



MENTAL HEALTH RESPONSE TO MASS VIOLENCE AND TERRORISM



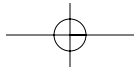
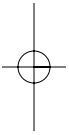
A FIELD GUIDE



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov



U.S. DEPARTMENT OF JUSTICE
Office of Justice Programs
Office for Victims of Crime
www.ojp.usdoj.gov/ovc



MENTAL HEALTH RESPONSE TO MASS VIOLENCE AND TERRORISM



A FIELD GUIDE

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
2005

ACKNOWLEDGMENTS

This publication was produced under Interagency Agreement #RA00C5400A between the U.S. Department of Justice (DOJ), Office for Victims of Crime (OVC), and the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA). DOJ provided funds for the development of the document; SAMHSA provided funds for the editing, design, and layout of the publication; and the Federal Emergency Management Agency (FEMA) provided the funds for printing. The document was written by Deborah J. DeWolfe, Ph.D., M.S.P.H., and reviewed by a group of experts on mass violence and mental health response. The SAMHSA Disaster Technical Assistance Center (DTAC), ESI, under contract with CMHS, edited the document and designed the cover and layout for this publication.

Disclaimer

The content in this publication is solely the responsibility of the author and does not necessarily represent the position of U.S. DOJ, OVC; SAMHSA or its centers. This publication is a companion piece for *Mental Health Response to Mass Violence and Terrorism: A Training Manual* (SAMHSA Publication No. SMA 3959), and all material referenced in the *Field Guide* is cited in the *Training Manual*, References and Additional Reading section.

Public Domain Notice

All material appearing in this publication is in the public domain and may be reproduced or copied without permission from SAMHSA or CMHS. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, Department of Health and Human Services (DHHS).

Electronic Access and Copies of Publication

This publication can be accessed electronically through the following Internet connections: www.samhsa.gov and www.ncjrs.org. For additional free copies of this document, please contact SAMHSA's National Mental Health Information Center, and ask for Publication No. SMA 4025, at 1-800-789-2647, 1-866-889-2647 (TDD); or contact the OVC Resource Center, and ask for Publication No. NCJ 205452, at 1-800-851-3420, 1-877-712-9279 (TTY).

Recommended Citation

U.S. Department of Health and Human Services. *Mental Health Response to Mass Violence and Terrorism: A Field Guide*. DHHS Pub. No. SMA 4025. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

Originating Office

Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Rockville, Maryland 20857
DHHS Publication No. SMA 4025
Printed 2005

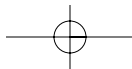
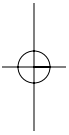
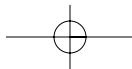
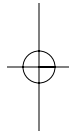
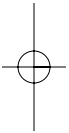


TABLE OF CONTENTS

Introduction	vii
Key Principles for Mental Health Intervention	1
Survivors' and Families' Immediate Needs	5
Psychological First Aid and Counseling Skills	7
Establishing Rapport	8
Active Listening	8
Some Possible Do's and Definite Don'ts	9
Psychological First Aid	11
Problem Solving	12
A Word of Caution	14
Confidentiality	14
When to Refer for Mental Health Services	15
Populations with Special Needs	17
Age Groups	18
Table 1: Reactions to Trauma	19
Highly Impacted Survivors and Families	24
Cultural, Ethnic, and Racial Groups	24
People with Serious and Persistent Mental Illness	26
Human Service, Criminal Justice, and Emergency Response Workers	26
Stress Prevention, Management, and Intervention	27
Table 2: Organizational Approaches	29
Table 3: Individual Approaches	30
Internet Sites	31



INTRODUCTION

This *Field Guide* is intended for mental health and disaster workers; first responders; government agency employees; and crime victim assistance, faith-based, healthcare, and other service providers who assist survivors and families during the aftermath of mass violence and terrorism. All who come in contact with victims and families can contribute to restoring their dignity and sense of control by interacting with sensitivity, kindness, and respect. This *Field Guide* provides the basics of responding to those in crisis.

Human-caused events such as mass shootings, bombings, riots, exposure to biohazards, and acts of terrorism are deliberately planned and perpetrated for political, sociocultural, revenge-motivated, or hate-based reasons. Acts of mass violence and terrorism target a building, neighborhood, particular site, or event. Those confronted with life threat, mass casualties, overwhelming terror, and human suffering may experience severe psychological stress and trauma. Survivors, families, and the affected communities cope not only with the resulting deaths, injuries, and destruction but also with the horrific knowledge that their losses were caused by intentional human malevolence. When rescue and recovery efforts extend over weeks and months, family members endure prolonged uncertainty and an ongoing threat of possible future attacks, which contribute to heightened anxiety and a sense of vulnerability. These traumatic realities also impact first responders, media personnel, government officials, and others whose job-related responsibilities bring them in contact with the disaster's tragic impact.

Because disasters caused by mass violence and acts of terrorism are also crimes, law enforcement and the criminal justice system fill primary roles. When the underlying motivation is terrorism, Federal criminal justice agencies are responsible for the investigation and prosecution. The disaster's impact zone becomes a

secured crime scene. Crime victims and their families have the legal right to receive information about criminal justice activities, participate in the criminal justice process, and receive protection from intimidation and harassment. They may apply for benefits and compensation for crime-related expenses. This interplay of emergency response, criminal justice, and disaster relief and recovery systems is a defining feature of the response to mass violence and terrorism.

This *Field Guide* includes essential information about survivors' and family members' reactions and needs, with specific suggestions for assisting children, adolescents, adults, and older adults. It describes basic "helping" skills with indicators for when to refer someone to a licensed mental health professional. The last section presents strategies for worker* stress prevention and management.

This *Field Guide* draws from material contained in *Mental Health Response to Mass Violence and Terrorism: A Training Manual* and highlights practical approaches. The *Training Manual* provides in-depth and comprehensive information, and references for additional reading.

*In this *Field Guide*, the term "worker" refers to service providers and others who assist survivors and families.



KEY PRINCIPLES FOR MENTAL HEALTH INTERVENTION

Workers assisting survivors and family members may find the following key principles helpful, as they frequently are used by seasoned crime victim assistance and disaster mental health professionals:

- ◆ No one who witnesses the consequences of mass criminal violence is unaffected by it.
- ◆ Mass violence and terrorism result in two types of human impact—individual and community.
- ◆ Mental health, crime victim assistance and other human services must be uniquely and individually tailored to the communities they serve. Cultural competence is essential.
- ◆ While most traumatic stress and grief reactions are normal responses to extraordinary circumstances, a significant minority of survivors experience serious, long-term psychological difficulties.

- ◆ Most survivors and families respond to active, genuine interest and concern. However, some will reject services of all kinds.
- ◆ Mental health assistance is practical, flexible, empowering, and respectful of survivors' needs to pace their exposure to harsh realities resulting from the event. First and foremost, providers must **do no harm** when intervening.
- ◆ Procedures and protocols used by emergency services, law enforcement, medical examiners' offices, and the criminal justice system can confuse and distress survivors. Clear, sensitive explanations are helpful.
- ◆ Support from family, friends, and the community helps survivors and families cope with trauma and loss.

When mass violence occurs, innocent and unsuspecting people are caught by surprise in the course of their daily routines. These people usually are well-functioning and resilient. They have the capacity to cope with the profound psychological demands and losses they experience. Communities, families, and social support systems pull together to comfort and support those most impacted.

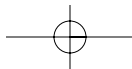
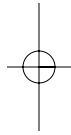
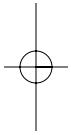
Workers providing emotional support take a practical, down-to-earth approach. They reach out to survivors and respectfully offer reassurance, a listening ear, a warm beverage, concrete information about what will happen next, and practical assistance with immediate tasks. Survivors and families may gather at designated sites such as community centers, schools, employment settings, local places of worship, and disaster relief centers. They may not think they need "psychological counseling" or "mental health services" but may welcome genuine concern and help to cope with the stress. "Mental health support" can even take place over a cup of coffee.

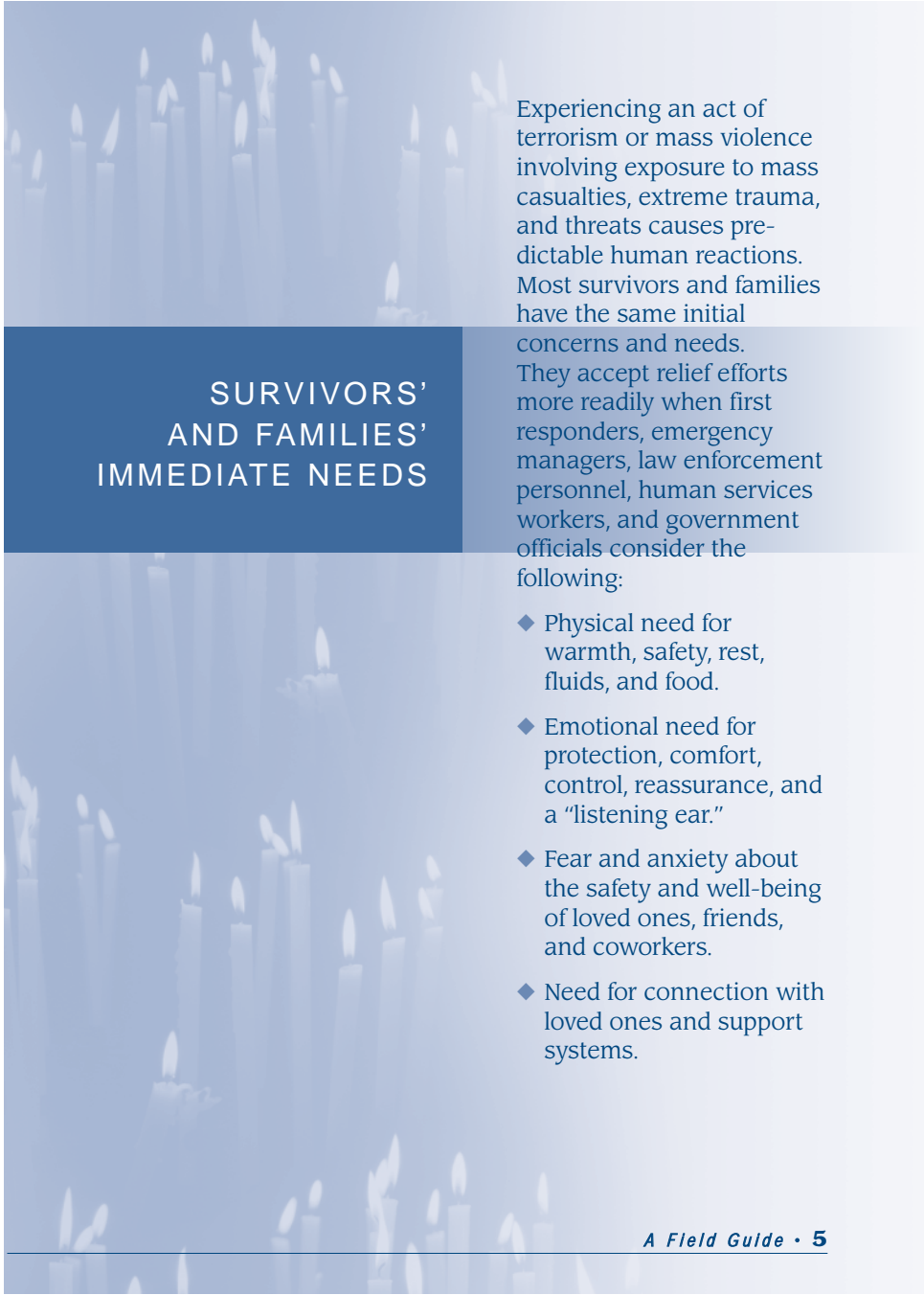
Communities vary in their cultural, racial, and ethnic compositions including: the presence of refugee or immigrant groups,

the primary languages spoken, and demographic and socio-economic characteristics. A particular group may have been the target of violence due to prejudice or hate. If the alleged perpetrators are from a particular country or group, U.S. citizens and residents with similar physical characteristics or origins may be at risk for harassment and retaliatory violence. Crisis mental health support must help each affected group in the community.

Tailor Support to Community Needs

- ✓ Be culturally sensitive.
- ✓ Provide information and services in the appropriate language.
- ✓ Understand the disaster's specific impact on affected cultural groups.
- ✓ Collaborate and consult with trusted organizations and community leaders to serve all members of the community.





SURVIVORS' AND FAMILIES' IMMEDIATE NEEDS

Experiencing an act of terrorism or mass violence involving exposure to mass casualties, extreme trauma, and threats causes predictable human reactions. Most survivors and families have the same initial concerns and needs.

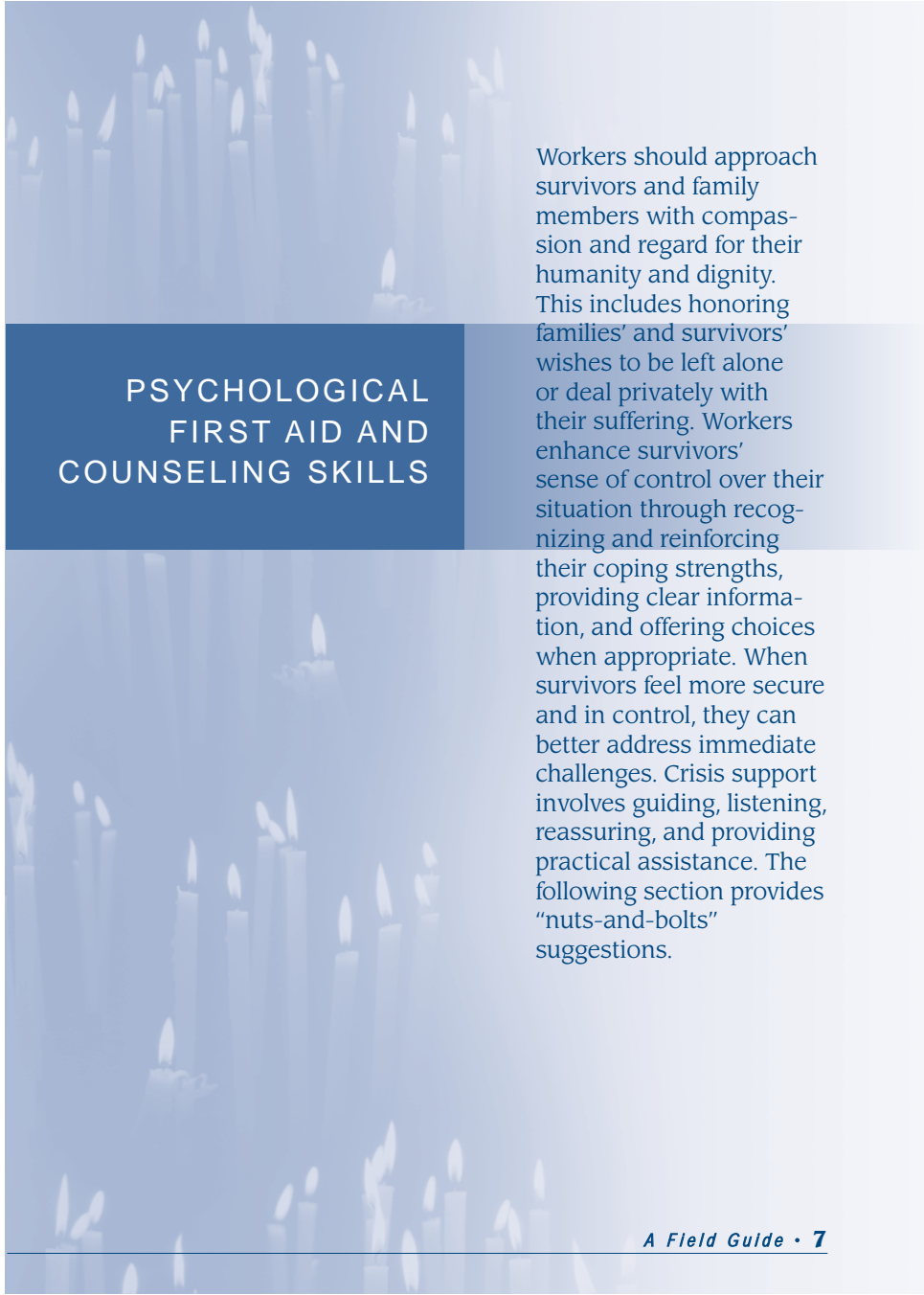
They accept relief efforts more readily when first responders, emergency managers, law enforcement personnel, human services workers, and government officials consider the following:

- ◆ Physical need for warmth, safety, rest, fluids, and food.
- ◆ Emotional need for protection, comfort, control, reassurance, and a “listening ear.”
- ◆ Fear and anxiety about the safety and well-being of loved ones, friends, and coworkers.
- ◆ Need for connection with loved ones and support systems.

- ◆ Desire for frequent updates regarding the status of rescue and recovery efforts, criminal investigations, potential threats, and what is going to happen next.
- ◆ Need for clear, sensitive explanations of: emergency medical procedures; medical examiner's office procedures and protocols; the criminal justice process; the rationale for high-impact operational decisions; and immediately available services, benefits, grants, and assistance.
- ◆ Need for death notification conducted in a straightforward, clear, and compassionate manner.
- ◆ Normal trauma reactions such as fearfulness, numbness, jumpiness, sleep and concentration problems, and replaying traumatic images and sounds.

In the days and weeks following mass violent victimization, initial shock gives way to the realization of personal losses. The life-changing implications of death, the destruction of home and community, serious injuries, and the loss of a sense of safety and security in the world become increasingly apparent. Other consequences such as loss of employment, and relocation of home, school, or place of worship exacerbate disruption and grieving. Survivors and families psychologically pace themselves according to individual timeframes and personal coping styles.

Survivors and families often face numerous logistical and practical issues that can seem overwhelming. Workers may facilitate assistance with transportation, child care, locating a missing loved one or pet, funeral arrangements, finding temporary housing, filling prescriptions, replacing eyeglasses, and providing healthy foods and beverages. They also may help facilitate filling out the necessary paperwork for obtaining crime victim compensation and benefits, a death certificate, disaster-related unemployment, insurance benefits, and financial assistance. Through helping with practical tasks, workers often earn survivors' trust and the privilege to support them when they express their pain, fear, sorrow, and anger.



PSYCHOLOGICAL
FIRST AID AND
COUNSELING SKILLS

Workers should approach survivors and family members with compassion and regard for their humanity and dignity. This includes honoring families' and survivors' wishes to be left alone or deal privately with their suffering. Workers enhance survivors' sense of control over their situation through recognizing and reinforcing their coping strengths, providing clear information, and offering choices when appropriate. When survivors feel more secure and in control, they can better address immediate challenges. Crisis support involves guiding, listening, reassuring, and providing practical assistance. The following section provides "nuts-and-bolts" suggestions.

Establishing Rapport

When making initial contact, workers should introduce themselves and briefly explain their roles. They may ask permission to sit down, since standing over people when they are seated may seem intimidating. Workers convey genuine interest and concern through eye contact, the assurance of safety, offering a warm beverage, and a calm presence. They provide comfort, support, and nonjudgmental response to expressed immediate needs. Trust and safety are enhanced when workers listen to what distressed survivors and family members choose to discuss and avoid asking intrusive questions.

Active Listening

Workers listen most effectively when they absorb information through their ears, eyes, and hearts. Some tips for effective listening are:

- ◆ **Support personal “pacing”**—Many survivors and family members want to talk about their traumatic experiences. Putting terrifying and tragic experiences into words and having them heard while receiving emotional support can contribute to the healing process. Others may choose to focus on concrete tasks or seemingly inconsequential matters, temporarily avoiding direct discussion of their trauma and loss. Workers should look for cues regarding comfort levels, coping style, and appropriate pacing, and allow survivors and family members to take the lead with personal sharing.
- ◆ **Allow silence**—Silence can give a person time to reflect and become aware of feelings. Silence may help survivors identify what is most important to them at the moment, or be a prompt for elaboration on thoughts and reactions. Simply “being with” the survivor or family member can be supportive.
- ◆ **Attend nonverbally**—Eye contact, head nodding, caring facial expressions, and being at the same physical level (e.g., sitting,

standing) let the person know that the worker is listening. Observing and heeding cultural differences with regard to non-verbal communication conveys cultural sensitivity and can enhance acceptance of help.

- ◆ **Paraphrase**—The worker conveys understanding, interest, and empathy by repeating portions of what the person has said. Paraphrasing also checks for accuracy, clarifies misunderstandings, and lets the person know that he or she is being heard. Good lead-ins are: “So you are saying that...,” “It sounds like you...,” or “I have heard you say that...” Paraphrasing may seem awkward at first, but is an effective tool for building trust.
- ◆ **Reflect feelings**—The worker may notice that the person’s tone of voice or nonverbal gestures suggest emotions such as anger, sadness, or fear. Possible responses are, “You seem afraid of spending the night at home alone. Is that true?” This helps the person to identify and articulate emotions and needs.
- ◆ **Allow expression of emotions**—Communicating intense emotions through tears or venting is an important part of healing. It often helps the survivor or family member work through feelings so that he/she can better address the immediate tasks at hand. Workers should stay relaxed and let the person know that it is okay to feel and express emotions. [Suggestions in the “Stress Prevention, Management, and Intervention” section may be helpful.]

Some Possible Do’s and Definite Don’ts

Do say:

- ✓ You have temporarily lost your sense of safety and security. You will feel better over time.
- ✓ It is understandable that you feel this way.

- ✓ This is your body's and mind's way of dealing with what has happened to you. Your reactions are normal.
- ✓ Feeling intense emotions and having thoughts that you have never had before is normal. You are not going crazy.
- ✓ You didn't do anything wrong. It wasn't your fault. You did the best you could.
- ✓ Things will never be the same as they were, but you will gradually feel better.

Don't say:

- ✓ It could have been worse. You're lucky that....
- ✓ It's best if you just stay busy.
- ✓ You should count your blessings, it will make you feel better.
- ✓ I know just how you feel.
- ✓ He/she is in a better place now.
- ✓ You need to get on with your life.

While the human desire is to try to "fix" the survivor's or family member's painful situation or to make them feel better, hearing comments in the preceding "Don't Say," however, can make a person feel discounted, judged, misunderstood, or more alone. Workers may find it difficult not to overidentify with survivors and families. They should allow survivors and families the space for their own experiences, feelings, and perspectives—whatever they are. Simply listening with respect, concern, and calmness can comfort them.

Psychological First Aid

During and immediately after an act of mass violence or terrorism, those most affected may experience shock, confusion, fear, numbness, panic, and anxiety. They may “shut down.”

Witnessing or suspecting the death of loved ones or friends can be emotionally overwhelming. Some people may be locked in disbelief. When the perpetrators have not been apprehended or the event is considered terrorism, all may experience a sense of continued threat and danger. Workers have seven immediate tasks and purposes:

1. Identify those in need of medical attention for intense stress reactions.
2. Provide protection from further harm, and assistance to a safe environment.
3. Ensure that survivors are warm/cool enough and are being given fluids and food.
4. Promote a sense of security through orienting and reassurance.
5. Connect survivors with family, friends, and loved ones.
6. Provide information about the crime scene and perpetrators, status of rescue efforts, and what will happen next.
7. Connect survivors and family members with resources for immediate help (e.g., voluntary agencies, crime victim assistance, systems for locating missing persons, emergency shelter and food, faith-based resources, and disaster mental health and psychiatry).

Problem Solving

Stress resulting from trauma, crime victimization, and sudden bereavement often causes disorganized thinking, concentration problems, and difficulty planning and making decisions. Some people react by feeling overwhelmed and may become either immobilized or unproductively overactive. Workers can encourage survivors and family members to participate in simple concrete tasks to help them focus and assume a more active role in coping. Also, workers can guide individuals through the following problem-solving steps to help prioritize and address immediate issues.

◆ Identify current priority needs and problems and possible solutions

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

Selecting one solvable problem and then successfully addressing it can help restore a sense of control and capability. Avoid picking a complex problem first. Support the person in identifying a task that is easily completed.

◆ Assess functioning and coping

“How are you doing? How do you feel about how you are coping?”

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

Through observation, gently asking questions, and reviewing the magnitude of the person’s problems and loss, the worker develops an impression of the person’s capacity to address current challenges. Based on this assessment, the worker may

point out coping strengths, facilitate the person's engagement with social supports, or make referrals. The worker may also seek consultation from a medical or mental health professional.

◆ **Evaluate available resources**

"Who might be able to help you with this task/problem?"

"What resources and options might be helpful?"

Explore existing sources of assistance and support such as immediate and extended family, loved ones, friends, neighbors, coworkers, religious leaders, and healthcare providers. Connect the survivor or family member with the appropriate community, crime victim assistance, and disaster relief resources and assess if he/she is able to make the calls and complete the required paperwork. Assist with accessing resources when necessary.

◆ **Develop and implement a plan**

"What steps will you take to address this problem?"

Encourage the survivor or family member to say out loud what they plan to do and how. Offer to check in for support and to see how he/she is doing. If the worker has agreed to perform a task or get information, it is very important to follow through. A plan may focus on a very short timeframe or limited actions. For example, a plan could be to make two phone calls. Being reliable and following up, even when there is no new information, helps survivors gain control. Workers should promise only what they can do, not what they **would like** to do.

A Word of Caution

When confronted with a survivor's or family member's seemingly overwhelming and heart-wrenching needs, workers can feel the understandable impulse to help in every way possible. Workers may become over-involved and do too much for the survivor or grieving family, which is usually not in the survivor's or family's best interest. While being helpful and available, workers should also convey their confidence in the individual's coping abilities and resilience. When survivors and families are empowered to address their own problems, they feel more capable to tackle the next challenge.

Confidentiality

The privilege of helping others carries ethical responsibilities. Helping people in need involves learning their problems, concerns, fears, and anxieties—sometimes with very personal details. This sharing must be done with a sense of trust, built upon mutual respect, and the understanding that all discussions are confidential. No person's situation or "case" should be discussed elsewhere without the consent of the person being helped, except in extreme situations when the worker believes the person might harm him/herself or others. Under those circumstances, workers should report concerns to their supervisors so that the appropriate authorities may be contacted.

Workers should avoid discussing information in public places, such as restaurants, that might give the impression that privacy is not being protected. Only by maintaining the trust and respect of the survivor or family member can the privilege of helping continue.



WHEN TO REFER FOR MENTAL HEALTH SERVICES

Workers should make referrals to mental health and other healthcare professionals when they encounter survivors and family members with severe physical or emotional reactions. Some may have preexisting physical or psychiatric conditions that have worsened because of traumatic stress. The following reactions, behaviors, and symptoms signal a need for the worker to consult with his or her supervisor and, in most cases, refer the person for assessment and more specialized assistance. In all instances, **when in doubt, consult.**

- ◆ **Disorientation:** The person is dazed and unable to give date or time, location, and events of the past 24 hours, or understand what is happening.
- ◆ **Anxiety and Hyperarousal:** The person is highly agitated, restless, jumpy, and on edge; is unable to sleep; has frequent disturbing

nightmares, flashbacks, and intrusive thoughts; or broods over circumstances surrounding the event.

- ◆ **Dissociation:** The person exhibits pronounced emotional disconnection, an incomplete awareness of the traumatic experience, a sense of seeing him/herself from another perspective, a perception that the environment is unreal or that time is distorted.
- ◆ **Depression:** The person exhibits pervasive feelings of hopelessness and despair; unshakeable feelings of worthlessness, guilt, or self-blame; frequent crying for no apparent reason; withdrawal from others; or inability to engage in productive activity.
- ◆ **Mental Illness:** Symptoms include hearing voices, seeing things or people that are not there, delusional thinking, appearing out of touch with reality, and excessive pre-occupation with an idea or thought.
- ◆ **Inability to Care for Self:** The person does not eat, bathe, or change clothes; is apathetic, isolated from others, and unable to manage activities of daily living.
- ◆ **Suicidal or Homicidal Thoughts or Plans:** The person makes statements like "I can't go on," "I just want to end this terrible pain I'm feeling," "I wish that I had died," "I want to join my husband in heaven," or "I'm going to get even." The person feels pervasive self-blame or sense of responsibility for another person's death.
- ◆ **Problematic Use of Alcohol or Drugs:** The person makes references to getting drunk, getting high, or not being able to stop drinking; blocks out pain with mood-altering substances; relapses from previous abstinence; misses work or other obligations due to alcohol or drug use; or expresses concern about a family member's substance use.
- ◆ **Domestic Violence, Child Abuse, or Elder Abuse:** The person mentions instances of inappropriate anger or violence toward family members.



POPULATIONS WITH SPECIAL NEEDS

Terrorism and mass violence inevitably touch all who are in their zone of impact. This zone may include people of different ages and economic means; people of various cultural, racial, and ethnic backgrounds; people with different sexual orientations and family configurations; people who speak foreign languages; people from many occupational groups; and people who have roles in emergency response and recovery efforts.

The basic human need for survival, safety, protection, connection with loved ones, and accurate information are shared, while additional needs may be more specific to a particular group. Workers are most effective when they are informed about, respectful of, and responsive to the various groups in the affected community. Special consideration should be given to the following groups as well as others with special needs:

- ◆ Age groups (e.g., children, teenagers, older adults);
- ◆ Highly impacted survivors and families;
- ◆ Cultural, ethnic, and racial groups;
- ◆ People with serious and persistent mental illness;
- ◆ Human service, criminal justice, and emergency response workers.

Age Groups

Each age group is vulnerable in unique ways to the stress of trauma, victimization, and sudden bereavement. Some of the reactions listed in Table 1 may be immediate, while others may appear months later. Table 1 describes possible behavioral, physical, and emotional reactions of different age groups and options for helpful intervention.

TABLE 1: REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION

Ages	Behavioral	Physical	Emotional	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 • Fear 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

Continued from previous page

TABLE 1:		REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION		
Ages	Behavioral	Physical	Emotional	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

TABLE 1:		REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION		
Ages	Behavioral	Physical	Emotional	Intervention Options
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 • Use of alcohol or illegal drugs 	<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

Continued from previous page

TABLE 1:		REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION		
Ages	Behavioral	Physical	Emotional	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 • Hypervigilance • Isolation, withdrawal, shutting down • Increased use of alcohol or illegal drugs 	<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

TABLE 1: REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION

Ages	Behavioral	Physical	Emotional	Intervention Options
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 • Increased susceptibility 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 "handouts" 	<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

Highly Impacted Survivors and Families

Research has shown that those who directly experience violent victimization and mass traumatization, witness the serious injury and physical mutilation of others, or suffer the murder of a loved one have a likelihood of intense and prolonged emotional, behavioral, and physical reactions. They are likely to suffer high levels of distress during the immediate response phase and may have periods of difficulty for years to come. Critical events that occur throughout the criminal justice process, such as trials, sentencing hearings, and appeals, are especially significant to this group and are often linked to restimulation of psychological wounds.

Workers support these survivors and family members by providing respectful and practical assistance, making needed information reliably available, and supporting the multiple pathways for coming to terms with overwhelming trauma and loss. Religious and cultural traditions; spiritual practices; community, family, and personal rituals; and symbolic gestures can soothe survivors' anguish and assist them with finding meaning and the courage to continue living. At different points during the process of coming to terms with loss and trauma, activities and interventions such as counseling, support groups, medication, spiritual guidance, social activism, helping others, artistic expression, and symbolic healing rituals may be helpful.

Cultural, Ethnic, and Racial Groups

Workers must respond sensitively and specifically to the various cultural groups affected by mass violence. The death of a loved one, community trauma, and mass victimization are interwoven with cultural overlays. Rituals surrounding death, the appropriate handling of physical remains, funerals, burials, memorials, and belief in an afterlife are all deeply embedded in culture and religion. The serious injury of a family member brings families from different cultures into contact with Western medicine and the

healthcare delivery system. The situation may be even more challenging when English is not the family's primary language.

Cultural and ethnic groups with histories of violent oppression, terrorism, or war in their countries of origin may interpret community violence in the United States through their experiences of prior traumatization. Those who have suffered from political oppression and abuses of military power may find the prominent visibility of uniformed personnel highly distressing or even traumatizing. Some survivor groups may live in a context of poverty, discrimination, or marginalization and face high rates of violent crime in their neighborhoods, potentially making them more vulnerable to disaster impact.

Workers convey cultural sensitivity when they provide informational briefings, notifications, and applications for services and benefits in primary spoken languages. Workers must learn about each affected group's cultural norms, practices, and traditions; views regarding mental health, trauma, and grieving; and the group's local history and community politics. Establishing working relationships with trusted organizations, service providers, and community leaders often facilitates increased acceptance.

Workers communicate cultural sensitivity when they:

- ✓ Use culturally accepted courteous behavior (e.g., greetings, physical space, know who is considered "family");
- ✓ Describe their role in culturally relevant terms;
- ✓ Take time to establish rapport;
- ✓ Provide information and services in appropriate languages;
- ✓ Ask about cultural practices when they are unsure;
- ✓ Value diversity and respect differences;
- ✓ Develop and adapt approaches and services to fit special group needs.

People with Serious and Persistent Mental Illness

Many survivors with mental illness function fairly well following a community disaster, especially if essential services and support networks have not been interrupted. Most have the same capacity as the general population to “rise to the occasion” and perform heroically during the immediate response period. However, those who are directly involved and traumatized by the event may need additional mental health support services, medications, or hospitalization to regain stability. For survivors previously diagnosed with posttraumatic stress disorder (PTSD), emergency response stimuli (e.g., sirens, helicopters, mass casualties) may trigger an exacerbation due to associations with prior traumatic events.

The range of support services designed for the general population is equally beneficial for survivors and family members with mental illness. As with all special population groups, workers need to be aware of how people with mental illness perceive disaster assistance and services, and build bridges that facilitate access.

Human Service, Criminal Justice, and Emergency Response Workers

Workers in all aspects of emergency response and disaster relief experience considerable demands to meet the needs of survivors, families, and the community. Depending on their role, workers may be exposed to human suffering, fatalities, people with serious physical injuries, family demands and anguish, community anger, and other difficulties. They may experience physical stress symptoms or show signs of stress overload. Indicators include irritability, over-involvement with and inability to leave the operation, difficulty focusing, being unproductive, feeling depressed, or feeling emotionally overwhelmed. Workers may intervene by suggesting or using the strategies described in the next section.



STRESS
PREVENTION,
MANAGEMENT, AND
INTERVENTION

Workers must cope with a range of challenging stressors. The devastating losses, casualties, destruction of property, and emotional pain of survivors and bereaved loved ones touch providers in powerful and personal ways. The emergency response working environment often involves physical hardship, unclear roles and responsibilities, limited resources, rapidly changing priorities, intrusive media attention, and long work hours.

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

A proactive stress management plan focuses on two critical contexts: the organizational and the individual. Adopting a preventive approach allows managers and workers to anticipate stressors and manage potential crises rather than simply reacting to them after they occur.

When stress prevention and management strategies are built into operations and the organizational culture, providers feel valued and supported as they engage in this emotionally demanding work. Suggestions for organizational stress prevention, management, and intervention are presented in Table 2, and suggestions for individual stress prevention, management, and intervention are presented in Table 3.

TABLE 2: ORGANIZATIONAL APPROACHES FOR STRESS PREVENTION, MANAGEMENT, AND INTERVENTION	
Dimension	Intervention
Effective Management Structure and Leadership	<ul style="list-style-type: none"> • Clear chain of command and reporting relationships • Available and accessible leads and clinical supervisors • Use of managers experienced in emergency response and community trauma
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, community memorial) • Training and orientation for all workers
Functionally Defined Roles	<ul style="list-style-type: none"> • Staff who are oriented and trained according to written role descriptions for each assignment setting • When setting is under jurisdiction of another agency (e.g., Mayor's Office, Medical Examiner's Office, American Red Cross), staff are informed of mental health provider's role, contact people, and mutual expectations
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 • Necessary supplies (e.g., paper, forms, pens, educational materials) • Communication tools (e.g., mobile phones, radios) • Delegating "regular" workload so workers do not attempt disaster response and usual job
Team Support	<ul style="list-style-type: none"> • Buddy system for support and monitoring stress reactions • Positive atmosphere of support, mutual respect, and tolerance • Clinical support, 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 • "Floating through" work areas to observe signs of stress • Education about signs and symptoms of worker stress and coping strategies • Intervention plan incorporating elements from Table 3 • Exit plan for workers leaving the operation

TABLE 3: INDIVIDUAL APPROACHES FOR STRESS PREVENTION, MANAGEMENT, AND INTERVENTION

Dimension	Intervention
Management of Workload	<ul style="list-style-type: none"> • Setting task priority levels with realistic work plans • Recognizing that “not having enough to do” or “waiting” is an expected part of disaster mental health response
Balanced Lifestyle	<ul style="list-style-type: none"> • Eating nutritious food and staying hydrated, avoiding excessive caffeine, alcohol, and tobacco • Getting adequate sleep and rest, especially on longer assignments • Getting physical exercise when possible • Maintaining contact and connection with primary social supports
Stress Reduction Strategies	<ul style="list-style-type: none"> • Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, gentle stretching, meditation, washing face and hands, progressive relaxation) • Pacing self between low and high-stress activities • Using time off to “decompress” and “recharge batteries” (e.g., getting a good meal, watching TV, exercising, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times
Self-Awareness	<ul style="list-style-type: none"> • Recognizing and heeding early warning signs for stress reactions • Accepting that one may not be able to self-assess problematic stress reactions • Recognizing that over-identification with or feeling overwhelmed by victims’ and families’ grief and trauma may signal a need for support and consultation • Understanding the differences between professional helping relationships and friendships to help maintain appropriate roles and boundaries • Examining personal prejudices and cultural stereotypes • Recognizing when one’s own experience with trauma or one’s personal history interfere with effectiveness • Being aware of personal vulnerabilities and emotional reactions and the importance of team and supervisor support

INTERNET SITES

American Academy of Child and Adolescent Psychiatry

<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

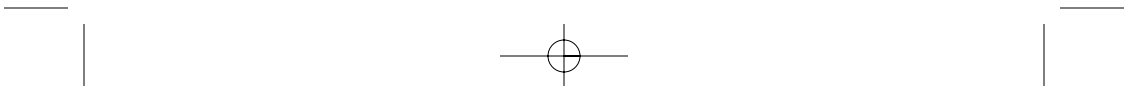
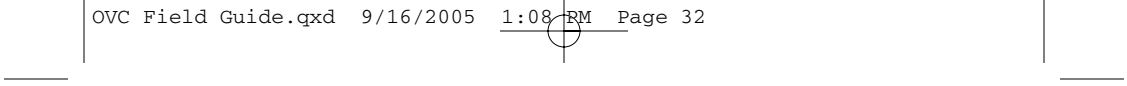
<http://www.ojp.usdoj.gov/ovc/>

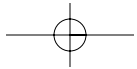
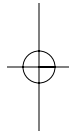
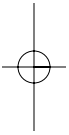
Office for Victims of Crime Resource Center

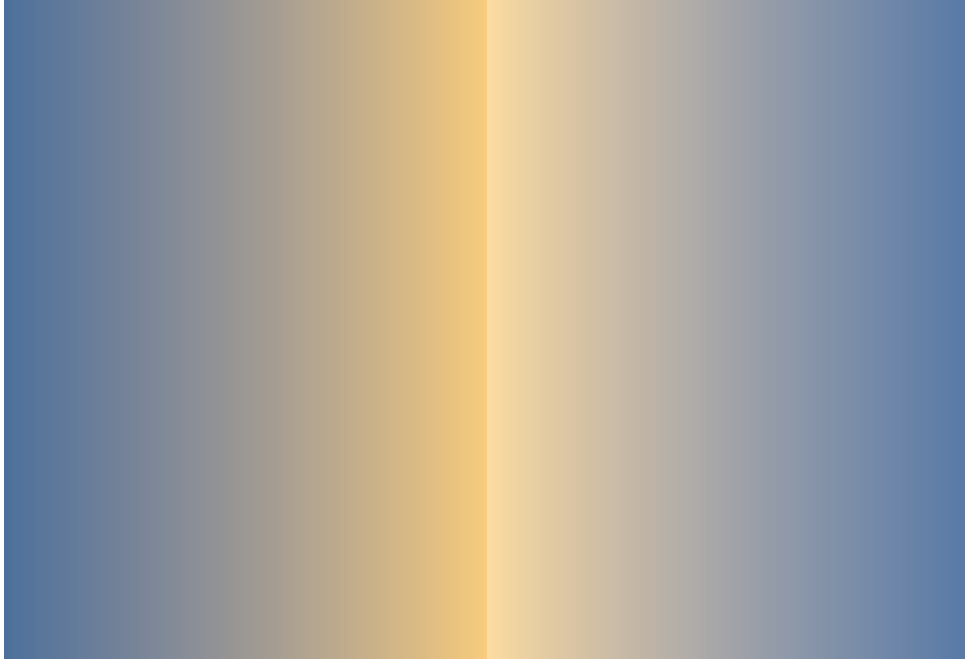
<http://www.ncjrs.org>

**Substance Abuse and Mental Health Services
Administration**

<http://www.samhsa.gov>







U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services
Administration
Center for Mental Health Services
1 Choke Cherry Road
Rockville, MD 20857
DHHS Publication No. SMA 4025
Printed 2005

U.S. Department of Justice
Office of Justice Programs
Office for Victims of Crime
810 Seventh St., NW
Washington, DC 20531
DOJ Publication No. NCJ 205452

