

MENTAL HEALTH RESPONSE TO MASS VIOLENCE AND TERRORISM



A TRAINING MANUAL

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

2004

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TABLE OF CONTENTS

Preface	vii
Chapter I. Background and Overview	2
Purpose of the Manual	4
Overview of the Manual.....	5
Overview of Resources	7
Glossary of Acronyms	7
Chapter II. Human Responses to Mass Violence and Terrorism	8
Population Exposure Model.....	11
<i>Population Exposure Checklist</i>	11
Traumatic Event and Stressor Characteristics.....	12
Survivor Characteristics	14
Immediate Adult Reactions to Trauma, Victimization, and Sudden Bereavement.....	16
<i>Physical Reactions</i>	16
<i>Behavioral Reactions</i>	16
<i>Emotional Reactions</i>	17
<i>Cognitive Reactions</i>	17
Long-Term Responses of Adults.....	17
<i>Traumatic Bereavement</i>	18
<i>Screening and Assessment Checklist</i>	18
Model of Human Responses to Trauma and Bereavement	19
Children and Adolescents: Priority Considerations and Reactions	21
<i>Traumatic Event and Stressor Characteristics</i>	23
<i>Post-Trauma and Grief Reactions</i>	23
<i>Screening and Assessment Checklist</i>	24
Older Adults: Priority Considerations and Reactions	24
<i>Screening and Assessment Checklist</i>	25
Cultural and Ethnic Groups: Priority Considerations and Reactions.....	26
<i>Cultural Response Checklist</i>	27
Recommended Reading	28
Chapter III. Mental Health Intervention	30
Key Principles for Mental Health Intervention.....	31
<i>Mental Health Assistance Coordination</i>	33
<i>Mental Health Service Provider Groups</i>	33

Immediate Mental Health Intervention	34
<i>Goals and Priorities</i>	34
Immediate Mental Health Interventions with Adults	35
<i>Psychological First-Aid</i>	35
<i>Crisis Intervention</i>	36
<i>Informational Briefings</i>	38
<i>Crime Victim Assistance</i>	38
<i>Community Outreach</i>	39
<i>Psychological Debriefing</i>	40
<i>Psycho-Education</i>	41
<i>Mental Health Consultation</i>	42
Long-Term Mental Health Interventions with Adults.....	43
<i>Goals and Priorities</i>	43
<i>Crime Victim Services</i>	44
<i>Brief Counseling</i>	46
<i>Support Groups</i>	47
Immediate Mental Health Interventions for Children and Adolescents.....	48
<i>Goals and Priorities</i>	48
<i>Psychological First-Aid</i>	49
<i>Play Areas</i>	49
<i>Participation in Disaster Relief</i>	49
<i>School Interventions</i>	50
<i>Classroom Interventions</i>	50
Long-Term Mental Health Interventions for Children and Adolescents	50
<i>Goals and Priorities</i>	50
<i>Brief Counseling</i>	51
<i>Support Groups</i>	52
Considerations for Immediate and Long-Term Mental Health Intervention	
With Cultural and Ethnic Groups	52
<i>Tips for Working with Interpreters</i>	53
<i>Basic Cultural Sensitivity Checklist</i>	53
Key Events with Mental Health Implications.....	54
<i>Death Notification</i>	55
<i>Ending Rescue and Recovery Operations</i>	56
<i>Applying for Death Certificates When No Identified Remains Have Been Found</i>	56
<i>Events Involved in Criminal Justice Proceedings</i>	57
<i>Returning to the Crime Scene and Disaster-Impacted Areas</i>	58
<i>Memorials and Funerals</i>	59
<i>Determination of Formulas and Methods for Distributing Federal, State, Employer, and</i> <i>Charity Funds to Victims and Families</i>	60
Interventions with the Community.....	60
<i>Memorials, Rituals, and Commemorations</i>	60
<i>Usual Community Gatherings</i>	61
<i>Symbolic Gestures</i>	62
Recommended Reading	66

Chapter IV. Organizational Preparation and Response to Mass Violence and Terrorism and the Mental Health Role.....68

- Emergency Operations.....69
- Crisis Mental Health Response71
- Key Considerations for Mental Health Providers Responding to Criminal Mass Violence73
- Crisis Mental Health Response: Future Directions75
- Long-Term Mental Health and Crime Victim Assistance Services76
- Recommended Reading77

Chapter V. Stress Prevention, Management, and Intervention.....78

- Sources of Stress79
- Stress Prevention, Management, and Intervention80
 - Environmental Context*.....80
 - Individual Context*.....83
- Compassion Fatigue and Secondary Traumatization.....83
- Signs and Symptoms of Worker Stress86
 - Mental Health Provider Stress Reactions*86
- Rewards and Joys of Disaster Work88
- Recommended Reading88

Chapter VI. Setting Up Training90

- Rapid Response Training91
- Comprehensive Training.....92
- Selection of Qualified Trainers92
- Setting Up Training.....93
- Who Should Attend?93

Chapter VII. Comprehensive Training Course Outline.....94

- Course Overview95
- Course Objectives.....95
- Overview of Comprehensive Training Course.....96
- Module 1: Introduction.....97
- Module 2: Criminal Mass Victimization99
- Module 3: Adult Responses to Mass Violence and Terrorism101
- Module 4: Organizational Response and Mental Health Roles104
- Module 5: Community Crisis Response and Mental Health Interventions.....106
- Module 6. Children’s and Adolescents’ Reactions and Interventions110
- Module 7: Cultural and Ethnic Groups: Considerations and Interventions113
- Module 8: Planning Workgroups115
- Module 9: Stress Prevention, Management, and Intervention117
- Training Overheads121
- Handouts166
- Videotapes169

Chapter VIII. Additional Training Needs and Options.....	170
Training for Paraprofessional Staff.....	171
<i>Counseling Skill Development</i>	171
<i>Counseling Interventions</i>	171
<i>Self-Awareness</i>	172
<i>Assessment of Mental Health and Other Problems</i>	172
<i>Legal, Ethical, and Program Considerations</i>	172
Training for Human Service Workers.....	172
Topics and Considerations for In-Service Training	173
References and Additional Reading	175
Internet Sites	184
Figures and Tables	
Figure 1: Population Exposure Model	11
Figure 2: Model of Responses to Trauma and Bereavement	20
Figure 3: ICS Organizational Components.....	70
Figure 4: ICS Unified Command	71
Table 1: Comparison of Mass Violent Victimization and Natural Disasters	9
Table 2: Survivor Characteristics	15
Table 3: Reactions to Trauma and Suggestions for Intervention	63
Table 4: Environmental and Organizational Approaches for Stress Prevention and Management	81
Table 5: Individual Approaches for Stress Prevention and Management	84

PREFACE

The Emergency Mental Health and Traumatic Stress Services Branch (formerly the Emergency Services and Disaster Relief Branch) of the Center for Mental Health Services (CMHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office for Victims of Crime (OVC) in the Office of Justice Programs (OJP), U.S. Department of Justice (DOJ), formed a collaboration in 1999 to provide mental health training, technical assistance, and consultation services for professionals assisting victims of crime. As part of a formal agreement between the two agencies, this training manual was developed to assist mental health providers in better serving victims of terrorism and mass violence.

CMHS has extensive experience in a number of areas surrounding disaster response, including crisis counseling. OVC works with Federal, State, and local governments and nongovernmental partners in promoting justice and healing for all victims of crime. Both CMHS and OVC have drawn on their considerable experience to develop this manual and provide the most relevant and comprehensive information available to mental health and crime victim service providers in responding to victims of terrorism and mass violence. Through the preparation of this document, both CMHS and OVC are furthering their goals of addressing the mental health needs of victims, survivors, and communities in the aftermath of terrorist and mass violence crimes.

The events of September 11, 2001, the Oklahoma City bombing, and other events both in the United States and abroad, have served as dramatic examples of the need for mental health services in the wake of terrorism and mass violence. Because the risk of becoming a victim of mass violence has risen dramatically in the last decade, the need for competent mental health services following a disaster has increased significantly. This manual seeks to present mental health and crime victim service providers with a comprehensive and informative resource for assisting terrorism and mass violence victims and affected members of the communities in which acts occur. To do so, it explores an array of reactions providers may encounter following an incident. In addition, providers are presented with characteristics of the criminal justice system and how best to support victims and survivors participating in this process. Furthermore, the manual provides information for providers to understand and manage their own work-related stress.

The primary goal of this manual is to enable mental health and crime victim service providers to help victims, survivors, and the community-at-large cope and recover through outreach and support. To further this goal, the manual includes a training course for providing mental health

services in the wake of a disaster. Included are field and training resources such as handouts, overheads, and rapid field training Modules—including supplementary training for paraprofessionals. By preparing in advance, providers will be better equipped to help victims, survivors, and affected individuals cope with the profound losses and traumatic experiences that stem from these crimes.

The targeted audiences for this publication are mental health professionals, crime victim assistance providers, and faith-based counselors who respond to acts of mass violence and terrorism. However, many people affected by mass violence or a terrorist incident will turn to their health care providers. This manual can provide valuable information to this audience as well.

The companion Field Guide may be used with this publication to assist mental health and crime victim service providers while on site of a terrorist or mass violence incident. The Field Guide was developed to further assist providers with the complex task of counseling victims and the community in the wake of a disaster.

Both CMHS and OVC hope that those who receive this training find it helpful to understand the unique mental health needs of terrorism and mass violence victims. We thank you for your continued work on behalf of those in need.

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CHAPTER I

BACKGROUND AND OVERVIEW

Over the last decade, U. S. citizens increasingly have been the targets of mass violence and terrorism. The Los Angeles civil unrest following the Rodney King verdict in 1992, the World Trade Center terrorist bombing in New York City in 1993, the Oklahoma City terrorist bombing in 1995, the mass shootings at Thurston High School in Oregon in 1998 and at Columbine High School in Colorado in 1999, and the terrorist attacks of September 11, 2001, in New York, Virginia, and Pennsylvania, have resulted in thousands of fatalities and many more people whose lives have been changed forever. School violence continues to threaten the safety of children, teachers, and other school personnel. Terrorist acts against the United States also have been carried out overseas—the bombing of Pan Am Flight 103 in 1988, the bombing of military barracks at Khobar Towers in 1996, and the bombing of U.S. embassies in Kenya and Tanzania in 1998.

Each tragic event affects the country as a whole, touches those residing in the affected communities, and alters the lives of those directly victimized. Growing evidence suggests that terrorism and mass violence places victims, bereaved family members, and

emergency response personnel at risk for long-term physical, emotional, and psychological consequences (Office for Victims of Crime, 2000; Center for Mental Health Services, 2000b). Each criminal act of mass violence generates its own sequence of criminal justice activities—potentially including investigations, arrests, trials, sentencing, and appeals—each step bringing related challenges for families and victims.

For more than 25 years, under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974, the Federal Government has provided mental health assistance following presidentially declared disasters (P.L. 93-288 as amended). Most of these disasters have been nature-caused. The Federal Government has increasingly been called upon to assist communities responding to human-caused mass violence and terrorism. Because terrorist acts are Federal crimes, Federal criminal justice agencies have statutory responsibilities related to protecting victims' rights and providing support services, including responding to the psychological consequences.

The U.S. Department of Justice's (DOJ) Office for Victims of Crime (OVC) has developed a working definition of "mass violence," which is

"an intentional violent criminal act, for which a formal investigation has been opened by the Federal Bureau of Investigation (FBI) or other law enforcement agency, that results in physical, emotional, or psychological injury to a sufficiently large number of people as to significantly increase the burden of victim assistance for the responding jurisdiction" (p. 17580, U.S. Department of Justice, 2001). Terrorism has been defined in the U.S. Criminal Code as "an activity that (a) involves a violent act or an act dangerous to human life that is a violation of the criminal laws of the United States or of any State, or that would be a criminal violation if committed within the jurisdiction of the United States or of any State; and (b) appears to be intended to intimidate or coerce a civilian population, to influence the policy of a government by intimidation or coercion, or to affect the conduct of a government by assassination or kidnapping" [18 U.S.C. 3077].

To better serve victims of devastating attacks, an interagency agreement between the DOJ, OVC, and the U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) was signed in 1999 and concluded

in 2001. This joint effort combined the substantial expertise, knowledge, and field experience of each agency.

Since 1984, the DOJ's OVC has assisted crime victims through funding, direct support, and advocacy and compensation programs for crime-related expenses at the State and local levels. OVC has supported the development and provision of training on a range of crime-related topics, resource materials, and demonstration projects—all aiming to help victims recover from the emotional and material effects of crime and to ensure their rights as they participate in the criminal justice system. OVC has undertaken pioneering work to better serve victims of rape, sexual and physical abuse, domestic violence, hate crimes, and homicide. OVC developed innovative programs and approaches to respond to the victims and their families of the bombing of Pan Am Flight 103, the Oklahoma City bombing, and the September 11, 2001, terrorist attacks.

Since 1974, SAMHSA's CMHS has provided technical guidance and consultation to State mental health authorities to help them develop effective mental health recovery programs following presidentially-declared disasters. Operating through an interagency agreement with the Federal Emergency



N COLLABORATION
WITH FEMA, CMHS
HAS TRAINED
ADMINISTRATORS,
MANAGERS, AND MENTAL
HEALTH PROVIDERS FROM
ALL 50 STATES AND THE
DISTRICT OF COLUMBIA
TO BETTER PREPARE
THEM SHOULD DISASTER
STRIKE IN THEIR
COMMUNITIES.

Management Agency (FEMA), CMHS has supported and overseen nearly 200 post-disaster mental health recovery programs. The majority of these programs, known as Crisis Counseling Programs (CCPs), have served communities following an array of natural disasters, including floods, tornadoes, hurricanes, earthquakes, and wildfires. In addition, CMHS has supported the development of numerous technical assistance publications. In collaboration with FEMA, CMHS has trained administrators, managers, and mental health providers from all 50 States and the District of Columbia to better prepare them should disaster strike in their communities. More recently, CMHS has supported CCPs designed to meet specialized needs following the Los Angeles civil unrest, the Oklahoma City bombing, and the September 11 terrorist attacks.

The partnership between SAMHSA and DOJ brings together the breadth of skills, experience, and perspectives developed over years of assisting people affected by violent crime and natural disasters. The combined efforts aim to respond effectively to the mental health needs of individuals and communities affected by mass violence and terrorism and to protect the

rights of victims and families. This manual provides orienting information and a training course designed to enable human service providers to:

- ◆ Help victims, survivors, and family members cope with trauma and loss;
- ◆ Help victims, survivors, and family members participate in the criminal justice process;
- ◆ Assist the community-at-large in recovery through education, outreach, and support; and
- ◆ Understand and manage service providers' own work-related stress responses.

Purpose of The Manual

This manual contains “the basics” of what mental health providers, crime victim assistance professionals, and faith-based counselors need to know to provide appropriate mental health support following incidents involving criminal mass victimization. The manual is primarily for mental health professionals, yet all service providers will find much of the material to be useful. Program planners, administrators, and clinical supervisors must acquaint themselves with the information in this manual to

develop mental health response programs, respond to emerging issues and needs, and address clinical challenges. Psychological support and treatment, crime victims' services, and spiritual guidance and support are essential components of a crisis response. Mass acts of violence and terrorism commonly have widespread community impacts as well. Mental health intervention targets affected individuals and families as well as the larger community.

Human service workers, including disaster relief volunteers, faith-based volunteers, senior center personnel, cultural group social service providers, public assistance workers, and day care center staff, have contact with survivors, their families, and bereaved loved ones. Many who are experiencing post-event physical and psychological symptoms seek initial treatment and assistance from their health care providers. Each of these service provider groups may benefit from the material in this manual and the related training in order to better understand and more effectively serve survivors and families of victims.

Mental health professionals, crime victim assistance providers, and faith-based

counselors responding to mass acts of violence and terrorism must be prepared and mobilize rapidly. Priorities and areas of emphasis for each group may conflict, overlap, or leave gaps in service. Preplanning and post-event coordination are essential to minimize heat-of-the-moment misunderstandings and turf battles. The training course outlined in Chapter VII provides an opportunity for these disciplines to share their experience and knowledge, receive a common foundation of information, and collaborate in order to best respond to community needs.

Overview of The Manual

This manual includes background information for mental health responders, guidance for setting up the training course, training course design, and recommendations for in-service training addressing long-term recovery issues. The training course and materials may be adapted for preparedness training before a crisis has occurred, for immediate mental health response training shortly after an incident, or as part of staff training for a long-term mental health recovery program. A brief description of each chapter follows.

Chapter II: Human Responses to Mass Violence and Terrorism

The impact of mass criminal victimization is widespread and to varying degrees affects victims, responders, and the community-at-large. This chapter describes characteristics of disaster events that are likely to result in serious and long-lasting psychological effects. It compares the dimensions of human-caused and natural disasters. Survivor risk factors that can contribute to severe, persistent reactions are discussed, as are characteristics related to resilience. This chapter presents the physical, behavioral, emotional, and cognitive reactions to trauma, victimization, and sudden bereavement experienced by adults, adolescents, and children. Considerations for responding to cultural, racial, and ethnic groups also are discussed.

Chapter III: Mental Health Intervention

Since tragic events change not only individual lives, but also the sense of safety within the entire community, this chapter describes individual and community-based mental health interventions. A discussion of key concepts for mental health support and intervention may assist all service providers in dealing

with victims, survivors, and family members. Cultural sensitivity and competence is essential for mental health responders. This chapter describes a range of immediate and long-term mental health interventions appropriate for adults, children, and adolescents. A table with common reactions to trauma and practical suggestions for intervention is provided at the end of the chapter.

Chapter IV: Organizational Preparation and Response To Mass Violence and Terrorism and the Mental Health Role

The organizational structure for emergency response to mass casualty criminal incidents is complex. Emergency medical services, law enforcement, search and rescue, the medical examiner's office, emergency management, the criminal justice system, and government authorities have key roles and responsibilities throughout the immediate response. Jurisdictions may move from the local to State to Federal levels and span various agencies. The mental health response supports the primary emergency response agencies in authority. This chapter provides an overview of the incident command system and the roles, jurisdictions, and responsibilities of these key organi-

zations, and emphasizes the importance of coordination among all responder groups.

Chapter V: Stress Prevention, Management, And Intervention

While helping survivors and their loved ones following tragic events is often meaningful and rewarding, it can also be psychologically demanding. This chapter describes sources of mental health responder stress, including environmental and individual factors. It presents a range of approaches for stress prevention, management, and intervention. Mental health providers engaged in crisis response over an extended period are at risk for compassion fatigue and secondary traumatization. The chapter emphasizes critical components of a comprehensive, multifaceted program for staff stress prevention and intervention.

Chapter VI: Setting Up Training

Training may be provided as part of preparedness activities to orient mental health providers joining the immediate response and as part of more formal mental health program implementation. Training should be adapted to the unique characteristics of the incident, local issues, and community needs,

and to the service provider groups attending the training. Effective trainers are excellent facilitators of adult learning and have relevant knowledge and experience in at least several of the following areas: community crisis response, disaster mental health, trauma, bereavement, crime victimization, crime victim advocacy, and stress management. Specialists in topics such as children and trauma, cultural competence, or the criminal justice process, and representatives from key agencies or programs may present portions of the comprehensive training.

Chapter VII: Comprehensive Training Course Outline

The training course outline includes nine modules with objectives, materials, procedures, and duration described for each one. Each module integrates brief lectures with overheads, group discussions with questions, videotapes, and group learning exercises. The training design may expand or contract depending on local needs. The outline is not intended to be a detailed prescriptive curriculum, instead it highlights necessary topics and provides methodological suggestions for addressing them. Trainers may incorporate and adapt the materials as needed.

Chapter VIII: Additional Training Needs and Options

Each disaster, community, and mental health intervention program will generate additional training needs beyond the course outlined in Chapter VII. In-service training for mental health providers may address phase-related issues such as acknowledgment of the 1-year anniversary or emerging mental health needs such as brief counseling for traumatic bereavement and post-traumatic stress disorder (PTSD). Training may be provided for paraprofessional counselors working under the auspices of the intervention program or for human services workers employed by other agencies.

Overview of Resources

Recommended readings and references throughout this manual provide more information on research, field experience, and sound clinical suggestions. References cited throughout the manual, as well as additional resources, are included at the end of the manual. Recommended videotapes for use in the comprehensive training are listed at the end of Chapter VII. A list of useful Internet sites is provided at the end of the References section.

Glossary of Acronyms

ARC	American Red Cross
AG	Attorney General (Federal and State)
ATF	Bureau of Alcohol, Tobacco and Firearms (Federal)
CMHS	Center for Mental Health Services (Federal)
DOJ	Department of Justice (Federal)
DOEd	Department of Education (Federal)
DMH	Department of Mental Health (State)
DMHS	Disaster Mental Health Services
EMS	Emergency Medical Services
EOC	Emergency Operations Center (local, State)
ESF	Emergency Support Function
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
ICP	Incident Command Post
ICS	Incident Command System
LFA	Lead Federal Agency
MOU	Memorandum of Understanding
OVC	Office for Victims of Crime (Federal)
PIO	Public Information Officer
PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SMHA	State Mental Health Authority
UC	Unified Command
VOAD	Voluntary Organizations Active in Disaster
VOCA	Victims of Crime Act
VOLAGS	Voluntary Agencies



CHAPTER 11

HUMAN RESPONSES TO MASS VIOLENCE AND TERRORISM

Violent incidents resulting in mass casualties and victimization send waves of shock and trauma throughout the community, the State, and often across the Nation. This chapter focuses on the physical and psychological effects of these tragic events and how they are expressed among different groups. Because the impact of mass violence is typically widespread, a population exposure model portrays the victim, family, responder, and community groups that may be affected. This model may help mental health response managers and planners identify priority groups for mental health services.

Table 1 compares the attributes and effects of mass violent victimization and natural disasters. This template may provide a structure for further inquiry and study. Survivor characteristics—both risk factors and resiliency factors—are described. Risk factors contribute to the variability in individuals' responses to identical exposures to severe trauma, particularly over time.

The section on adult reactions to trauma, victimization, and sudden bereavement describes the range of potential physical, behavioral, emotional, and cognitive reactions experienced by traumatized

T A B L E 1 : COMPARISON OF MASS VIOLENT VICTIMIZATION AND NATURAL DISASTERS		
DIMENSION	Mass Violent Victimization	Natural Disasters
Examples	<ul style="list-style-type: none"> • Mass riots • Terrorist bomb • Bioterrorism • Hostage taking • Mass shooting • Aircraft hijacking • Arson 	<ul style="list-style-type: none"> • Hurricane • Flood • Drought • Earthquake • Volcanic eruption • Tornado • Wildfire
Causation	<ul style="list-style-type: none"> • Include evil human intent, deliberate sociopolitical act, human cruelty, revenge, hate or bias against a group, mental illness. 	<ul style="list-style-type: none"> • Is an act of nature; severity of impact may result from interaction between natural forces and human error or actions.
Appraisal of Event	<ul style="list-style-type: none"> • Event seems incomprehensible, senseless. • Some view as uncontrollable and unpredictable, others view as preventable. • Social order has been violated. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Assumptions about humanity are shattered; individuals no longer feel that the world is secure, just, and orderly. • Survivors confronted with the reality that evil things can happen to good people. • People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time. 	<ul style="list-style-type: none"> • Spiritual beliefs may be shaken (e.g., “How could God cause this destruction?”). • Loss of security in “terra firma” that the earth is “solid” and dependable. • People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.

Continued on next page

T A B L E 1 : COMPARISON OF MASS VIOLENT VICTIMIZATION AND NATURAL DISASTERS

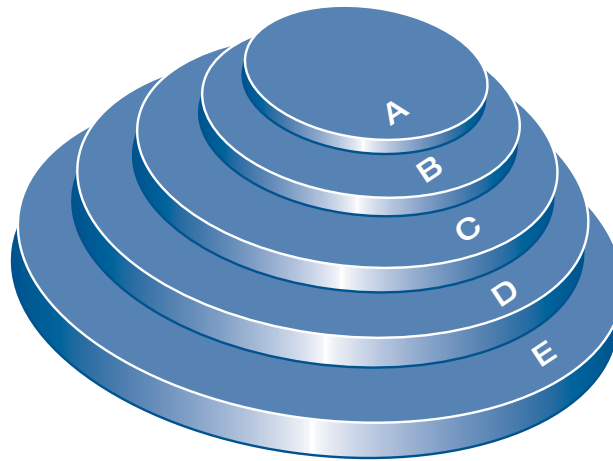
DIMENSION	Mass Violent Victimization	Natural Disasters
Stigmatization of Victims	<ul style="list-style-type: none"> • Some victims may come to feel humiliation, responsibility for others' deaths, survivor guilt, self-blame, and unworthy of assistance, thus assigning stigma to themselves. • The larger 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Impact • Outcry • Disbelief, shock, and denial • Interaction with criminal justice system • Working-through process • Coming to terms with realities and losses • Reconstruction 	<ul style="list-style-type: none"> • Warning, threat • Impact • Rescue and heroism • Honeymoon • Interaction with disaster relief and recovery • Disillusionment • Coming to terms with realities and losses • Reconstruction
Media	<ul style="list-style-type: none"> • 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 violations of privacy. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Victims' needs may conflict with necessary steps in the 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 remedy or punishment is inadequate in comparison to the crime and their losses. 	<ul style="list-style-type: none"> • 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.

and bereaved individuals. A graphic model of human responses to trauma and bereavement portrays the emotions and processes associated with coping with extreme trauma and loss. Three special populations addressed are children and adolescents, older adults, and cultural, racial, and ethnic groups. A model of responses to trauma and bereavement, practical assessment checklists, and tables are included in this chapter. The recommended reading section at the end of the chapter includes detailed information on the effects of traumatic stress and bereavement, research reviews, screening and assessment, and the combined impact of crime victimization and community trauma.

Population Exposure Model

Mental health providers new to responding to community disasters and widespread trauma must consider a community perspective as well as individual psychological effects. The collective social, political, environmental, and cultural impacts of community disaster interact with individual reactions and coping. A public health approach helps the provider develop a macro-view of the

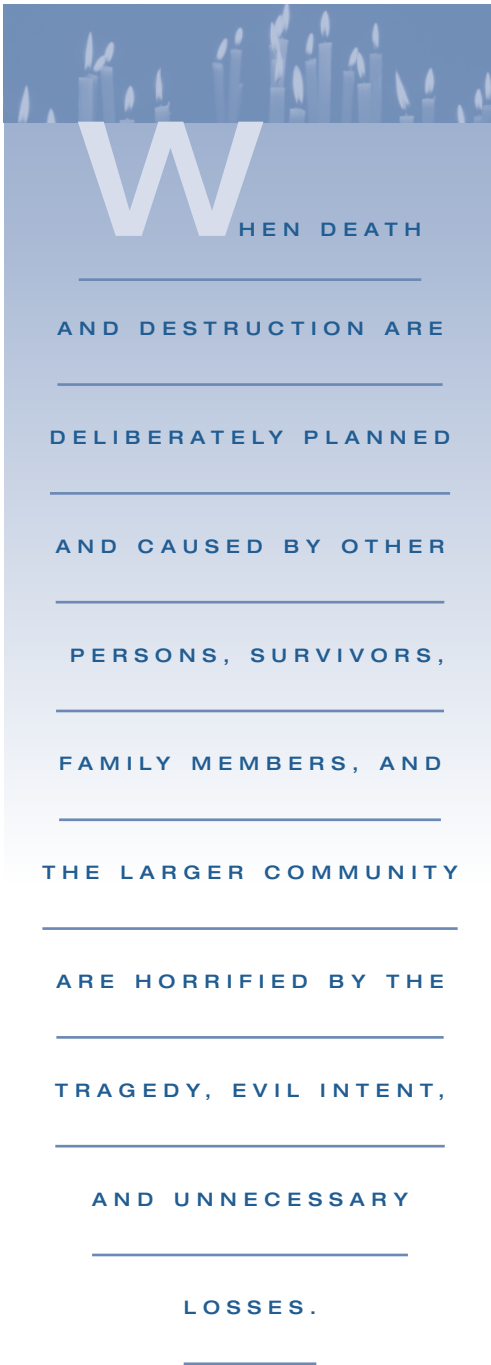
FIGURE 1: POPULATION EXPOSURE MODEL



- A:** Community victims killed and seriously injured
Bereaved family members, loved ones, close friends
- B:** Community victims exposed to the incident and disaster scene, but not injured
- C:** Bereaved extended family members and friends
Residents in disaster zone whose homes were destroyed
First responders, rescue and recovery workers
Medical examiner's office staff
Service providers immediately involved with bereaved families, obtaining information for body identification and death notification
- D:** Mental health and crime victim assistance providers
Clergy, chaplains
Emergency health care providers
Government officials
Members of the media
- E:** Groups that identify with the target-victim group
Businesses with financial impacts
Community-at-large

Population Exposure Checklist

- ✓ Identify direct victims and highly impacted families
- ✓ Identify comparable groups for A, B, C, D, E in model
- ✓ Identify cultural and ethnic groups and special populations present in A, B, C, D, E
- ✓ Determine impact and mental health service needs for each group (see Chapter III)



entire community and the gradations of effects and needs across population groups (Burkle, 1996). A concentric circle model, in Figure 1, depicts the spectrum of populations affected following large-scale disaster (Tucker et al., 1999; Wright, Ursano, and Bartone, 1990).

The model's underlying principle is that the individuals who are most personally, physically, and psychologically exposed to trauma and the disaster scene are likely to be affected the most. This relationship has been consistently demonstrated in numerous research studies and reviews (Norris et al., 2002, Shariat et al., 1999; Young et al., 1998; Green, 1996; Marsella et al., 1996; Green and Solomon, 1995; Lurigio et al., 1990). The model may be used as a conceptual aid for planning because it portrays general trends. It is important to remember that models are generalizations. There will always be individuals within each category who suffer severe reactions requiring more intensive mental health assistance. Many of these individuals are at risk because of pre-existing vulnerabilities, another key consideration for planning and screening. These survivor-related risk factors are addressed later in the chapter.

Traumatic Event And Stressor Characteristics

As shown in Figure 1, the level of exposure to the traumatic event and the stressors associated with that event are highly correlated with mental health outcomes especially in "most exposed" groups. However, not all events and traumatic stressors are equal in their potential for psychological impact. Eight dimensions of traumatic exposure associated with post-traumatic stress are:

1. Threat to life and limb;
2. Severe physical injury;
3. Receipt of intentional injury;
4. Exposure to the grotesque;
5. Violent/sudden loss of a loved one;
6. Witnessing or learning of violence to a loved one;
7. Learning of exposure to a noxious agent;
8. Causing death or severe injury to another.

(Green, 1993)

Most of these dimensions are inherent in mass violence and terrorism. The level of community trauma is increased when there are both large numbers of victims

relative to non-victims and high numbers of fatalities and serious injuries (Tierney, 2000). A prolonged recovery effort involving body-handling and delayed death notifications is related to increased post-traumatic stress in emergency workers as well as waiting families (Ursano and McCarroll, 1994). The grieving process is intensified and complicated when a loved one's death is sudden, violent, random, preventable, mutilating, and associated with multiple other deaths (Rando, 1996). In addition, when no physical remains of the deceased are identified, many families have even more difficulty accepting the death and memorializing their loved one.

When death and destruction are deliberately planned and caused by other persons, survivors, family members, and the larger community are horrified by the tragedy, evil intent, and unnecessary losses. They may be both enraged and terrified by their inherent vulnerability to such random, yet deliberate acts. Incessant questioning "Why me?," "How could this have happened?," "Why my child's school?," "What terrible thing is going to happen next?" interacts with the need to blame and demand justice. Survivors feel confused, out of control, frightened, and unable to

make sense of an act that seems incomprehensible. Since the goal of mass murder of innocent civilians appears outside the bounds of rational human behavior, the perceived vulnerability of future attacks causes many to live with high levels of anticipatory anxiety and hyper-vigilance.

Research comparing the psychological effects of human-caused versus natural disasters has yielded equivocal results (Norris et al., 2002; Green and Solomon, 1995). Considering the consequences of causation exclusively, studies have not consistently demonstrated that one type of disaster is "worse" than the other. When the eight dimensions listed previously also are considered, however, terrorist acts and mass violence that result in a significant number of deaths and serious injuries can be expected to have profound and long-lasting physical, emotional, and financial effects for many survivors and family members (Norris et al., 2002; Office for Victims of Crime, 2000; Green, 1993). Traumatic events intentionally perpetrated through human design "may be qualitatively different in a psychological sense than threat or injury arising from nature or mishap, since betrayal by other human beings must be dealt with in addition to the vulnerability

and helplessness caused by the sudden threat" (Green, 1993).

Deliberately human-caused disasters may be motivated by terrorism targeting innocent people, prejudice and hate toward a group, revenge and a misguided desire to "get even," social tensions resulting from oppression and poverty, or by the delusional paranoia or obsessions of a person with untreated or undiagnosed mental illness. Terrorist acts are calculated, yet are designed to be unpredictable. The ruthless intent underlying terrorism is to harm and kill defenseless people for political or sociocultural purposes. Terrorists seek to intimidate a civilian population. The killing of innocent people becomes a vehicle for delivering a message. When children are among those who are killed, the community loses its sense of being able to protect and provide safety for its children. "The great threat of terrorism is that anyone, anytime, anywhere can be a target. No one is immune; no one is protected" (American Psychological Association Task Force, 1997).

Mass acts of violence may be motivated by hate and may target victims based on their race, religion, ethnicity, gender, sexual orientation, or country of origin. Victims of hate crimes are attacked due to a core characteristic that is

immutable. Instead of feeling they have suffered a random act of violence or one that was economically motivated, victims, as well as the larger targeted group, continue to feel vulnerable to intentional attacks. Victims of bias crimes may confront institutional prejudice as they seek medical care or the prosecution of criminals, causing them to feel betrayed by the American system (Office for Victims of Crime, 1995).

Survivor Characteristics

For decades, clinicians and researchers have grappled with why survivors, when exposed to identical trauma and tragedy, respond with considerable variability, especially over time. Some survivors incorporate catastrophic experiences into their life stories and find meaning or increased self-respect through their suffering. Others continue to feel devastated and embittered, suffer lasting psychological problems, and fail to find a path to resolution that allows them to move on with their lives. Characteristics of the individual survivor can provide a buffer from long-term effects or may set the stage for great difficulty.

In the immediate aftermath of a large-scale, severely

traumatic event, highly exposed survivors' physiological and psychological reactions primarily are linked to the event. As time passes, characteristics within the individual survivor play increasingly important roles in alleviating or worsening psychological reactions. Biological, genetic, personality, temperament, and socioeconomic factors as well as prior traumatic life events contribute to the survivor's vulnerability to traumatic events (Shalev, 1997, 1996; Yehuda and McFarlane, 1997). Predictors of an increased risk for trauma-related psychiatric problems include a prior, pre-existing, or family history of psychiatric disorder or substance abuse; neuroendocrine vulnerability; early and prior traumatization; family instability; female gender; lower education level; and poverty (Halligan and Yehuda, 2000). Women have a higher prevalence of depression, anxiety, and PTSD (Kessler et al., 1994) and may have increased vulnerability due to sociocultural and biological factors.

In addition, pre-existing attachment disturbances or difficulties with separation anxiety contribute to the likelihood of developing persistent traumatic grief or experiencing complicated bereavement (Jacobs, 1999).

Each predictor or risk factor tips the balance of the survivor's vulnerability in the direction of increased risk. With multiple risk factors, their accumulated weight increases the potential for long-term psychological consequences.

Experience in communities following natural disasters has shown that survivors with serious and persistent mental illness have many of the same needs for social and psychological support as the general population (Center for Mental Health Services, 1996). When housing, medication, and case management services remain stable, most people with mental illness function reasonably well and, at times, heroically, following disasters. Post-traumatic stress reactions should not be interpreted automatically as exacerbations of pre-existing illness.

Likewise, survivor resilience is enhanced through the absence of psychiatric or substance abuse problems, biological and neuroendocrine "protection," family stability, and financial resources. Survivor resilience is linked to being able to understand, tolerate, and cope effectively with the inevitable aftermath of severe trauma: intrusive thoughts, sleep disturbances, numbness, and anxiety (Yehuda and McFarlane, 1997). The ability to self-regulate emotions and reactions is in part related to

TABLE 2 : SURVIVOR CHARACTERISTICS

SURVIVOR GROUPS' CHARACTERISTICS	RESILIENCY FACTORS
<ul style="list-style-type: none"> • Prior or pre-existing mental health or substance abuse problems • Prior traumatization or unresolved losses • Female gender • Low socioeconomic status, low education • Family instability, conflict, single-parent household • Perceived or real lack of social support, isolation • Overuse of coping strategies such as avoidance and blaming self or others 	<ul style="list-style-type: none"> • Relative mental health, absence of history of diagnosable psychiatric problems • Capacity to tolerate emotions and cope flexibly with symptoms associated with trauma and bereavement • Self-perception of having ability to cope and control outcomes • Higher socioeconomic status, higher educational level • Immediate and extended family providing practical, emotional, and financial support • Effective use of social support systems

the survivor's cognitive appraisal of the event and his or her resulting trauma symptoms (e.g., "These are temporary, normal reactions" versus "I'm going crazy;" "I'm dead inside;" "My reactions indicate I'm in real danger;" "The disaster is over" versus "Nowhere is safe;" "I attract disasters.") (Ehlers and Clark, 2000). For many survivors, social support contributes to resilience. The survivor must be able to engage with family, friends, and social support networks to derive a sense of connectedness and comfort from such interactions (Kaniasty and Norris, 1999).

Cultural, racial, or ethnic group affiliation may promote resilience through social, family, and community support. Cultural beliefs, traditions, and rituals may provide mechanisms to understand the tragedy and move through the recovery process. Alternatively, poverty,

violence, and family disruption associated with disenfranchised groups can compound the effects of overwhelming trauma and loss. The experience of marginalization can deepen inner coping strength, or it can erode the person's capacity to tolerate life's relentless challenges.

Table 2 summarizes key risk and resiliency factors. Assessing these risk factors in combination with the survivor's degree of trauma and loss exposure provides a preliminary way to identify the most vulnerable survivor groups. These factors may be included in a brief screening checklist to help mental health providers determine those in greatest need of mental health support.

Research following the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City provides a case example of the significance of

survivor characteristics and their association with psychological outcomes. North et al. (1999) found that nearly half of the blast survivors studied had one or more active post-disaster psychiatric disorders, and one-third met the criteria for PTSD at 6 months after the bombing. Two-thirds (66 percent) of the respondents with a previous psychiatric disorder at any time in their lives suffered a psychiatric disorder after the bombing, compared to 29 percent with no psychiatric history. Conversely, when the researchers looked at those study participants who had PTSD, they found that 74 percent had not experienced it before the bombing. Similarly, 56 percent who experienced major depression after the bombing had no pre-disaster history of it. Women had twice the rate of PTSD as men, and more than twice the rates of depression and generalized anxiety disorder.

Immediate Adult Reactions to Trauma, Victimization, And Sudden Bereavement

Survivors' acute reactions immediately after a life-threatening violent incident range from detached shock and numbness to fright, panic, and hysteria. Many survivors experience disbelief and some degree of disorientation. Most are focused on communicating with family and loved ones. Some may require emergency medical attention for stress reactions and others desperately want to help with rescue efforts. Emotional turmoil is common. Survivors may go through, virtually simultaneously, a range of emotions such as anger that rises to rage, fear that rises to terror, confusion that rises to feelings of chaos, self-blame that evolves to profound guilt, sorrow that evolves into grief, and relief that is experienced as euphoria (Young, 1989).

Each survivor's personal experience before, during, and after mass violence is unique. Even though all have gone through the same incident, and may experience a similar range of post-trauma reactions, each survivor's

thoughts and perceptions, the specifics of what was witnessed, and how it touched him/her are part of a person-specific pattern. Research findings suggest that those who have more extreme, pronounced, acute reactions are more likely to develop long-lasting and severe post-trauma responses (Bryant and Harvey, 2000; North et al., 1999; Young et al., 1998).

Post-trauma reactions are expressed through different pathways: physical, behavioral, emotional, and cognitive. Complex biopsychophysical interactions between parts of the brain, different neurotransmitter systems, and neurohormones play a role in increasing or regulating arousal symptoms associated with traumatic stress (Halligan and Yehuda, 2000; van der Kolk, 1996).

These complex internal processes underlie the more observable reactions listed below. Additional research is needed to more fully understand these complex interactions and their application to clinical assessment and intervention. The following lists of post-trauma symptoms enumerate the range of common survivor reactions:

Physical Reactions

Physical reactions can include:

- 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

Behavioral Reactions

Behavioral reactions can include:

- Sleep disturbances and nightmares
- Jumpiness, easily startled
- Hyper-vigilance, 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

Emotional Reactions

Emotional reactions can include:

- Shock, disbelief
- Anxiety, fear, worry about safety
- Numbness
- Sadness, grief
- Longing and pining for the deceased
- Helplessness, powerlessness, and vulnerability
- Disassociation (disconnected, dream-like)
- Anger, rage, desire for revenge
- Irritability, short temper
- Hopelessness and despair
- Blame of self and/or others
- Survivor guilt
- Unpredictable mood swings
- Re-experiencing pain associated with previous trauma

Cognitive Reactions

Cognitive reactions can include:

- 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 spiritual or religious beliefs

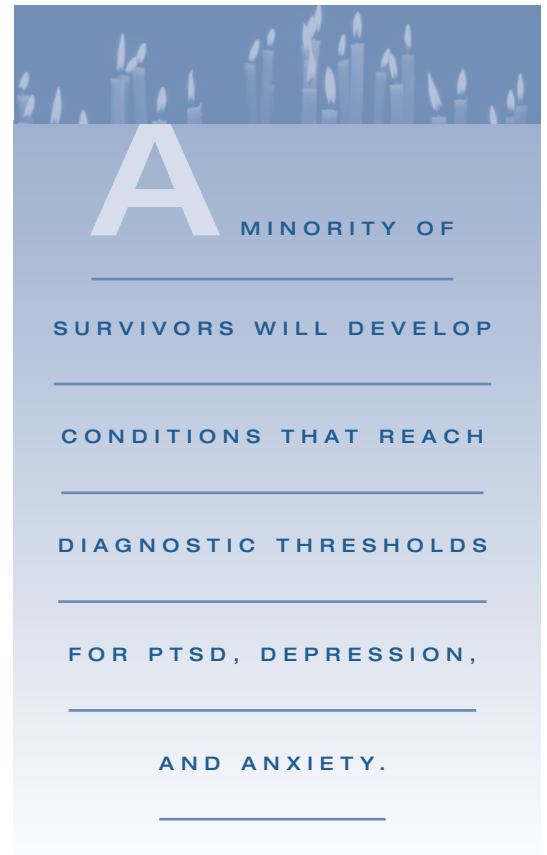
Long-Term Responses Of Adults

Early mental health intervention efforts focus on normalizing post-trauma reactions and informing survivors that their reactions are normal responses to abnormal events. The majority of survivors experience a gradual reduction in the intensity and pervasiveness of their post-traumatic symptoms, taking months to years depending on the level of exposure and the presence of vulnerability risk factors (Green and Solomon, 1995).

A minority of survivors will develop conditions that reach diagnostic thresholds for PTSD, depression, and anxiety.

Others will suffer significant psychological distress over an extended period of time with symptom severity that falls short of a diagnosable disorder.

Research on the psychological effects following different types of disasters is difficult to



compare and use for predictive purposes (Tierney, 2000). Study measurements have been taken at different time intervals, after different types of disasters, using different instruments, and have examined different outcomes. In general, researchers have found a considerable range (4 to 54 percent) in the proportion of survivors experiencing diagnosable mental disorders following disasters and other traumatic events (Green and Solomon, 1995; American Psychiatric Association, 1994). The majority of studies have examined the effects of natural disasters, yet most experts agree that the psychological impact of criminal mass victimization involving mass casualties are at the higher end of the range (Norris et al., 2002; Center for Mental Health Services, 2000b; Office for Victims of Crime, 2000). These findings were supported by studies following the Oklahoma City bombing (North et al., 1999; Shariat et al., 1999).

The dichotomy of “normal” versus “abnormal” reactions implied in the maxim “normal reactions to an abnormal situation” is restrictive and carries potential stigma. While useful in the beginning to help survivors understand, accept, and cope with their inevitable

and disturbing symptoms, psychological support and treatment for those experiencing higher levels of distress also should be destigmatized. Over time, the individual survivor’s risk and resiliency factors described earlier in the chapter, in addition to their level of trauma and loss exposure, have increasing influence over mental health outcomes. In general, survivors who lack effective social supports, who lack psychological resilience, or who experience the chronic life stressors associated with lower social class and marginalization are at greater risk (Tierney, 2000).

Traumatic Bereavement

When traumatic circumstances surround the sudden death of a loved one, or when the bereaved was also involved as a victim in the event or witnessed the death, the bereaved must cope with both trauma and grief. For many

survivors and loved ones, post-traumatic reactive processes override mourning, and grieving is initially blocked (Raphael, 1997; Rando, 1993). Instead of cherishing reminders of the deceased, the person may avoid them because they conjure up traumatic memories. During the grieving process, the contents of dreams typically reflect longing for the deceased by experiencing them as alive and then feeling a harsh sense of loss upon waking and realizing that the person is dead (Raphael and Martinek, 1997). Trauma-based dreams can be nightmares and may involve re-experiencing the trauma with intense fear and feelings of vulnerability upon waking.

This interplay of trauma and grief often intensifies symptoms common to both. The traumatically bereaved person can experience trauma and grief processes simultaneously as well as in an

Screening and Assessment Checklist

- ✓ Trauma and loss exposure
- ✓ Presence of risk and resiliency factors
- ✓ Current psychological distress
- ✓ Prior coping with major stressors
- ✓ Availability of social support
- ✓ Current pressing concerns

alternating sequence—with hallmark symptoms of each. Assessment and intervention must be responsive both to distinct post-traumatic and bereavement processes as the person's psychological response moves between the two.

When a victim's physical remains are not found and identified, the bereaved family must adapt alternative funeral and burial rituals. Families can be plagued with thoughts and questions about the circumstances of death and how much their loved one might have suffered, without physical evidence of how and where the person died. These challenges to the grieving process are often compounded by the lengthy process of criminal prosecution and sentencing.

When the traumatic death results from a mass-casualty incident, the individual death may get lost in the broad scope of the tragedy. The loved one's death becomes subsumed in the larger event's label (e.g., "Columbine Massacre," "Oklahoma City Bombing," "September 11th," "9/11"). This loss of the individuality of the death can seem dismissive and minimize personal losses (Spungen, 1999).

Model of Human Responses to Trauma and Bereavement

Survivors and bereaved loved ones go through a repetitive up-and-down emotional and physical process as they work through extreme trauma and unexpected bereavement. This nonlinear process can seem endless and relentless. Initially, the psychological enormity of the tragic event overwhelms the psyche; the mind simply cannot take it in all at once. Self-protective mechanisms kick in, usually unconsciously, that allow the person to distance temporarily from the horror of it all. Internal "monitors" allow the person to take in what he or she can manage of the harsh realities and then to numb or partially disconnect for respite. A survivor or family member may be able to deal with the "facts" of the tragedy only by keeping emotions about those facts compartmentalized. Victoria Cummock, whose husband was killed on Pan Am Flight 103, writes eloquently from experience about this process:

Denial is an adaptive reaction that protects survivors of homicide from the full force of the tragedy. This coping

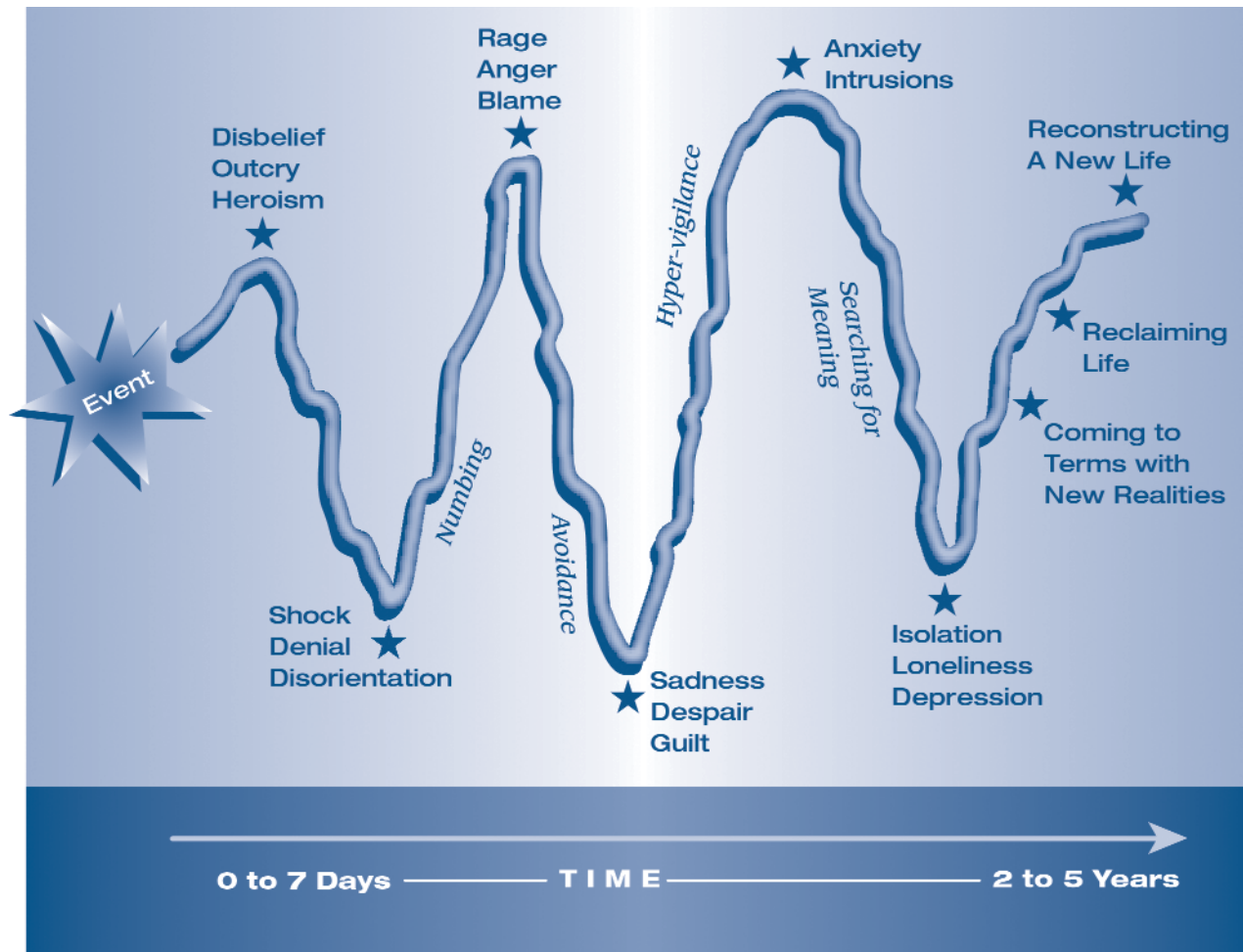
mechanism is a gradual and graceful way to deal with the murder of a loved one, allowing families the time that they need to make the transition from shock and denial into the grieving process.

(Cummock, 1996)

Gradually, the facts and realities associated with the event become more deeply understood. Small and large losses become apparent. When a person has difficulty tolerating, regulating, or managing the emotions and physical sensations associated with this unfolding, avoidance and denial may be used instead of other coping strategies. Periods of feeling "more normal" are punctuated with trauma-based bolts of fear and anxiety, and upwellings of grief and longing.

For many, this gradual adjustment to new realities occurs in conjunction with an onslaught of post-traumatic symptoms and traumatic grief reactions. Prominent features that may develop in the person's life are disturbed sleep, intrusive upsetting thoughts, yearning for the event not to have happened, jumpiness and agitation, self-doubts, anxiety about the future, profound sadness, and questioning basic assumptions about the world and humanity.

FIGURE 2: MODEL OF RESPONSES TO TRAUMA AND BEREAVEMENT



(Note. Adapted from CMHS, 1994)

Becoming stable and getting adequate rest is a priority when these symptoms are intense and constant. Temporarily distancing from triggers and reminders may help survivors reduce this reactivity and their emotional swings.

The time required to reach the sense of “coming to terms with the new realities,” “reclaiming life,” and “reconstructing one’s life” is variable. Experiencing extreme trauma and suffering through homicide of a child,

spouse, or significant other can take years to integrate into the tapestry of one’s life in a way that allows one to embrace the future with hope. Some survivors can “get stuck” in enduring anxiety, phobic avoidance, post-traumatic stress syndromes, depression, or substance abuse problems. These reaction patterns need to be addressed so the survivor may resume the process of working through the trauma and loss and finding ways to live with what has happened.

Figure 2 captures elements of this “working through” process. It incorporates the interweaving of trauma and grief reactions and the roller coaster of emotions that survivors often describe. For some individuals, the “event” may not be actual exposure to the shooting or trauma, but enduring the threat and anticipation while being aware that others were being killed or injured. This normal process moves back and forth from periods of high to low intensity. The high peaks and

low valleys suggest the intensity of these emotions may sometimes be overwhelming and warrant additional medical, psychological, or spiritual support.

The stars in Figure 2 represent reminders and triggering events that can activate intensification of symptoms and reactions, often causing the person to question if he or she will ever feel “normal” again or if “backsliding” is occurring. Potential triggers include holidays, birthdays, surprise encounters with personal reminders of the deceased or the event, necessary official procedures, particular media stories, delayed receipt of belongings or identified remains, and anniversaries of the event. Because these mass violent events are also crimes, the criminal justice system is actively engaged. The phases and events in the criminal justice process often continue over a period of years and can be extremely distressing for victims and loved ones. Triggering criminal justice procedures include the investigation, arrests, hearings, continuances, trials, verdicts, sentencing, and appeals. When the alleged perpetrators have not been arrested, the absence of justice can contribute to difficulties in moving toward closure.

When considering the challenging human process of coming to terms with horrific life events, key points to keep in mind are listed below:

- ◆ The majority of people will move through this progression successfully without mental health or other “professional” help; it is a normal life process. Sometimes mental health providers can be most helpful by staying out of the way of this natural “working through,” or by providing brief assistance along the way and then respectfully leaving survivors to their journeys;
- ◆ Some survivors and bereaved loved ones may “get stuck” in high intensity reactions, avoidance, or persistent psychological problems. Mental health intervention addresses these issues so that the person returns to the “working through” process; and
- ◆ The process moves toward a stage that involves “coming to terms with realities and losses,” “reclaiming life,” and “reconstructing new life.” These concepts convey a different meaning from the term “recovery.” The person

will not return to the life they knew before the tragedy. They must reconnect with and reconstruct a new life (Spungen, 1999).

Children and Adolescents: Priority Considerations And Reactions

A child experiences disasters, violent victimization, and sudden death of loved ones within the context of his or her stage of psychological development, life and family situation, and critical caretaking relationships. Incomprehensible, terrifying events can stimulate overwhelming and unfamiliar physical reactions and emotions that can be traumatizing to children. The boundaries between fact and fantasy, and internal and external experience can become blurred. The child’s universe can become chaotic and filled with potential danger.

A young child relies on the stability and predictability of his or her environment, and the secure availability of dependable caretakers. Family, significant adults, pets, playmates, school, and neighborhood are important



AS WITH ADULTS,
 THE CLOSER AND MORE
 EXPOSED CHILDREN OR
 ADOLESCENTS ARE TO
 THE TRAUMATIC EVENT,
 THE MORE AFFECTED THEY
 ARE LIKELY TO BE.
 (PYNOOS, 1996; VOGEL AND
 VERNBERG, 1993)

features in a child’s world. When a major traumatic event occurs, much of what is known and familiar may be disrupted, if not destroyed. Human-caused violence may confound the child’s trust in adults or in human nature. The child may experience feelings of homicidal rage toward the perpetrator, which may be disorienting and frightening. Children commonly arrive at erroneous conclusions, sometimes implicating themselves in causing or worsening the incident, which can result in feelings of guilt and shame. A review of studies on childhood traumatic stress found that:

- ◆ Children experience the full range of post-traumatic stress reactions;
- ◆ The level of exposure to the trauma is strongly associated with the severity and course of post-traumatic symptoms;
- ◆ Grief, post-traumatic stress, depression, and separation anxiety reactions are independent of, but interrelated with, one another; and
- ◆ Parent and child experience similar levels of distress in response to

shared traumatic experience.

(Pynoos, Steinberg, and Goenjian, 1996; Vogel and Vernberg, 1993).

As children move into adolescence, they become more concerned with peer acceptance, appearing competent, and achieving independence from their families. Underlying this movement toward separation is the simultaneous wish to maintain the more dependent role of childhood. When a major traumatic event directly impacts the adolescent’s parents, caretakers, school, or immediate community, it can disrupt the normal developmental process. Fears, anxieties, and vulnerabilities associated with a younger age may resurface. The normal self-centeredness of adolescence may give way to preoccupation with death and danger, a sense of alienation, or feelings of guilt (Vogel and Vernberg, 1993). In general, as adolescents mature, they are more likely to experience and express the post-traumatic symptoms associated with adult trauma responses (Cohen, Berliner and March, 2000).

The subjective experience of a child or adolescent during a traumatic event involves “intense moment-to-moment

perceptual, kinesthetic, and somatic experiences accompanied by appraisals of external and internal threats” (Pynoos, 1996). Children process information and experience and express emotions in qualitatively unique ways (Center for Mental Health Services, 2000c). They may use self-protective dissociation to control their overwhelming emotions, leaving memory gaps or amnesia for parts or all of the event. Anxiety-inducing reminders may seem strange and confusing in their effects, causing the child to feel less secure.

Traumatic Event and Stressor Characteristics

As with adults, the closer and more exposed children or adolescents are to the traumatic event, the more affected they are likely to be (Pynoos, 1996; Vogel and Vernberg, 1993). Children’s subjective experiences and perceptions regarding a traumatic event are significant as well. For example, if the child thought that a parent was killed, thought the parent was safe when there actually was danger, or thought that he could have prevented the tragedy, his or her trauma responses are likely to be linked to these perceptions. Dimensions of a traumatic event and related stressors

associated with greater post-traumatic reactivity and long-term difficulties include:

- ◆ Exposure to direct life threat and physical injury;
- ◆ Witnessing mutilating injuries or grotesque injuries (especially of family and friends);
- ◆ Hearing unanswered screams for help and cries of distress;
- ◆ Degree of brutality and malevolence associated with victimization;
- ◆ Extent of violent force and use of weapons;
- ◆ Unexpectedness and duration of the event; and
- ◆ Separation from family members, especially when they are at risk.

(Pynoos, 1996; Vogel and Vernberg, 1993).

Most child experts agree that when faced with severe trauma that is sufficiently shocking and terrifying, post-traumatic reactions are inevitable for most children and may be expressed immediately or become apparent over time (Gordon and Wraith, 1993). While family stability and supportive protection and communication contribute to the child’s resilience and aid recovery, they do not prevent symptoms from occurring altogether.

Post-Trauma and Grief Reactions

Children and adolescents may experience physical, emotional, behavioral, and cognitive reactions in varying levels of intensity and sequencing. Children may appear to cope well, yet may struggle with fears and self-doubts. Some children and adolescents will have pervasive and intense reactions to seemingly low levels of exposure; others will appear to have minimal reactions to high degrees of traumatic exposure. Siblings and friends of children who were primary victims may have vicarious reactions, also experiencing symptoms.

Watching disaster news coverage and viewing destruction, devastation, and human carnage and suffering can be terrifying to children. Children who have witnessed the disaster only through the media also can experience symptoms. Parents, school administrators, teachers, and caretakers need to work together to protect children from media exposure. When children do view disaster scenes on television, thoughtful explanations and emotional support are indicated.

When the young person is coping with both trauma and grief reactions, responses can

be multilayered, with a confusing mix of feelings related to the loss of their loved one interspersed with post-trauma symptoms and periods of shutting down emotionally to avoid pain. Efforts at relieving traumatic anxiety often take psychological priority over mourning (Pynoos and Nader, 1993). A review of the reactions below provides ample evidence of the potential for significant psychological and developmental disruption (Gordon and Wraith, 1993; Pynoos and Nader, 1993; Vogel and Vernberg, 1993).

Young Children (1–5 years):

- Helplessness and passivity
- Heightened arousal and agitation
- Generalized fears and anxieties
- Cognitive confusion
- Inability to comprehend and talk about event or feelings
- Sleep disturbances, nightmares
- Anxious attachment, clinging
- Regressive symptoms
- Unable to understand death as permanent
- Grief related to abandonment of caregiver
- Somatic symptoms

School-Aged Children (6–11 years):

- Responsibility and guilt
- Repetitious traumatic play and retelling
- Reminders trigger disturbing feelings
- Sleep disturbances, nightmares
- Safety concerns, preoccupation with danger
- Aggressive behavior, angry outbursts
- Irrational fears and traumatic reactions
- Close attention to parent’s anxieties and reactions
- Preoccupation with “mechanisms” of death
- Concentration and learning problems
- School avoidance
- Worry and concern for others

Pre-Adolescents and Adolescents (12–18 years):

- Detachment from feelings
- Shame, guilt, humiliation
- Self-consciousness

Screening and Assessment Checklist

- ✓ Trauma and loss exposure (objective and subjective)
- ✓ Current level of distress
- ✓ Social, academic, emotional, and behavioral changes
- ✓ Traumatic reminders at home and school
- ✓ Ongoing stressors at home and school
- ✓ Other trauma in the past year

- Post-traumatic acting out
- Life-threatening reenactment
- Rebellion at home or school
- Abrupt shift in relationships
- Depression, social withdrawal
- Decline in school performance
- Desire for revenge
- Radical change in attitude
- Premature entrance into adulthood

Older Adults: Priority Considerations And Reactions

The wisdom and experience accrued over a lifetime can provide older people with tools to cope with the losses, changes, and painful emotions associated with mass trauma and victimization. They may have successfully adjusted to deaths of family members and

friends, or to losses of physical abilities, life roles, and employment. Most have been touched, at some point in their lives, by the vagaries of random, unexpected life events as well as crime victimization. Research following natural disasters has shown that social support is often mobilized when the older person's life or health is threatened, but assistance is less forthcoming when the older person is faced with property damage or disruptions in daily living (Kaniasty and Norris, 1999).

When older adults have entered the "elderly" stage in the aging process and have health problems or have become physically frail, their experience of the tragedy often is influenced by their physical needs. A sudden, threatening, traumatic event evokes fear, helplessness, and a vulnerability in many survivors. When an older person already feels

increasingly vulnerable due to changes in health, mobility, cognitive abilities, and sensory awareness, the feelings of powerlessness associated with the trauma can seem overwhelming (Young, 1998). Sudden evacuations from nursing homes, residential facilities, motor home parks, senior apartment complexes, or moves from one facility to another often are disorienting and confusing. Cognitive decline may make it more difficult for older persons to understand evacuation instructions or emergency assistance information and to begin the process of coping with unexpected, disruptive changes (Massey, 1997). Sensory impairment may cause elderly survivors to not respond to offers of help.

The untimely, traumatic deaths of children or grandchildren may be especially difficult for older adults. An important sense of continuity of the

Screening and Assessment Checklist

- ✓ Trauma and loss exposure
- ✓ Psychological and physical distress
- ✓ Medical and health conditions
- ✓ Sensory, cognitive, behavioral abilities and needs
- ✓ Prior coping with trauma and loss
- ✓ Current living situation
- ✓ Current priority concerns and needs
- ✓ Availability of social support



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family, its traditions and legacies, may be lost. Family support and contact important to the elder may be diminished due to the next generation's preoccupation with the aftermath of the tragedy and their immediate losses. With the reduced availability of family support, the elder may fear being moved to an institution. This fear may cause underreporting of concerns, difficulties, and reactions related to traumatization and bereavement.

Following the traumatic death of adult children who are also parents, grandparents may assume the parenting role with their grandchildren. They are faced simultaneously with grieving the death of their own child, assisting their grandchildren to cope with the loss of their parent(s), giving up their lifestyle and routines, and making numerous adaptations and changes to accommodate becoming a parent again. When health and financial issues are present for the grandparent(s), their stress load may seem unmanageable.

Health status, cultural background, prior traumatization, religious affiliation, proximity of family and other social support, and living situation influence the older adults' experience of mass violence and terrorism. A gradual building of trust and

rapport is necessary to effectively assess mental health needs (Center for Mental Health Services, 1999b).

Cultural and Ethnic Groups: Priority Considerations And Reactions

Acts of terrorism and mass violence inevitably touch people from different cultures and diverse backgrounds. Victims of the September 11 terrorist attacks came from many different countries. Some were U.S. citizens, some had visas to work or study in the United States, some were illegal immigrants, and some were visiting for other purposes. Death, community trauma, and violent victimization were interwoven. Rituals surrounding death, the appropriate handling of physical remains, funerals, burials, memorials, and beliefs of an afterlife are deeply embedded in culture and religion. The serious injury of a family member in the United States brings families from different cultures in contact with Western medicine; the health care delivery system is made even more challenging when English is not the primary language.

Cultural and ethnic groups with histories of violent oppression, terrorism, and war in their countries of origin may experience community violence in the United States through the lens of their prior traumatization. Those who have suffered from political oppression and abuses of military power in their countries of origin can find the high visibility of uniformed personnel highly distressing, if not retraumatizing. When it is assumed that the perpetrators of mass violence are from a particular part of the world or ethnic group, members of that group living in the United States may face threats and harassment. For example, after the September 11 attacks, violence against citizens of Middle Eastern descent and those who had similar physical attributes was reported frequently. These individuals became victims of hate-based crimes, harassment, and intimidation, while at the same time coping with their own losses and reactions to the terrorist attacks.

Survivors from particular groups may live in a context of poverty, discrimination, or marginalization as illegal immigrants and face high rates of violent crimes in their neighborhoods. Exposure to chronic community violence influences how an individual

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 the United States
- ✓ Signs and symptoms of post-traumatic stress, grief, depression, and anxiety
- ✓ Views about mental health and providers
- ✓ Professional courtesy (e.g., greetings, who to talk to first, who is “family”)

responds to a discrete, larger-scale violent event. When members of a group have had prior contact with law enforcement and have experienced stereotyping and prejudice, they may be suspicious of the primary role of law enforcement in controlling the crime scene.

When cultural, racial, or ethnic groups within a community are affected by an incident involving mass criminal victimization, mental health providers must consult with community leaders, cross-cultural experts, and culturally competent mental health practitioners to effectively assess mental health effects and needs. Cultural and ethnic norms and traditions dictate what constitutes “mental health” and “mental illness,” how traumatic stress and grief

are experienced and expressed, how the mental health responder is perceived, and who is considered “family.” Over-diagnosis is common when Western mental health professionals work with people from different cultures (Paniagua, 1998).

Ethnocultural studies following natural disasters, industrial accidents, and terrorist attacks within the United States and around the world have found universal as well as culture-specific features in post-trauma responses (deVries, 1996). Biophysical research findings suggest that all people experience similar underlying physical and biological responses to severe trauma, but that the psychological and behavioral manifestations vary across cultures (Marsella et al., 1996). Considerable variation

exists across cultures regarding tolerance for the expression of strong emotions. Culture may place differential emphasis on particular symptoms, assign unique attributions to the intensity of their experience as well as expression, and shape the general tone of emotional life to which a person should aspire. The threshold at which “normal” is demarcated from “abnormal” may vary by gender, ethnicity, and cultural group (Manson, 1997).

Adding complexity, there is variation within cultural groups due to generational differences, levels of acculturation, multicultural influences, and life situations within the United States. Mental health responders must be cautious about generalizing culture-specific characteristics to every member of that group; they must learn to ask effective questions and be open to revising assumptions.

The Los Angeles civil unrest of 1992, following the acquittal of four police officers in the beating of Rodney King, resulted in 52 deaths, 2,664 injuries, and more than 12,500 arrests (Center for Mental Health Services, 2000b). This outbreak was fueled by underlying, unresolved issues among racial, cultural, and ethnic groups in the community; high unemployment and poverty; and high

levels of gang and drug activity. Effective mental health assessment and intervention had to take into account the many layers of cultural influence and differences in this disaster involving mass violence. Bridging cultural differences and language barriers was a priority, if mental health providers were to access and assist affected groups.

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CHAPTER III

MENTAL HEALTH INTERVENTION

Mental health support, psychological first-aid, and crisis intervention have become expected and valued components of disaster response, particularly following mass casualty incidents. A range of mental health services are provided for victims, bereaved family members, first responders, disaster workers, and the community-at-large. Mental health workers assist with hotlines responding to queries about missing persons, on death notification teams, at respite centers for rescue and recovery workers, at the site of the disaster to support grieving loved ones, and as consultants to government officials. Mental health services are practical, accessible, empowering, and compassionate.

This chapter presents the key overarching principles for mental health intervention following mass violent victimization. Only credentialed mental health professionals should provide some of these interventions; others are appropriate for all human service and crime victim assistance workers serving survivors. The mental health response manager usually determines the appropriate scope of practice for providers with varying backgrounds. This chapter provides general guidelines.

Immediate and long-term interventions with adults, followed by similar information related to children and adolescents, are presented. The “immediate” time frame generally refers to the first several weeks post-incident; “long-term” refers to months, sometimes years, after the event. Since many long-term interventions require specialized in-service training, this chapter provides only an orienting overview. Chapter VIII includes topics for in-service training. Many of the immediate interventions are appropriate throughout the recovery period, especially in first contacts with survivors, family members, and the community-at-large.

Special considerations for mental health intervention with older adults are included throughout the chapter. Developing cultural competence and effectively serving all groups in the community is important. Suggestions for cultural sensitivity are included throughout the chapter and addressed in a specific section toward the end of this chapter.

Because these tragic events occur in a larger community and recovery context, the next section describes predictable events with mental health implications, such as death notifications and stages in the

criminal justice process. The mental health support role is discussed in relation to each event. Then, the importance of community support through memorials, rituals, and maintenance of local traditions is discussed. A practical table providing a list of reactions to trauma and intervention options for different age groups appears at the end of the chapter.

Key Principles For Mental Health Intervention

Violence, destruction, and death that is deliberately and malevolently caused by another human is horrific and tragic. Victims, responders, the community, and sometimes the entire country experience the impact of mass criminal victimization, along with varying degrees of outrage, sadness, and feelings of vulnerability. The following 10 key principles guide mental health providers, as well as other responders and human service workers assisting survivors:


- 1. No one who witnesses the consequences of mass criminal violence is unaffected by it.** Many groups may be emotionally affected,

including emergency responders, government officials, media personnel, disaster workers, the community, those who view extensive media coverage, and mental health providers. A range of psychological support and educational interventions are important components of the overall response;

- 2. Mass crimes, involving trauma and loss, affect both the individual and the community.**

Psychological and physical damage to community structures that normally provide social support can compound an individual survivor’s trauma and grief effects. This community harm impedes the recovery process. Blaming and scapegoating of particular groups, which may occur during the aftermath of mass victimization, can undermine the community’s integrity and its capacity to care for its members. Intervention on both the individual and the community levels is necessary;

- 3. Most people pull together and function following a mass tragedy, but their effectiveness is diminished**



MOST SURVIVORS
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and they may have brief periods of being emotionally overwhelmed.

Because of the magnitude and severity of psychological impacts inherent in mass violent criminal victimization, a wide range of intense emotional, physical, and behavioral responses are expected. However, human resilience and kindness predominate;

- 4. While most traumatic stress and grief reactions are normal responses to extraordinary circumstances, a significant minority of survivors experience serious long-term psychological difficulties.* Survivors personally involved in the traumatic incident who experienced a threat to their lives, the death of a child, spouse, or significant other, are more likely to suffer long-term mental health consequences (North et al., 1999). In addition, survivors with prior histories of traumatization, psychiatric problems, or substance abuse are at greater risk;
- 5. Mental health, crime victim assistance, and other human services must be tailored to the communities they serve.* Cultural competence is

essential. Communities vary according to demographic characteristics, regional differences, religious affiliations, and cultural, ethnic, and racial groups represented. Each variable must be considered when developing an effective mental health response;

- 6. Most survivors respond to active, genuine interest and concern. However, some will reject services of all kinds.* Respectful human kindness is the basis for intervention. This includes supporting survivors' choices to not receive outside assistance, and understanding that, for some, choices may change over time;
- 7. Mental health assistance is practical, flexible, and empowering. It reflects survivors' needs to pace their exposure to harsh realities resulting from the event. First and foremost, providers must do no harm when intervening.* Mental health providers sensitively must determine each survivor's needs and coping style, quickly establish rapport and connection, and offer support and assistance appropriate for that

individual. Some survivors manage their intense reactions through protective denial and distancing, so that they may gradually come to realize the magnitude of the tragedy and their losses;

8. Law enforcement procedures, medical examiner's protocols, disaster relief requirements, and criminal justice proceedings often confuse and distress survivors.

Mental health efforts that include effective coordination with key response agencies can mitigate survivors' frustration, anger, and feelings of helplessness. Providing clear information and support, and facilitating access to resources can help survivors and family members feel more in control and less alone;

9. Provision of mental health services is an element of a multidisciplinary emergency response and supports the efforts of the primary responding agencies.

Law enforcement, emergency medical services, and rescue and recovery personnel have primary responsibilities and roles. Importantly, each contact with a survivor has the

potential for easing the pain of the tragedy, whether by a mental health worker, a crime victim assistance provider, an emergency responder, or a disaster worker; and

10. Support from family, friends, and the community helps survivors cope with the trauma and their losses.

Social support from loved ones and social networks comforts survivors, reduces their alienation and isolation, fosters hope, and promotes healing. Effective intervention involves connecting survivors with their primary supports and facilitating support systems coming together.

Mental Health Assistance Coordination

Mental health support may be provided by mental health professionals, crime victim services counselors, mental health volunteers from the American Red Cross and other responding voluntary organizations, and faith-based counselors. Effective coordination between responder groups providing mental health support is necessary to reduce conflicts and potentially intrusive duplications of effort, and to ensure appropriate services for survivors. Each

group has a significant role in the overall response effort, so teamwork and cooperation are essential. Preplanning and preparedness involve defining the roles, responsibilities, and procedures for coordination between the various mental health responder groups and participating in drills before the event occurs.

Mental Health Service Provider Groups

In reality, all first responders, government officials, law enforcement personnel, crime victim assistance providers, and employers, as well as those more formally charged with "mental health services" have the potential to positively affect the mental health of survivors and family members. While the material presented here is oriented toward "counseling and support services," all who come in contact with survivors may find useful suggestions. The terms "mental health responder," "mental health worker," and "mental health provider" are used interchangeably to refer to individuals whose response efforts involve alleviating the pain and distress of affected groups and individuals.

Crime victim assistance providers assist crime victims and family members to access crime victim benefits and services and to provide

information regarding the criminal justice process. They also use many of the mental health interventions described in this chapter. While “crime victim assistance providers” are mentioned specifically when warranted by the context, they are intended to be included in the various mental health worker designations.

The term “mental health professional” refers to social workers, psychologists, psychiatrists, and other credentialed or licensed mental health providers. In general, psychological support, comfort, and practical assistance may be provided by other appropriately trained and supervised responders. Assessments and interventions with people showing higher levels of distress or with prior psychiatric problems, facilitation of group interventions, and mental health consultation with organizations and officials should be provided by mental health professionals. The designation “mental health response manager” refers to individuals responsible for determining needs, service targets, the mental health response plan, and the scope of practice for mental health responder groups, and for screening, training, assigning, and supervising mental health responders.

Immediate Mental Health Intervention

Goals and Priorities

During and immediately following a mass violent incident, those most impacted may experience shock, confusion, fear, numbness, panic, anxiety, distancing and “shutting down.” Witnessing or suspecting the deaths of friends or family members can be emotionally overwhelming. Survivors who are not physically injured may be taken to separate sites to be interviewed as witnesses and to be connected with loved ones. Those with injuries are taken quickly to area hospitals. When the perpetrators have not been apprehended or the event is considered to be terrorism, all experience a sense of continued danger and threat. Mental health responders have four initial, immediate intervention goals: (1) identify those in need of immediate medical attention for stress reactions; (2) provide supportive assistance and protection from further harm; (3) facilitate connecting survivors with family and friends; and (4) provide information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts.

During this phase of the response, emotional stabilization is the primary objective. Because an overriding response of many crime victims is to feel vulnerable and fearful, interventions emphasize protection, safety, and promotion of a sense of security.

Acute response shock and confusion gradually give way to increasing awareness and understanding of what has occurred and the related personal consequences. Those most affected and their loved ones may be in hospitals, gathered at sites awaiting critical information, searching for missing loved ones, or in their homes. If homes and buildings were destroyed, those displaced may be in shelters, at alternate care facilities, staying in hotels, or in the homes of friends and family.

Mental health response managers quickly must determine those groups most affected and the best ways to reach them. Assuming that the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, intervention goals follow:

- ◆ Alleviate distress through supportive listening,

providing comfort, and empathy;

- ◆ Facilitate effective problem-solving of immediate concerns;
- ◆ Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor; and
- ◆ Provide psycho-educational information regarding post-trauma reactions and coping strategies.

Immediate Mental Health Interventions With Adults

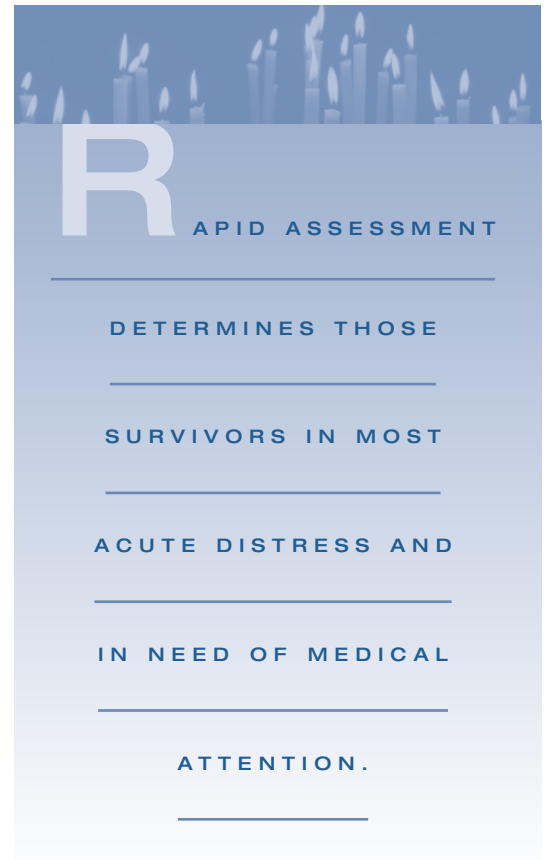
The following section describes eight interventions commonly used during the immediate aftermath of an incident involving mass violent victimization:

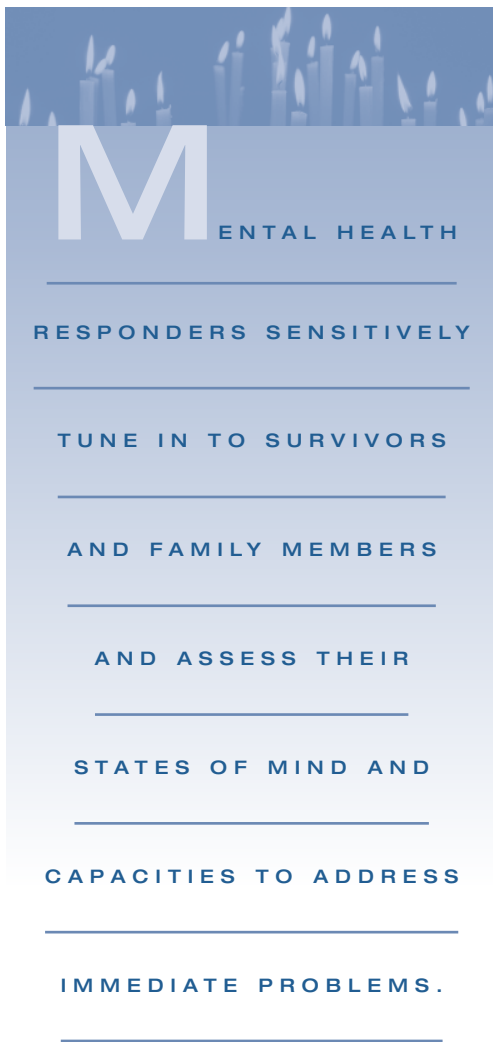
1. Psychological first-aid;
2. Crisis intervention;
3. Informational briefings;
4. Crime victim assistance;
5. Community outreach;
6. Psychological debriefing;
7. Psycho-education; and
8. Mental health consultation.

These interventions may be used with adults, older adolescents, and elderly individuals with adequate cognitive abilities. Descriptions of the interventions include guidance on when they are most appropriate, who should provide them, and how they can be implemented most effectively.

1. Psychological First-Aid

Rapid assessment determines those survivors in most acute distress and in need of medical attention. Initial triage decisions are based on observable and apparent data. Survivors experiencing obvious physiological stress reactions including shaking, screaming, or complete disorientation may need emergency medical attention. Those survivors who appear profoundly shut down, numb, dissociated, and disconnected may also require medical attention. Medical assessment and assistance are necessary for elderly survivors who are vulnerable because of health conditions and physical or cognitive limitations. When survivors do not speak English, effective assessment and triage involves ready access to bilingual mental health responders and interpreters. Survivors who appear at risk for life-endangering behavior need to be evaluated by a mental health or other





appropriate professional and receive necessary protective action.

Emergency intervention involves three basic concepts: protect, direct, and connect (Myers and Wee, 2003). Survivors need to be protected from viewing traumatic stimuli, from onlookers, and from the media. When disoriented or in shock, survivors should be directed away from the trauma scene and danger, and toward a safe and protected environment. A brief human connection with the mental health responder can help to orient and calm survivors. Also, responders help survivors connect with loved ones and needed resources.

Psychological support involves:

- ◆ Comforting the distressed survivor;
- ◆ Addressing immediate physical necessities (e.g., dry clothing, fluids, food, shelter);
- ◆ Supporting reality-based, practical tasks;
- ◆ Providing concrete information about what will happen next to increase a sense of control;
- ◆ Listening to and validating feelings;

- ◆ Linking the survivor to systems of support;
- ◆ Normalizing stress reactions to trauma and sudden loss; and
- ◆ Reinforcing positive coping strengths.

(Centre for Mental Health Services and NSW Psychiatric Institute, 2000; Osterman and Chemtob, 1999; Young, 1998; Raphael et al., 1996; Myers, Zunin and Zunin, 1990)

Mental health responders sensitively tune in to survivors and family members and assess their states of mind and capacities to address immediate problems. Intervening involves taking the survivor's lead in terms of pacing the interaction and not probing areas that are obviously painful. A number of experts have argued that when survivors or family members are using denial, wishful thinking, forgetting, or distancing to regulate their intense reactions, immediate interventions should not attempt to penetrate these coping defenses (Raphael and Dobson, 2002; Sitterle and Gurwitsch, 1999; Lord, 1996).

2. Crisis Intervention

The goals of crisis intervention involve helping survivors regain some sense of control

over their immediate situations and re-establish rational problem-solving abilities. Crisis intervention typically involves four components: (1) promote safety and security; (2) identify current priority needs, problems, and possible solutions; (3) assess functioning and coping; and (4) provide reassurance, normalization, psycho-education, and practical assistance.

1. 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. When given simple choices, many come to feel less powerless as they exercise some control over their situations—which is critical for engaging initial coping.

2. Identify current priority needs and problems and possible solutions:

“Describe the problems/challenges that you are facing right now.”

“Who might 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. Assist with accessing resources when necessary.

3. Assess functioning and coping:

“How are you doing? How do you feel you are coping with this?”

“How have you coped with stressful life events in the past?”

Through observation, asking questions, and reviewing the magnitude of the survivor’s problems and losses, the worker 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 worker also may seek consultation from a medical or mental health professional.

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. For other survivors, detailed verbalization of their traumatic experience can facilitate some reality-based acceptance that, in turn, can contribute to appropriate problem-solving.

4. Provide reassurance, normalization, psycho-education, and practical assistance:

Support, reassurance, and acknowledgment and normalization of feelings and reactions occur throughout the intervention. It is important that the survivor feel the response provided by the worker is both personal and individual. Mental health workers must pay close attention to the individual’s experience and style and not offer “pat” or “canned” responses. Psycho-education should address the particular reactions mentioned by the survivor, and provide additional information through a brochure or individualized information. Practical assistance may involve helping to arrange childcare, making a phone call, or obtaining critical information.

Mental health responders are challenged to determine how to assist each individual survivor and not to apply the same approaches to all. The

importance of flexibility and sensitivity is underscored as responders intervene with survivors from different cultural groups. The basic operating principle of “first, do no harm” dictates that responders approach each person and family with respect and sensitivity, and be vigilant to cues that might suggest their services are not wanted or their approach needs to be altered.

3. Informational Briefings

In large-scale crises, rumors and misinformation are common. Survivors and loved ones need accurate, reliable information delivered often, clearly, humanely, and in the appropriate languages. They seek information regarding the location and well-being of loved ones, progress of rescue and recovery efforts, the disaster’s impact and resulting loss of life, current levels of threat and danger, and what might happen next. Receiving procedural information and updates regarding criminal investigations and the rescue operation can promote a sense of control when survivors feel powerless. Informational briefings may be provided by a government official, a law enforcement representative, or a spokesperson from a medical examiner’s office. Official personnel should be available to provide current and

accurate information in response to the questions of loved ones and family members (Sitterle and Gurwitch, 1999).

Mental health responders typically do not provide informational briefings directly, however, they may consult with those responsible for them. Mental health providers may convey information to officials about the value of frequent briefings for survivors and family members. When cultural and ethnic groups are affected, mental health consultants may promote equivalent access to information and government officials, and facilitate liaisons with cultural group leaders. Mental health professionals also may offer suggestions regarding appropriate wording or terminology, the level of detail for sensitive information, approaches for addressing intense emotional reactions from survivors, and language to convey messages of compassion and condolence.

4. Crime Victim Assistance

Crime victim services are a central element of effective response. Interventions linked to the criminal justice process include:

- ◆ Protecting and advocating for the rights of crime victims;

- ◆ Providing information about the criminal justice process and the roles of the various participants in that process, provided in the primary, spoken languages;
- ◆ Facilitating access to State crime victim and other appropriate compensation programs for payment of crime-related expenses as well as other community resources; and
- ◆ Streamlining procedures for accessing services and benefits and responding to unique needs.

While no one can undo the losses and trauma of the event, sensitive and responsive recognition of victims’ rights and needs throughout the criminal justice process can mitigate some of the most painful effects. When a large number of survivors have a “need to know” following a mass criminal event, an effective, centralized, and accessible system of information dissemination is appropriate. An active, working partnership between mental health responders and crime victim assistance providers ensures that the broad range of survivor and family needs will be addressed. Cross-referral, cross-training,

and cross-consultation is recommended (Office for Victims of Crime, 2000).

5. Community Outreach

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism. Many survivors will not seek mental health services actively, especially during the first several weeks. They often are not aware of the crime victim benefits available to them. When mental health providers sensitively initiate contact with survivors, their access to mental health services, crime victim services, practical assistance, and information about criminal justice proceedings can be established. When cultural, economic, language, transportation, disability, or age-related barriers exist, outreach is a valuable tool for reaching special populations and at-risk survivors.

Community outreach involves:

- ◆ Initiating supportive and helpful contact at sites where survivors are gathered;
- ◆ Reaching out to survivors through the media, the Internet, and 24-hour telephone hotlines with responders who speak different languages;
- ◆ Participating in or conducting meetings for

natural pre-existing groups through religious organizations, schools, employers, community centers, and other organizations; and

- ◆ Providing psycho-educational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers.

Mental health outreach workers form alliances with existing, trusted community entities and leaders to gain credibility and acceptance. Skilled outreach workers take the approach that they must earn the right to serve. While simple in concept, community outreach requires a range of skills. Outreach mental health workers must be comfortable initiating conversations with survivors who have not requested their services. Good interpersonal skills and the ability to quickly establish rapport, trust, and credibility are necessary. Workers must be able to think on their feet and be diplomatic. While it is ideal for outreach workers to be from the cultural and ethnic groups they are serving, this is not always possible, especially in the first weeks after an event. Workers must be knowledgeable and respectful of the values and practices of the cultural groups impacted by the event.





IN RECENT YEARS,
MANY MENTAL HEALTH
EXPERTS HAVE EXPRESSED
CONCERNS ABOUT THE
INDISCRIMINATE USE OF THE
TERM “DEBRIEFING” TO
APPLY TO A WIDE ARRAY OF
INDIVIDUAL AND GROUP
APPROACHES FOR VARIOUS
POPULATIONS.

6. Psychological Debriefing

A variety of organizations currently provide “psychological debriefing” in the aftermath of traumatic events. While most debriefing approaches are generally well-received by participants and perceived as helpful, it is important for community leaders to be well-informed about the specific intervention techniques being used in order to assure that any services provided are truly helpful and appropriate.

In recent years, many mental health experts have expressed concerns about the indiscriminate use of the term “debriefing” to apply to a wide array of individual and group approaches for various populations. In 2001, a panel of international experts convened to examine early intervention techniques stated the following:

Use of the term “debriefing” for a variety of mental health interventions is misleading. Workshop participants recommended that this stand-alone term no longer be used to describe early mental health interventions following mass violence and disasters. For clarity, “debriefing” should be used only to describe operational debriefing,* and should not be used to describe psycho-

logical debriefing, Critical Incident Stress Debriefing (CISD), and so on.

National Institute of Mental Health, 2002

*Note: As used in this context, the term “operational debriefing” refers to routine information sharing without the psychological or emotional processing components.

Behind the concerns expressed regarding the indiscriminate use of the term debriefing is a concern regarding the varying quality and appropriateness of group interventions in the immediate aftermath of crisis events. While there are different views among experts on specific debriefing techniques, there is growing consensus regarding the need for more precision in tailoring intervention techniques for specific populations (Watson, 2004). It is generally agreed that there is no “one size fits all” approach that works for all populations and types of disasters.

The most commonly used debriefing technique is the Critical Incident Stress Debriefing (CISD) model, which was developed originally for emergency responders, who are occupationally exposed to repeat trauma and at risk for accumulated stress effects

(Mitchell, 1983; Mitchell and Everly, 1993). The CISD model, which is intended to be implemented as a part of a larger Critical Incident Stress Management (CISM) approach, has often been modified for particular groups with needs different from emergency responders.

A variety of group and individual psychological debriefing approaches have been used with a wide range of groups including emergency responders, employee groups, highly exposed survivors, community bystanders, and groups from the larger affected community. Some approaches may be referred to inaccurately as CISD, and sometimes simply referred to as “debriefing.” Therefore, in all situations, it is important to carefully assess the actual techniques being implemented.

Careful attention must be paid to individual exposure levels and response to a traumatic event when considering the timing and goals of any group intervention techniques. For example, intervention techniques that strongly encourage “emotional processing” in the immediate aftermath of a trauma may not be appropriate for many individuals who are still in a state of shock or agitation (Watson, 2004).

In addition, mental health providers should be careful not to “promise” more than an intervention can actually deliver. While group techniques may provide an early method of survivor contact and may be useful for social support, preliminary screening and psycho-education, there is no evidence that existing early debriefing techniques alone can “prevent” later mental health needs. In addition, many experts have expressed concerns that mandatory participation in debriefings that require emotional processing in the immediate aftermath of a trauma can actually increase stress levels (Watson, 2004).

Facilitating group approaches requires extraordinary skill and care and should not be performed without specific training. Simply knowing and following the steps of a specified debriefing model is not enough. A skilled group facilitator will carefully assess the needs of a group and will take care to assure that activities do not disrupt the normal human processes of remembering, forgetting, meeting challenges, and incorporating losses (Raphael and Wilson, 2000).

When working with disaster victims at a time of great vulnerability, it is important to

assure that any psychological interventions do no harm. When in doubt about the appropriateness of a group intervention technique, community leaders may be well advised to seek “a second opinion.” Consultation with a variety of experts with careful attention to the goals, required training, and demonstrated evidence base for specific populations can help assure that early intervention sets a foundation for emotional recovery for all individuals exposed to trauma.

7. Psycho-Education

Psycho-education is a core component of mental health response for survivors and their families, health care providers, social service workers, and providers of other community services. Information is provided about post-trauma reactions, grief and bereavement, effective coping strategies, and when to seek professional consultation. Brochures or simple handouts that describe common physical, emotional, cognitive, and behavioral trauma reactions for children and adults are widely distributed in appropriate languages. Material should be oriented specifically to the actual event and locale and adapted to each survivor group or audience to ensure age-appropriate, role-specific, and

culturally relevant materials. All forms of media are used to disseminate information, so that the messages reach the largest number of people.

Validation and reassurance through psycho-educational information mitigate survivors' fear that they are "going crazy." When survivors learn their reactions are "normal" and expected following similar events, many can understand, accept, and cope with their reactions and situations. However, some survivors experience this normalization of their pain as minimizing or dismissive. Psycho-education is more successful when mental health responders adapt their educational comments and materials to each survivor's concerns and style.

Parents and caretakers typically ask mental health providers questions about how best to help children following traumatizing mass victimization. Educational presentations for parents may be offered through schools, religious organizations, and other community organizations. Psycho-education regarding children's needs addresses common questions and provides practical guidance.

Samples of brochures and public information materials are readily available in print

(American Red Cross, 2001, 1997; Office for Victims of Crime, 2001; Center for Mental Health Services, 2000a, 1995; American Academy of Child and Adolescent Psychiatry, 1998; American Psychological Association, 1996; Grollman, 1995; Lord, McNeil and Frogge, 1991) and on the Internet (see Internet Sites at the end of this publication).

8. Mental Health Consultation

Emergency services and law enforcement administrators make many decisions that have mental health implications for survivors. Government officials also make critical decisions, provide information, and make statements directly to survivors and their families and through the media. Mental health professionals can be brought into decision-making and planning teams to advise leaders regarding mental health issues. Leaders may seek mental health consultation on issues such as optimal scheduling, mental health support, and leave time for rescue and recovery workers; sensitive procedures for obtaining personal information and DNA samples from families for body identification; whether children should accompany families to the disaster site; rituals and memorials for honoring the dead; integrating acknowl-

edgment of the tragedy into traditionally celebratory or recreational events; and management roles and support as affected employees return to work. When mental health consultation is sought, inadvertent retraumatization or unnecessary stress may be avoided (Pynoos and Nader, 1988). To function effectively in this consulting role, mental health professionals must be well-versed in emergency and criminal response protocols, as well as experienced in reactions to disaster, trauma, and bereavement.

Survivors with serious psychological reactions to the traumatic event also may be members of religious groups, students at local schools, recipients of services at senior centers, community mental health center consumers, or members of culturally identified organizations. Service providers, clergy, principals, and teachers can be supported and educated through mental health consultation regarding the effects of trauma and how best to assist their constituents. In addition, impacted businesses, organizations, or government offices may seek to develop systematic mental health support and recovery assistance for their employees and managers (Young et al., 1998).

Long-Term Mental Health Interventions With Adults

Goals and Priorities

Mental health response managers must set realistic goals, priorities, and expectations for long-term mental health services. This is a time when need probably will exceed available resources. Managers must be vigilant to prevent programs and staff from overextending and suffering stress overload.

The immediate interventions of psychological first-aid and crisis intervention may be adapted for initial contact with survivors seeking psychological support and mental health services during the recovery period. Survivors and family members may have delayed reactions or have traumatic symptoms triggered by reminders, community events, or criminal justice proceedings. They may need to wait for physical injuries to heal before seeking psychological assistance. Many seek more intensive counseling and psychotherapy following immediate intervention. Specialized services are provided by mental health professionals with training in treating PTSD, depression,

anxiety, and traumatic bereavement.

Crime victim assistance, community outreach, psycho-education, and community-building interventions are ongoing. Mental health providers should design their intervention services to be appropriate to the particular group receiving those services and relevant to their stage in the recovery process.

Activities for long-term mental health intervention include:

- ◆ Identifying individuals and groups in need of mental health and crime victim assistance services;
- ◆ Using systematic screening approaches to prioritize the delivery of more intensive mental health services;
- ◆ Providing different levels and types of mental health services: outreach, consultation, crisis intervention, and individual and group counseling;
- ◆ Supporting the provision of a range of crime victim services: accessible crime victim benefits, available criminal justice procedural information, practical assistance, and trouble-shooting;





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- ◆ Providing mental health support and consultation for community rituals, memorials, and other community events; and
- ◆ Providing appropriate psycho-educational information to all affected survivor and responder groups and health care and social service providers in the community.

In this section, crime victim services, brief counseling interventions, and support groups are briefly discussed. These overviews orient the reader to possibilities and highlight directions for further study and training. Recommended readings are provided at the end of the chapter.

Crime Victim Services

Crime victims are eligible to receive compensation for certain crime-related expenses. Eligibility and benefits vary from State to State. These benefits may include payment for medical and mental health treatment expenses, funeral and burial expenses, and compensation for lost wages and loss of support. Assistance, including crisis intervention, emergency transportation and shelter, counseling and criminal justice advocacy, also is available. Through close coordination

and communication with crime victim assistance providers, mental health workers can be informed about helpful resources.

For many survivors and family members, understanding and participating in the criminal justice process is a critical part of coming to terms with being traumatically victimized. Crime victim assistance seeks to safeguard victims' rights by ensuring access to information on all criminal justice proceedings. Survivors and family members may observe trial proceedings and provide victim impact statements. They are entitled to explanations of the trial process, updates on current developments, and emotional support. Mental health providers should be trained specifically to provide mental health services during trial proceedings because they need to be knowledgeable about criminal justice proceedings and their mental health implications.

The following descriptive overview of criminal justice procedures is intended as an orientation for mental health workers who may be unfamiliar with the steps in the judicial process. Following an act of mass violence or terrorism, when the investigation has identified suspect(s) and sufficient evidence, the alleged perpetrator(s) are

arrested. If the alleged perpetrator is charged as a juvenile, his or her identity may not be disclosed. Upon completion of an initial investigation, the investigating law enforcement agency makes recommendations for criminal offense charges to the prosecutor's office. The case is then transferred to the prosecutor's office. When no suspects are identified or no arrests are possible, family members' and victims' reactions are related to the absence of criminal justice proceedings and, ultimately, to the absence of possible justice for the wrongs they have suffered.

Some of the evidence collected at the crime scene will be essential to the prosecution of the case and will not be released until after the trial. Other items, not required as evidence, such as personal effects or clothing, may be returned to families and loved ones. It may be difficult for loved ones to see the deceased's personal items for the first time when they are presented at trial. Prosecutors and crime victim assistance and mental health providers often prepare family members for seeing personal items to be presented at trial. For example, personal items held as evidence following the terrorist bombing of Pan Am Flight 103 in 1988 were returned to

families and loved ones after the trial was concluded 13 years later. Each item was cleaned, packaged, and personally delivered by detectives from Lockerbie, Scotland.

The prosecutor may conduct a preliminary hearing or grand jury to determine if sufficient evidence exists to charge an individual with a crime. Then, an arraignment hearing is held and the accused is informed formally of the charges pending. At this point, the accused becomes referred to as "the defendant." The defendant enters a plea of "guilty" or "not guilty." Each of these steps is likely to be psychologically distressing for survivors and loved ones. Their sense of control is enhanced by being informed, anticipating events and how they might react, and planning for social support.

A long delay may occur before the case goes to trial. The case may be postponed several times before the trial or sentencing is actually heard, making it difficult for family members to make arrangements or take time off from work. Delays and postponements also can increase victims' fear of testifying. If there has been considerable publicity surrounding the event, the location of the trial may be

moved to another part of the country, making it more difficult for survivors or loved ones to attend. They still need accurate information and updates regarding the discovery process, continuances, and plea or sentencing bargaining. The trial, sentencing, and appeals processes may continue for years after the event. Some survivors are likely to be involved in providing victim impact statements to the judge and jury.

Because of the long time span involved in these cases, mental health and crime victim services need to be available over an extended period. The "working through" and reconstruction processes from a traumatic loss often take years and occur in stages over time. Inevitably, key events in the criminal justice process trigger reactions and pain. However, these expressions may also lead to a gradual integration and acceptance of the tragedy.

"Responding to Terrorism Victims: Oklahoma City and Beyond" provides a detailed account of crime victim assistance services and underscores the considerable overlap and coordination between mental health and crime victim services (Office for Victims of Crime, 2000). Additional background

information is available in the Attorney General Guidelines for Victim and Witness Assistance (U.S. Department of Justice, 1999) and through the OVC Resource Center (www.ncjrs.org).

Brief Counseling

Survivors most immediately exposed to the event, and those who suffered the death of loved ones or serious injuries, may need intensive counseling (North et al., 1999; Green, 1993). In addition, survivors and community members with prior or pre-existing psychiatric conditions or substance abuse problems, and those with histories of prior traumatization are at greater risk for long-term difficulties (Halligan and Yehuda, 2000; North et al., 1999; Breslau et al., 1998). Some survivors will continue to experience high levels of psychological distress and may suffer disturbing and intrusive symptoms that interfere with their daily functioning. Survivors who are developing PTSD or who already have developed PTSD remain “stuck” on the trauma. They constantly relive it through their thoughts, feelings, or actions, and begin to organize their lives around avoiding triggers and reminders. They continually act out their overgeneralized sense that the world is unsafe (van der Kolk,

McFarlane, and van der Hart, 1996). The therapeutic goals of long-term interventions involve:

- ◆ Stabilizing emotions and regulating distress;
- ◆ Confronting and working with the realities associated with the event;
- ◆ Expressing related emotions during and since the event;
- ◆ Understanding and managing post-trauma symptoms and grief reactions;
- ◆ Developing a sense of meaning regarding the trauma;
- ◆ Coming to accept that the event and resulting losses are a part of one’s life story; and
- ◆ Moving on and reconstructing one’s life.

Most therapeutic approaches recognize the vulnerable survivor’s capacity to confront painful realities and the intense emotions that develop gradually. The treatment process must move at a rate the survivor can tolerate. The therapeutic relationship is an essential part of this process. The survivor progresses to facing the trauma experience and losses, self doubts, fears, and pain when there is sufficient trust that the

therapist is genuinely engaged and can truly bear witness to the personal significance of the trauma. The therapist must be able to remain solidly and empathically engaged while hearing of the horror, tragedy, and intense emotions associated with the traumatic event (Raphael and Wilson, 1993; Herman, 1992). The normal “working through” process that allows traumatized survivors and bereaved family members to move on and reconstruct their lives can take years. Five years was common for survivors of the Oklahoma City bombing (Office for Victims of Crime, 2000).

Counseling may use a particular treatment approach or incorporate a combination of different approaches. Treatments commonly used for post-traumatic stress and traumatic bereavement include cognitive-behavioral therapy (Ehlers and Clark, 2000; Young et al., 1998; Foa, Rothbaum, and Molnar, 1995); phase-oriented treatment (van der Kolk et al., 1996; Herman, 1992); bereavement counseling (Raphael et al., 2001; Rando, 1993; Worden, 1982); eye movement desensitization and reprocessing (EMDR) (Shapiro, 1995); brief dynamic therapy (Marmar, Weiss, and Pynoos, 1995; Lindy, 1996; Horowitz, 1986); and psychopharmacology (Friedman et al., 2000;

Davidson and van der Kolk, 1996). These modalities have varying levels of scientific evidence supporting their efficacy. Many practicing mental health professionals attempt to match the treatment approach to the recipient's perception of its acceptability and helpfulness. The various trauma and bereavement psychotherapy approaches have elements in common as well as differences. All approaches set stabilizing the survivor's post-trauma reactivity as a primary objective. Psychopharmacological treatment can help reduce the severity of symptoms so the survivor can function better and engage in psychotherapy more effectively.

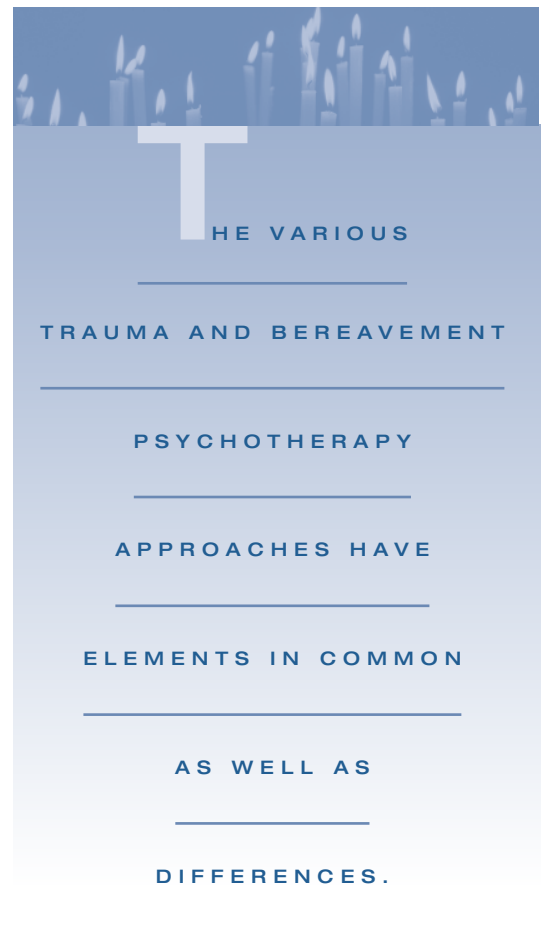
Cognitive-behavioral treatment focuses initially on teaching skills to manage anxiety, cope with stressors, and challenge irrational and maladaptive thoughts. Dynamically oriented approaches place greater initial emphasis on developing the therapeutic alliance, and then on the symptom reduction and relief that can occur by telling the "trauma story" in a safe environment. Cognitive-behavioral approaches incorporate repeated exposure to details of the trauma while actively managing the related distress facility. Dynamic approaches look for links between key

aspects of the trauma, the survivor's vulnerabilities, prior life experiences, and past coping behavior. Bereavement counseling often takes a more developmental or stage-related approach, viewing successful "working through" of a traumatic death as requiring completion of a series of tasks. Each approach considers the recovery process to occur in stages over an extended period of time. Thus, returns to treatment for "booster" sessions or for additional support and processing are expected as survivors confront environmental triggers and challenges in their psychological recovery.

Mental health responders may employ intervention strategies used in these modalities to assist with crisis intervention. Having the necessary skills to conduct meaningful assessments and provide a course of treatment with at-risk survivors, however, requires specific training and supervision, as well as a mental health professional license or certification, depending on State regulations.

Support Groups

Group treatment is especially appropriate for survivors of mass victimization because groups provide social support through validation and normalization of thoughts,





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emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others who understand can be powerful. In addition, group reinforcement for stress management and problem-solving techniques may bolster courage and creativity. Because some trauma survivors feel isolated in their struggles to cope, groups provide much needed social connection through support for shared experiences. Sharing helpful information about service and financial resources and other types of assistance is another important function of support groups.

Groups with homogenous memberships may be offered for parents, children, members of a particular neighborhood or commonly affected occupational group, and for survivors who suffered a particular trauma or loss (e.g., bereaved parents, people who lost their jobs as a result of the trauma, grandparents who are raising grandchildren). Group members may be connected by age, gender, or cultural group. Support group sessions often combine some structured sharing and discussion about trauma experiences and recovery issues and psycho-educational presentations.

Because of the potential for intense group dynamics and

members with complicated trauma and grief reactions, these groups should be facilitated by an experienced mental health professional, ideally with a co-facilitator. In most instances, groups should be time-limited with expectations defined at the outset. A cohesive, effective group often will want to continue meeting. Mental health response managers and facilitators must decide if continuing the group is the best use of limited program resources, given other community needs. Group members may elect to transition into a more self-help or social support model. Facilitators may assist with this transition, but end their formal role with the group.

Immediate Mental Health Interventions for Children and Adolescents

Goals and Priorities

Initial contacts with children, adolescents, and their families often take place at schools, hospitals, family notification and support sites, and shelters providing support services. These settings typically serve multiple functions, so the environment can be chaotic, noisy, and not be suited for

lengthy or private conversation. In the immediate aftermath of a horrific incident involving mass violent victimization, parents and caretakers attempt to respond to their children's needs as well as their own. They seek mental health consultation regarding their children's well-being. Parents and caretakers ask questions about their children's behavior, what to tell their children about the specifics of the incident, how to help them deal with a missing or deceased parent, if they should limit TV exposure to traumatic scene replays, and if their child should go to a funeral, stay with an out-of-town relative, or see them cry. Psycho-education for parents and caretakers is an essential component of early mental health response.

Through psycho-educational and other immediate mental health interventions, the mental health response assists traumatized and bereaved children to:

- ◆ Regain a sense of safety and security;
- ◆ Gain an understanding and acceptance of the events that have occurred;
- ◆ Appropriately identify and express reactions;
- ◆ Grieve and effectively cope with traumatic stress; and

- ◆ Resume age-appropriate roles and activities.

(Pynoos and Nader, 1993; Vernberg and Vogel, 1993)

The last two goals are not likely to be achieved during the short term, yet they do underlie mental health intervention throughout the recovery period. The following section highlights several interventions: psychological first-aid, play areas, participation in disaster relief, and school interventions. The table at the end of this chapter provides specific suggestions for intervening with children and adolescents.

Psychological First-Aid

Children and adolescents directly involved in the traumatic event, or witnesses to it, may need immediate mental health support. If they appear to be disoriented, in shock, or behaving strangely, one-to-one support with a protective adult and contact with a child mental health professional are necessary. Immediate interventions include physical comforting, rest, 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, and opportunities to verbalize (Pynoos and Nader, 1993). In addition, traumatized children may be calmed with

snacks for nurturance, blankets for warmth and nesting, familiar structured play activities, and appropriate limit setting (James, 1989).

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. Certified pet therapy animals have been used successfully in play areas (American Psychological Association Task Force, 1997). Providing a setting and structure for play gives children an opportunity to release energy and be distracted from the trauma, and gives parents some respite. While play activities should not involve "focused therapy," child mental health professionals may offer individual nondirective and nonintrusive interventions regarding feelings, talking about experiences, or correcting misconceptions with children and their parents.

Participation in Disaster Relief

Some adolescents value playing an active role in the relief effort and helping others. They may feel enhanced self-efficacy and greater mastery of their situations when

contributing in meaningful and concrete ways. For example, they may assist with food and beverage distribution, moving supplies, child care, functioning as helpers at an operations center, etc. However, it is critically important that they not be asked to function in roles that expose them to additional trauma. Their role in assisting others should be viewed, in part, as a mental health intervention and should be monitored accordingly.

School Interventions

School is a central part of children's and adolescents' lives. The school environment provides an ideal locus for mental health contact because it is familiar, offers structures conducive to re-establishing routines and a group setting in which sharing of experiences and group support may occur. Schools constitute the most effective and efficient context for post-trauma mental health assistance for children and their families (Pynoos et al., 1998). Mental health support must be provided to principals, teachers, and other school personnel. Teachers and staff may experience their own trauma and grief reactions, as well as anxiety about returning to a seemingly unsafe school environment. They need support to address the incident's impact on

themselves and their own families.

Multifaceted school interventions are recommended (Flynn and Nelson, 1998). Telephone hotlines for parents, staff, and students that provide up-to-date information and mental health support may be established. Schools often set up walk-in clinics or drop-in centers for students to self-refer or for referral by teachers or parents. Informational, psycho-educational, and supportive meetings may be provided for parents and caretakers. Special support groups may be provided for at-risk students who were directly exposed, whose parent was killed, or who are having severe reactions. Absenteeism outreach that is nonpunitive and responsive to students' and parents' concerns helps facilitate students' return to school.

Classroom Interventions

Classroom interventions are conducted as soon after the traumatic incident as possible. Teachers and child mental health professionals may cooperatively facilitate interventions. The objectives of these age-appropriate classroom sessions are to: (1) foster cognitive understanding of the facts surrounding the trauma and to clarify misconceptions; (2) provide an

opportunity to discuss and express thoughts and feelings; (3) identify at-risk students and staff; and (4) plan for a gradual return to normal routines (Gillis, 1993; Klingman, 1993). Intervention methods are drawn from an array of options including group discussion, free or focused drawing, sentence-completion, and story-telling (Young, 1998; Vernberg and Vogel, 1993; Federal Emergency Management Agency, 1991b).

Classroom intervention addresses the level of exposure and trauma experienced by the class and minimizes the potential for restimulating fears and anxieties. Mental health professionals must take care to avoid exposing children who were not directly involved in the trauma to material that could become a basis for subsequent post-traumatic stress reactions. The overarching principle, "first, do no harm," again has relevance.

Long-Term Mental Health Interventions for Children and Adolescents

Goals and Priorities

Children and adolescents who have witnessed and closely experienced an incident

involving mass violence or who have suffered the traumatic death of a loved one can face significant psychological effects and an extended recovery. Pre-existing adjustment or learning difficulties often are exacerbated. The sense of innocence and security associated with childhood may be lost. The normal developmental stages associated with growing up bring predictable challenges, yet the traumatized child's ability to negotiate these challenges is compromised. Family, school, and other networks in the child's world all have important roles in the recovery process. Mental health intervention and treatment address the following five areas:

1. Understanding the child's unique experience of the trauma;
2. Assisting the child in developing strategies to cope with traumatic reminders;
3. Addressing grief and the interplay of traumatization and bereavement;
4. Intervening with post-trauma adversities such as a decline in school performance; and
5. Identifying and redressing missed developmental opportunities and

trauma-based self-attributions and worldview.

(Pynoos et al., 1998)

These various areas and tasks may be addressed in school, group, family, and individual interventions, and through different therapeutic modalities. The following discussion explores both brief counseling and support groups. A multifaceted approach includes thoughtful construction of a "safety net" for the child's welfare. Both the Recommended Readings at the end of the chapter and the Reference List at the end of the manual provide additional resources for mental health professionals. Clearly, specialized training is necessary.

Brief Counseling

The safety, rapport, and trust developed in one-to-one counseling may be necessary for the traumatized and/or bereaved child or adolescent to explore underlying fears, fantasies, distorted perceptions, guilt, shame, and self-blame. Over time, the child may approach the terror, horror, and helplessness that they experienced during the event. As the child develops the ability to identify, understand, and manage feelings, he or she is more able to deal with difficult, painful



memories. The child therapist uses a range of supportive, nonthreatening approaches including art and play therapy, therapeutic games, and psychodrama.

Support Groups

Many children and adolescents benefit from group activities and support. School classes, religious groups, day camps, youth groups, day care centers, and 4-H clubs are often suitable for mental health intervention. These interventions may involve a memorial or commemorative activity, or education about some related aspect of the event, followed by a discussion of reactions, feelings, and coping skills. Through these group interventions, at-risk children may be identified and contact may be made with their families. In addition, ongoing support groups may be offered for highly exposed and traumatized children and adolescents. These groups for at-risk children are more therapeutic in nature and may follow a structured format over 6 to 10 weeks. Groups may be helpful, especially for traumatized adolescents, to allow working through disturbances in peer relationships (Pynoos and Nader, 1993).

Considerations For Immediate And Long-Term Mental Health Intervention with Cultural and Ethnic Groups

The increasing population diversity of the United States and the constant flow of visitors from other parts of the world ensure that survivors of acts of mass violence and terrorism are likely to be culturally, racially, and ethnically diverse. Similarly, survivor's experiences are shaped, in part, by their cultural, ethnic, and racial backgrounds. Different levels of acculturation within a cultural group may result in younger survivors having a more bicultural or dominant culture perspective; older survivors may adhere more to the ways of their countries of origin (Paniagua, 1998). Also, cultural differences between rural and urban survivors, among the various regions of the United States, across differences in educational and socioeconomic levels, among different age groups, and among different religious and nonreligious groups, color how people view the event, mental health intervention, healing, and recovery. Consequently, mental health services,

criminal justice procedures, emergency medical services, and medical examiner's office protocols require culturally sensitive explanation, adaptation, and liaison.

Mental health responders may conduct triage and immediate interventions with survivors who do not speak English, who attribute very different meanings and expectations to traumatization, who express emotions and symptoms in culture-specific ways, and who have divergent notions regarding "mental health," "recovery," and appropriate psychological intervention.

Groups with different cultural customs define "family" in different ways and have different traditions and rituals surrounding death and burial. Mental health providers quickly must become culturally competent with each affected survivor group. Cultural experts, community leaders of the affected cultural groups, elders, and indigenous social service providers can provide valuable insights, training, and consultation for mental health workers. Cultural competence is the responsibility of each mental health responder, program administrator, manager, and supervisor. Competencies include:

- ◆ Valuing diversity, respecting differences,

and seeking to develop and adapt service delivery models to fit cultural groups;

- ◆ Recognizing differences in communication styles, social etiquette, and problem-solving methods;
- ◆ Providing services and information in appropriate languages;
- ◆ Understanding of and respect for different cultural definitions of personal well-being and recovery from traumatic events;
- ◆ Knowing which “accepted” crisis intervention practices fit and which do not;
- ◆ Incorporating the sophisticated and varied cultural pathways to mental health including healing rituals;
- ◆ Using strength-based and empowerment approaches to cultural group survivorship and healing; and
- ◆ Providing extensive and ongoing cultural competence training and supervision of mental health responders.

(U.S. Department of Justice, 2000; Nader et al., 1999; Hernandez and Isaacs, 1998).

Tips for Working with Interpreters

- ✓ Avoid using relatives, children, and friends as interpreters
- ✓ Use certified, qualified interpreters with mental health and trauma training
- ✓ Allow opportunity for interpreter to build rapport with survivor
- ✓ Allow at least twice as much time. Use sequential mode of interpretation (survivor speaks, interpreter interprets what has been said into English, mental health provider speaks, interpreter speaks again)
- ✓ Be aware of the interpreter’s discomfort, avoidance, and biases
- ✓ Interpreters should also receive cultural competence training, if possible
- ✓ Debrief interpreter’s reactions

(Paniagua, 1998; Westermeyer, 1995)

Basic Cultural Sensitivity Checklist

- ✓ Convey respect, good will, nonjudgment, courtesy
- ✓ Ask permission to speak with the person or family
- ✓ Explain role of mental health worker in culturally relevant terms
- ✓ Acknowledge differences in behavior due to culture
- ✓ Respond to concrete needs

(Paniagua, 1998; Young, 1998)

The following description of interventions used after the 1989 mass shooting of school children and staff in Stockton, CA, illustrates cultural competence and a blending of approaches:

With an awareness of cultural beliefs and practices including religious and

medical practices, the school principal invited local clergy including Cambodian and Vietnamese Buddhist monks, a Vietnamese Catholic priest, and Protestant ministers to perform a blessing ceremony upon the school and school grounds. This included the exorcism of



spirits including the bad spirit of the man who killed the children and himself and the spirits of dead children who might grab other children and take them into the next world. Children were given chants to use when frightened; children and adults were given factual information to dispel rumors and unfounded fears.

(Dubrow and Nader, 1999)

Loss of hope, meaning, and perceived control are universal aspects of trauma. The rebuilding of hopes, reconstructing of meaning, and finding a sense of empowerment to regain control are necessary for recovery from trauma and loss (Herman, 1992). Experts propose that there are meaning-making and self-organizing parts within everyone that are particularly active following catastrophic traumatic events. These parts can help survivors construct meaning around horrific events or may lead them to the repetitive rigidity associated with post-traumatic stress disorder (Gusman et al., 1996).

Community-building and empowerment are essential for regaining control and fostering community survivorship. On the individual level, human contact, kindness, listening,

and respect can transcend cultural differences and provide an avenue for survivors to be heard and witnessed regarding their traumatic experiences and losses.

Key Events with Mental Health Implications

Survivors' and family members' psychological responses to mass criminal victimization occur within a context of a number of predictable events, each with inherent mental health implications. These events may be tied to relief, rescue, and recovery efforts; criminal justice proceedings; and cultural and religious rituals for honoring those who were killed. While individuals vary in their reactions to these events, mental health responders can be more effective when they anticipate and prepare for their potential psychological impact. The following discussion focuses on seven key events, potential psychological reactions to them, and possible mental health interventions. Events included in this section are: (1) death notification; (2) ending rescue and recovery operations; (3) applying for death certificates when no identified remains have been found; (4) events involved in

criminal justice proceedings; (5) returning to the crime scene and disaster impacted areas; (6) memorials and funerals; and (7) determination of formulas and methods for distributing Federal, State, employer and charity funds to victims and families. Each occurrence of mass violence or terrorism has unique elements and circumstances with significant mental health consequences. An important component of the mental health response is identifying events with potential mental health implications during the aftermath, determining potential mental health needs, and flexibly and creatively implementing a system for mental health support and intervention.

Death Notification

Mental health professionals may have an immediate support role with bereaved families and loved ones during and after formal death notification. Mental health professionals typically do not deliver information regarding deaths, but may participate on teams with the person(s) responsible for this notification. These teams may include a representative from the medical examiner's office, a funeral director, a health care professional, a chaplain, and a mental health professional (Jordan, 1999). Mental health

professionals provide support to the family receiving the news, mental health consultation, and conducting the notifications when requested.

Including a mental health professional with child specialization on the notification team is advised when families have questions about their children's needs (Sitterle and Gurwitch, 1999). Notifiers can more sensitively provide death notification for families from different cultural and ethnic backgrounds when they are informed about the group's customs regarding the expression of grief and anguish and rituals surrounding death and burial.

The most traumatic moment for many people is notification of a sudden death and can become a focal point for later PTSD (Young, 1998; Lord, 1996). Properly conducted, the notification process can help begin healing. The following guidelines are included in the Mothers Against Drunk Drivers comprehensive curriculum on death notification (Lord, 1996):

- ◆ Obtain critical information before notification. It is important to be able to provide information about how, when, and where the person died, how the identification was made, and where the body is. If possible, learn

about the person(s) to be notified, any medical conditions, and who is included in their support system;

- ◆ Notify the family member of the deceased simply, directly, and in-person. After the persons responsible for notification have identified themselves and are seated, clarify the family members' relationship to the deceased. Using the victim's name, state clearly and without euphemisms that he or she has died. Use warmth and compassion and say, "I'm sorry." Do not take the deceased's personal items to the notification;
- ◆ Expect intense emotional and physical reactions (flight, fight, and freeze). A member of the team should have CPR training and be able to treat shock reactions. Respond non-judgmentally and supportively to all reactions and questions. Avoid leaving the bereaved person alone, but do allow privacy for grief reactions;
- ◆ Provide practical assistance. The bereaved person may need assistance making arrangements to be transported to identify or

view the body. They may need help making phone calls to arrange for transportation, child care, or to contact relatives or their employer; and

- ◆ Help the family decide about viewing the body or photographs. Ensure that the bereaved person is informed and prepared regarding what they will see and the condition of the body. For many, it is very important to see the remains of their loved one. A lesson learned from the Oklahoma City bombing is that many families ended up regretting not viewing their loved one's remains. They had been discouraged from doing so because of the degree of mutilation (Office for Victims of Crime, 2000; Jordan, 1999). For others, viewing the body may be seen as inappropriate for cultural or religious reasons. Family members should be supported in making informed choices and encouraged to have accompaniment and support.

Mental health professionals may provide training for notifiers on how best to support those receiving the devastating information. Families may prefer to have privacy after receiving the

notification or they may desire continued support from the mental health professional. The Mother's Against Drunk Drivers resource materials provide additional guidance regarding delivering sensitive death notification (Lord, 1996).

Ending Rescue and Recovery Operations

Waiting for official notification that a loved one was killed violently is excruciating. Family members must depend on rescue workers and passively wait, while the site of impact is typically secured by local law enforcement and, in some cases, military units. Families hold out hope that their loved one was spared and many protect themselves from the anguish associated with the reality of their loved one's death through denial. Often, it is not until the body is recovered and official death notification received, that the death is accepted and grieving may begin.

The psychological impact for affected families is profound and intense when a recovery operation ends before all bodies have been recovered. Some feel the physical body and person they loved is being abandoned. They are left in a state of limbo, unable to accept the reality of the death and to engage in rituals to acknowledge the ending of their loved one's life. For some

cultural groups, failure to provide a proper burial has far-reaching meanings.

Officials responsible for deciding when to end body recovery operations may consult with mental health professionals regarding how to sensitively communicate this to families. It is critically important that families receive this information directly from the proper authorities and not through the media. Typically, families focus on several questions, "Is there a chance anyone is still alive?" "What is the condition of the bodies?" "How much did my loved one suffer?" and "Will all the bodies be recovered?" Officials should be truthful, straightforward, and precise. They should provide loved ones with the facts so that they may better understand why certain decisions are being made (Cummock, 1996).

Applying for Death Certificates When No Identified Remains Have Been Found

An official death certificate is required for beneficiaries to receive life insurance benefits, Social Security benefits, Federal and State victims compensation, death benefits from State and Federal Workers Compensation, and death benefits from the Public Safety Officers Benefit Program. Three weeks after

the September 11 attacks on the World Trade Center, families could begin the procedures for obtaining death certificates at the Family Assistance Center.

Government officials recognized that remains, if they were ever found, would not be identified for months, which could threaten many families' financial stability because they would not be able to access death benefits.

Families with limited savings and resources needed to address their financial needs quickly. Families needed to complete legal procedures and provide documentation to obtain a death certificate so that they could receive funds and benefits payable upon death. Some experienced this step as abandoning hope and betraying their commitment to their loved one. Bereaved family members had to act more accepting of the death than they truly felt.

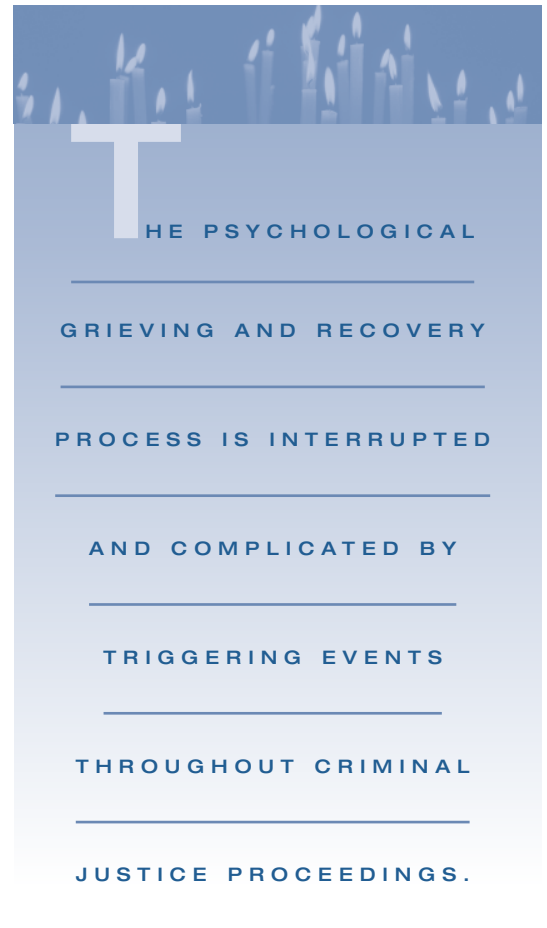
Mental health professionals can assist families as they struggle with the dilemmas posed by the decision to apply for a death certificate. Mental health workers can accompany families as they meet with attorneys, provide documentation, and complete forms. They can offer alternative perspectives when families view obtaining the death

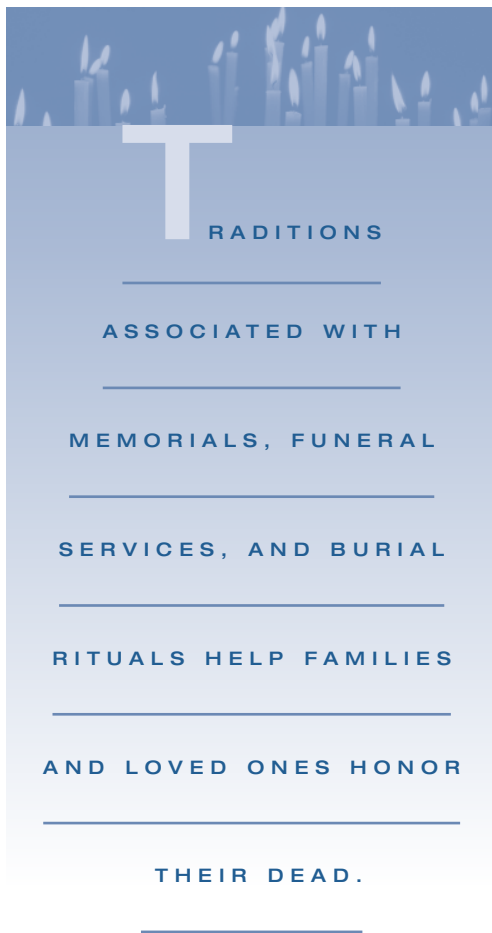
certificate as a betrayal or acceptance of the death. In some cases, mental health professionals can explore other financial options with those who are unable to begin the process of obtaining a death certificate.

Events Involved in Criminal Justice Proceedings

The psychological grieving and recovery process is interrupted and complicated by triggering events throughout criminal justice proceedings. Survivors, loved ones, and the community demand that justice be served. Some sense of resolution is often linked to trial outcomes. However, for many, the devastating consequences of the evil acts of the perpetrators are never adequately or justly redressed through the criminal justice system. When the alleged perpetrator(s) are not identified or arrested, survivors and victims' families must live with the knowledge that the perpetrators are alive and at large.

Survivors are thrown into an unfamiliar and disorienting criminal justice system. Criminal justice procedures may not appear to make sense and can seem removed from the attainment of justice. Crime victim assistance providers, law enforcement personnel, prosecutors' offices,





and mental health providers work together to ensure that survivors have:

- ◆ Information about the investigation, the criminal justice system, and upcoming proceedings and status updates;
- ◆ Psychological support that anticipates and responds to the impact of key events in proceedings; and
- ◆ Opportunities to make informed decisions regarding participation in the criminal justice process.

Key events with mental health implications during the criminal justice process include the investigation, lack of arrests, prosecution, court delays, sentencing, and possible post-disposition events such as an appeal, parole hearing, escape from prison, a request for clemency or pardon, and an execution (U.S. Department of Justice, 2000).

Returning to the Crime Scene and Disaster-Impacted Areas

The first time survivors return to or view the scene of mass violence can be extremely upsetting, if not overwhelming. Many view the impact zone as sacred ground and expect the

area to be treated with respect and reverence. Visiting the actual location of the event can trigger a range of intense reactions. When property destruction is widespread, witnesses can view the physical damage as visible evidence of their personal losses. When physical damage has been repaired and cleaned up quickly, those most closely affected may find that everything “looks the same,” when nothing for them is the same.

Residents returning to homes or apartments where mass trauma took place may have lost their sense of home as a safe haven. Their neighborhood may sound and look like a “combat zone” with sirens, police-enforced checkpoints, and a massive rescue and recovery operation underway. Views out of windows may be permanently altered. When buildings are deemed to be sufficiently safe, residents may be allowed to return to their homes for 15 to 30 minutes to retrieve important items and check on pets who may have been trapped. Law enforcement typically controls this process and maintains security at the buildings. Mental health providers may talk with residents as they wait for entry, providing support for concerns about valued

possessions and pets or helping with housing issues.

Employees may be returning to their place of employment or students to a school where the mass violence or terrorist attack took place. Frequently, survivors experience previously unexpressed traumatic reactions, such as a profound upwelling of grief. They may feel unsafe, insecure, and unable to concentrate on their duties. Mental health professionals may provide consultation to employers and school administrators on re-entry activities, mental health interventions, and reasonable expectations of job or school performance.

Mental health professionals may assist those returning to or viewing impact sites by describing what they will see, hear, and smell, and by informing families and victims about what they will be allowed to do at the site. Mental health professionals may help families and victims anticipate and prepare for their reactions. As family members were transported by ferry to Ground Zero, the site of the World Trade Center attacks, mental health and spiritual care providers offered gentle, nonintrusive support. Before boarding the ferry, a representative from the Police Department briefed families. Mental health workers

provided note cards and pens for loved ones to write messages to leave at the site. As family members walked from the ferry to the site, recovery workers stopped working, took off their hard hats, and silently paid respect to the grieving families. Some family members were overcome by their physical and emotional reactions, and required emergency medical attention. Many families requested chaplains to assist with honoring their deceased loved ones. Mental health professionals solved the immediate concerns and needs of the families and maintained a nonintrusive, supportive presence.

Memorials and Funerals

A site for memorializing often spontaneously appears within hours of a mass tragedy. Community members bring flowers, photographs, mementos, and messages. The site, often close to the location where the violence occurred, becomes a place for remembering, honoring, grieving, and giving and receiving support. Following the September 11 terrorist attacks on the World Trade Center, families and friends posted photographs of missing loved ones in the hope they would be found alive. Thousands of photographs of people on vacation, with their

families, at weddings, at work, graduating from college, or playing sports were posted on walls in public areas in New York City. Gradually these pictures, capturing so much life and vibrancy, became a memorial of tragic loss.

Mental health professionals may assist government officials or emergency managers to consider appropriate and protected locations for memorials. Logistical issues often need to be addressed following a large-scale, mass-casualty tragedy. At memorial sites, mental health professionals may be available for support. At the same time, mental health professionals should allow and support the natural human processes that take place and not intrude on mourners' private moments.

Traditions associated with memorials, funeral services, and burial rituals help families and loved ones honor their dead. When the family has not received physical remains, funeral directors, mental health professionals, and faith-based counselors may assist the family in defining meaningful rituals and symbolic gestures to both acknowledge the death and commemorate the life of the victim. Funerals are typically private. Mental health providers should attend only

as participants unless they have specifically been requested to serve a different function.

Determination of Formulas And Methods for Distributing Federal, State, Employer, and Charity Funds to Victims and Families

Mass violence and terrorist attacks against U.S. citizens can cause the desire to help those victimized. This desire translates into sizable donations of money, goods, and services that need to be managed and appropriately distributed. Charities, employers, and a number of Federal and State programs have funds for providing assistance and benefits to victims and families. Congress established the Federal Victims Compensation Fund following the September 11 terrorist attacks. Victims and families of those killed could apply for compensation for physical injuries, lost wages, lost future earnings, and pain and suffering resulting from the attacks.

Challenging issues surrounding eligibility criteria, definitions of “family” and “spouse,” citizenship status, disability compensation, treatment of high vs. low-income individuals, deduction of other Federal benefits, differential benefits for emergency

services or military personnel, and fairness and equity can result in divisive conflicts between victim groups, government officials, elected officials, and fund administrators. In addition, those victimized by previous terrorist attacks both inside and outside of the United States may feel that their needs were ignored in the face of current, larger compensation levels. Similarly, subsequent victims may feel that prior victims were treated more generously.

Interventions With the Community

Violent acts that victimize a group of people harm not only individuals but also the community. Before the tragedy, the community may have thought that “this sort of thing doesn’t happen here.” The community’s collective assumption pertaining to safety and the ability to protect its citizens from criminal attack are shattered. The reality that any community is vulnerable to random acts of mass violence and terrorism penetrates a sense of security, the fabric of the social order. In communities with high rates of violent crime and prior mass violence, the current incident involving mass victimization reinforces the perception that the community’s systems for

ensuring public safety are ineffective and, in some instances, that the community must be attracting violence. In each scenario, the community’s perceived capacity to protect and care for its members has been damaged. Community-based healing activities and rituals may reinforce community strengths and promote community recovery.

Memorials, Rituals, and Commemorations

For many survivors, bereaved families, and affected community members, rituals and symbolic gestures provide a way to acknowledge the tragedy, experience emotions, reaffirm life, honor “goodness” in the community, grieve what has been lost, communicate messages of hope and remembrance, and join with others (Sitterle and Gurwitch, 1999; Flynn, 1995; Rando, 1993). Symbolic activities may connect people with each other and to the past and the future, as well as to a power or spirit beyond the human realm. Rituals may be personal such as privately reading a letter to a deceased loved one at a cemetery, or community-wide such as reading the names of those killed while lighting a candle for each person or honoring victims by installing a symbolic work of art or planting a tree at a public ceremony. Effective

community memorial and commemorative events transcend political, religious, class, and cultural differences and provide an opportunity for all to come together. When these differences have played a role in the event's impact or the community's recovery, such as with racially motivated or hate-based crimes, community leaders need to foster understanding, tolerance, and forgiveness across groups through public ceremonies.

Mental health professionals may function in a consulting role and should not be over-directive in planning these ceremonies. Survivor and community ownership of an event enhances the significance for those the event is intended to help. Mental health consultants may suggest strategies to include children or other special survivor groups. They may alert planners to the potential for misunderstandings or alienation of survivors or groups through the use of particular language or symbolic activities. Mental health professionals may attend these community gatherings to provide psychological support as needed and requested.

The six-month and one-year anniversaries of a traumatic event trigger many reactions in

survivors. The anniversary can be a time of remembering and acknowledging losses and the people who were killed along with celebrating human resilience, kindness, and the courage to continue (Center for Mental Health Services, 1994). Community and religious leaders may provide messages of hope, tolerance, and healing. Commemorative plaques, trees, art projects, pins, or dedications may be incorporated. Group activities such as singing, participating in a period of silence, or sharing food together may contribute to community building.

Typically, criminal justice proceedings have not concluded when the one-year anniversary occurs. When investigations or criminal justice proceedings are ongoing, planners must clarify the purposes and focus for the one-year anniversary, as distinct from the determination of cause or the achieving of justice. Consultation with and participation of community members and representatives from all affected community groups ensure that commemorative events have meaning for all community survivors.

Usual Community Gatherings

Most communities have an annual schedule of events that may include holiday commem-



orations, fairs, parades, and festivals. Similarly, schools have activities throughout the academic year such as homecoming weekend, plays, musical performances, and proms. Religious groups also mark the year with ceremonies and symbolic rituals. Each cultural group has gatherings with meanings tied to central beliefs and long-held traditions. Communities have found that a sense of continuity and strength can be provided through familiar events, especially when they are combined with an appropriate acknowledgment of the community tragedy.

Continuing familiar gatherings promotes hope and the sense that the community can overcome harm and eventually recover. Decisions to cancel or postpone these events must be made carefully, as they can provide valuable opportunities for social support and healing.

Mental health professionals may assist community leaders in deciding whether to hold a celebratory event in the wake of a tragedy, considering the potential for minimizing the enormity of people's losses. Mental health consultants may suggest ways to adapt the event so that it both honors the losses sustained by the community and provides a venue for members to come together. Community and

religious leaders often play a significant role and may provide comfort, inspiration, and perspective to their constituents in attendance.

Symbolic Gestures

Symbols and rituals can have profound significance for people who wish to communicate gratitude and good will or who are searching to find meaning, courage, and hope. Even simple gestures can become powerful conveyors of compassion and condolence. In Oklahoma City, following the bombing of the Federal Building in 1995, a brown teddy bear linked rescue and recovery workers inside the perimeter and the community members standing vigil outside the chain-link fence surrounding the secured bombing site. Each day, the bear was hugged by community members outside and then carried inside and hugged by workers:

The bear became a link between those inside who were involved in some of the most difficult work imaginable and those who stood vigil outside wanting so much to help. It was the *bearer* or their connection, their affection, their hope...such a simple, but moving, way to connect people necessarily separated by role, steel, and

troops, yet connected by their common hopes and persistence.

(Flynn, 1995)

Similarly, many families waiting for the recovery of their loved ones' bodies and formal notification of their deaths expressed appreciation of the recovery workers through gifts of yellow ribbons held by guardian angel pins:

The purpose of the ribbons was to recognize workers' valor and courage, to provide guidance and support, and to symbolize care and concern for workers' safety and welfare during the dangerous search for bodies. The firefighters were grateful and, in fact, insisted on wearing the ribbons before entering the bombing site.

(Sitterle and Gurwitch, 1999)

Mental health responders often are awed by the comforting and healing power of symbolism and rituals. Frequently, the best of the human spirit is communicated in the simplest manner. Mental health workers may assist affected groups in developing rituals or provide assistance with the logistics necessary to carry out their ideas. The power of the symbolic gestures come from survivors' hearts and minds. Mental health responders need to take care

TABLE 3 : REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1 - 5	<ul style="list-style-type: none"> • Clinging to parents or familiar adults • Helplessness and passive behavior • Resumption of bed wetting or thumb sucking • Fears of the dark • Avoidance of sleeping alone • Increased crying 	<ul style="list-style-type: none"> • Loss of appetite • Stomach aches • Nausea • Sleep problems, nightmares • Speech difficulties • Tics 	<ul style="list-style-type: none"> • Anxiety • Generalized fear • Irritability • Angry outbursts • Sadness • Withdrawal 	<ul style="list-style-type: none"> • 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 (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

Continued on next page

not to interfere in this important process.

Summary Table

Table 3 summarizes information provided in Chapters II and III. Trauma reactions are divided by age with intervention options applicable to each age group. These practical suggestions are appropriate for all human service workers, disaster relief workers, crime victim assistance providers, and mental health responders. All workers are advised to exercise caution when intervening in ways that might penetrate victims' self-protective coping. With immediate response interventions, being supportive and fostering safety and security are priorities.

T A B L E 3 : R E A C T I O N S T O T R A U M A A N D S U G G E S T I O N S F O R I N T E R V E N T I O N

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
6 - 11	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Change in appetite • Headaches • Stomach aches • Sleep disturbances, nightmares • Somatic complaints 	<ul style="list-style-type: none"> • Fear of feelings • Withdrawal from friends, familiar activities • Reminders triggering fears • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self blame • Guilt 	<ul style="list-style-type: none"> • 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
12 - 18	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Appetite changes • Headaches • Gastrointestinal problems • Skin eruptions • Complaints of vague aches and pains • Sleep disorders 	<ul style="list-style-type: none"> • Loss of interest in peer social activities, hobbies, recreation • 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 	<ul style="list-style-type: none"> • Give additional attention and consideration • Relax expectations of performance at home and school 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 activities and school events • Develop school programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens

Continued on next page

TABLE 3 : REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
Adults	<ul style="list-style-type: none"> • Sleep problems • Avoidance of reminders • Excessive activity level • Protectiveness toward loved ones • Crying easily • Angry outbursts • Increased conflicts with family • Hyper-vigilance • Isolation, withdrawal, shutting down 	<ul style="list-style-type: none"> • Nausea • Headaches • Fatigue, exhaustion • Gastrointestinal distress • Appetite change • Somatic complaints • Worsening of chronic conditions 	<ul style="list-style-type: none"> • Shock, disorientation, and numbness • Depression, sadness • Grief • Irritability, anger • Anxiety, fear • Despair, hopelessness • Guilt, self-doubt • Mood swings 	<ul style="list-style-type: none"> • Protect, direct, and connect • Ensure access to emergency medical services • Provide supportive listening and opportunity to talk about experience and losses • Provide frequent rescue and recovery updates and resources for questions • Assist with prioritizing and problem-solving • Assist family to facilitate communication and effective functioning • Provide information on traumatic stress and coping, children’s reactions, and tips for families • Provide information on criminal justice procedures, roles of primary responder groups • Provide crime victim services • Assess and refer when indicated • Provide information on referral resources
Older Adults	<ul style="list-style-type: none"> • Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems 	<ul style="list-style-type: none"> • Worsening of chronic illnesses • Sleep disorders • Memory problems • Somatic symptoms • More susceptible to hypo and hyperthermia • Physical and sensory limitations (sight, hearing) interfere with recovery 	<ul style="list-style-type: none"> • Depression • Despair about losses • Apathy • Confusion, disorientation • Suspicion • Agitation, anger • Fears of institutionalization • Anxiety with unfamiliar surroundings • Embarrassment about receiving “hand outs” 	<ul style="list-style-type: none"> • Provide strong and persistent verbal reassurance • Provide orienting information • Ensure 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 experience, losses, and expression of emotions • Provide crime victim assistance

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C H A P T E R I V

ORGANIZATIONAL PREPARATION AND RESPONSE TO MASS VIOLENCE AND TERRORISM AND THE MENTAL HEALTH ROLE

Following a mass casualty criminal incident, emergency response priorities involve saving lives, protecting the safety of first responders, securing the crime scene, and initiating investigation activities. The mental health response must not interfere with these priorities. Mental health providers often are unfamiliar with the unique demands associated with responding to criminal mass victimization.

In particular, mental health responders must be oriented to three critical aspects of emergency operations: (1) the incident command structure and the position and function of mental health in that structure; (2) first responder immediate response priorities following a mass casualty incident; and (3) the role and boundaries of the mental health response in an ongoing criminal investigation.

Preplanning, training on response protocols, and pre-establishing relationships and channels of communication are essential for effective integration of mental health services into the overall emergency response.

States vary in their levels of emergency mental health preparedness. States are working toward clearly defined and practiced plans that involve coordination between the Department of

Emergency Management (DEM), the Department of Mental Health (DMH), law enforcement agencies, and the crime victim assistance and compensation agency at the State level. They also are coordinating with the necessary county and local mental health response plans and cadres of trained providers. This degree of planning and preparedness requires a high level of commitment, funding, a State mandate, and repeated training and drills. This process helps ensure that appropriately trained mental health providers are available to respond and provide mutual aid of mental health services following community crises.

The community's emergency response must be carried out in a protocol-driven and efficient manner. This saves lives. Mental health responders must understand that they are part of the larger organizational structure. During the emergency response phase, mental health workers have a support role and operate in settings and circumstances controlled by other entities.

Emergency Operations

The scope, complexity, and nature of an incident determine the level of

emergency response. The local jurisdiction responds initially, but large-scale mass casualty incidents often require a multi-county response, a State response, or a Federal response. Many communities use the Incident Command System (ICS) structure or a locally determined variation to organize and manage the emergency response. The ICS is a standardized approach for commanding, controlling, and coordinating the response to all types and sizes of emergency incidents.

An effective ICS structure includes common terminology, integrated communication, a top-down organizational structure, and comprehensive resource management. This standardization helps expand the incident response when the demands of the emergency situation exceed available resources. Figure 3, the first organizational chart, illustrates the ICS. Figure 4 shows the ICS with a Unified Command (UC) with police, fire, and Emergency Medical Services (EMS) in charge. A mass casualty incident would necessitate this type of structure (Federal Emergency Management Agency, 1998).

The Incident Commander, the first senior emergency responder to arrive at the scene, is responsible for protecting life and property

and implementing the response plan. The Incident Commander is accountable for both first responder and public safety. Command can be transferred as an incident becomes more complex and as the responsible agency jurisdiction changes. Authority may shift as the cause of the incident becomes clearer. For example, the local fire chief may respond to an explosion and be the Incident Commander.

At the local level, the Police and Sheriff's departments, Emergency Medical Services (EMS), Urban Search and Rescue, the Fire Department, the Medical Examiner's Office, the Department of Emergency Management, and the American Red Cross may have high-profile roles (Federal Emergency Management Agency, 1998). If an incident is human-caused, jurisdiction may shift or expand to include State law enforcement. If it is determined to be an act of terrorism, authority shifts to the Federal Bureau of Investigation (FBI) (United States Government, 2001). The FBI has a law enforcement function and oversees technical activities such as forensics, intelligence, negotiations, and the investigation.

As shown in Figures 3 and 4, four functional components support incident management:

FIGURE 3: INCIDENT COMMAND SYSTEM (ICS) ORGANIZATIONAL COMPONENTS

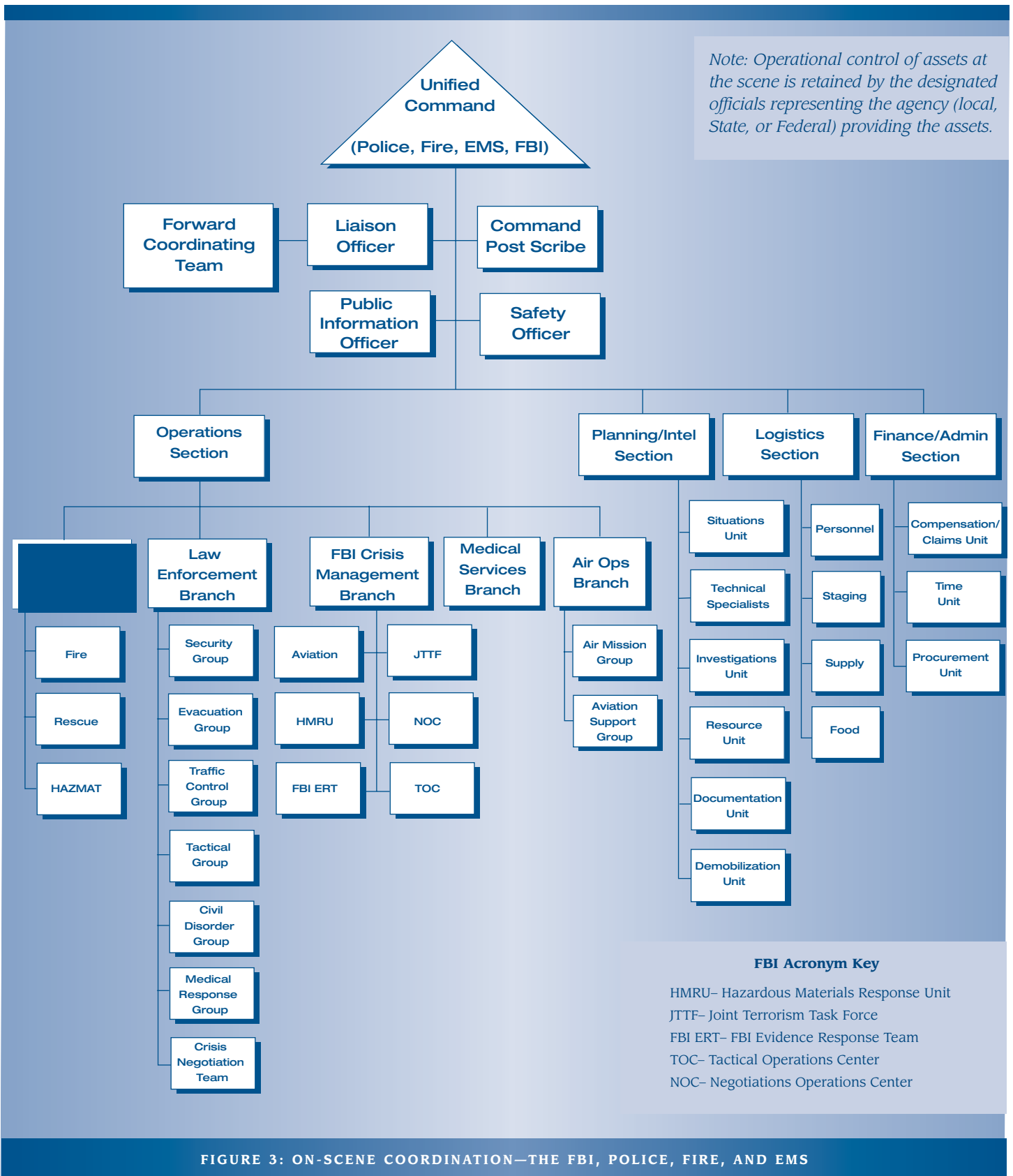
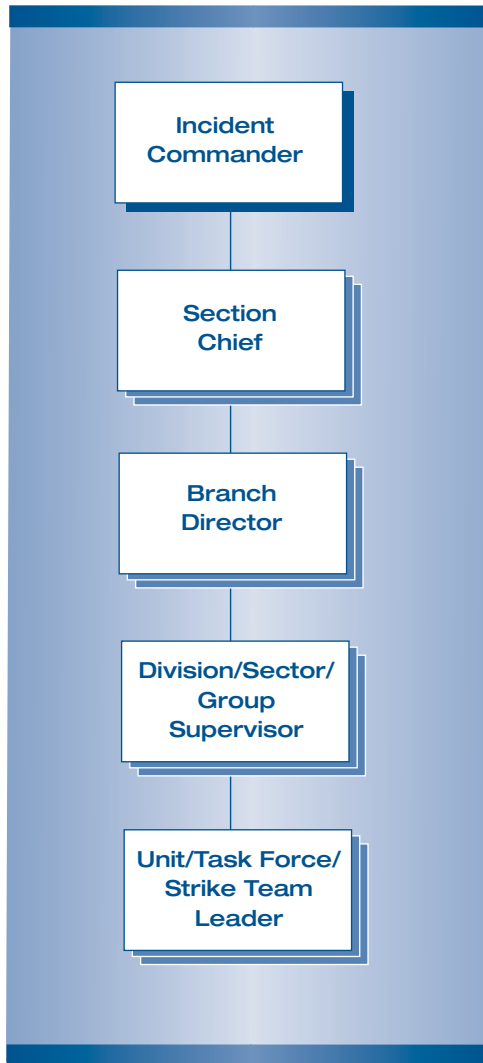


FIGURE 3: ON-SCENE COORDINATION—THE FBI, POLICE, FIRE, AND EMS

United States Government (2001), Interagency Domestic Terrorism Concept of Operations Plan

FIGURE 4:
ICS UNIFIED COMMAND



planning, operations, logistics, and finance/administration. These components are the foundation upon which the ICS is built and apply to routine emergencies as well as to mass casualty incidents. The ICS operates at an Incident Command Post located near the site of the incident. The Operations Section Chief or Logistics Section Chief may request mental health services, and chaplaincy services for

emergency responders at the staging area, a respite area, or as they end shifts. Mental health services may be requested for families and loved ones gathering near the disaster impact zone, which is also a crime scene. Initially, when crisis mental health response plans are not in place, these services usually are provided by mental health professionals, or chaplains affiliated with the local Fire and Police Departments. In States prepared with an integrated crisis mental health plan, providers from the local mental health agency may respond to the scene. In the future, “crisis mental health” or “victim services” may become a recognized and established

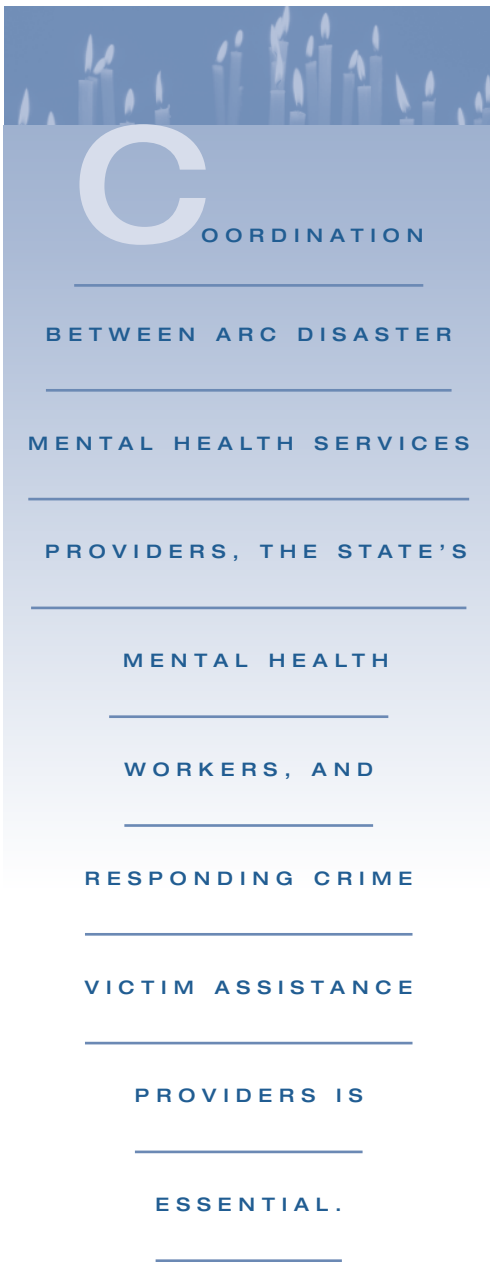
component within the Operations Section of the ICS for incidents involving criminal mass victimization (B. Hammond, personal communication, 7/30/01).

Crisis Mental Health Response

The Incident Commander is responsible for the on-scene response. When there are

multiple sites of impact or a need for a more community-wide response, an Emergency Operations Center (EOC) typically is set up by the local or State Department of Emergency Management (DEM). The EOC is where department heads, government officials, and volunteer agencies gather to coordinate the larger community response. The Incident Commander establishes and maintains liaisons with primary responding agencies and organizations, including the EOC. At the EOC, the public health or human services functions have jurisdiction over mental health services for the public. The DMH may be requested to manage the delivery of mental health services at particular sites. Depending on the State’s level of preparedness, the DMH may or may not be able to respond to the request.

Voluntary agencies such as the American Red Cross (ARC) are often represented at the EOC. The ARC usually has responsibility for mass care, including feeding and sheltering victims. The ARC disaster mental health function is activated following mass casualty incidents. ARC disaster mental health services (DMHS) personnel quickly arrive on-scene to provide mental health support for victims and family members and to provide stress



management services for other ARC staff and volunteers. Local mental health providers initially may volunteer through ARC or provide services under other auspices. Coordination between ARC disaster mental health services providers, the State's mental health workers, and responding crime victim assistance providers is essential.

An excerpt from the Federal Emergency Management Agency (FEMA) After Action Report from the Oklahoma City bombing demonstrates this collaboration and partnering:

The American Red Cross (ARC), which is responsible for immediate protective measures for disaster victims, worked in concert with local clergy and other support groups to establish the Family Notification Center, also known as the Compassion Center. For two weeks, 250 mental health professionals volunteered their expertise in support of the shocked and grief-stricken community. The center provided victim information, crisis counseling, and resource information at one location to better assist victims' families and friends.

(Federal Emergency Management Agency, 1995)

Similarly, in New York City following the September 11 terrorist attacks, the Mayor's Office established the Family Assistance Center for families of victims, survivors, and others affected by the attacks. Numerous Federal, State, and city agencies; insurance companies; legal assistance resources; World Trade Center companies; and voluntary agencies were represented.

Mental health, crime victims services, therapeutic child care, translation services, spiritual care, and disaster psychiatry services were available. Hundreds of providers worked under the auspices of the State Office of Mental Health, ARC, the State Crime Victims Compensation Board, local crime victim assistance programs, and Disaster Psychiatry Outreach. All providers had special identification (ID) for access to the Family Assistance Center.

Managing the outpouring of volunteers wanting to provide mental health support has become a challenge following recent mass casualty incidents (Center for Mental Health Services, 2000b). When local planning and preparatory mental health training have not taken place, the genuine need for mental health services will remain unmet

until these mental health volunteers are screened, oriented, and integrated into the emergency response. Systems must quickly be established to: track mental health provider contact information, availability, relevant professional experience, and areas of specialization; check credentials; schedule; and provide ID badges. No individual should be allowed to provide mental health services without proper identification, authorization, and orientation. To avoid the need to develop and implement systems under emergency conditions, communities are advised to develop systems before a disaster occurs.

In many parts of the country, the immediate mental health response often occurs in a crisis-driven manner, drawing from resources that happen to be available or from invited “experts” who are flown in for several days or weeks. The ARC may bring in hundreds of trained disaster mental health volunteers over a period of weeks or months, but eventually the local mental health system assumes responsibility for mental health services.

Key Considerations For Mental Health Providers Responding to Criminal Mass Violence

Mental health providers must be knowledgeable about the issues unique to responding to a mass criminal event. Emergency responders face unfamiliar circumstances, uncertainty about what might happen next, and lack of precedence on how best to respond. Operational decisions with far-reaching consequences must be made rapidly and often with partial information. Mental health workers need to recognize the larger context and conscientiously follow guidelines set forth by the mental health response manager and the Incident Commander. The following parameters provide further guidance for mental health responders:

- ◆ ***The Incident Commander is in charge and directs when and where mental health services are provided.*** The mental health response is subordinate to the emergency response, the goals of law enforcement, and the criminal investi-

gation process. Mental health responders provide emotional support, stabilization, and assistance as directed by the Incident Commander. In most instances, victims and witnesses initially are interviewed by investigators before they can speak with mental health providers. Frequently, mental health providers are first assigned to work with worried and frantic loved ones at the crime scene;

- ◆ ***Securing and protecting the crime scene are law enforcement priorities.*** The scene of the incident automatically becomes a crime scene and the focus of a criminal investigation. Anything contained within this “crime scene” area may be evidence. Evidence must not be disturbed before it has been documented and collected, thus necessitating tight security and control by law enforcement officials (e.g., the FBI, National Guard, local police officers). Unauthorized passage through a secured area could jeopardize the safety of emergency workers and mental health workers.

Mental health responders and victims’ loved ones do

not have access to the crime scene and are frequently directed to a nearby site. This may cause distress for family members who want to help locate and rescue their loved ones. Mental health responders may be asked to help distraught family members at a gathering site or hospital. Mental health workers must remain within the geographic boundaries of their assignments and have appropriate identification and legitimate assignments for access to protected areas;

- ◆ **Information regarding the status of victims is released by designated government officials through sanctioned channels.** Through the course of coordinating with emergency responders, law enforcement, or the Incident Commander, mental health providers may learn the status of individual victims—whether they were killed, injured, or missing. Families are desperate for this information. However, it is outside of the mental health responder's role to deliver this information to families, the media, or anyone else before it has been officially verified and

formally provided. This can be a challenging and stressful position for mental health providers (R. Benedetto, D.P.A., personal communication, 7/31/01). In fact, mental health providers may choose to avoid seeking this information before official family notification or only receive it as a part of briefing for their immediate support role with a particular family;

- ◆ **Mental health providers must work within established protocols for dealing with the media to protect survivors and families.** Catastrophic mass casualty disasters attract considerable media attention. Typically, reporters seek interviews with victims and those most seriously affected. They may approach mental health providers to gain access to victims. Mental health responders should not act as agents for the media, and recruit or coach victims. Also, mental health providers should avoid describing how first responders, victims, and family members are reacting when giving media interviews, which can give the appearance of a violation of confidentiality and might undermine the

credibility of mental health efforts. The mental health response manager coordinates with the Incident Commander to clarify protocols and to ensure that adequate security and protection from the media is provided for survivors and bereaved family members.

In addition, the mental health response manager works with the ICS Public Information Officer to ensure appropriate mental health information is provided to the public. Using the media to disseminate helpful mental health information is a valuable way to reach large numbers of people. Under no circumstances should mental health responders provide information to the media without prior authorization sanctioned by the agency or organization of which they are a part; and

- ◆ **Conflicts may arise between law enforcement's search for information relevant to the criminal investigation and the prosecutorial process and mental health's protection of client confidentiality.** Pre-incident planning, coordination, communication, and cross-training between law enforcement and mental health

providers can alleviate turf battles regarding roles and boundaries (B. Hammond, personal communication, 7/30/01). Teamwork and cooperation are fostered through a respectful understanding of each group's responsibilities and obligations. Mental health providers are not trained to be detectives or to know what information is relevant to the investigation process, yet they may counsel witnesses or suspects. They have a legal and ethical duty to protect the privacy of those with whom they speak. Mental health goals are to stabilize survivors' emotional reactivity and to facilitate appropriate coping, which also may enable survivors and family members to participate more helpfully in the investigative process.

Mental health providers should consult first with their clinical supervisor or the mental health response manager with questions regarding whether information gained through a counseling contact has relevance to the criminal investigation (R. Benedetto, D.P.A., personal communication, 7/31/01). A determination may be made for the worker to maintain confidentiality and to trust that the criminal investigative process

will uncover the information, or the mental health response manager may consult with the agency's legal counsel or the State's attorney. Ideally, the mental health response manager and the Incident Commander have a cooperative alliance for sorting out these inevitable challenging dilemmas.

Crisis Mental Health Response: Future Directions

Every community should have a Crisis Mental Health Plan as part of its overall Emergency Operations Plan. Local mental health providers are pretrained and their job descriptions include responding to the psychological needs of first responders and community members during and after community crises. Crisis mental health responders may be drawn from community mental health centers, crime victim assistance programs, faith-based counseling agencies, and social service agencies that serve special populations. While involving mental health professionals as volunteer responders adds depth to human resources, the community's crisis mental health plan should not rely on volunteers only. Management and supervision positions, in particular, should be filled by



individuals whose job descriptions include these responsibilities. In addition, responders should be prepared to step into the community's ICS and EOC structures and have prior relationships with the key players.

The crisis mental health plan fits more effectively into the overall emergency response when the ICS management structure is used. An On-Site Commander functions as the mental health response manager and stays at the Incident Command Post or the EOC, coordinates with other responding entities, receives information from the field, and manages and directs the mental health response and resources. A Personnel Coordinator must be activated quickly to facilitate callout and deployment of mental health personnel. Depending on the magnitude of the incident and the degree of mental health preparedness of the community, the response structure may range from paralleling the ICS to providing limited mental health support at designated sites. At a minimum, each site should have a Coordinator, and every five mental health responders should have a Lead. The City of Austin Mental Health Crisis and Disaster Plan provides an example of a plan that utilizes the ICS structure and is integrated into the local

emergency response and the crime victim services agency (see Recommended Reading at end of this chapter). While specific descriptions of comprehensive crisis mental health plans are beyond the scope of this manual, the following components generally are addressed:

- ◆ Training and guidelines for crisis mental health interventions;
- ◆ Descriptions of assignment settings and mental health roles;
- ◆ Callout, deployment, human resource management;
- ◆ Certification and badging for responders;
- ◆ ICS and EOC structure, responsibilities, and the role of mental health;
- ◆ Mental health response management, supervision, and line-staff roles and responsibilities defined;
- ◆ Services to special populations, use of interpreters, guidelines, and resources;
- ◆ Communications, transportation, supplies, and logistics;
- ◆ Public information and dealing with the media;
- ◆ Mutual aid agreements; and
- ◆ Mental health staff stress management.

Every State Mental Health Authority (SMHA) should have a federally funded full-time position for disaster mental health planning and response and a State disaster mental health plan (Center for Mental Health Services, 2000b; American Psychological Association Task Force, 1997). The State disaster mental health coordinators' responsibilities typically include: (1) ensuring that all counties have plans and participate in drills; (2) providing repeat training on disaster mental health for all counties; (3) maintaining a resource bank of post-disaster psycho-educational materials; (4) maintaining cooperative relationships with State, Federal, and voluntary agencies involved in emergency and disaster response; and (5) helping counties obtain Federal grants for post-disaster mental health services.

Long-Term Mental Health And Crime Victim Assistance Services

The Office for Victims of Crime (OVC) has authority to provide assistance to victims of acts of terrorism or mass violence. Since victims of terrorism and mass violence experience a

range of physical, financial, emotional, and legal needs that may persist over an extended period of time (Office for Victims of Crime, 2000), Federal funding that supplements existing State resources is available. OVC assistance includes funding for counseling, community needs assessment, crime victim services, and technical assistance and training. State crime victim compensation programs reimburse crime victims or their families for out-of-pocket expenses such as medical expenses, mental health counseling, funeral and burial costs, and lost wages related to their victimization. State and local victim service agencies provide assistance to victims of Federal and State crimes such as criminal justice advocacy, temporary shelter, and crisis counseling (U.S. Department of Justice, 2001). Eligibility and benefits vary from State to State, and may change with the particular terrorist or mass violence event, so mental health providers and others working with victims should learn about Federal and State eligibility requirements. OVC coordinates with local and State programs to maximize services for victims. For information about OVC grant programs, see the OVC Resource Center Web site at www.ncjrs.org or call 1-800-851-3420.

Recommended Reading

American Psychological Association Task Force. (1997). *The Task Force on the Mental Health Response to the Oklahoma City Bombing: Implications for Future Mass Casualty and Terrorist Incidents*. Prepared for the American Psychological Association.

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CHAPTER V

STRESS PREVENTION, MANAGEMENT, AND INTERVENTION

When mental health professionals, crime victim assistance counselors, and other responder groups come forward to assist survivors following mass violence and terrorism, they experience the rewards associated with meaningful service and cope with a range of challenging stressors. The devastating losses, deaths and injuries, destruction of property, and emotional pain of survivors and bereaved loved ones can touch providers in powerful and personal ways. The emergency response working environment can involve physical hardship, unclear roles and responsibilities, limited resources, rapidly changing priorities, intrusive media attention, and long work hours. When an ongoing threat of future attacks or potential exposure to biohazards exist, workers cope with risks and threats to their own safety while helping others.

Despite the inevitable stresses and challenges associated with community crisis response, workers experience personal gratification by using their skills and training to assist fellow humans in need. Active engagement in the disaster response and “doing” for others can be an antidote for feelings of vulnerability, powerlessness, and outrage commonly experienced by

nonimpacted community members. Witnessing the courage and resilience of the human spirit and the power of human kindness can have profound and lasting effects.

Mental health providers may work for several intense weeks as part of the immediate response and then return to their former jobs and lives. They may be local community members, or from other counties in the State providing mutual aid, or have flown in from other parts of the country as volunteers or paid consultants. Others may continue working for several years as mental health and crime victim services programs are developed, funded, and implemented. New staff may join the mental health response as formal intervention programs become funded and operational months after the disaster. Each scenario presents the worker with distinct stress-related challenges and may expose to the mental health response manager potential targets for stress management interventions.

This chapter discusses factors that contribute to worker stress and provides strategies for stress prevention and management. In counseling and assistance programs that continue for months, and even years, mental health providers counsel survivors and family

members suffering significant psychological difficulties related to their trauma and losses. Mental health response managers must implement systems for clinical training, supervision, and case consultation to ensure high quality, appropriate mental health services and to mitigate the inevitable stress associated with this work. The end of the chapter includes a list of signs and symptoms of worker stress.

Sources of Stress

Mental health 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.

For example, high exposure assignments may involve participating in death notifications, accompanying and supporting families at morgues, supporting families as they provide DNA samples, viewing physical injuries and mutilation, counseling families who are planning funerals with no physical remains or formal death notification, supporting

family members who are waiting for rescue and recovery information, and ongoing bereavement counseling following the traumatic death of a loved one. These assignments can be particularly challenging when prior professional roles have not included similar activities.

Inevitably, a criminal mass casualty event is experienced personally to some degree by all who reside in the targeted community. Mental health responders, who also are residents of the impacted community, may have been personally affected, may know victims, or may be touched through acquaintance networks. These individuals are at risk for stress reactions and should be assessed, monitored, and supported by their immediate supervisors.

Mental health providers and crime victim assistance counselors often are drawn to their professions from a desire to help people. This altruism and dedication to making a positive difference in people's lives, while valuable qualities, can contribute to unrealistic expectations or frustration with "interfering" policies. Altruism run amok may lead to taking on too many responsibilities, ignoring professional boundaries, and working beyond physical, psychological, and training limits. Responders, especially those

who are inexperienced, face a particularly high risk of damaging over-involvement following mass violence and terrorism because of the powerful feelings evoked.

The terms “compassion fatigue” (Figley, 2001; 1995), “vicarious traumatization” (Pearlman and Saakvitne, 1995), and “empathic strain” (Wilson and Lindy, 1994) describe the gradual psychological and physical erosion that can occur when mental health providers become overloaded with traumatic material, and their usual professional management and personal coping strategies begin to falter. As mental health workers’ relationships with survivors and bereaved families deepen, the possibility for over-identification and over-involvement increases. Over time, mental health providers are more likely to encounter their own unresolved losses or traumatic experiences which can interfere with therapeutic effectiveness and lead to added stress.

Stress Prevention, Management, And Intervention

Effective mental health response managers and supervisors are well informed

about the factors associated with worker stress and integrate a range of administrative controls and stress management strategies. Under the intense working conditions that are inevitable following criminal mass violence, supervisors and managers must assume shared responsibility for promoting a positive and healthy work environment, and not rely exclusively on workers’ initiating their own self-care practices.

A proactive stress management plan focuses both on the environment and the individual. Providers feel valued and supported when stress prevention and management strategies are built into mental health operations and the organizational culture.

Environmental Context

A clear organizational structure with defined roles and responsibilities for line-staff responders, leads, supervisors, and managers reduces the potential for staff stress (Quick et al., 1997). Research with first responders has shown that training and preparation helps reduce on-the-job stress (Ursano, et al., 1996). Consistent adherence to administrative controls, such as limiting shifts to no more than 12 hours and rotating between high, mid, and low-

stress tasks promotes occupational health. Pre-event training in high-stress tasks contributes to a more prepared mental health work force. While guidelines may be difficult to put in place during the first week after a mass casualty incident when resources are likely to be overwhelmed, managers should aim for them as quickly as possible.

Team support also is a critical stress-reducer. The mental health response manager and supervisors are role models. If they do not observe the stress management practices that they recommend for staff, their efforts may lack credibility. Managers should address the following dimensions when designing a mental health response that prioritizes environmental and organizational health:

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

Table 4 provides strategies that address these six dimensions. Many suggestions for the immediate response time frame are applicable for the

ENVIRONMENTAL AND ORGANIZATIONAL APPROACHES FOR STRESS PREVENTION AND MANAGEMENT

	Immediate Response	Long-Term Response
Effective Management Structure and Leadership	<ul style="list-style-type: none"> • Clear chain of command and reporting relationships • Available and accessible leaders and clinical supervisors • Use of managers experienced in emergency response and community trauma 	<ul style="list-style-type: none"> • Full-time disaster and crime victim assistance-trained supervisors and program manager with demonstrated management and supervisory skills • Clinical supervisors and consultants experienced in content areas and trained in MH response to community trauma • Clear and functional organizational structure • Program direction and accomplishments reviewed and modified as needed
Clear Purpose, Goals, and Training	<ul style="list-style-type: none"> • Clearly defined intervention goals and strategies appropriate to different assignment settings (e.g., crisis intervention, psychological debriefing) • Training and orientation provided for all MH workers 	<ul style="list-style-type: none"> • Community needs, focus, and scope of program defined • Periodic assessment of service targets and strategies • In-service training on current recovery topics • Staff trained and supervised to define limits, make referrals • Feedback provided to staff on program accomplishments, numbers of contacts, etc.
Functionally Defined Roles	<ul style="list-style-type: none"> • Staff oriented and trained with written role descriptions for each assignment setting as part of preparedness plan • When setting is under the jurisdiction of another agency (e.g., Mayor’s Office, Medical Examiner’s Office, American Red Cross), staff informed of MH role, contact people, and mutual expectations 	<ul style="list-style-type: none"> • Job descriptions and expectations for all positions • Participating crime victim services’ and recovery agencies’ roles defined and working relationships with key agency contacts maintained
Administrative Controls	<ul style="list-style-type: none"> • Shifts no longer than 12 hours, with 12 hours off • Rotation between high, mid, and low-stress tasks • Breaks and time away from the assignment encouraged and required when necessary • Necessary supplies available (e.g., paper, forms, pens, educational materials) • Communication tools available (e.g., cell phones, radios) 	<ul style="list-style-type: none"> • Limits on working more than 40 hours/week • Two consecutive days off and vacation time required • Limits on and rotation from high-exposure duties (e.g., groups with bereaved parents, trauma counseling)

Continued on next page

TABLE 4 : ENVIRONMENTAL AND ORGANIZATIONAL APPROACHES FOR STRESS PREVENTION AND MANAGEMENT		
Dimension	Immediate Response	Long-Term Response
Team Support	<ul style="list-style-type: none"> • Buddy system for support and monitoring stress reactions • Positive atmosphere of support, mutual respect, and tolerance with “thank you” and “good job” said often 	<ul style="list-style-type: none"> • Team approach that avoids a program design with isolated workers from separate agencies • Informal and formal case consultation, problem-solving, and resource sharing • Regular, effective meetings with productive agendas, personal sharing, and creative program development • Clinical consultation and supervision processes built on trust, safety, and respect
Plan for Stress Management	<ul style="list-style-type: none"> • Attention to workers’ functioning and stress management • Supervisors “float through” work areas to observe signs of stress • Education about signs and symptoms of worker stress and coping strategies • Individual and group support, defusing, and debriefing provided • Exit plan for workers leaving the operation: debriefing, re-entry information, opportunity to critique, and formal recognition for service 	<ul style="list-style-type: none"> • Ongoing education and workshops regarding long-term stresses of disaster MH work and methods for self-monitoring and intervention • Comprehensive plan for environmental, organizational, and individual approaches and implementation timeline • Plan for regular stress interventions at work and meetings (see Table 5) • Confidential individual counseling available for work-related issues • Extensive program phase-down plan: timelines, debriefing, critique, formal recognition, celebration, and assistance with job searches

long-term response as well. Some approaches eliminate potential stressors, while others minimize the effects of unavoidable stressors. Mental health planners and managers must adapt the following to their own locale, resources, and disaster.

Many of these principles were applied at the Compassion Center (the family gathering site) in Oklahoma City following the Alfred P. Murrah building bombing, and at the

Family Assistance Center in New York City following the World Trade Center terrorist attacks. At the Compassion Center, a stress management team focused exclusively on the needs of mental health workers and volunteers (Sitterle and Gurwitch, 1999). “Defusing” sessions, which consisted of 20–25 minute, structured conversations about distressing aspects of the assignment followed by psycho-education, were required for workers at the end

of every shift. Mental health professionals participated in no more than two death notifications during a shift, four notifications in total, and attended defusing sessions after each notification. Stress management information was readily provided and available. Mental health professionals were available for consultation and support on an informal, individual basis and more formally when needed. The long-term response program, Project Heartland, contracted with an area psychologist to

provide group debriefing and psychological support sessions with staff and confidential individual counseling for self-referring staff members.

At the Family Assistance Center, mental health workers were divided into teams assigned to different areas and functions within the center. Another team supported families and victims on the buses as they were brought to the center. Each team leader oriented and monitored their mental health providers, ensured that they took breaks and had meals, and provided support and consultation as providers engaged in difficult and distressing situations.

Participation in high-stress assignments such as accompanying families to Ground Zero and intensive contacts with distraught, grieving families was limited, and workers rotated into lower-stress activities. Shifts were limited to 10 hours; taking a day off every seven days was required. Mental health professionals were designated to address mental health and other staff stress issues and to provide support, defusings, and debriefings.

Individual Context

Entering a chaotic setting and providing mental health services to victims and family members immediately after a

mass violent and highly traumatizing incident is likely to stimulate anxiety, adrenalized responses, and the intense desire to be helpful. While few would question that psychologically healthy and well-balanced individuals are best equipped to implement and maintain an effective mental health response, it can be challenging to function within a balanced range, especially during the initial stages of response. Mental health response planners and managers need to build in a range of supports and interventions that are appropriate to their workers' needs and personal styles. In addition, workers must assume personal responsibility for taking care of themselves, to remain effective and not impose burdens on others. Asking for help and support should be encouraged and validated.

As the community's mental health needs change over time, so, too will workers' stress management intervention needs. The individual component of a staff stress management program should address:

- ◆ Management of workload;
- ◆ Balanced lifestyle;
- ◆ Strategies for stress reduction; and
- ◆ Self awareness.

Table 5 provides practical suggestions. Immediate response suggestions apply to the long-term response as well. Involving staff in defining program norms and developing program-wide stress management practices encourages ownership and follow-through, and builds a basis for team support.

Compassion Fatigue and Secondary Traumatization

National experts experienced in the mental health response to acts of mass violence and terrorism emphasize the need for systematic and comprehensive stress management with mental health staff (Center for Mental Health Services, 2001). The stressors associated with dealing with mass criminal victimization and mass casualties are intense and long lasting. Like other responder groups, mental health providers risk becoming secondary victims of the crime and its aftermath. Mental health response managers must evaluate how long mental health workers should remain in high-exposure roles and whether certain assignments should be time-limited.

TABLE 5 : INDIVIDUAL APPROACHES FOR STRESS PREVENTION AND MANAGEMENT		
Dimension	Immediate Response	Long-Term Response
Management of Workload	<ul style="list-style-type: none"> • Clarification with immediate on-site supervisor regarding task priority levels and work plan • Recognition that “not having enough to do” or “waiting” is an expected part of crisis mental health response • Existing “regular” workload delegated so workers do not attempt disaster response plus usual job 	<ul style="list-style-type: none"> • Planning, time management, and avoidance of work overload (e.g., “work smarter, not harder”) • Periodic review of program goals and activities to meet stated goals • Periodic review to determine feasibility of program scope with human resources available
Balanced Lifestyle	<ul style="list-style-type: none"> • Nutritional eating and hydration, avoidance of excessive junk food, caffeine, alcohol, or tobacco • Adequate sleep and rest, especially on longer assignments • Physical exercise and gentle muscle stretching when possible • Contact and connection maintained with primary social supports 	<ul style="list-style-type: none"> • Family and social connections maintained away from program • Exercise, recreational activities, hobbies, or spiritual pursuits maintained (or begun) • Healthy nutritional habits pursued • Over-investment in work discouraged
Stress Reduction Strategies	<ul style="list-style-type: none"> • 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 batteries” (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times 	<ul style="list-style-type: none"> • Cognitive strategies employed (e.g., constructive self-talk, restructuring distortions) • Relaxation techniques (e.g., yoga, meditation, guided imagery) explored • Pacing self between low and high-stress activities, and between providing services alone and with support • Talking with coworkers, friends, family, or counselor about emotions and reactions
Self-Awareness	<ul style="list-style-type: none"> • Early warning signs for stress reactions recognized and heeded (see “Signs and Symptoms” section) • Acceptance that one may not be able to self-assess problematic stress reactions • Over-identification with or feeling overwhelmed by victims’ and families’ grief and trauma may result in avoiding discussing painful material • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995) 	<ul style="list-style-type: none"> • Exploration of motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) • Understanding when “helping” is not being helpful • Understanding differences between professional helping relationships and friendships • Examination of personal prejudices and cultural 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’ frustration, anger, anguish, and hopelessness resulting in loss of perspective and role • Realizing when own disaster experience or personal history interferes with effectiveness • Involvement in opportunities for self-exploration and addressing emotions evoked by disaster work

Self-awareness involves recognizing and heeding early warning signs of stress reactions and understanding one's countertransference reactions. Countertransference refers to the impact that the survivor and his or her situation has on the mental health provider. Depending on the provider's history and vulnerabilities, countertransference reactions might involve: survivor guilt; helplessness at not being able to protect child victims from being killed; feeling heroic, altruistic, and indispensable to the response operation; finding the anguish of bereaved parents to be intolerable; or questioning human nature, God, or one's basic assumptions about the world. These reactions may not be fully conscious yet they can erode the provider's perspective and ability to maintain balance.

As a result of over-identification with survivors, mental health responders may not exercise appropriate personal and professional boundaries in their work. This is especially dangerous for those who seek to "fix" survivors' problems or try to right the wrongs experienced by them. The unfortunate reality is that many survivor losses are permanent and survivors will never be as they were before

the event. These realities can be difficult for providers to accept, especially when their lives and sense of self are tied to "making" survivors feel better. Supervisors must recognize these understandable tendencies and assist workers with setting realistic goals and expectations.

Alternatively, mental health providers may distance themselves to avoid experiencing survivors' anguish and rage and unconsciously restrict survivors' emotional expression (Wilson and Lindy, 1994). During the immediate response, when mental health workers are typically engaged for a time-limited assignment, it may be less crucial or appropriate to explore providers' countertransferential reactions in depth. However, it can be extremely useful to identify and label these reactions and to help the responder put them in context. This may occur in defusing sessions, supervisor support contacts, or debriefing sessions.

Clinical supervision and case consultation help mental health workers identify, understand, and address countertransferential reactions. When providers have a grounding in clinical theory and can view their work from a theoretical perspective, they

are better able to maintain their professional role and "psychological space." Group case consultation built on solid clinical principles, safety, and trust can infuse necessary social support and human connectedness into work teams.

Training staff to identify vulnerabilities and measure stress symptoms helps workers to monitor themselves and each other. When the psychological demands are great and the mental health response is prolonged, a systematic approach involving ongoing assessment and educational and therapeutic interventions with staff may be indicated.

Mental health responders must maintain genuine empathic engagement with survivors and bereaved family members and "be willing to enter their affective space...to join and hold them in their loss in an effort to understand their experience and help them tolerate it" (Charney and Pearlman, 1998). Figley (1995) describes four reasons why trauma workers are especially vulnerable to compassion fatigue: (1) empathy is a necessary skill, yet it inducts traumatic material from the survivor to the provider; (2) many workers have personally experienced some type of trauma; (3) unresolved trauma will be activated by reports of

similar trauma by clients; and (4) children's traumatic experiences are provocative for caregivers. This normalization of compassion fatigue can provide the foundation for a proactive and responsible approach to addressing staff stress, in much the same way that survivors' responses are addressed.

Signs and Symptoms of Worker Stress

Educating supervisors and staff about signs of stress enables them to be on the lookout and to take appropriate steps. When mental health response programs emphasize stress recognition and reduction, norms are established that validate early intervention rather than reinforcing the "worker distress is a sign of weakness" perspective.

Mental Health Provider Stress Reactions

Psychological and 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, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors
- Feeling misunderstood or unappreciated

Cognitive:

- Memory problems and forgetfulness
- Disorientation and confusion
- Slowness in thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Difficulty concentrating
- Limited attention span
- Loss of objectivity
- Inability to stop thinking about the disaster

Behavioral:

- Change in activity level
- Decreased efficiency and effectiveness
- Difficulty communicating
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits

- Sleep disturbances
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, isolation
- Vigilance about safety or environment
- Avoidance of activities or places that trigger memories
- Proneness to accidents
- Blaming and criticizing others

Physical:

- Increased heartbeat, respiration
- 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 reaction


- Fatigue that does not improve with sleep
- Decreased resistance to colds, flu, or infection
- Flare-up of allergies, asthma, or arthritis

As with trauma survivors, assessment hinges on the question of “How much normal stress reaction is too much?” Each worker has his or her own pattern of stress responses. Some may respond physically with headaches or sleep problems; others may have trouble thinking clearly or may isolate themselves from others. Mental health responders commonly experience many of the reactions listed with limited job effects.

However, functioning is likely to be impaired when responders experience a number of stress reactions simultaneously and with moderate intensity. When this stress overload occurs over an extended period of time without adequate rest and rejuvenation, the worker may experience adverse health and more pronounced psychological effects. Taking a break from the disaster assignment for a few hours at first, and then longer if necessary is often helpful. Using the stress management strategies described in this chapter can help counteract stress effects.

Clinical supervisory support benefits mental health workers when their personal coping strategies are wearing thin. Over time, mental health providers may engage in more concrete “doing for” assistance as an antidote to feeling helpless to relieve the seemingly bottomless pain of some victims and families. Supervisors and consultants may intervene by exploring the provider’s underlying feelings and motivations, identifying appropriate roles and boundaries, and redefining the goals of mental health interventions.

Clinical support also might involve an exploration of distressing aspects of assignments and their meanings, the worker’s prior related experiences and vulnerabilities, and his or her personal coping strategies. Supervisors can make suggestions for stress reduction activities. These supportive contacts might also include the validation and normalization of reactions. In most cases, stress symptoms gradually subside when the worker is no longer in the emergency response environment or has achieved a balance of time off and outside, nonrelated activities. When symptom reduction does not occur, professional mental health assistance is indicated.



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Rewards And Joys of Disaster Work

Most people find it enormously rewarding to help survivors, family members, and communities following tragic incidents involving mass victimization. Responders witness both gut-wrenching grief and sorrow and the power of the human spirit to survive and carry on. Assisting people as they struggle to put their lives back together is fundamentally meaningful. Mental health workers 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 mass tragedy.

Recommended Reading

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DC: American Psychological Association.

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C H A P T E R V I

SETTING UP TRAINING

Training may be offered soon after a mass criminal incident to orient immediate responders, or later as part of mental health program implementation of local or State planning and preparedness activities. The focus, content emphasis, and length of the training varies according to its timing and function. Training participants may be mental health professionals only, a mixture of licensed mental health professionals and paraprofessionals, or a more diverse group that also could include crime victim assistance providers, law enforcement personnel, emergency services workers, voluntary agency providers, disaster relief personnel, medical examiner's office staff, and volunteers from faith-based organizations and chaplains. To be effective, trainers must adapt modules to the needs of the particular groups in attendance.

Each incident involving mass violence is unique. The timing and setting of its occurrence; the assumed reasoning behind the malevolent act; the ages and characteristics of the perpetrator(s), victims, affected families, and those killed; and the nature of the community and its reaction all contribute to the overall mental health impacts. Trainers need to recognize the

importance of these variables and responsibly orient themselves to significant dynamics pre-existing within the community and those recently provoked by the tragedy.

Effective crisis mental health responders are flexible, easily able to establish rapport, respectful of differences among people, able to remain calm in the presence of intense emotional expression, and tolerant of ambiguity and confusion. Not everyone is suited to the rigors of responding to community crises. Participation in appropriate training can prepare workers for the unique organizational, procedural, emotional, and environmental aspects of mass criminal incident response.

While mental health providers attending the training undoubtedly will have relevant skills from prior professional activities and training, the complex and varied demands present most providers with some significantly different challenges. Prior experience with grief and bereavement counseling, disaster mental health response, critical incident stress management, hospital-based social work, faith-based emergency response, crime victim assistance and advocacy,

trauma counseling, and crisis intervention can provide a helpful foundation for acquiring additional necessary skills.

Training combines lecture presentations, films, skills practice, self-awareness exploration, group discussion, and experiential learning. Participants are exposed to case scenarios and videotapes that simulate mass crisis situations, to explore their own reactions and achieve some stress-inoculation before assignment. Adult training is most effective when participants learn by seeing, doing, discussing, practicing, and receiving new information presented through multiple methods.

The training process is not designed to be a psychological “debriefing” for those personally affected by the tragedy. When it is necessary to involve workers who are also survivors, they should participate in a supportive group session before the training and also be individually assessed. Staff and program supervisors may find that these individuals’ personal reactions may interfere with their functioning as mental health responders. Survivors who are also mental health responders should be cautioned about their

increased vulnerability for adverse reactions and closely monitored and supported by supervisors. Trainers and supervisors should check in with local mental health responders, observe stress levels, and provide opportunities for expressing thoughts, feelings, and reactions.

Rapid Response Training

During the immediate aftermath, administrators must rapidly identify and deploy staff. If a pretrained cadre of mental health professionals does not already exist, then training becomes a priority. Even those with prior training and experience need to be oriented to the current disaster and response operation. An initial four to eight-hour rapid response training should be offered quickly and repeated as new mental health responders enter the operation.

Chapters II, III, IV, and V provide useful background and content for distribution at the training. Also, the CMHS companion *Field Manual for Mental Health and Human Service Workers in Major Disasters* provides a practical overview and “how to” information. It is a valuable pocket guide for ready-reference in the field.

Comprehensive Training

Mental health training may take place after the immediate response phase for workers providing short and long-term mental health services. These mental health providers may be employed through a Federally funded crisis response program or may be local mental health professionals who encounter survivors as they carry out their usual roles.

The comprehensive training program described in Chapter VII requires between 2.5 and 4 days, depending on the emphases and amount of time allocated to different topics and activities. Representatives from key agencies and specialists with particular survivor groups may present portions of the training. Comprehensive training addresses:

- ◆ Human reactions to mass victimization and traumatic loss;
- ◆ General principles for community trauma response and crime victim services;
- ◆ Mental health interventions appropriate to each survivor group;
- ◆ Local, State, and Federal response to mass

community violence and terrorism; and

- ◆ Mental health staff stress prevention, management, and intervention.

Selection of Qualified Trainers

Comprehensive training must be taught by a qualified mental health professional or team of trainers with collective experience and knowledge in disaster, trauma, crime victimization, and traumatic bereavement. Trainers should have formal training on these topics. In addition, the training team collectively needs prior community trauma response, crime victim assistance, and disaster mental health experience, particularly with long-term recovery issues.

Not only should the trainers have the requisite knowledge to present the material, but they also should be engaging presenters and highly skilled with group processing of emotions. Trainers must be able to model skills, as well as teach them.

Trainers coming from outside the geographic area will need to become familiar with the local community and the specifics of the recent incident of mass criminal victimization—its impact, population

groups affected, extent of property damage, status of criminal justice efforts, and relief and recovery activities to date. Videotapes of news coverage, summary newspaper articles, grant applications, and emergency management bulletins can be useful sources of background information.

When training participants include recently hired staff of a Federally funded, post-disaster, mental health program, training should be consistent with funding guidelines for services. Trainers need to be familiar with these guidelines and incorporate them into training content. For example, if funding supports a limited number of counseling sessions, valuable training time is better spent focusing on interventions appropriate to that time frame.

The comprehensive training program could include different trainers with special expertise in certain topics, such as traumatic bereavement, children and trauma, or the Federal response. A crime victim assistance provider might present a session on Federal and State crime victim rights, services, and benefits. Topical presenters should also be familiar with long-term community trauma and grief recovery processes, so that their presentations are

relevant to the needs of the participants. When particular cultural or ethnic groups are affected by community victimization, representatives of these groups may be included in the training. These representatives may be community leaders, social service agency workers, or educators on cultural sensitivity and competence.

Setting Up Training

The training should be held in a comfortable setting with audiovisual equipment suitable for the room and size of the group. To avoid last minute problems, trainers should anticipate possible malfunctions and plan backups. Although fewer than 30 participants is an ideal class size for training, logistics may dictate that the group be larger. Under those circumstances, having additional small group facilitators and trainers to review and give feedback on role-plays enhances the depth of the training.

Who Should Attend?

All service providers, supervisors, and administrators should attend the training. When individuals who

have not been oriented to the material presented in this training provide clinical supervision or administer crisis response programs, unnecessary conflicts and inconsistencies arise. Paraprofessional counselors need initial training in basic counseling skills before attending the comprehensive training. This basic training allows them to become familiar with the role of counselor and the inherent ethical and boundary issues involved. An overview is provided in Chapter VIII.

Representatives from law enforcement, emergency services, crime victim assistance programs, faith-based organizations, the ARC, or Federal agencies assisting the community may attend the training. These individuals bring valuable information and perspective. Their presence and participation convey the importance of the multidisciplinary effort involved in emergency response and recovery. Program administrators need to balance the need for a cohesive group training with the value of including people from key agencies and referral sources. When appropriate, the training may be designed so that a broader group is included in the first day and only the mental health workers in the remaining days.





CHAPTER VII

COMPREHENSIVE TRAINING COURSE OUTLINE

The comprehensive training course requires 2–4 days, depending on the depth and scope of material presented. It has nine major content areas, organized into “modules,” each requiring from 1–4 hours. Each of the nine modules has five components:

1. Topics Covered;
2. Objectives;
3. Time Required;
4. Materials Required; and
5. Procedures.

Most of the modules include a balance of lectures, overheads, videos, and experiential activities. Module 9, Stress Prevention, Management, and Intervention, includes group and individual exercises that can be used throughout the training to vary the teaching method and pace of the training. Examples of overheads and references for videotapes are included at the end of this chapter. Handouts and lecture content may be drawn from Chapters II–V of this manual. Trainers are encouraged to develop their own disaster and crisis response stories and case examples to bring the training to a more personal and specific level.

This comprehensive training may be held weeks or months

after crisis impact. The specific lecture content for each topic will need to be adapted to the current stage in the recovery process, the appropriate response activities, and current and anticipated criminal justice proceedings. Chapter VIII describes training topics for subsequent in-service training and training modules during the long-term response phase.

Trainers are encouraged to become knowledgeable about the current incident. Media coverage, consultation with managers of the immediate mental health response, emergency response reports, and grant applications for funding of mental health programs can provide essential information. Local information can be woven into the training and used as examples throughout the more general discussions of common issues. Videos from local news coverage or special reports are an effective component of training.

Content experts may conduct portions of the training (e.g., a child specialist, a representative from law enforcement, a resource person from a cultural group, a crime victim assistance educator, and an emergency manager).

Course Overview

The following overview lists course objectives, training content areas, and suggested time requirements. The training content is not further divided into daily agendas, because it is assumed that the trainer's preferences, training class' composition and needs, timing of the training, and current local issues will dictate this level of specificity.

Course Objectives

- ◆ Understand human reactions to incidents of mass violence and terrorism including incident-related risk factors, at-risk survivor groups, post-traumatic stress, traumatic bereavement, and key events affecting the recovery process;
- ◆ Identify the key concepts and principles of mental health intervention, the differences between natural and criminally, human-caused disasters, the interplay of the criminal justice process and survivors' psychological reactions, and the simultaneous and

interacting community and individual impacts;

- ◆ Learn and convey the organizational aspects of the local, State, and Federal responses to mass violence and terrorism including the roles and responsibilities of emergency services, law enforcement, the medical examiner's office, voluntary agencies, and the supporting role of mental health services;
- ◆ Master methods for providing appropriate mental health assistance to survivors and bereaved family members in community settings with emphasis on psychological first-aid, crisis intervention, crime victim assistance, psycho-education, community outreach, psychological debriefing, group counseling, and stress management techniques;
- ◆ Lay out key considerations for intervening effectively with special populations including children and adolescents, the elderly, and local cultural and ethnic groups and methods for adapting mental health services to fit particular communities;

- ◆ Present methods for providing mental health services at the community level including psycho-education through the media and group presentations, consultation with employers and social service agencies, and assistance with community rituals and memorials; and
- ◆ Understand the dynamics of mental health worker stress and the strategies for preventing, managing, and intervening with stress overload and vicarious traumatization at the personal, group, and administrative levels.

The time and content emphasis devoted to each module varies according to the audience. The time and content emphasis devoted to each module varies according to the audience, the goals of the training, the amount of time after the incident, and the total time allocated for the training session. For example, a one-day training during the immediate response phase might briefly include all topics but not include group exercises. The emphasis in Module 5 on immediate interventions would provide practical guidance readily

Overview of Comprehensive Training Course

Module 1:	
Introduction	1 hour
Module 2:	
Criminal Mass Victimization	1.5 hours
Module 3:	
Adult Responses to Mass Violence and Terrorism	2.5 hours
Module 4:	
Organizational Response and Mental Health Roles	1.5 hours
Module 5:	
Community Crisis Response and Mental Health Interventions	4 hours
Module 6:	
Children’s and Adolescents’ Reactions and Interventions	3 hours
Module 7:	
Cultural and Ethnic Groups: Considerations and Interventions	2 hours
Module 8:	
Planning Workgroups	1.5 hours
Module 9:	
Stress Prevention, Management, and Intervention	2 hours

applicable to the current disaster response. Each module is intended to expand or contract, be more clinically

oriented or more appropriate for a lay audience, and shift in focus depending on the phase of the recovery process.

MODULE 1

Materials Required

- Training handouts
- Name tags

Introduction

Topics Covered

- Distribution of materials
- Welcome and brief overview of the training
- Introductions
- Training objectives, agenda, and materials

Objectives

- Introduce trainers and participants
- Review training objectives, agenda, and values underlying the training
- Begin group building through participant disclosure
- Model listening skills

Time Required

1 hour

Procedures

Distribute Materials: Distribute name tags, handout materials, booklets, etc.

Welcome and Brief Overview: Give a welcoming statement, brief overview of the training day, and discuss logistics (e.g., breaks, lunch, phones, bathrooms, etc.). Encourage group participation and questions.

Introductions: Trainers introduce themselves, highlighting trauma, crisis, crime victim, disaster, and other related experience. Participants introduce themselves giving name, agency affiliation, current job, description of experience with current incident and prior crises or disasters, and expectations for the training. The trainer needs to model active listening and may briefly bring out points relevant to training content.

Training Goals and Objectives: Review the goals and objectives for training. Trainer addresses participants' stated expectations, commenting on what will and will not be included in the training and how other training needs may be met.

MODULE 1:
Introduction *(Continued)*

Agenda and Training Techniques: Review overall training agenda and discuss training techniques (e.g., short lecture, discussion, videos, small group exercises, and role-plays). Discuss rationale and values underlying techniques (e.g., people learn by doing, trauma response work affects mental health providers personally so sharing and support is important, balance learning new content with developing new skills).

MODULE 2

Criminal Mass Victimization

Topics Covered

- Definitions of terrorism and mass violence occurring in the United States
- Comparison of natural and criminally human-caused disasters
- Unique aspects of human reactions to mass violence and terrorism
- Current incident information

Objectives

- Acquaint participants with characteristics of traumatic exposure
- Compare the impact of natural and criminally human-caused disasters and related implications for mental health intervention
- Provide orientation to the current incident—its scope, impact, populations affected, emergency response efforts, and status of criminal justice activities
- Increase understanding of unique elements of the current incident that may contribute to mental health effects

Time Required

1.5 to 2 hours

Procedures

Definitions: Using Overheads #1 and #2, present definitions for terrorism and mass violence. Discuss how mass violent incidents can target a group of individuals, affect entire communities, and strain social support systems.

Dimensions of Traumatic Exposure: Discuss these generic dimensions (see Overhead #3) and their relationship to increased post-traumatic stress in victims, responders, and the community-at-large. Focus presentation on the current incident.

Comparison of Natural and Criminally Human-Caused

Disasters: Discuss the dimensions listed on Overhead #4. The lecture content is provided in Chapter II and in Table 1.

Materials Required

- Overheads #1–4
- Video of news coverage of current incident and response

MODULE 2:
Criminal Mass
Victimization
(Continued)

Description of the Current Incident: Provide overview of information about the current incident including nature of the event, number of people killed and injured, scope of property damage, populations affected, emergency response and recovery efforts, relief efforts, and status of criminal investigation and criminal justice proceedings.

Processing Trainees' Reactions to the Incident: Depending on the size of the group, facilitate small or large group discussions focusing on questions such as the following: What did you think or feel as you watched the video? What reactions might you expect the people who directly experienced this incident to have? What aspects of this incident would you expect to be related to mental health effects? What do you think will be the difficulties/challenges for this community during the recovery/reconstruction process?

This discussion is not intended to be a “debriefing” for those who had personal exposure to the incident. The discussion provides an opportunity for trainers and/or program managers to continue assessing if there are participants who may be too involved in their own reactions to assist others effectively.

Refer to Overhead #4 and review assumptions and predictions that participants have regarding the community's response to each dimension. Begin fostering the “anticipate and think-on-your-feet” approach to community trauma response. This can become an exercise in connecting theory with real world issues.

Display photographs, newspaper articles, and maps of impacted areas. This can be a group activity, if some participants have been involved in the mental health response immediately after the incident. It can give them an opportunity to describe their experiences while educating new staff.

MODULE 3

Adult Responses to Mass Violence and Terrorism

Topics Covered

- Population Exposure Model
- Survivor risk and resiliency factors
- Model and phases of psychological response
- Physical, behavioral, emotional, and cognitive reactions
- Traumatic grief

Objectives

- Acquaint participants with the community impacts of mass victimization
- Orient participants to survivor risk and resiliency factors that can assist with screening and prioritization of mental health services
- Present a phenomenological model of coping with phases of psychological response
- Provide information about the normal range of reactions to trauma and sudden bereavement including considerations for older adults
- Address the interplay of trauma and grief processes
- Explore participants' personal reactions to the video and begin discussing countertransference and the importance of self-awareness

Time Required

2.5 hours

Procedures

Population Exposure Model: Use Overhead #5, or Figure 1. Discuss collective trauma and the potential widespread effects, emphasizing the differences between individually experienced trauma and community trauma. Involve participants in identifying the groups that compose the various concentric circles and the potential nature of impacts. Orient participants to think on the “macro” community level.

Materials Required

- Overheads #5–13
- Videotapes: “OVC Special Award for Extraordinary Response to International Terrorism” and “Disaster Psychology”

MODULE 3: Adult Responses to Mass Violence and Terrorism *(Continued)*

Survivor Risk and Resiliency Factors: Pose the question “Why, when faced with identical overwhelming traumatic circumstances, do people have such different reactions, particularly over time?” Continue with the public health perspective initiated in the section above, and discuss screening and allocation of limited mental health services. Present material related to survivor vulnerability and resilience. Ask the group to brainstorm implications for outreach and service delivery. Use Overhead #6.

Model and Phases of Psychological Responses: Using Overhead #7 or Figure 2, discuss the phenomenological process of coping with trauma and sudden bereavement. Encourage participants to share what they have seen clinically and ways that they have helped survivors “understand” and tolerate this “working through” process. Chapter II also provides presentation material. Discuss the process in terms of phases as well as the influence of predictable events in the criminal justice process. Address the importance of denial. Connect this presentation with survivor risk and resiliency factors. Emphasize that each survivor is unique, and that a model is a generalization. Use Overhead #8 to address phases in the community. These are typically used following natural disasters. Facilitate a group discussion regarding their current applicability.

Show Videotape: Ask the group questions about survivor reactions in the film and where these reactions “fit” or “didn’t fit” in the model just discussed. Begin discussing the physical, behavioral, emotional, and cognitive symptoms of trauma and bereavement portrayed in the video, and if they seemed to change over time. If appropriate, ask participants to speculate which survivors in the film would need more intensive mental health services, and why. Provide short lectures on topics relevant to current disaster and phase.

Participant Self-Reflection: Invite participants to explore what touched them personally as they watched the film—which survivors, what circumstances, and why they were impacted. Use this discussion to model giving permission and control (“Share what you feel comfortable talking about here.”), good listening skills, nonjudgmental acceptance, and normalization. Continue with a lecture about countertransference in very practical terms, and introduce the importance of self-awareness, self-care, talking with others, stress management,

MODULE 3: Adult Responses to Mass Violence and Terrorism *(Continued)*

and staff consultation. As a wrap-up, ask the group to comment on techniques and approaches used by the facilitator and their applicability to work with survivors.

Range of Adult Reactions to Trauma and Bereavement: Use Overheads #9–12 in this section. Use case examples, examples from the film, participant examples from the current disaster, and their other clinical experiences to make these lists come alive. Focus on reactions that are relevant to the timing of the training and what participants may deal with in their work with survivors. Emphasize that for the majority of survivors, these reactions are normal and will subside over time—with episodic resurgences triggered by events in criminal justice proceedings, media coverage, anniversaries, holidays, and other traumatic reminders.

Considerations with Older Adults: Using Overhead #13, discuss the challenges faced by older adults, particularly the elderly. Discuss this population in relation to issues and needs expressed in the current disaster. Review the section in Chapter II and Table 3. Expand section if this is a highly impacted group.

Interplay of Trauma and Grief: Review this section in Chapter II. Survivors who suffered serious and disabling physical injuries, those who had a loved one killed in the incident, and those who were both involved and suffered the death of a family member or close friend experience an intensification of both trauma and grief responses. Often, post-trauma reactions take precedence and must be dealt with before grieving can take place. The process of “working through” is more arduous and often takes longer, because of the overlay of psychological processes. If traumatic grief is prevalent in the current disaster, focused, in-service training, clinical supervision, and consultation on this topic are strongly encouraged.

MODULE 4

Organizational Response And Mental Health Roles

Topics Covered

- Federal, State, local, and volunteer agencies involved in crisis response
- Incident Command System (ICS) and Unified Command (UC)
- Local crisis response and key area resources
- Glossary of acronyms

Objectives

- Acquaint participants with representatives from primary responding agencies (e.g., emergency management, law enforcement, crime victim assistance-witness program, State crime victims compensation program, ARC, OVC, CMHS, FEMA)
- Orient participants to the organizational context of community crisis response and the role of mental health
- Provide an overview of Federal programs that supplement State resources for mental health and crime victim services
- Inform participants of the chronology of emergency response and criminal justice events involved in the current incident
- Increase knowledge of local resources, contacts, and how to access them

Time Required

1.5 hours

Procedures

Organizational Aspects of Crisis Response: Local, State, or Federal representatives may conduct much of this section. Participants benefit from having names and faces to attach to unfamiliar agencies. Review the background information and figures provided in Chapter IV. Include key topics: the ICS, UC, emergency response procedures, coordination between law enforcement and mental health, the EOC, lead agencies, and participating agencies. Use Overhead #14 and organizational charts in the figures. Mental health responders need to

Materials Required

- Overheads #14 and #15
- Figure 4
- Handouts from agencies represented
- Contact information for local resources
- Videotape: "Surviving the Secondary Device"

**MODULE 4:
Organizational
Response and Mental
Health Roles**
(Continued)

understand the big picture of emergency operations, the organizational players, and their roles. Show the video to graphically portray a bombing incident crime scene and some of the issues and challenges associated with emergency response. Ask participants to discuss the potential mental health impacts of procedures described in the film.

Local, State, and Federal Response and Recovery Activities:

Present a chronology of emergency response and law enforcement activities, highlighting aspects that might have mental health implications. Plan the presentation according to the current phase in the response so that participants become informed about the history, as well as who the current key players are, and current phase-related recovery issues and activities. Representatives from Federal agencies that have funds available for mental health and crime victim services may provide information relevant to the incident, the phase, timing, and the participants. If the ARC has been active providing disaster mental health services (DMHS), a DMHS volunteer or staff person could present information about community reactions and needs.

Mental Health Roles in Crisis Response: Using Overhead #14, briefly describe the various mental health roles as they relate to this discussion of the larger organizational context during the early response phase.

Emergency Response Lingo and Defining Acronyms: Distribute the glossary of acronyms, or develop a similar list for the current local, State, and Federal agencies.

MODULE 5

Community Crisis Response and Mental Health Interventions

Topics Covered

- Key concepts of community crisis response
- Mental health interventions
- Key events with mental health implications
- Community interventions
- Limits and boundaries of mental health intervention

Objectives

- Orient participants to normal stress reactions to mass violence and sudden bereavement
- Acquaint participants with mental health interventions used following community disasters as distinct from traditional office-based clinical practice
- Increase understanding of the importance of community rituals and interventions and the mental health role
- Describe key events in emergency response and recovery and the criminal justice process that have mental health implications
- Provide guidance regarding professional and ethical limits and boundaries

Time Required

Up to 4 hours

Procedures

Key Concepts of Community Crisis Response: Using Overheads #16 and #17 and material in Chapter III, review basic orienting principles for community response. Emphasize flexibility, empowerment, respect for differences, and practicality.

Community Crisis Response vs. Traditional Office-Based Practice: Discuss how community crisis response differs from traditional therapy. Emphasize aspects such as the service provider goes to the client, rather than the client coming to the office (especially initially); early intervention focuses on

Materials Required

- Overheads #16–29
- Sample public information brochures and materials
- Case scenarios
- Videotapes: “Hope and Remembrance,” “Death Notification,” and “The News Media’s Coverage of Crime and Victimization”

**MODULE 5:
Community Crisis
Response and Mental
Health Interventions**
(Continued)

problem-solving rather than achieving insight; and terms like “mental health” and “counseling” are de-emphasized and terms like “assistance with problem-solving” and “providing support and an ‘ear’” are emphasized.

Immediate Mental Health Interventions: Adapt this section to the current phase of response, training participants in attendance, survivor populations affected, and the needs of the group. Overheads #18–27 provide information about a range of interventions. Use concrete examples of appropriate interventions, selecting from the material in the overheads. Clearly describe each intervention and give examples of when it is used. Demonstrate the intervention and then have the group practice through role-plays. Including all of these steps will enhance learning through hearing, seeing, and then doing.

Role-Play Exercises: Facilitate brief role-play exercises throughout this section. Develop case scenarios that exemplify relevant situations and the approaches being taught. The focus might be psychological first-aid, a supportive conversation about a survivor’s trauma experience, or providing psycho-educational information through reviewing a brochure and discussing coping strategies. Participants need to have their performance anxieties relieved while receiving feedback to enhance their learning.

Assessment and Referral: Provide program guidelines for assessment and referral. Define when mental health providers should consider the level of distress and symptoms to be such that a referral, more formal assessment, and more “advanced” intervention are indicated. Participants will need a program procedure for case consultation and referral.

Long-Term Mental Health Interventions: The facilitator must determine which interventions are most relevant. Community outreach is often an important element of service delivery. A section on strategies and skills for effective outreach may assist with this less formal style of service delivery.

Crime Victim Assistance: Mental health workers must be familiar with the criminal justice process and crime victim rights and issues, as well as the role of crime victim advocates. A specialist in this area may present this information, as it relates specifically to the current criminal justice response, if this is not in the trainer’s background.

**MODULE 5:
Community Crisis
Response and Mental
Health Interventions**
(Continued)

Limits and Boundaries of Mental Health Intervention: When the incident has particularly tragic and heart-wrenching consequences, mental health responders are often challenged to maintain appropriate professional and ethical boundaries. The common risks and pitfalls listed on Overhead #28 provide a basis for lecture, discussion, and establishing clear service or program guidelines. Using examples for each pitfall will help participants apply them to their own practices.

Key Events with Mental Health Implications: The facilitator and group may identify anticipated key events (see Overhead #29) and discuss anticipated mental health needs. If specific skill-building is called for, then focus section in that direction (e.g., for participation on death notification teams, for assisting survivors with return to work anxieties). This could include large group brainstorming of service delivery ideas. A small group exercise could assign a key event to each small group, and request that each group brainstorm creative mental health service and outreach suggestions. The section emphasizes thinking on the “macro” community level and anticipating events that will send ripples of mental health effects through the community, as well as at the “micro” level of the specifics of what an intervention would look like.

Community Intervention: Provide a brief lecture on the importance of disseminating information on trauma, stress, and coping. Community education is essential. Show samples of educational efforts (e.g., brochures, public information media spots, Internet sites, newspaper articles, etc.). Mental health providers may help plan community events or be present as a support (Overhead #30). Again, fit this discussion to real events and needs occurring in the community.

Often, mental health providers are asked to give presentations to different audiences including survivor groups defined by age, culture, needs, employment, or affiliation with an organization. Other audiences might be service provider groups such as primary care providers, health care professionals, disaster workers, faith-based counselors, or school teachers. Specific training modules need to be developed to address these particular needs and groups. The facilitator should address these topics in a way that fits the needs of the group. However, additional in-service training is also recommended.

**MODULE 5:
Community Crisis
Response and Mental
Health Interventions**
(Continued)

Show Videotape: The videotape “Hope and Remembrance” deals with the importance of community ritual and memorials. The video is moving and is likely to elicit reactions and emotions. It can provide an opportunity for self-reflection, facilitator modeling of good listening and “counseling” skills, and discussion of countertransference vulnerabilities.

MODULE 6

Children's and Adolescents' Reactions and Interventions

Topics Covered

- Age-related reactions and concerns
- Age-appropriate interventions
- Coordination with the schools
- Special projects

Objectives

- Provide information about children's normal and problematic responses to trauma, loss, and family stress
- Assist participants in understanding developmental influences so they can design appropriate interventions
- Identify strategies for working with the local schools and children's organizations
- Provide examples of creative projects and partnerships
- Brainstorm

Time Required

Up to 3 hours

Procedures

Children's Reactions to Crisis and Trauma: Review background material in Chapters II and III, and Recommended Reading. Present a lecture on children's reactions emphasizing developmental stages and the significant role of the family. Identify features of the current event that have salience for children (e.g., witnessing frightening events in person or on the television, separation from family members, traumatic reminders at school). Use Overheads #31–33 as a starting point. Discuss observed expressions of distress and trauma in children following the recent disaster and interventions with children to date.

Risk Factors: Review Overhead #34. Discuss at-risk groups of children in the community. Using the concentric circle model (Overhead #5), identify groups of children and adolescents with different levels of exposure.

Materials Required

- Overheads #5 and #31–36
- Handout: "Age Specific Interventions for Children and Adolescents"
- Videotape: "Children and Trauma: The School's Response"
- Examples of coloring books, expressive and commemorative school projects (photos, journals, posters, drawings, and documentaries)

**MODULE 6:
Children's and
Adolescents'
Reactions and
Interventions** *(Continued)*

Interventions: Present a lecture on appropriate interventions with children for different phases. Emphasize the importance of parent education, support and consultation. The handout can provide a structure for this lecture. Encourage participants to assess the child or group before initiating expressive or reenactment activities and to use them only when confident that they will not be retraumatizing. With highly exposed children, many of these interventions are most appropriate in the context of a therapy relationship. The lecture on intervention options may be broken up by group discussion, showing examples, role-plays, and demonstrations of techniques. This presentation should fit the roles of the participants.

Show Videotape: "Children and Trauma" captures many of the points discussed, demonstrates techniques, and emphasizes the importance of school involvement in interventions. Discuss relevant aspects of the film and participant reactions.

Systematic Strategy for Assessing the Needs of Children: If a high rate of more serious trauma and grief reactions are anticipated because of the presence of risk factors and the dynamics of the incident and recovery efforts, a systematic system for screening children is advised. Multiple strategies including gathering assessment information from parents and teachers and directly from children and adolescents should be used. Overhead #35 provides guidance for topics to include in an assessment. Checklists have been developed for this purpose. The program must define procedures and protocols for systematic screening. The participants may practice brief screening interviews with parents, children, or teachers—depending on the program's plan and their roles.

Psychological Tasks: Using Overhead #36, discuss the psychological tasks that a child must accomplish to integrate the traumatic experience and move on. Discuss how age and developmental stage affect the child's capacity to accomplish these tasks and how these affect intervention strategies. Emphasize that children may harbor a distorted understanding of the event, what caused it, or their role in it. These idiosyncratic distortions must be uncovered and corrected for the child to work through their experiences.

When children have been highly impacted, child specialists may conduct specific in-service training for mental health

MODULE 6:
Children's and
Adolescents'
Reactions and
Interventions *(Continued)*

professionals on providing counseling for traumatized and bereaved children and their families.

School Systems: Schools are a critical point of contact to reach children, parents, caretakers, and school personnel who have regular contact with children. However, gaining access to schools can be challenging. Access may be facilitated through coordination with the U. S. Department of Education, which has a crisis intervention program, the State Department of Education, or more local official entities that have vested interests in children's welfare. Other, less official channels include working with the school nurse or counseling staff, presenting educational sessions at PTA meetings, and conducting in-service training for teachers. Hiring former school personnel as program staff can be helpful for gaining credibility and acceptance.

Determine what angles would help to promote collaboration and a working relationship. These might be referrals for at-risk children and families (due to the disaster), consultation and training with school counselors and nurses, or parent presentations. The interventions listed in the handout may be used for training teachers and mental health professionals for classroom sessions.

Other organizations serving children may be more accessible and welcoming of outside assistance. Possibilities include day care centers, YMCA/YWCA youth programs, scout programs, religious youth groups, summer camps, or community centers.

School and Community Projects: The videotapes shown have demonstrated numerous ways that children can participate in community commemoration. Display samples of children's projects. Expressive activities provide a vehicle for expression, validation and normalization, gaining social support, and "working through" reactions. Engage participants to brainstorm innovative projects for the current crisis to foster community healing and survivorship.

MODULE 7

Cultural and Ethnic Groups: Considerations and Interventions

Topics Covered

- Cultural competency
- Cultural information about affected groups

Objectives

- Identify special populations including cultural, ethnic, racial, immigrant, and refugee groups affected by the disaster
- Review unique issues associated with each group and special considerations for intervention
- Understand how traumatic stress, grief, healing, and recovery may be experienced and expressed by each group

Materials Required

- Overheads #37–39
- Handouts and resource materials on specific groups in community
- Videotapes about working with particular groups in the community

Time Required

2 hours

Procedures

Cultural, Ethnic, Racial, Immigrant, and Refugee Groups: Staff must acquire cultural competency with and earn the acceptance of affected groups in the community. Chapters II and III highlight important topics. Overhead #37 presents components of cultural competence. Program managers should strongly state the program's position regarding valuing diversity and respecting differences, and that everyone in the community should have access to high quality, appropriate services. Managers may present steps that the mental health program is taking to promote cultural awareness and sensitivity and to ensure cultural competence.

Information about Local Affected Groups: Representatives from local ethnic, cultural and racial groups may present portions of this section. Overhead #38 may provide guidance regarding topics to address in these presentations. They may share information about their groups' experience with the disaster and the crisis response. Ideally, a specialist in the group's cultural experience can provide insights on how to work most effectively with the group and avenues for credible

**MODULE 7: Cultural
And Ethnic Groups:
Considerations and
Interventions** *(Continued)*

liaison and helpful collaboration. Additional training on cultural issues and awareness may be provided as in-service training.

Basic Cultural Sensitivity: The tips listed on Overhead #39 are the basics of respectful engagement with all people, yet must be especially emphasized when trying to bridge cultural differences. If interpreters are being used, suggestions are included in Chapter III.

Planning Workgroups

Topic Covered

- Program planning for special population groups

Objectives

- Develop specific program strategy plans for addressing the mental health needs of each affected special population group in the community
- Encourage a team approach to program planning
- Identify expertise and interests of mental health staff relevant to special groups
- Identify strategies for outreach, relationship-building with community leaders and agency resources, and culturally sensitive interventions

Materials Required (For each workgroup)

- Flip chart
- Pens
- Questions

Time Required

1.5 hours

Procedures

Identifying Special Populations: Identify groups requiring special program focus. Examples are children; older adults; traumatically bereaved family members; people who lost their jobs as a result of the disaster; people with disabling injuries resulting from the incident; people in institutions, people with pre-existing disabilities; cultural, ethnic, and racial groups; and people with serious and persistent mental illness. Human service workers in the community might receive a different set of interventions, as a target group for networking, outreach and educational presentations.

Special Population Workgroups: Establish workgroups of participants for each identified population group. Assign tasks to the workgroups. Group tasks could include: (1) identifying points of contact to reach the group; (2) identifying group leaders, key people, and gatekeepers; (3) identifying future significant events with mental health implications; (4) reviewing effective program or outreach strategies to date; and (5) brainstorming program ideas, intervention, or outreach strategies for the future. Groups may take 45

MODULE 8:
Planning Workgroups
(Continued)

minutes to discuss and generate ideas and then transcribe them to the flip chart. Then each group may present their ideas to the larger group for input and discussion.

The trainer further comments on groups or issues raised, summarizes common themes and challenges, and recognizes the work of each group. This exercise provides a welcome opportunity to encourage teamwork and demonstrate the benefits of a collective process.

The program manager may discuss how the workgroup ideas will be addressed and incorporated into the program plan.

MODULE 9

Stress Prevention, Management, And Intervention

Topics Covered

- Sources and nature of worker stress
- Organizational and individual approaches
- Self-awareness
- Stress reduction strategies

Objectives

- Provide information regarding sources and symptoms of worker stress and compassion fatigue
- Introduce and discuss specific organizational and individual approaches to prevent and manage work-related stress
- Enhance team support and group cohesiveness
- Identify individual vulnerabilities to stress and personal prevention and management strategies

Time Required

2 hours (Exercises can be interspersed throughout the training course.)

Procedures

Sources of Stress: Using Overhead #40, discuss potential sources of work-related stress. Use examples relevant to the timing of the training. Engage participants to identify examples in each category. This exercise could be made more personal by asking participants to identify their top three stressors. These work-related stressors could be compiled, voted on, and tallied—arriving at the top 10 stressors identified by the entire group. These results could be the basis for subsequent problem-solving exercises addressing these top stressors.

The trainer may lecture on sources of stress for workers, adding to the material generated by the group. The lecture might include topics such as participants' motivations for helping and how these might also generate stress; discomfort being with someone who is angry, tearful, grief stricken,

Materials Required

- Overheads #40–44
- Flip chart
- Pens

MODULE 9:
**Stress Prevention,
Management, and
Intervention** *(Continued)*

hopeless, depressed, emotionally shut down, etc.; identifying images or events that are traumatic; and difficulties managing the boundaries of the “helper-helpee” relationship—especially under such tragic life circumstances.

Concept of Stress: Overhead #41 provides important perspectives on stress—that it is both good and bad and, most importantly, identifiable and manageable. In moderation, stress can enhance performance and mental acuity. Too much stress continuing over a period of time can erode well-being, coping, and eventually health. The program managers, supervisors, and individual staff members each have responsibility to prevent and manage stress. Review Chapter V.

Symptoms of Worker Stress: Review list of worker stress symptoms in Chapter V. Invite participants to identify symptoms that they have experienced during the current crisis response. Participants may complete an assessment checklist to determine how they are doing and their personal areas of vulnerability. Figley (2001) provides resources for assessment.

Coping Strategies: Invite participants to list coping strategies that they use to reduce stress. Next, ask participants to identify three strategies that they think they should use to reduce stress. Divide the group into groups of three or four and ask them to share what they have identified. Also, remind the group that this can be another opportunity to practice listening skills. Then, ask the groups to consider how coworkers and the program as a whole might support their staff’s continuing efforts to do what is helpful to them and to begin doing activities on their “should” lists.

Ask each group to summarize and report ideas, and write on a flip chart. The flip chart list will contain some ideas for assisting staff with follow through on stress management. Model giving positive and encouraging feedback. Make the point that giving positive feedback and saying “thank you” often can be a powerful stress intervention.

This exercise can specify methods of team support for stress management (e.g., group walks at lunch, reduced group rates at a nearby gym, on-site yoga classes at lunch, a positive incentive system for stress-reducing activities with “rewards,” buddy support, and accountability system).

MODULE 9:
**Stress Prevention,
Management, and
Intervention** *(Continued)*

Organizational and Individual Approaches to Preventing and Managing Stress: Using Overheads #42 and #43, present information contained in Tables 4 and 5. Program managers may discuss how organizational recommendations are addressed and the plan for future stress management. They may make a strong statement about the program's commitment to supporting workers and promoting stress management. Stress reduction strategies generated in the previous exercise may also provide examples.

Team Building Exercise: Ask participants to jot down their best team experiences (sports, clubs, jobs, etc.). Then, invite them to silently reflect on the characteristics of those teams and the roles they had. List these characteristics on a flip chart and lecture on what contributes to effective work teams.

Next, ask participants to consider how they want to work together and what norms or principles they would like to see the group adopt. Examples might include "We will encourage, initiate, and participate in direct communication;" "We will discuss work issues with an involved third person as they occur;" "We will responsibly manage our time and workload;" or "We will treat each other with respect." Combine individual lists to generate a list that reflects all of the input.

After reviewing the combined list, each participant votes on his or her top three. Narrow the list down to five to seven briefly stated items and ask, "Is there anything on this list with which anyone cannot live?" The agreed upon list can be written up and posted at program offices. At staff meetings, groups can check back to determine how they are abiding by the principles. A more formal evaluation can provide the basis for future team-building interventions. This process may be started at the comprehensive training and then continued at in-service training sessions.

Self-Awareness Exercises: Self-awareness is an essential ingredient in understanding and managing stress and addressing compassion fatigue. In this initial training, it is important that participants do not feel pushed to disclose personal information that they do not want to share. Over time, it will be important for staff to understand and deal with their personal reactions, countertransference, their own experiences of trauma and loss, and their motivations for and vulnerabilities to helping survivors. This process may occur

MODULE 9:
**Stress Prevention,
Management, and
Intervention** *(Continued)*

through in-service workshops, group consultation, group debriefing sessions, clinical supervision, or confidential individual counseling support.

Stress Reduction Exercises: These exercises can be incorporated at different points during the training. Later, they can be used to start or end staff meetings, group consultation sessions, or as scheduled activities:

1. Invite the group to stand and stretch, reaching hands toward the ceiling and breathing deeply with each stretch;
2. Facilitate a guided imagery process. Ask participants to close their eyes and sit comfortably. Dim the lights and encourage deep breathing, physical relaxation, and visualization of a personal and peaceful place;
3. Encourage participants to take a quiet 15-minute break by themselves. They might walk outside, noticing vegetation, smells, etc., or sit and read or write, or close their eyes and meditate. Suggest that the group maintain silence during the break as an experiment; and
4. As a homework exercise, encourage participants to do one self-care activity. This could be exercising, reading a book, spending time with a friend or family member, doing a crossword puzzle, working in the yard, taking a bath, etc. The next morning in class, invite participants to share what they did. Again, respond positively to participants' efforts. These activities and the group encouragement help foster a workplace culture that supports stress management.



Terrorism within the United States

“An activity that involves a violent act or an act of dangerousness to human life that is in violation of the criminal laws of the United States, or of any State...and that appears to be intended to intimidate or coerce a civilian population...or to influence the policy of government by assassination or kidnapping.”

[18 U.S.C. 3077]

Mass Violence within the United States

“An intentional violent criminal act, for which a formal investigation has been opened by the FBI or other law enforcement agency, that results in physical, emotional, or psychological injury to a sufficiently large number of people as to significantly increase the burden of victim assistance for the responding jurisdiction.”

Dimensions of Traumatic Exposure

- Threat to life and limb
- Severe physical harm or injury
- Receipt of intentional harm or injury
- Exposure to the grotesque
- Violent/sudden loss of a loved one
- Witnessing or learning of violence to a loved one

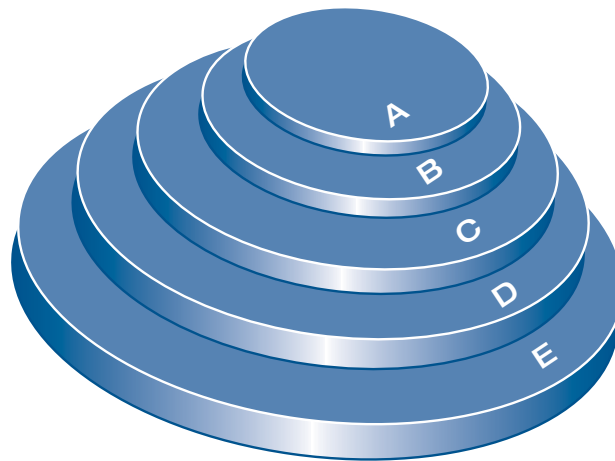
(Green, 1993)

Comparing Criminally Human-Caused and Natural Disasters

- Causation
- Appraisal of Event
- Psychological Impact
- Subjective Experience
- Worldview/Basic Assumptions
- Stigmatization of Victims
- Phases of Recovery
- Media
- Secondary Injury

Population Exposure Model

FIGURE 1: POPULATION EXPOSURE MODEL



- A:** Community victims killed and seriously injured
Bereaved family members, loved ones, close friends
- B:** Community victims exposed to the incident and disaster scene, but not injured
- C:** Bereaved extended family members and friends
Residents in disaster zone whose homes were destroyed
First responders, rescue and recovery workers
Medical examiner's office staff
Service providers immediately involved with bereaved families, obtaining information for body identification and death notification
- D:** Mental health and crime victim assistance providers
Clergy, chaplains
Emergency health care providers
Government officials
Members of the media
- E:** Groups that identify with the target-victim group
Businesses with financial impacts
Community-at-large

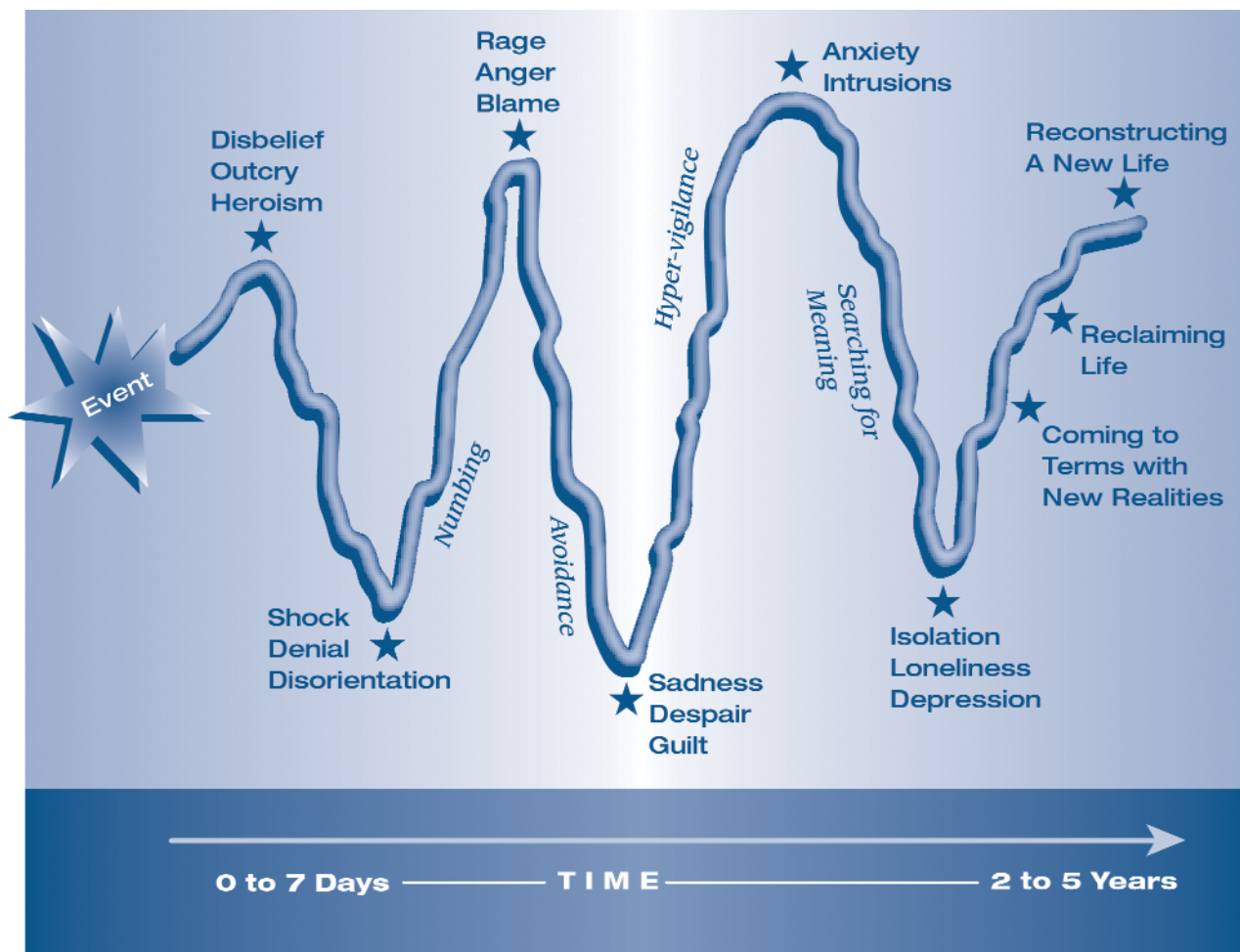
Survivor Risk and Resiliency

Factors

- Psychological
- Capacity to tolerate stress
- Prior trauma history
- Socioeconomic and educational level
- Family stability
- Social support
- Female gender

Model of Psychological Responses to Trauma and Traumatic Bereavement

FIGURE 2: MODEL OF RESPONSES TO TRAUMA AND BEREAVEMENT



(Note. Adapted from CMHS, 1994)

Community Response Phases

- Impact
- Heroic
- Honeymoon
- Disillusionment
- Reconstruction

Physical Reactions

- Agitation, hyper-arousal
- Fatigue, exhaustion
- Hot or cold sensations
- Gastrointestinal distress
- Tightness in throat, chest
- Appetite change
- Worsening of health conditions

Behavioral Reactions

- Sleep problems, nightmares
- Jumpiness, easily startled
- Hyper-vigilance
- Crying and tearfulness
- Avoidance of reminders
- Increased family conflicts
- Isolation, social withdrawal

Emotional Reactions

- Shock, disbelief
- Anxiety, fear about safety
- Irritability, anger, rage
- Sadness, grief, depression
- Numbness, disconnection
- Hopelessness and despair
- Survivor guilt, self-doubt

Cognitive Reactions

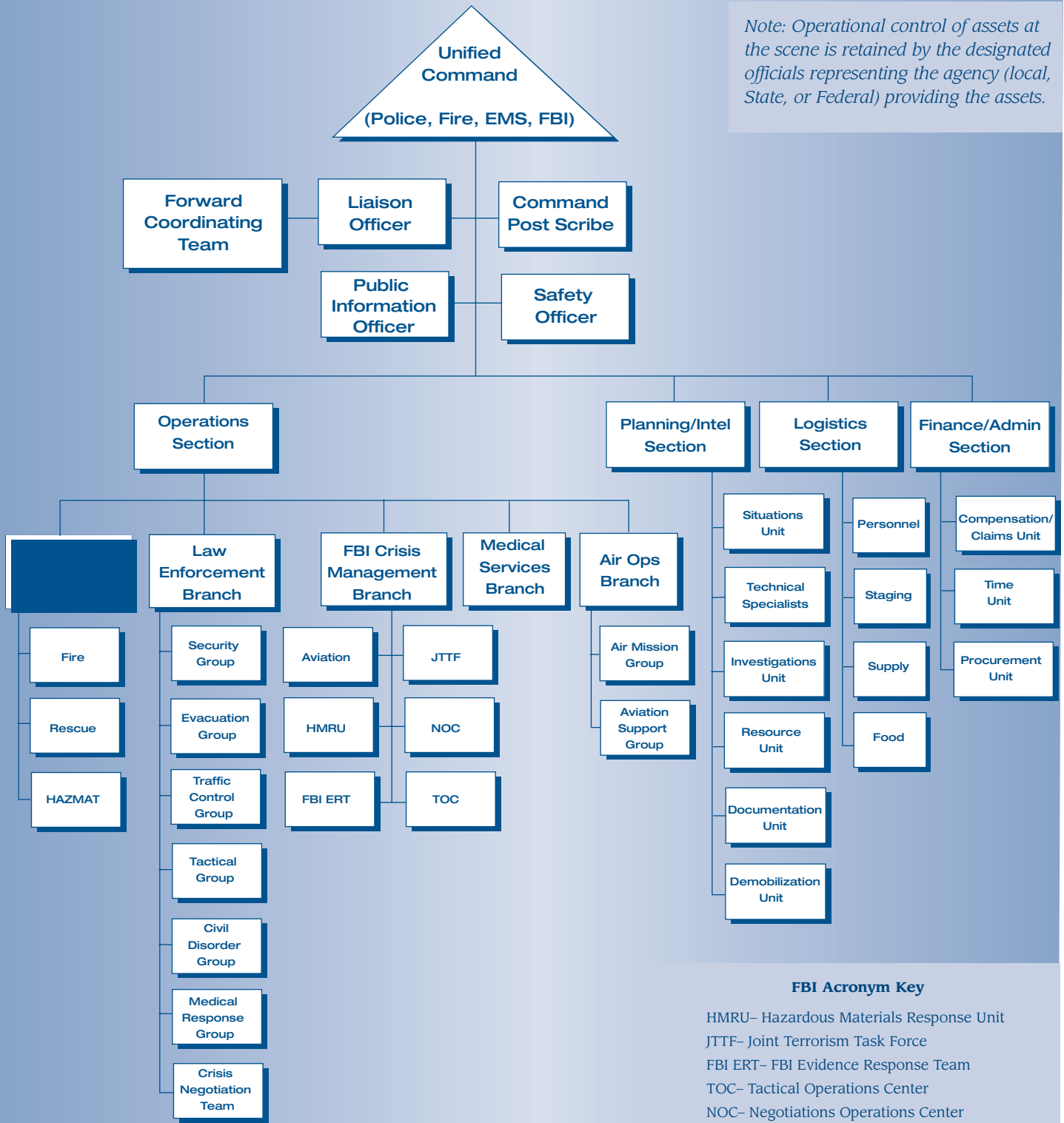
- Confusion, disorientation
- Intrusive thoughts, images
- Recurring dreams, nightmares
- Memory and concentration difficulties
- Difficulty making decisions
- Focus on protecting loved ones
- Questioning spiritual beliefs

Considerations with Older Adults

- Physical vulnerability
- Chronic health conditions
- Medication needs
- Auditory, visual, mobility, or cognitive impairment
- Increased anxiety, confusion
- Loss of home health support

Incident Command System (ICS) Organizational Components

Note: Operational control of assets at the scene is retained by the designated officials representing the agency (local, State, or Federal) providing the assets.



FBI Acronym Key

- HMRU- Hazardous Materials Response Unit
- JTTF- Joint Terrorism Task Force
- FBI ERT- FBI Evidence Response Team
- TOC- Tactical Operations Center
- NOC- Negotiations Operations Center

FIGURE 3: ON-SCENE COORDINATION—THE FBI, POLICE, FIRE, AND EMS

Mental Health Roles in Crisis Response

- Mental health consultation
- Liaison with key agencies
- Psycho-education through media
- Mental health services with survivors, families
- Mental health services with responders
- Stress management support

Key Concepts

- Normal reactions to an abnormal situation
- Avoid “mental health” terms and labels
- Assume competence and capability
- All who witness are affected
- Respect differences in coping

Key Concepts (continued)

- First, do no harm
- Assistance is practical and flexible
- Focus on strengths and potential
- Encourage use of support network
- Tailor for active, community fit
- Be innovative in helping

On-Scene Interventions

- Direct to medical care, safety, shelter
- Protect from trauma, media, onlookers
- Connect to family, information, comfort

(Myers and Wee, 2003)

Immediate Interventions

- Rapid assessment and triage
- Psychological first-aid
- Crisis intervention
- Crime victim assistance
- Psycho-education

Immediate Interventions

(continued)

- Informational briefings
- Community outreach
- Participation in death notifications
- Mental health consultation
- Debriefing and community meetings
- Information and referral

Psychological First-Aid

- Provide comfort, empathy, an “ear”
- Address physical needs
- Provide concrete information about what will happen next
- Link to support systems
- Reinforce coping strengths

Crisis Intervention

- Promote safety and security
- Gently explore trauma experience
- Identify priority needs and solutions
- Assess functioning and coping
- Provide: Reassurance
 - Psycho-education
 - Practical assistance

Crime Victim Assistance

- Protect victims' rights
- Ensure control over media contacts
- Provide criminal justice information
- Facilitate access to compensation
- Streamline bureaucratic procedures

Community Outreach

- Initiate contact at gathering sites
- Set up 24-hour telephone hotlines
- Outreach to survivors through media, Internet
- Educate service providers
- Use bilingual and bicultural workers

Participation in Death Notification

Responsible notifier:

- Obtains critical information
- Notifies next-of-kin directly, simply, in person
- Expects intense reactions
- Provides practical assistance
- Mental health participates on team, provides support and information

Brief Trauma Intervention

- Factual information
- Thoughts during event
- Reactions and feelings
- Psycho-education
- Problem-solving and action

Long-Term Interventions

- Community outreach
- Brief counseling
- Support and therapy groups
- Crime victim assistance
- Psycho-education

Beware! Common Pitfalls And Risks

- Over-involvement, doing too much
- Confusing friend and counselor roles
- Becoming lax about confidentiality
- Providing services beyond competency
- “I’m the only one who can...” syndrome
- Disengaging from family and own life

Key Events with Mental Health Implications

- Death notification
- Ending rescue and recovery
- Applying for death certificates
- Criminal justice proceedings
- Returning to impacted areas
- Funerals and memorials

Community Interventions

- Memorials and rituals
- Usual community gatherings
- Anniversary commemorations
- Symbolic gestures

Preschool-Age Children's Reactions

- Sleep problems, nightmares
- Clinging, separation anxiety
- Helplessness, passivity
- Death not permanent
- Fearfulness
- Regression
- Repetitive play

School-Age Children's Reactions

- Sleep problems, nightmares
- Preoccupation with disaster, death
- Fears about safety
- Self blame, guilt, responsibility
- Angry outbursts
- Retelling and repetitious play
- Social withdrawal
- Somatic complaints
- School performance problems

Pre-Adolescents and Adolescents

- Sleep problems and nightmares
- Self blame, guilt, shame
- Self-consciousness
- Depression, social withdrawal
- Desire for revenge
- Somatic complaints
- Aggressive and risk-taking behavior
- School performance problems

Risk Factors for Children

- Exposure to direct life threat and injury
- Witnessing mutilating injuries
- Hearing unanswered cries for help
- Degree of brutality and violence
- Unexpectedness and duration
- Separation from family

*(Pynoos, 1996;
Vogel and Vernberg, 1993)*

Screening Checklist

- Trauma and loss exposure
- Current level of distress
- Social, academic, emotional, and behavioral changes
- Traumatic reminders at home and school
- Ongoing stressors at home and school
- Other trauma in the past year

Tasks for Psychological Recovery

- Regain a sense of safety and security
- Gain understanding of child's unique experience of the trauma
- Gain understanding of actual events that have occurred
- Identify and express reactions and emotions
- Grieve and cope with traumatic stress
- Resume age-appropriate roles and activities

*(Pynoos and Nader, 1993;
Vernberg and Vogel, 1993)*

Cultural Competence

- Recognize the importance of culture and respect diversity
- Maintain a current profile of the cultural composition of the community
- Recruit disaster workers who are representative of the community or service area
- Provide ongoing cultural competence training to disaster mental health staff
- Ensure that services are accessible, appropriate, and equitable
- Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks
- Involve as “cultural brokers” community leaders and organizations representing diverse cultural groups
- Ensure that services and information are culturally and linguistically competent
- Assess and evaluate the program’s level of cultural competence

(CMHS, 2003)

Cultural Group Information

- Meanings associated with the event
- Experience with emergency response
- Trauma and violence in country of origin
- Signs and symptoms of trauma, grief
- View about mental health, providers
- Tips for professional courtesy

Basic Cultural Sensitivity

- Convey respect, good will, courtesy
- Ask permission to speak with people
- Explain role of mental health worker
- Acknowledge differences in behavior due to culture
- Respond to concrete needs

(Paniagua, 1998; Young, 1998)

Sources of Stress

- Exposure to trauma
- High-intensity assignments
- Environmental factors
- Organizational factors
- Individual factors

Stress Is:

- Normal
- Necessary
- Productive and destructive
- Acute and delayed
- Cumulative
- Identifiable
- Preventable and manageable

Organizational Approaches

- Effective management structure
- Effective managers and supervisors
- Clear purpose and goals
- Functionally defined roles
- Team support
- Plan for stress management

Individual Approaches

- Management of workload
- Balanced lifestyle
- Stress reduction strategies
- Self-awareness

Compassion Fatigue

“The natural consequent behaviors and emotions resulting from knowing about a traumatic event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person.”

(Figley, 1995)



HANDOUTS

AGE-SPECIFIC INTERVENTIONS FOR CHILDREN AND ADOLESCENTS

Age Group	At Home	At School or Other Organizations For Children
Pre-Schoolers	<ul style="list-style-type: none"> • Maintain family routines • Give extra physical comfort and reassurance • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Encourage expression of feelings through play • Monitor media exposure to disaster trauma • Develop disaster safety plan 	<ul style="list-style-type: none"> • Draw expressive pictures • Tell stories of disaster and recovery • Use coloring books on disaster, loss, coping with feelings • Read books on related themes • Use dolls, puppets, toys, blocks for re-enactment play • Facilitate group activities that foster empowerment and understanding • Talk about safety and self protection • Provide parent education and support meetings • Provide absenteeism outreach to families and children* • Identify stressed children for assessment and referral* • Provide in-service training on children and disaster, trauma, and grief* • Provide school-based crisis hotline* • Provide educational brochure for parents* • Encourage students to resume normal roles and routine activities*
Elementary-Age Children	<ul style="list-style-type: none"> • Give additional attention and consideration • Set gentle but firm limits for acting-out behavior • Listen to child's repeated telling of disaster experience • Encourage verbal and play expression of thoughts and feelings • Provide structured but undemanding home chores and rehabilitation activities • Rehearse safety measures for future disasters 	<ul style="list-style-type: none"> • Encourage free drawing after discussion of disaster • Encourage free writing after discussion of disaster, complete-a-sentence exercise • Tell stories of disaster, loss, and recovery • Read books on related themes that may generate discussion or healing • Create a play about related themes and survivorship • Facilitate school study or projects to increase understanding, promote discussion • Talk about safety, family protection, school and family preparedness* • Teach calming techniques (deep breathing, visualization)* • Conduct small group or individual interventions for at-risk children* • Conduct group "debriefing" discussion to express and normalize reactions, correct misinformation, and enhance coping and peer support*

Continued on next page

AGE - SPECIFIC INTERVENTIONS FOR CHILDREN AND ADOLESCENTS		
Age Group	At Home	At School or Other Organizations For Children
Pre-Adolescents And Adolescents	<ul style="list-style-type: none"> • Give additional attention and consideration • Encourage discussion of disaster experiences with peers, significant adults • Avoid insistence on discussion of feelings with parents • Encourage physical activities • Encourage resumption of regular social and recreational activities 	<ul style="list-style-type: none"> • *All interventions starred above apply • Conduct school programs for assisting community with recovery, helping others • Conduct projects for commemoration and memorialization • Encourage discussion of losses and feelings with peers and adults • Address rebellious, risk-taking, aggressive, or isolating behaviors • Resume sports, club, and social activities when appropriate



VIDEOTAPES

Death Notification. Mother's Against Drunk Drivers (MADD), 1996. Available: www.madd.org

Disaster Psychology: Victim Response. Catonsville, MD: Instructional Media Resources, University of Maryland, Baltimore County, 1985.

The Federal Emergency Management Agency (FEMA) funded the two videotape projects listed below through the Crisis Counseling Program. Copies are available at no charge from the Center for Mental Health Services, National Mental Health Services Knowledge Exchange Network, P.O. Box 42490, Washington, DC 20015 or by contacting www.mental-health.org or calling 1-800-789-2647.

Children and Trauma: The School's Response. Alameda County Department of

Mental Health, Santa Cruz County Department of Mental Health, and California Department of Mental Health, 1991.

Hope and Remembrance. Texas Department of Mental Health, 1997.

The Office for Victims of Crime (OVC), U.S. Department of Justice, funded the two videotape projects listed below. Copies are available at no charge through the OVC Resource Center at www.ncjrs.org or by calling 1-800-851-3420.

Special Award for Extraordinary Response to International Terrorism. Office for Victims of Crime, 2001.

The News Media's Coverage of Crime and Victimization. National Victim Assistance Academy, 2000.

The Bureau of Justice Assistance, U.S. Department of Justice, funded the videotape project listed below. Copies are available at no charge through the OVC Resource Center at www.ncjrs.org or by calling 1-800-851-3420.

Surviving the Secondary Device: The Rules Have Changed. Georgia Emergency Management Agency, 1997.



CHAPTER VIII

ADDITIONAL TRAINING NEEDS AND OPTIONS

In the immediate phase of crisis response, training quickly provides necessary logistical and intervention information. The training is action-oriented, brief, and repeated as new mental health staff join the operation. Several months after the disaster, program managers assemble a group of more permanent workers. When the mental health response program's organizational structure and procedures have become further defined, they resemble an established program, as opposed to a rapid-response mobilization.

The comprehensive disaster mental health training presented in Chapter VII may be conducted at this point in the implementation process, or may have been offered earlier. This comprehensive training provides extensive disaster mental health and crime victim background and intervention information, and also addresses team development and worker stress management. Over the duration of the mental health program, in-service continuing education is essential, as new training needs are identified and phase-related issues emerge.

Paraprofessional peer counselors can be valuable members of disaster mental health recovery programs.

While bringing varied and salient life experiences to their disaster work, paraprofessionals need additional training on counseling skills, mental health assessment and referral, and ethical issues.

This section addresses training needs beyond the comprehensive training outlined in Chapter VII. Training options included in this chapter are:

- ◆ Training for paraprofessional staff;
- ◆ Training for human service workers; and
- ◆ Topics and considerations for in-service training.

Training for Paraprofessional Staff

Paraprofessional counseling staff may be recruited from existing community programs such as crime victim advocacy and service programs, senior outreach services, faith-based programs, cultural group-oriented service programs, or disaster response volunteer organizations. These workers often reflect the demographic characteristics and ethnic and cultural groups present in the disaster-affected community. Solid interpersonal communication skills, the ability to work cooperatively with others, the psychological capacity to help

others without judgment, and the ability to maintain confidentiality are desired qualities for paraprofessional counselors.

When paraprofessional staff have participated in a training session on counseling skills before the program's comprehensive disaster mental health training, they are able to engage with the material from a broader context and foundation. An initial two or three-day training course with regular weekly or biweekly continuing education and supervision sessions is suggested.

Newly trained paraprofessional counselors should initially work in teams with mental health professionals. It is critically important that roles and limits are clearly defined for paraprofessional counselors and that they have ready access to clinical supervisors.

The following topics are recommended for inclusion in training for paraprofessional staff:

Counseling Skill Development

Active listening: Using nonverbal cues, giving minimal encouragement (nods and "uh-huhs"), conveying empathy, paraphrasing,

reflecting feelings, summarizing, differentiating content and feelings.

Asking questions: Interviewing techniques, asking open and closed questions, focusing with questions, avoiding using questions to give advice or make judgments.

Providing support and encouragement: Establishing rapport, empowering the survivor, giving positive feedback about coping strengths, offering suggestions, avoiding communication blocks and unhelpful phrases.

Counseling Interventions

Crisis intervention: Assessing capacity to live independently, evaluating suicide and dangerousness risk, giving reassurance, building hope, protocols for immediate response, procedures for consultation, referral and follow-up.

Listening to disaster experiences: Active listening to the telling (and retelling) of traumatic and loss experiences, exploring feelings and reactions, educating about traumatic stress and healthful coping strategies.

Problem-solving: Identifying and defining the problem, exploring feelings, brainstorming solutions and resources, setting realistic

goals, taking action, evaluating results.

Self-Awareness

Motivations for helping:

Exploring personal experiences, understanding helping relationships versus friendships, over-identifying with survivors.

Awareness of feelings:

Identifying and articulating feelings, becoming familiar with range of “feeling words,” tolerating expressions of intense emotions that may be uncomfortable.

Stereotypes and values:

Exploring personal biases and prejudices, avoiding judgmental attitudes, promoting respect for differences.

Assessment of Mental Health and Other Problems

- ◆ Basic overview of post-traumatic stress, grief and loss, depression, anxiety, alcohol and drug abuse, child and elder abuse, mental illness, cognitive impairment/dementia—symptom recognition, initial assessment strategies, procedures for consultation, referral and follow-up.

Legal, Ethical, and Program Considerations

- ◆ Confidentiality, State law, and reporting requirements and procedures;
- ◆ Record keeping, program reporting and monitoring;
- ◆ Boundaries of relationship with clients;
- ◆ Stress prevention and management (Chapter V); and
- ◆ Consultation, supervision, and continuing education.

Paraprofessional staff training emphasizes that the helping person is in a privileged position. Helping someone in need implies a sharing of problems, concerns, and anxieties—sometimes with very personal details. This sharing cannot be done without a trust built upon mutual respect and the explicit understanding that all discussions are confidential and private. This mutual respect also involves acceptance of the survivor’s experience, thoughts, and feelings. Judging, moralizing, or telling survivors how to feel only alienates and undermines the helping relationship.

Counseling skill-building through role-playing, observing role models, discussing case examples, and giving and receiving feedback

helps paraprofessional staff gain competency. Having clear guidelines for assessment and referral helps counselors function within the boundaries of their training. Training facilitators must be adept at identifying and processing feelings, evaluating and promoting counseling skill development, and providing clear and concise procedures for handling challenging situations. Training for paraprofessional counselors should be ongoing and integrated with case consultation and practicing counseling skills.

Training for Human Service Workers

Human service workers may be directly involved in the disaster relief effort through Federal, State or local agencies, emergency services, law enforcement, crime victim services agencies, the American Red Cross, the Salvation Army, or local religious organizations. Most will benefit from focused training on disaster mental health issues geared to their respective roles. Developing a good working relationship with these entities for mutual referrals is a valuable by-product of such training. The companion Field Manual is a helpful resource as an adjunct to training.

This training can be accomplished in several ways. Representatives from the various agencies and organizations may attend the comprehensive mental health course described in Chapter VII. When this occurs, the trainer should rearrange the training schedule so that representatives from outside agencies attend for the first day, or mornings. The training agenda should efficiently address these representatives' needs, while meeting the diverse training needs of the mental health program staff.

Another alternative is providing on-site disaster mental health training with each group. The training then can specifically address each group's needs. Activities, overheads, videos, and handouts can be used from the comprehensive training as needed. However, losing exposure to the entire mental health program staff is a trade-off.


Disaster relief and recovery workers compose one type of human service worker involved with survivors. Other human service workers encounter survivors in the course of conducting business or providing services. Examples are home health nurses, public assistance workers, school personnel, building permit inspectors,

faith-based staff, or primary health care providers. Disaster mental health training and educational materials can assist these individuals in better serving survivors and to refer those in need for mental health services. Also, these individuals can distribute disaster stress and coping brochures to survivors.

The program may establish a task group to design outreach strategies, training presentations, and educational materials for these collateral providers and human service workers in the community. Since experience has shown that many survivors are more likely to talk with their physician, faith-based counselor, or someone already known to them before talking with a professional, outreach and education with these groups is extremely important.

Topics and Considerations For In-Service Training

The comprehensive training course provides staff with an overview of mental health interventions following incidents involving mass violence and terrorism. Because of the significant psychological and physical impact of these events,



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additional training and clinical supervision on group and individual counseling interventions with survivors and family members is necessary. As staff engage with the various disaster-affected communities over time, additional phase-related training needs become apparent. These identified training needs may involve particular population groups, specific community issues, or needed modifications of intervention strategies. Timing or phase-related topics, such as the one-year anniversary of the disaster, may become relevant.

In-service training also brings the staff together to strengthen group cohesion, social support, morale, and creativity. The focus of the session may be tending to the emotional challenges of disaster work through personal sharing and problem-solving new solutions. Some of the suggestions and exercise ideas in Chapter V, "Stress Prevention, Management and Intervention," can be included in the training. A skilled facilitator may identify organizational issues or procedures that may interfere with staff well-being or program effectiveness that can be addressed through team-building interventions.

The following are examples of in-service training topics:

- ◆ Media policies, relations, and dissemination of public information;
- ◆ Public speaking skills for disaster mental health presentations;
- ◆ Stress management interventions for survivors, disaster workers, and program staff;
- ◆ Addressing compassion fatigue and secondary traumatization;
- ◆ Outreach, support, and interventions with emergency responders and other high-exposure occupational groups and their families;
- ◆ More extensive training on serving children, elder adults, or ethnic/cultural groups in the community;
- ◆ Long-term family stress issues, family counseling, and intervention;
- ◆ Criminal justice process and impact on survivors and families;
- ◆ Mental health program role and interventions with post-traumatic stress disorder, traumatic bereavement, anxiety disorders, depression,

adjustment to disabling injuries, and alcohol and drug abuse problems;

- ◆ Expressive intervention approaches (art, music, drama, writing, community projects) with adults and children;
- ◆ Individual and group trauma and grief counseling with at-risk children;
- ◆ Models for therapy and support groups;
- ◆ Community organizing to address unmet disaster-related needs;
- ◆ Anniversary reactions and commemorative events;
- ◆ Steps for program phase-down and termination of program and services; and
- ◆ Final celebration of program success and lessons learned.



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<http://www.aacap.org>

American Psychiatric Association

<http://www.psych.org>

American Psychological Association

<http://www.apa.org>

American Red Cross

<http://www.redcross.org>

Federal Emergency Management Agency

<http://www.fema.gov>

International Society for Traumatic Stress Studies

<http://www.istss.org>

Mothers Against Drunk Drivers (MADD)

<http://www.madd.org>

National Center for Post-Traumatic Stress Disorder/U.S. Department of Veteran Affairs

<http://www.ncptsd.org>

National Child Traumatic Stress Network

<http://www.nctsnet.org>

Office for Victims of Crime/U.S. Department of Justice

<http://www.ojp.usdoj.gov/ovc/>

Office for Victims of Crime Resource Center

<http://www.ncjrs.org>

Substance Abuse and Mental Health Services Administration

<http://www.samhsa.gov>