss the trauma with others because they fear it will bring their loved one more shame.

Family members may avoid the things that the trauma survivor avoids because they want to spare the survivor further pain, or because they are afraid of his or her reaction. For example, the wife of a combat veteran who is anxious about going out in public may not make plans for family outings or vacations because she is afraid to upset her husband. Though she doesn't know what she can do to "fix" the problem, she does know that if the family goes to a public event, the husband will be anxious and irritable the whole time.

Guilt and Shame

Family members can feel guilt or shame after a traumatic event for a number of reasons. A family member may experience these feelings if he or she feels responsible for the trauma. For instance, a husband whose wife is assaulted may feel guilt or shame because he was unable to protect her from the attack. A wife may feel responsible for her husband's car accident if she thinks she could have prevented it if she had gotten the car's brakes fixed. A family member may feel guilt and shame if he or she feels responsible for the trauma survivor's happiness or general well-being, but sees no improvement no matter how hard he or she tries to help. Sometimes, after years of trauma-related problems in a family, a family member may learn about posttraumatic stress disorder and realize that this is the source of their family problems. The family member may then feel guilty that he or she was unsupportive during the years.

Anger

Anger is a very common problem in families that have survived a trauma. Family members may feel angry about the trauma and its effect on their lives. They may be angry at whomever they believe is responsible for the traumatic event (this includes being angry at God). They can also feel anger toward the trauma survivor. Family members may feel that the survivor should just "forget about it" and get on with life. They may be angry when their loved one continues to "dwell" on the trauma. A wife may be mad because her husband can't keep a job or because he drinks too much or won't go with her to social events or avoids being intimate with her or doesn't take

care of the kids. Family members may also feel angry and irritable in response to the anger and irritability the trauma survivor directs at them.

Negative Feelings

Sometimes family members have surprisingly negative feelings about the traumatized family member. They may believe the trauma survivor no longer exhibits the qualities that they loved and admired. A person who was outgoing before a trauma may become withdrawn. A person who was fun loving and easy-going before a trauma may become ill tempered. It may be hard to feel good toward a person who seems to have changed in many ways. Family members may also respond negatively to behaviors that develop following a trauma. For instance, family members may be disgusted by a woman's over-drinking in response to a trauma.
Family members may also have negative feelings about the survivor that are directly related to the traumatic event. For example, a wife may no longer respect her husband if she feels he didn't behave bravely during a traumatic event. A husband whose wife was raped may feel disgusted about what happened and wonder if she could have done something to prevent the assault. A son may feel ashamed that his father didn't fight back when he was beaten during a robbery. Sometimes people have these negative feelings even when they know that their assessment of the situation is unfair.

Drug and Alcohol Abuse

Drug and alcohol abuse can become a problem for the families of trauma survivors. Family members may try to escape from bad feelings by using drugs or drinking. A child or spouse may spend time drinking with friends to avoid having to go home and face an angry parent or spouse. On the other hand, spouses sometimes abuse drugs or alcohol to keep their loved ones "company" when they're drinking or using drugs to avoid trauma-related feelings.

Sleep Problems

Sleep can become a problem for family members, especially when it is a problem for the trauma survivor. When the trauma survivor stays up late to avoid going to sleep, can't get to sleep, tosses and turns in his or her sleep, or has nightmares, it is difficult for family members to sleep well. Often family members are also unable to sleep well because they are depressed and/or they are worried about the survivor.

Health Problems

Family members of trauma survivors can develop health problems for a number of reasons. Bad habits, such as drinking, smoking, and not exercising may worsen as a result of coping with a loved one's trauma responses. In addition, many illnesses can be caused by trauma-related stress if it goes on for an extended period of time. When family members constantly feel anxious, worried, angry, or depressed, they are more likely to develop stomach problems, bowel problems, headaches, muscle pain, and other health problems.

A NATIONAL CENTER FOR PTSD FACT SHEET: MANAGING GRIEF AFTER DISASTER

By Katherine Shear, Ph.D.

The recent terrorist disasters left many people suddenly bereaved of spouses, children, parents, close friends, and coworkers. In the immediate aftermath, some have been numb or unable to accept the loss. Many have felt shocked, lost, anxious, depressed, and physically unwell as a result of this loss. For many, the pain has been intense and unrelenting. In the acute aftermath of the violent death of a loved one, a sense of disbelief or intense, uncontrollable emotionality is very frequent.

Distressing physical symptoms are also common (Lindeman, 1944; Stroebe & Stroebe, 1993). These emotional and bodily reactions may be very strong and can themselves be traumatizing, especially if they are unfamiliar and unexpected. Such a secondary reaction can further amplify the pain caused by the loss and can be mitigated by information about grief and stress reactions. It is important to realize that intense and unfamiliar emotionality is entirely normal and does not necessarily have implications for long-term emotional stability or health. The fact that a popular Internet book site lists 2,776 titles on the topic attests to the fact that grief is both common and difficult. In ordinary, peaceful times millions of people die every year, each leaving friends and family bereaved. Many experience numbness or intense pain in the immediate aftermath. For most, this initial reaction subsides with time, and the bereaved person finds a way to again engage fully in life. However, studies show bereaved individuals, in general, are at risk for longer term mental and physical health problems. It is a good idea to provide ongoing support, monitor the outcome of grief, and know that professional intervention can be helpful.

Given the universality of bereavement, there has been relatively little research to characterize its course, develop a nosology for bereavement problems, identify risk factors, or guide treatment. The information provided below draws upon what has been done and upon ongoing work.

The Course of Bereavement

The course of bereavement has become increasingly better understood since the mid ‘80s, with the development of several measures that have proven consistent across some populations. These include the Texas Revised Inventory of Grief (Faschinbauer, Zisook & DeVaul, 1987), Core Bereavement Items (Burnett, Middleton, Raphael & Martinek, 1997), Criteria for Complicated Grief Disorder (Horowitz, Siegel, Holen, et al., 1997), and the Inventory of Complicated Grief (Prigerson et al., 1995). Few studies have targeted a full range of ages and circumstances of death and the bereaved. Most of the information available refers to older people or widows, although selected studies have targeted parents of deceased children, surviving friends and partners of HIV sufferers, parents of children who have died violently, and combat veterans. However, younger

individuals, especially men, may be at highest risk for complications, relative to a comparison group of same age and sex (Ball, 1977; Stroebe & Stroebe, 1983).

Research by Stroebe and colleagues (1993) provides a model of the type of study needed. These researchers compared widows and widowers under retirement age to a control group consisting of married couples, interviewing participants 4 to 7 months following their loss and again at 14 months and at two years. The researchers found that widows who participated were more depressed than widows who did not while the reverse was true for widowers. It is important to keep in mind that most studies of bereavement have succeeded in recruiting only about one-third of eligible individuals, so all data need to be viewed in light of the characteristics of the individuals who choose to participate. Given this caveat, studies consistently find bereaved individuals to have higher levels of depressive symptoms than matched controls in the 6-12 months after the death. Most of those with milder levels of depression improve by year 2, while those who are clinically depressed (about 20%) remain depressed. Somatic symptoms are reported by widows and widowers at a rate nearly 10 times the rate reported by members of the control group in the initial 6 months, and these symptoms are still reported 4 times as much at two years.

Less is known about the course of bereavement following violent death, but available studies have consistently found that symptoms and impairment are more prolonged and a sense of resolution less likely (e.g., Murphy, 2000). A recent study of women college students (Green, 2001) found those who experienced a violent loss had symptoms and impairments similar to those who experienced assault. A dissertation study by Pivar documented grief symptoms in 70% of veterans and found that these could be differentiated from symptoms of PTSD and depression. Taken together, this work suggests that sudden violent bereavement is a very intense stressor. While many people will find a way to cope without intervention, skilled professional assistance may be important in decreasing the morbidity and even mortality of those bereaved as a result of disaster. In order to provide such assistance, professionals need to be informed about grief and about treatment strategies that have been developed and tested.

The Experience of Grief

Grief is the process by which we adjust to the loss of a close relationship. Therefore, grief is an inevitable companion to love and attachment. The lives of those we love are interwoven with our own in thousands of small and large ways. One's immediate family, in particular, contributes to a sense of comfort, security, and happiness and reinforces behavior. Endocrine function can become entrained by cues from another person. When this happens, losing that person requires a period of physiological adjustment. In all cases, loss of a loved one engenders feelings of loneliness, sadness, and vulnerability. The death of someone close also makes one's own death imaginable, thus evoking fear of dying. When a person experiences the death of someone close, that person is confronted by mortality and undergoes a certain degree of acute separation distress. Sometimes, there is also guilt about

being alive when the other person has died, or there is guilt about not being able to save the person or make his or her life or dying easier.

While grief is not the same for every person, there are certain commonalities. During the initial phase, the bereaved person is preoccupied with the deceased, preoccupied with feelings of yearning and longing, and with searching for him or her. While grieving, most people withdraw from the world and turn inward, often reviewing the course of the relationship, including positive and negative thoughts and feelings. People often also review the meaning the relationship had in their lives. Grief entails a host of painful emotions that can sometimes be very strong and persistent. Strong feelings of sadness and loneliness almost always occur following the death of a close friend or family member. Fear and anxiety are also common. Difficult feelings of resentment, anger, and guilt can occur. Experiencing any or all of these emotions following the loss of a friend or family member is perfectly normal.

As the transition to life without a friend or family member progresses, the intensity of grief subsides. The bereaved person accepts the death and begins to take some comfort in positive memories, establishing a permanent sense of connection to the person who died. It becomes possible to reengage in activities and relationships while still having memories of and maintaining a sense of closeness to the deceased. The period over which this adjustment occurs is variable, depending on the circumstances of the death, the characteristics of the bereaved, and the nature of the relationship. In some circumstances, intense grief persists for many months or even years. Intrusive images and disturbing ideas inhibit the healing process, and there is a sense that the death is unacceptable and unfair. For some who have difficulty coping with the death, grief sometimes seems to be all that is left of the relationship. Also, a decrease in the intensity of the grief may feel like a betrayal of the person who died. Some people also have persistent feelings of guilt. When a death is sudden, violent, and untimely, the bereaved will most likely also face other difficulties. The condition in which unmanageably intense and/or persistent grief symptoms occur is called Traumatic Grief. Symptoms of Traumatic Grief are listed in Table 1. Work is underway to establish diagnostic criteria and to develop treatments for this condition. Traumatic Grief may predispose to other psychiatric, medical, and behavioral problems that can complicate bereavement. These are generally treatable conditions and need to be recognized by professionals and by the bereaved individuals themselves.

Complications of Bereavement
Bereavement is a risk factor for a range of mental and physical health problems. Among these are the following:

- Prolonged grief or Traumatic Grief
- Onset or recurrence of Major Depressive Disorder
- Onset or recurrence of Panic Disorder or other anxiety disorders
- Possible increased vulnerability to PTSD

- Alcohol and other substance abuse
- Smoking, poor nutrition, low levels of exercise
- Suicidal ideation
- Onset or worsening of health problems, especially cardiovascular and immunologic dysfunction

Traumatic Grief
Grief will inevitably disrupt mental functioning following the death of a loved one. While it should be emphasized that grief itself is a normal process of adapting emotionally and cognitively to the loss or absence of a loved one, sometimes the intensity of a person's grief may be overwhelming or last longer than is healthy. This may occur for a variety of reasons. The relationship between the deceased and the bereaved might have been very close or complicated; the circumstances of the death may be sudden or traumatic, as in accident, disaster, or illness; or the grieving person may not have good coping skills or the social support that would help the grieving process. In situations like these, it may be helpful to seek professional help or counseling in order to resolve the grief.

When grief goes on longer than is healthy or when it is overwhelming, a diagnosis of Traumatic Grief might be appropriate. It may be helpful to draw an analogy to a physical illness. An illness is not a characteristic of a person; it is a state a person is in at a given time. Many illnesses are very treatable. Another analogy is to an acute injury. People are more or less vulnerable to disability from an injury, but some types of injury are so severe that they always cause impairment. Using such an analogy, it is possible to see that following an accident or disaster or the sudden death of a very close person, it is entirely normal to experience Traumatic Grief, just as it is quite normal to develop tuberculosis upon exposure to a virulent organism, and it is normal to be unable to walk on a broken leg. It is also clear that it is a good idea to diagnose and treat these conditions. No one would tell a person with pneumonia "pull yourself together" or "get on with it" or expect a person with a deep cut or a broken bone to heal him- or her. Although labels can be hurtful if misused, they can also be helpful. An ill person needs to have a "sick role" and to receive treatment. An ill person benefits from support and assistance from family and friends, as well as from treatment by a trained professional.

Table 1: Symptoms of Traumatic Grief (Prigerson, 1995)

- Preoccupation with the deceased
- Pain in the same area as the deceased
- Memories are upsetting
- Avoid reminders of the death
- Death is unacceptable
- Feeling life is empty
- Longing for the person
- Hear the voice of the person who died

- Drawn to places and things associated with the deceased
- See the person who died
- Anger about the death
- Feel it is unfair to live when this person died
- Disbelief about the death
- Bitter about the death
- Feeling stunned or dazed
- Envious of others
- Difficulty trusting others
- Lonely most of the time
- Difficulty caring about others

Risk Factors for Complications of Bereavement
Risk factors are those aspects of a situation that tend to increase vulnerability to complications and that may slow recovery. Existing studies suggest that risk factors relate to the characteristics of an individual, the nature of the relationship to the deceased, the circumstances of the death, and the social context within which recovery takes place. Some risk factors relate to the larger situation in which the bereaved finds him- or her, and some risk factors relate to the bereaved individual's specific history and makeup. While both kinds of risk factors raise the distress level of the bereaved person, it is useful for clinicians to be particularly aware of the bereaved's individual situation.

The following risk factors have been identified:

- ***Demographic factors***: Socioeconomic status: Lower socioeconomic status is related to a poorer health status in general. Bereavement appears to affect people similarly, regardless of socioeconomic status. Age: Bereavement appears to be somewhat more stressful for younger individuals than it is for older individuals, with the exception of elderly people. The disparity between how older individuals are affected and how elderly people are affected may be because the stress experienced by elderly people is related to preexisting health problems. Gender: There is some evidence that men, especially widowers, have more bereavement-related health problems than women, especially when dealing specifically with the loss of a spouse. Although both men and women are deeply affected by the loss of close family members and friends, the death of a child may be more difficult for mothers than for fathers. Women may also recognize the effects of bereavement more readily than men, and men and women may cope differently.

- ***Individual characteristics***: Overall, individuals who are defined as "neurotic" have been shown to have more health problems. Low internal locus of control is generally associated with more depression. This is not specific for bereavement. On the other hand, high internal locus of control does not act as a buffer for bereavement-related distress. Anecdotal evidence suggests

that a belief in life after death may be protective. However, when this was examined in a study, a protective effect was not found (Stroebe & Stroebe, 1987). Guilt or self-blame about the death may contribute to traumatic grief.

- ***Relationship quality***: Relationship quality may affect men and women differently when it comes to difficulty with bereavement. A good marriage may be associated with more bereavement-related problems in women, while the opposite may be true for men. In general, data does not support clinical lore that implies that bereavement problems occur because of ambivalence or problems in a relationship. It is very clear that in some instances an especially positive relationship may be associated with very difficult bereavement reactions.

- ***Circumstances of the death***: Not surprisingly, sudden death is associated with more symptoms of bereavement difficulty in the first 6 months after the loss. In some studies this difference was not present in later interviews, while in other studies it was. A low score on a measure of internal locus of control signified a greater likelihood for difficulty for younger bereaved spouses. In some studies, there is evidence of continuing distress from the loss for many years following a sudden, violent loss. Experiencing multiple losses or witnessing the death (especially a factor for children who witness a death) has been found to correlate with levels of grief intensity. Feelings of helplessness and powerlessness, survivor guilt, threat to one's own life, confrontation with the massive and shocking deaths and mutilations of others, and a violation of one's assumptive world of safety and meaning are traumatic factors that may impact a person's ability to resolve grief. It is clear that many of those bereaved by the WTC disaster may experience treatable psychiatric difficulties for a long period of time. It is important for professionals to be vigilant about this possibility.

- ***Social context:*** Both perceived and received social support are related to lower symptoms of depression in the general population, but there does not appear to be a specific relationship between social support and bereavement outcome. However, it is important to note that bereaved individuals often perceive that others lack empathy and that others are hostile about the bereaved's continued symptoms. This perception is likely related to a poorer outcome but has not been specifically studied. In general, however, social support and positive family functioning, along with the opportunity to express grief, may help to mitigate the negative effects of bereavement.

Treatment of Bereaved Individuals

Grief support groups and grief counseling are widespread and undoubtedly highly variable. Little information is available related to support group and counseling outcome. There is specific controversy regarding the importance of confronting the death (also called "grief work") in the early phase of grief. In one study (Stroebe),

investigators developed a measure to assess the extent to which individuals confronted or avoided their loss and used scores on this instrument to predict outcomes at later times. They found that low scores for widows did not influence outcome, but low scores for widowers predicted poorer outcome. There is some evidence that the occurrence of symptoms of major depression in the first month following the death predicts a worse course later, especially for suicidally bereaved individuals (e.g., Jordan, 2001).

It goes without saying that the loss of a close relationship permanently affects the bereaved person. It is not reasonable to think that one can recover from such a loss or resolve the loss. Such a loss is permanent and has permanent effects on the bereaved. Still, it is possible and important that the bereaved person will eventually have comforting memories of the deceased and feel interested in and able to engage in life. Weiss (1993) provides a list of reasonable expectations we can have for the bereaved. A person who has lost someone should eventually have (1) the ability to give energy to everyday life, (2) psychological comfort, or freedom from pain and distress, (3) the ability to experience satisfaction and gratification in life, (4) hopefulness for the future, and (5) the ability to function adequately in a range of social roles. How can a professional assist the bereaved in achieving these goals?

The Role of a Professional in the Early Phase of Disaster Bereavement

There is little data on the effectiveness of early intervention for grief. However, it is clear that early intervention is a good idea following a disaster, provided a skilled, empathic clinician administers the intervention. Although data suggest that even after sudden, violent death, most people eventually grieve successfully, the initial process can take a long time. Many people consider grief to be a personal experience and so do not turn to mental-health professionals for help with grief. However, when a loss is sudden and violent, the intensity of emotions can be frightening and the need for support and outside intervention greater. In response, the professional needs to engage in a skilled, supportive intervention. Useful components of such an intervention include:

- Providing information about grief and its symptoms, course, and complications
- Evaluating the nature of the individual's distress
- Helping to identify and solve practical problems
- Providing strategies for management of intense feelings
- Helping the person think about the death in a way that leads to emotional resolution

Affect-evoking interventions must be used with care and expert skill and be balanced with containing and soothing strategies. During the early phase of bereavement, it may be very useful to provide information and strategies for thinking about the death. It is best if the professional provides some follow-up and remains available for consultation and support, should this be needed.

Prigerson and Jacobs (2001) provide a list of "do's" and "don'ts" for how physicians might interact with family members following a patient's death. These may also be useful to consider. The authors recommend:

- Direct expression of sympathy
- Acknowledgement that the clinician does not know exactly what the bereaved person is going through
- Talking about the deceased, including saying his or her name
- Eliciting questions about the circumstances of the death
- Asking questions about feelings and about how the death has affected the person

The authors also provide a useful list of cautions about things that are ***NOT HELPFUL***, including:

- A casual or passive attitude (e.g., Do not merely say, "Call me if you want to talk," or ask "How are you?")
- Statements that the death is in any way for the best or acceptable (e.g., "He/she is in a better place," or "It's God's will.")
- An assumption that the bereaved is strong and will/should get through this
- Any kind of avoidance of discussion of the death or the person who died

Even given its private nature, variable course, and usual resolution, there are circumstances in which grief can be intense and prolonged, hindering reengagement in daily activities. When this occurs, a focused intervention may be needed. There is wide acknowledgment that bereavement can be prolonged and that it can lead to other mental-health problems, especially depression and anxiety. Therefore, professional intervention may be especially important if the bereaved exhibits the risk factors discussed above.

Treatment Strategies for Complications of Bereavement

Treatment should target the symptoms experienced by the patient. It is now very clear that bereaved individuals who have Major Depressive Disorder (MDD) respond to antidepressant medication and/or psychotherapy similarly to those who are not bereaved. A very interesting recent study suggests that treatment of MDD as early as a month after the death may be extremely helpful and prevent later symptoms. Similarly, for those who meet criteria for PTSD, it makes sense to provide treatment similar to that used with other PTSD patients.

However, the most common post bereavement problems center around traumatic grief reactions, and unfortunately, few treatments have been developed or tested for symptoms of Traumatic Grief. Studies of early intervention for grief document some reduction in grief symptoms, with support groups showing efficacy equal to that of active psychotherapy. An early study of a behavioral therapy called "guided mourning" also appeared to have beneficial effects, although grief outcome was not measured. A specific "Traumatic Grief Treatment" (TGT) is currently undergoing

randomized controlled testing. In a pilot study, TGT had a large effect size, even taking into consideration individuals who did not complete the full course of the treatment (Shear, 2001). Components of this treatment include:

- Providing information about bereavement and grief to bereaved individuals and their families
- The bereaved describing the deceased and relating the history of the relationship with the deceased
- Relating the story of the death and its aftermath
- Careful assessment of current grief levels, target grief levels, and components of grief (i.e., cognitive, behavioral, and somatic)
- Reviewing the bereaved's personal goals and determining how the bereaved person will know when these goals have been met
- Carefully managed imaginal exposure to the death and related events
- In vivo exposure to situations that are avoided and/or response prevention for situations of preoccupation
- Focusing on positive memories of the deceased

Therapists should undertake imaginal exposure only if they are familiar with this technique and with emotion control techniques. The remainder of the treatment may be of help alone, but it has not been tested. It is also important to evaluate the bereaved person's social support system and encourage engagement with existing supportive people. To date, no treatment has been proven effective in the early stages of bereavement, and there is some indication that for some people formal grief counseling can do more harm than good. In light of this, caution may be indicated.

Guidelines for early treatment in the acute phase of Traumatic Grief include:

- Allowing the bereaved person to talk about the nature and circumstances of their loss according to their own readiness (without probing)
- Educating about the course of bereavement and what to expect
- Assessing for possible troubling symptoms like an unusual intensity of grief reactions or intrusive thoughts
- Encouraging, as much as possible without intruding, the use of social support and the broadening of activities
- Encouraging positive memories and a feeling of connection to the deceased, which may help supplant traumatic memories

Pharmacotherapy may also be helpful for individuals suffering from Traumatic Grief. However, little has been done to test pharmacotherapy. As with depression and PTSD, it appears that serotonin active medications have some beneficial effect (Zygmont, 1998). Given the available information, it is important that clinicians learn to administer the techniques that appear to be efficacious.

ANNIVERSARY REACTIONS TO A TRAUMATIC EVENT: THE RECOVERY PROCESS CONTINUES

As the anniversary of a disaster or traumatic event approaches, many survivors report a return of restlessness and fear. Psychological literature calls it the anniversary reaction and defines it as an individual's response to unresolved grief resulting from significant losses. The anniversary reaction can involve several days or even weeks of anxiety, anger, nightmares, flashbacks, depression, or fear.

On a more positive note, the anniversary of a disaster or traumatic event also can provide an opportunity for emotional healing. Individuals can make significant progress in working through the natural grieving process by recognizing, acknowledging, and paying attention to the feelings and issues that surface during their anniversary reaction. These feelings and issues can help individuals develop perspective on the event and figure out where it fits in their hearts, minds, and lives.

It is important to note that not all survivors of a disaster or traumatic event experience an anniversary reaction. Those who do, however, may be troubled because they did not expect and do not understand their reaction. For these individuals, knowing what to expect in advance may be helpful. Common anniversary reactions among survivors of a disaster or traumatic event include: memories, dreams, thoughts, and feelings: individuals may replay memories, thoughts, and feelings about the event, which they can't turn off. They may see repeated images and scenes associated with the trauma or relive the event over and over. They may have recurring dreams or nightmares. These reactions may be as vivid on the anniversary as they were at the actual time of the disaster or traumatic event.

- ***Grief and Sadness***: Individuals may experience grief and sadness related to the loss of income, employment, a home, or a loved one. Even people who have moved to new homes often feel a sense of loss on the anniversary. Those who were forced to relocate to another community may experience intense homesickness for their old neighborhoods.

- ***Fear and Anxiety***: Fear and anxiety may resurface around the time of the anniversary, leading to jumpiness, startled responses, and vigilance about safety. These feelings may be particularly strong for individuals who are still working through the grieving process.

- ***Frustration, Anger, and Guilt***: The anniversary may reawaken frustration and anger about the disaster or traumatic event. Survivors may be reminded of the possessions, homes, or loved ones they lost; the time taken away from their lives; the frustrations with bureaucratic aspects of the recovery process; and the slow process of rebuilding and healing. Individuals may also

experience guilt about survival. These feelings may be particularly strong for individuals who are not fully recovered financially and emotionally.

- ***Avoidance***: Some survivors try to protect themselves from experiencing an anniversary reaction by avoiding reminders of the event and attempting to treat the anniversary as just an ordinary day. Even for these people, it can be helpful to learn about common reactions that they or their loved ones may encounter, so they are not surprised if reactions occur.

- ***Remembrance***: Many survivors welcome the cleansing tears, commemoration, and fellowship that the anniversary of the event offers. They see it as a time to honor the memory of what they have lost. They might light a candle, share favorite memories and stories, or attend a worship service.

- ***Reflection***: The reflection brought about by the anniversary of a disaster or traumatic event is often a turning point in the recovery process. It is an opportunity for people to look back over the past year, recognize how far they have come, and give themselves credit for the challenges they surmounted. It is a time for survivors to look inward and to recognize and appreciate the courage, stamina, endurance, and resourcefulness that they and their loved ones showed during the recovery process. It is a time for people to look around and pause to appreciate the family members, friends, and others who supported them through the healing process. It is also a time when most people can look forward with a renewed sense of hope and purpose.

Although these thoughts, feelings, and reactions can be very upsetting, it helps to understand that it is normal to have strong reactions to a disaster or traumatic event and its devastation many months later. Recovery from a disaster or traumatic event takes time, and it requires rebuilding on many levels - physically, emotionally, and spiritually. However, with patience, understanding, and support from family members and friends, you can emerge from a disaster or traumatic event stronger than before. If you are still having trouble coping, ask for help. Consult a counselor or mental health professional.

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