American Psychiatric Association
Committee on Psychiatric Dimensions of Disaster

Disaster Psychiatry Handbook

Supported by a generous grant from the
American Psychiatric Foundation

Last updated November, 2004

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Notes From the Oklahoma City's Recovery

A District Branch Perspective

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Taken from a presentation which was given on May 8, 1996, at the American Psychiatric Association's Annual Meeting in New York City.

On April 19, 1995, at 9:02 in the morning, Oklahoma City suffered the worst terrorist act on United States soil when a bomb exploded in front of the Murrah Federal Building in downtown Oklahoma City. 167 people died. 19 were children. More than 500 were physically injured.

The purpose of this article is to give the Oklahoma Psychiatric Association's perspective of the disaster and how we as an organization attempted to cope and assist Oklahoma in it's recovery. I have attempted to organize this experience in an outline form so other District Branches of the American Psychiatric Association may gain from our experience in developing programs that can be utilized in their areas when disasters occur. Although each disaster is different, it is my hope that others will be able to learn from our failures and successes.

When I'm asked, how did I get involved in all these activities following the bombing? I point out that, as with most individuals, I was thrown into it somewhat abruptly and without much time for preparation. I was installed as president of the Oklahoma Psychiatric Association just ten days prior to the disaster. So, as president of the OPA when the bombing occurred, I was drawn into the activities of the District Branch, the city and state in its development of programs for crisis intervention, education and treatment.

Let me begin by saying that the Oklahoma Psychiatric Association was not prepared for this disaster or any other. Two years earlier, the Executive Council of the OPA attempted to form a Disaster Committee, which would serve as a "team" that could do intervention in disasters, but this did not succeed. It seemed the Executive Council could not elicit the interest of its members. When the Council asked for input, many members felt the task was too large and expensive. So the plans for dealing with a disaster was tabled.

Initial Response to the Disaster

What was the initial response by the psychiatric community to the disaster? Keep in mind that this is from the district branch's perspective and other organizations may approach their experience from another direction. The response can be divided into five areas.

1. Crisis intervention. This involved pulling together a crisis team which would go into the disaster area and provide psychiatric services immediately to the victims and families of the disaster.

2. Assessing the needs of the community. When the disaster occurred, there was significant psychological trauma experienced by the community as a whole, not

just by the victims and their families. Although this trauma was less intense, psychiatric intervention became essential. Again the District Branch had no specific plan to initiate, but as an organization we knew we had to move quickly in providing psychiatric services. This led to the third issue.

3. Preparation for educating the community. There were five different groups that had somewhat different needs in understanding the disaster and coping with the overall effects. These were identified as:
    - the lay public;
    - teachers;
    - non-psychiatric mental health professionals;
    - non-psychiatric physicians; and
    - psychiatrists

    I will cover in more detail the different needs of these groups later.

4. Maintain support and network systems following the acute crises. As many of the members reached out to help during the acute stage of the disaster, the District Branch needed to provide a support network to keep these volunteers from being stranded out on a limb without relief. As best we could, the District Branch attempted to provide them with psychiatric, educational and emotional support beyond the first days and weeks of the disaster.

5. Debriefing of the caregivers. Oklahoma, probably like many District Branches, has very few qualified individuals to assist in the high level debriefing needed for the caregivers who were dealing with the psychiatric trauma. This became an essential issue the District Branch had to address not only for its members but other health professionals.

Utilization and Integration of Crisis Services

How do you approach the crisis? Remember, do not try to reinvent the wheel. What worked for Oklahoma was utilization of the structures that already existed.

1. Use the hospital and community disaster plans as a base. In Oklahoma City the hospital's disaster plan is referred to as "Code Black." This worked as an organizational base for the utilization and integration of psychiatric crisis intervention. When Code Black is initiated, all physicians and support personnel are to report to the hospitals where they work. This spreads the physicians and support personnel throughout the city avoiding over penetration of the services in one area.

2. Utilization of all mental health professionals and support personal. In organizing the psychiatric triage, use all hospital staff including psychiatrists, psychiatric nurses, psychologists, social workers, and chaplains. At the hospital where I

work, we also had the Sisters of Mercy to assist us. Think Treatment team approach.

One of the cornerstones of the District Branch's functioning, which allowed it to work as well as it did, was not planned. This was to have a member, preferably one of the co-chairs of the committee who is familiar with the hospitals in the area, to act as a communication central. Dr. John Poarch of Oklahoma City took this role and contacted by phone the department chairs of the different psychiatric departments or he would designate one of the attending psychiatrists in each of the hospitals. He then directed psychiatrists to various areas in need of psychiatric support. If a program or area needed psychiatrists or had too many psychiatrists, he could redistribute them. He then maintained communication through a number of key individuals and organizations and continued to direct psychiatric services throughout the area.

3. Form a "Crisis Team" from outside the disaster area. Although not well planned out, a crisis team from outside the disaster community provided services in the disaster area. Dr. Susan Daily, from Tulsa Oklahoma, who was the Disaster Committee chairperson quickly responded and organized a disaster team made up of psychiatrists and psychologists from outside the disaster area. This was a great personnel relief to the psychiatrists in the Oklahoma City area and brought to the disaster area those services that only a psychiatrist could provide.

4. Use your network for both personnel and financial support. Remember, in the chaos of the disaster, networking which was done prior to the disaster is still there for your use. If you have a Public Information Committee who has worked in forming coalitions in the past, this can be utilized at this time. Remember, if you need more help, do not hesitate to ask for assistance. As president of the Oklahoma Psychiatric Association, I was extremely pleased at the response of literally everyone to the needs of the community.

Educational Forums

1. As mentioned earlier one of the essential needs of the community was education. What are the educational forums available for this? Remember don't try to reinvent the wheel.

   Use the hospital and community service programs that are already in place. As mentioned previously, hospitals, mental health associations, schools and other businesses will have equipment, room, furnishings, and marketing tools to assist you in your needs.

2. Utilization of the media is essential, especially in the first hours of the disaster. The networking that your District Branch has already set up for media information can be used. Members who are willing to be interviewed for television, radio and

newspaper to help educate the public as to what is going on should be contacted immediately.
Having members of your district branch go to the media and be willing to man phones and to be interviewed is the first step in the education of the community.

Remember, as psychiatrists, we are often identified as the most experienced and knowledgeable on these types of issues and it is important to have a number of psychiatrists who are comfortable dealing with the media and can act in a professional, calming manner.

3. When presenting more formal presentations, utilize the educational watering holes. What I mean by this is utilize those places where individuals go for their continuing education. An example would be the hospital's CME programs. By contacting the director of the program, informing him of the need for preparing and educating the physicians and other staff on the expected psychiatric symptoms and treatments, we found we were more than welcomed and placed on their CME schedules immediately.

4. Structure educational programs through the existing organizational systems. Work with the systems and institutions not against them. Remember, we all have the common goal of wanting to assist the community.

5. Utilize the pharmaceutical companies to assist in funding. The pharmaceutical companies were more than willing to assist us with educational funding. This included funding for speakers and brochures to assist in educating the public and professionals.

Education of the Community

As I mentioned earlier, there are groups within the community that have special educational needs. I have divided them into five groups;

1. Lay Public
   A primary need of the lay public is that they are in need of a vocabulary that can describe what they experience and how to identify what is normal and abnormal. Information should also be provided on where to go if further help is needed.

2. Teachers
   Teachers represent a separate group that needs to be educated on specific issues of childhood and trauma. These professionals need to be able to identify and refer children who are having difficulties coping with the disaster. They also need the tools to provide support and education to the children in their classes as they cope with the many questions and situations that arise in a classroom.

3. Non-medical mental health professionals

Non-medical mental health professionals present a unique problem in that these groups are often trying to provide education to the public themselves. It is important to educate these individuals regarding the unique services that the psychiatrist can provide with our medical/psychiatric treatment in the care of their patients.

4. The non-psychiatric physician
   These physicians include the primary care doctors as well as other medical specialties that are involved in the care of the physically traumatized patients. Usually, they will be the first physician treating the patient.

   A primary objective of educating this group is to remind them that psychiatric trauma is highly probable in the physically injured and their family members are also at high risk. A review of the psychiatric symptoms and a summary of early treatment intervention are essential. Referral resources if psychiatric symptoms continue should be given to these physicians for quick and efficient treatment.

5. Psychiatrists
   Our colleagues need to be educated as well. Although the majority of us have dealt with problems such as Acute Stress Disorder, Posttraumatic Stress Disorder and other psychiatric disorders associated with traumatic events, a review and an update on treatments was found to be helpful by many psychiatrists. It is also essential to review the "caregivers" response to disasters which may indicate a need for debriefing or treatment of their colleagues or themselves.

Educational Goals

1. You must tailor your goals, objectives and information to each group's needs and stay within their level of expertise. Objectives should include:

   How to identify the patients
   What is the acute treatment or support that they can provide
   When to refer
   Who to refer to; and
   How to deal long term treatment issues

2. The best way to approach many of these groups is to provide brief 30 to 40 minute presentations like we experience at CME luncheons and dinner presentations. This will get them interested or whet their appetites so they will take an interest and be aware of the syndromes they may be facing.

3. Another goal is to provide further information for more intense programs to the community for those interested. Hopefully your District Branch will be organizing weekend symposiums. But also teaching facilities such as your local universities

will be quickly organizing these types of programs often, including outside speakers.

4. One of the problems which you need to try to avoid with outside speakers is a phenomenon which I first identified when Connie Chung, a national newscaster, came to Oklahoma City to broadcast for a syndicated television station. Ms. Chung arrived immediately following the bombing. During her television interviews, she kept sticking a microphone in the face of the various rescue workers, physicians, and other professionals, asking questions such as, "what are you going to do until the real help arrives?"

   Well, Oklahomans took quite an offense to this, feeling it implied that we, as a city, could not take care of our own, that we were not qualified nor had the expertise to deal with the needs of our community. Following this episode I began to note that when other outside experts came in, the audience were somewhat leery, cautious, and even defensive when the speaker would talk of their experiences. I made it a point to approach our speakers to express my concern over this phenomenon and to instruct them to be careful as to how they might critique various programs and systems.

   All the "experts" that I worked with were very sensitive to this and made everyone very comfortable, often stating how difficult it is to be an expert in this area because no two disasters are the same and geographical areas where they occur are also very unique. Many would say, "I am here to learn as much as I am here to teach," which would often set the stage for everyone to be open and receptive to the speakers.

5. Develop weekend symposiums with local, national and international speakers. It is amazing how quickly this can be accomplished. Within ten days following the bombing, the Oklahoma Psychiatric Association put on an all day seminar where we had speakers from California, Florida, and Missouri. Each one of the experts added to Oklahoma's knowledge base and our understanding of the disaster. I was truly amazed how quickly this came together. I would first say, never discourage the program planning. The key to this was our networking system, which was in place prior to the disaster.

Psychiatric Treatment and Support for the Community

1. It is important to maintain open communication between the different sectors of psychiatry. I divide the psychiatric community into three sectors, the academic, private and public sectors. It is very important to maintain communication among these organizations to try to:

2. Avoid duplication of services.

This is very difficult but if you have to err in one direction or the other, it would be to accept the duplication, although this may seem a waste of time, energy, and money. You are providing services quickly to people who might not have received them. Keep in mind that in disasters such as this, people go to areas where they have received support and assistance in the past. They would call hospitals, mental health associations, as well as the Psychiatric Association.

3. Avoid turf battles through personal contacts.
   It is inevitable that there is going to be turf battles. The only way that I have found to resolve them is to make person to person contacts. Remember we, as psychiatrists, are often considered the experts in communication, and we certainly need all our skills in dealing with these issues.

4. Address the issues of acute verses long term treatment.
   Frequently I would hear of a mental health professional making a commitment to a victim, family member or a rescue worker following a support group stating that they would offer psychological/psychiatric treatment and "don't worry about the bill." One needs to keep in mind that treatment may take years and this may be a very difficult commitment to keep. Please be aware of that you may be committing to the treatment of a chronic illness, which may need long term therapy or even hospitalization. If funding is made available, it may be just through a state or federally funded program, but not as a health care provider in the private sector. You would then have to deal with separation issues that could interfere with the patient's recovery.

5. Financial issues need to be addressed early.
   This issue needs to be addressed not only on an individual level but on a national level as well. It appears the federal government wants to look at the problems of treatment only on a short term basis. This may be more applicable to the physical problems, where the wounds heal fairly rapidly but not so with the psychiatric issues.

6. Assist the whole community with the grieving process
   As I mentioned earlier, the victims and their family members who were directly affected by the bombing need intense education and treatment, but the whole community was traumatized by this event. Oklahoma City, as a community, needed to grieve and heal from this traumatic event. Remember, as psychiatrists we need to assist through treatment and education all the victims of the disaster, which includes the entire community.

Network

If I could leave you with just one word that will best assist you in preparing and coping with a disaster the word would be, "Network." Keep in mind you probably have that network base in place already. You just need to reinforce the network and organize the

network so the disaster committee will have a direct access to the network when the unexpected disaster occurs.

Preparation For Disaster

1. For those district branches that have not suffered a disaster, I leave you with four steps which should begin the process of preparing for the unexpected disaster.

2. Keep it simple. Do not try to over organize;

3. Have co-chairs of the disaster committee located in different geographical areas. The need for this is somewhat self-explanatory, but you will see from my presentation how beneficial it was to have a member involved in the area of the disaster and one outside the area;

4. Learn how your local area's disaster systems works, but also investigate national systems that are in place for disasters; and

5. Do not try to reinvent the wheel. This is the key. Too many times we try to start from scratch, then become overwhelmed by the task and give up in frustration.

Chapter 2

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Establishing Liaison Before Disaster Strikes

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"We are Americans. We don't walk in fear." Colin Powell, Secretary of State, in response to terrorist attack on World Trade Center, September 11, 2001.

This chapter is intended to provide some basic information to district branches in helping them prepare a network prior to the time that disaster strikes. The establishment of key liaisons with critical community agencies and planners is essential if APA personnel are to effectively assist their communities once a disaster, whether it is natural or the result of some terrorist act, occurs. Unfortunately, the last decade has shown us how frequently Americans respond to disaster. Massive fires in Florida and California displaced 30,000 people; earthquakes have struck San Francisco; tornadoes have leveled communities in Orlando, Florida and Xenia, Ohio; floods have devastated parts of Texas, the Ohio Valley, and Mississippi delta. The World Trade Center bombing in New York, with the subsequent terrorist airliner attack and the destruction of those buildings recently, has driven home the need for community response and psychiatric assistance to survivors, as has the bombing of Pan Am 103 over Lockerbie, Scotland. Psychiatric reactions were common and prolonged following the Three-Mile Island partial meltdown in Harrisburg, Pennsylvania. The sarin gas attack on the Tokyo subway has sensitized all Americans to their vulnerability to chemical and biological weapons. A single industrial accident in Bhopal, India killed 3,800 people and injured 300,000.

It is clear that the elements that contribute to increased psychiatric casualties following a disaster include the terror that strikes a population, lack of information, distortion of threats by news and public media, the direct threat of injury or death, and the horror of exposure to grotesque stimuli. The more sudden and unexpected the threat and the more unprepared the society, the greater the long-term psychiatric consequences. When disasters or attacks are high in intensity and broad ranging in scope, producing massive loss of life, property and environmental destruction, larger numbers of individuals are directly and indirectly involved. If communities are unable to respond or respond in a haphazard manner, people become increasingly perplexed and helpless, and panic becomes more rampant. Disorganization leads to increased fear and an inability to function.

We know from past disasters that psychiatric casualties are increased when society is unable to assess the degree of threat, when mass casualties occur, when individuals are separated from their family units, and when society is slow to return to its normal pre-disaster level of functioning. Individuals at risk are those who have been specifically injured and those suffering from pre-disaster mental health problems, particularly major depression, generalized anxiety and panic disorder, Post-Traumatic Stress Disorder, substance abuse, somatization disorder, and adjustment disorders. Previous studies have shown between 22-48% of such patients go on to develop long-term psychiatric impairment. The physical trauma most associated with the development of psychiatric disorders include closed-head injuries with post-concussive syndrome, severe crush

injuries with metabolic disturbances, burns (especially about the face, head, genital and rectal areas), spinal cord injuries, amputations, and loss of sensory functions, such as sight or sound.

The Oklahoma City bombing of the Murrah federal building taught us many important lessons. Among the most important of which was the extent to which medical and rescue personnel were emotionally affected by their rescue duties. Leaders of that community learned that critical stress management intervention was crucial prior to the time of the emergency.

When disaster strikes, society must be able to initiate an immediate chain of command and send authorized competent observers with the power to deploy resources to the target area. Communications are vital for successful functioning, as are clear roles for each of the critical responder groups (i.e., police, fire, EMT, sanitation, rescue teams, etc.). Separate staging areas need to be developed for the different types of injuries encountered: those injured and likely to survive, those injured and likely to die, and the deceased who are recovered intact or as body parts. Efforts need to be directed toward providing immediate information and assistance to families and, as the World Trade Center attack has recently shown, to produce and coordinate comprehensive lists of individuals taken to hospitals, those found dead, and those unaccounted for. Programs have to be established to maintain the physical and mental health of the disaster workers and governmental officials at command and control centers.

Hospitals and community planning agencies need to work actively ahead of time to plan for both personnel and supplies that may be needed and to address staffing issues. They must provide immediate intervention for the overwhelming stress experienced by both victims and healthcare workers, minimize helplessness and depression by putting people to work, supervising them, and controlling their time and task functions. Tracking systems need to be carefully established prior to the onset of a disaster, as do specific plans for working with and controlling (to some extent) the information provided to the public so that it is accurate and does not breed panic. Transportation systems and the movement of personnel to remote sites are vital functions. It is important for mental health workers to establish liaison with family organizations and community agencies and provide support to them. Development of organizations of victims' families is critical and can be aided by mental health personnel.

Within the hospital setting, psychiatric personnel are crucial for psychiatric triage and must identify those individuals seen and treated in the emergency room who are likely to become future psychiatric casualties. Psychiatrists and other MH personnel must address the risks these patients face with them and their family members and establish comprehensive lists and follow-up plans for the future assessment and treatment of these patients. In addition, mental health personnel must provide the community planners and media with information that they have obtained regarding normal responses to abnormal situations and the type of emotional reactions that are likely to occur in victims, members of the community, and children. We know, for example, that

short-term psychiatric reactions occur at up to six times the rate expected in the general populations when populations are proximately exposed to disasters. Psychiatric symptoms of a more severe nature often appear 6-24 months post disaster, with the most frequent time of onset occurring 6-12 months post disaster. Single parents and children between the ages of 8-15 are the individuals at greatest risk for future delayed psychiatric illness.

In working with our medical colleagues, it is crucial to establish rapport and working relations with physicians of various disciplines, emergency rooms, civilian governmental agencies, and with patients and their families. Psychiatric disaster specialists must: 1) help the community define immediate reactions to the disaster, 2) provide indicated psychotherapy and medications to people experiencing acute reactions, and 3) establish a basis for the follow-up of individuals seen in acute treatment and triage facilities. We know that early psychiatric intervention reduces the long-term incidence of severe psychiatric casualties. Conversely, we know that when undiagnosed and untreated, co-morbid psychiatric disorders, which develop in the wake of a disaster, lengthen hospital stays, expose patients to more drug use and diagnostic procedures, increase the cost of medical management, reduce the efficacy of primary medical-surgical treatment, and increase the risk of complications.

In triaging, one needs to remember that our heroes are often at greater risk. Some 20% of rescue workers may experience some form of PTSD by the end of the first month after the disaster. The injured are at high risk, particularly children, the disfigured, patients with facial and genital burns, blast victims with sensory loss, traumatic amputees, concussive syndromes, and post-traumatic epileptics. Child psychiatrists have long cautioned us to beware the suddenly quiet child. Patients whose immediate reactions are overwhelming anxiety, fear, or uncontrolled grief when exposed to death and the grotesque are at higher risk for long-term anxiety disorders, as are patients who identify with dead victims and who believe "it could or should have been me." Parents who have lost a child require specific intervention.

It is essential that we communicate to governmental and media representatives that shock, disbelief, anger, numbing, anxiety, insomnia, and (at times) intrusive thoughts of the occurrence are normal responses to abnormal events and are usually short-lived and resolve completely.

When the community understands that we have knowledge based on long-term observations and a carefully developed scientific literature, they are desirous of our involvement in assisting them. This is what district boards bring to planners prior to the onset of disaster. It, therefore, behooves them to know the data related to family violence, somatization, prolonged recovery, depression, panic, anxiety, substance abuse, and PTSD as they relate to disaster survivors. Our literature concerning community and disaster organization, psychiatric triage, counseling techniques, debriefing, and the psychological maintenance of primary healthcare workers, leaders and families are valuable contributions to the planning effort.

The Role of the District Branch in Establishing Liaisons

The Committee on Psychiatric Dimensions of Disasters of the APA recommends that each district branch create a committee on disasters. Individuals within the district branch who have current liaisons with governmental agencies should be encouraged to join. Members should be recruited from communities across the branch and construct a community profile delineating the key agencies that would be responsible for response to a local disaster, looking at both external and internal resources and the infrastructure of their state and local organizations. State, county, and city governmental leaders charged with disaster response should be contacted. Liaisons should be formed with military facilities in the area and with regional civil defense and disaster planning agencies that transcend county or governmental boundaries. The key agencies within each jurisdiction include, but are not limited to, police, fire departments, EMT teams, ambulance services, hospitals, public health facilities, the FBI, FEMA, National Guard, military services, the coroner's office, the medical and dental societies, emergency response organizations (such as The Red Cross, Salvation Army, etc.), local church councils, transportation organizations (such as airport authority), and the media. Visits should be made to all these respective agencies before the time of the disaster, notifying them of the district branch's resources and willingness to work with them in any planning or preparation that is being undertaken in the community.

Once a key leadership structure has been developed within the district branch, the chief of police, mayor, and governor's council on disaster planning should be made aware of the branch's efforts, resources (i.e., local committee and personnel, support by the APA's Committee on Psychiatric Dimensions of Disaster, APA's website, etc.), and willingness to actively work with their respective organizations in disaster planning. By participating in the pre-disaster assessment, community profiling and resource allocation, a sense of presence, camaraderie, trust, and expertise is established, which becomes invaluable once a disaster occurs. Community experience has shown that those individuals known and trusted by the disaster coordinators are utilized when a crisis occurs. People volunteering after the fact are not, in general, well utilized.

Our psychiatric input is valuable in assisting with hazard, vulnerability and response function analyses, looking at the cascading consequences of previous disasters, and consequence management. Early participation with community agencies permits psychiatrists to assist in the analysis of the mission, create action plans and mission statements, develop courses of action, define essential tasks, establish responsibilities, determine areas of operation, and provide input into the suitability, feasibility, acceptability, and completeness of a community's response.

In summary

District branches should develop and maintain a disaster committee comprised of knowledgeable individuals throughout the jurisdiction of the district branch. This committee should work closely with the APA's Disaster Committee to share knowledge and expertise. This committee should construct community profiles, carefully defining critical facilities and response agencies that would be mobilized by a disaster. It should make careful note of both internal and external resources and the infrastructure in place to assist at the time of a disaster. A review of critical populations, with attention to racial, cultural, and religious aspects of the population, should be undertaken. The needs of special populations (the disabled, mentally impaired, psychiatrically ill, children, elderly, etc.) should be considered. Liaisons should be undertaken with executive authorities in each of the respective response organizations.

Suggested Readings

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Chapter 3

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Helping Adults After Disaster Strikes

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After a significant disaster, many adults who are exposed at different levels may experience emotional consequences. Some may benefit from the expertise of psychiatrists in the immediate aftermath of a disaster or after the passage of time. The following discussion of early and longer-term mental health interventions is based on recommendations of a consensus of experts in the field who considered published, peer-reviewed literature, including limited randomized controlled trials of interventions following mass disasters.

Immediately After a Disaster:

Psychiatrists helping individuals after a disaster should keep in mind that it is important to prevent panic, to help provide structure in a chaotic environment, and to assist in ensuring safety of survivors. This is important in response to any disaster, whether an act of terrorism, a natural or manmade disaster, or possible future acts of nuclear or biological terrorism. Large, established organizations such as the American Red Cross and the Federal Emergency Management Agency (FEMA) have an excellent track record in providing structure for assisting disaster victims. It is important to coordinate with local health and mental health departments, professional health and mental health groups (the American Psychiatric Association, the American Medical Association, the American Psychological Association, the National Organization for Victims Assistance (NOVA), and others) mental health consumer groups (National Alliance for the Mentally Ill, the local branch of the Mental Health Association), and faith based groups. The media can be used constructively to help victims find loved ones; to educate the public calmly about what has happened, what to expect, when and where to seek help; and to prevent panic.

It is important not to pathologize all emotional responses to disaster. A direct victim's initial response may represent what has been called "a normal response to an abnormal situation." That is, s(he) may experience temporary symptoms of altered sleep, anxiety or sadness, irritability, difficulty concentrating, fatigue, appetite changes, loss of interest, memory problems, or changes in usual behavior patterns. These are often time-limited and do not generally impair functioning for long periods. Supportive interventions include reassurance; ensuring adequate rest, with temporary use of sleeping aides indicated for severe insomnia; maximizing positive coping techniques (discussed below); and returning to the workplace or prior level of functioning as soon as possible.

The psychiatrist's role after disaster is a unique and important one. Psychiatrists are especially suited to triaging direct and indirect victims in various settings, such as on consultation in hospitals' emergency rooms, intensive care and burn units, general medical floors or inpatient psychiatry units. Or psychiatrists may volunteer for agencies such as the American Red Cross, where they may be part of a mental health team providing grief support, notification of death to family members, or crisis intervention. Other charitable organizations may provide venues for psychiatrist volunteers to access victims, who may otherwise avoid seeking mental health interventions. Psychiatrists can provide helpful liaisons with EAP reps in encouraging flexibility and support to traumatized workers—perhaps encouraging flexible hours, providing support

groups within the workplace, and attending to security issues. These are especially important if workers' place of employment has been the site of the trauma, as in a terrorist attack, natural disaster, or industrial accident.

Rescue workers or disaster response volunteers (including mental health professionals) have been called secondary or indirect victims. They may be at special risk in the immediate aftermath of a disaster because of long work hours with inadequate rest; prolonged exposure to physically hazardous conditions; witnessing tragedy in individuals they are trying to help or in their own colleagues; interacting with bereaved families; and being separated from their own families and traditional sources of social support. Rescue workers tend to be dedicated and trained to focus on others' needs, so they may need to be encouraged to take care of their own basic needs. Their agencies should be advised to see that they have adequate food, sleep, exercise or other recreation, and a nurturing environment just as direct survivors require.

Both direct and indirect victims may benefit from the following interventions in the immediate aftermath of disaster:

- A hierarchy of basic needs should be addressed, including:
    - Ensuring safety and security, both immediately and for possible ongoing threats
    - Providing food and shelter
    - Linking survivors to support services
    - Helping disaster victims to obtain information, especially information about loved ones
    - Helping survivors access normal social support networks (family, friends, community)
- "Psychological First Aid" should be administered:
    - Identify and support survivors who are the most distressed, while ensuring that they are safe from further threat.
    - Reduce physiological arousal, which may reinforce patterns of fear and increase risk for psychiatric illness.
    - Facilitate victims' accessing natural supports of family and friends.
    - Educate and communicate about stress responses to catastrophes, coping, risks for illness and services available.
- Screening and triage should focus on highly symptomatic or "at-risk" individuals within the first week post-disaster and beyond. Who is "at risk?" Experts agree that this group includes individuals:
    - with pre-existing psychiatric conditions or substance abuse problems
    - who are bereaved
    - who are children or elderly
    - who are injured
    - who are intensely exposed to the disaster (through proximity or long duration of exposure)
    - who have acute stress disorder or are clinically symptomatic as a result of the disaster. After 2 months post-disaster, if symptoms

have not occurred, follow-up should occur only if specifically requested for an individual.

- Outreach and dissemination of information:
    - Outreach involves informal support and assistance to survivors wherever they may group, such as the disaster scene, shelters, assistance centers, food banks, first aid stations, etc. Survivors often do not seek mental health assistance, because they may be preoccupied with their immediate surroundings, they may fear interventions due to stigmatization, or they may just want to avoid painful memories and feelings.
    - Information in the form of pamphlets, brief news releases, internet websites and training manuals for survivors and their caregivers can educate about symptoms that are expected, symptoms which suggest that professional help is needed, and where to go for help.

Mental health providers should make efforts to facilitate **coping and resilience** in survivors of disaster and rescue workers. Positive coping tools include such simple activities as:

- Getting together with colleagues, friends, or families to take advantage of important sources of social support
- Participating in healing rituals such as memorial services, visits to the site, or formal or informal spiritual activities
- Engaging in distracting activities, such as sports, creative hobbies, other recreational pursuits
- Positive reframing, or seeing the good that can often be brought out by a disaster—people working together positively, altruistic acts of kindness, a strengthened sense of community

Taking the time for "quality assurance" is crucial to recovery efforts:

- Assessing credentials of professionals providing interventions. They should have appropriate training and expertise, and should be responsible to appropriate leadership.
- Any clinical interventions should be consistent with best evidenced-based practices.
- If research is conducted to assess epidemiology and treatment of disaster-related mental health issues, this research should be ethical (conducted through the appropriate institutional review board), scientifically valid, and should not further harm survivors.

Clinical Interventions in the weeks following a disaster should be provided for individuals whose increased symptomatology impairs functioning or causes significant distress. Research has identified some characteristics of trauma victims immediately post-disaster that may predict later problems such as PTSD. These include experiencing dissociation or prominent anxiety and taking drugs or alcohol just after the trauma. Psychiatrists should be especially attentive to screening individuals who respond to trauma in these ways.

Psychotherapeutic Interventions: Specific brief cognitive behavioral approaches administered by trained clinicians may benefit direct survivors and bereaved persons. Randomized controlled trials have suggested that such focused interventions may reduce risks for acute stress disorder, posttraumatic stress disorder and depression. Although historically Critical Incident Stress Debriefing (CISD) has been offered to survivors and rescue workers, its benefit has not been consistently demonstrated. This structured intervention involves elements of introduction of goals; processing facts about the disaster and ensuing thoughts, emotions, and possible symptoms; an educational component; and a conclusion. However, CISD has fallen out of favor after recent studies have found that re-telling of traumatic events may actually increase anxiety in some individuals. Critical Incident Stress Management (CISM) refers to a rather diffuse system of interventions designed to reduce emotional sequelae. Whatever early intervention is delivered, it is important that these services are based on sound, evidence-based practices, that they do not further harm survivors, and that they are voluntary and acceptable to survivors.

Psychotropic Medications: Cautious use of medications in more severe immediate emotional reactions may be indicated. Hypnotics that are not habit forming may help provide rest on a temporary basis. For individuals with strong physiologic arousal (increased heart rate, jitteriness), short-term, low dose beta blockers may provide relief. Although recent research suggests that propanolol may impart some protection against PTSD development, this is not currently accepted clinical practice. Severe anxiety may benefit from short-term use of anxiolytics. Onset of acute stress disorder may warrant trial of an SSRI. However, when the use of psychotropics is necessary, be mindful of the availability of follow-up as well as ensuring compliance. For example, can the individual take their medication because they are displaced or can they get the medication?

After Time Has Passed:

Some individuals will have persistent problems and a few may experience onset of psychiatric conditions that would benefit from formal psychiatric interventions. Among these consequences are posttraumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, substance abuse problems, physical complaints and unhealthy lifestyles that may worsen existing medical problems. Treatments include:

Medications: Two selective serotonin reuptake inhibitors (SSRI's), paroxetine and sertraline, are currently approved for treatment of PTSD, and also treat panic disorder, depression and generalized anxiety. A large, placebo-controlled trial found that the NSRI venlafaxine was effective in treating chronic PTSD, with depressive symptoms improved. Tricyclic antidepressants (TCA's) and Monoamine Oxidase Inhibitors (MAOI's) are helpful for many with PTSD and/or other mood or anxiety conditions. Anti-epileptic drugs may be helpful for some with PTSD or in those with mood instability. Lamotrigine has shown efficacy in treating PTSD in a placebo-controlled trial. Anxiolytics should be used cautiously, with attention to their possible misuse; benzodiazepines have not

been shown to benefit the core symptoms of PTSD. Medications affecting adrenergic receptors that have been found useful include prazosin (controlled trial), clonidine, and propanolol. Use of adjunctive medications should be considered if a psychiatric medication is partially effective. Desyrel or cyproheptadine for sleep, triiodothyronine (T3) to agument antidepressants, and atypical antipsychotics (especially for irritability or aggression) are a few that are useful.

Psychotherapies: Cognitive, behavioral, and dynamic psychotherapies have all been shown to be useful in treatment of PTSD. Eye Movement Desensitization Reprocessing (EMDR) has not shown consistent benefit in studies. Studies have suggested that effective behavioral exposure therapies should control the duration of emotional exposure and avoid unstructured processing of painful emotion, which may be harmful to trauma victims. Teaching relaxation techniques and encouraging acquisition of new responses to trauma reminders may be helpful components of behavioral psychotherapies for PTSD. Exposure therapy and stress inoculation training are two specific types of cognitive-behavioral therapies with demonstrated efficacy in treating PTSD.

Because some cases of PTSD and other emotional sequelae of trauma may be long-term, psychiatrists involved in mental health administration after disaster should identify potential sources of funding for long-term treatment. Identifying federally funded grants and funding through professional or charitable organizations are an important aspect of planning for mental health treatment needs in the wake of disaster.

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Chapter 4

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Cultural and Ethnic Considerations in Disaster Psychiatry

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Introduction

The United States is becoming increasingly diverse. According to census information, minorities groups are rapidly growing. Hispanic Americans, for example, grew by 46% in the past decade, while whites grew 1%. (DHHS 2001). Our society will undoubtedly continue to be enriched by the ideas, perspectives, and contributions of the many ethnic groups of which it is composed. As mental health providers, however, we face the particularly challenging task of providing culturally informed care to a growing number of ethnic minority groups. Overall, ethnic minorities have similar rates of mental illness as whites when controlling for economic status, but minorities nevertheless have more difficulty obtaining adequate care. Much of this can be related to cultural differences between minorities and their providers. As the Surgeon General reports,

> Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender (DHHS, 1999, p.vi).

There is a great need for culturally informed treatment of ethnic minorities in disaster situations. In addition to the traditional barriers to mental health care, minorities may be exposed to more stressors during disasters, as will be discussed in this chapter.

It is beyond the scope of this chapter to provide information on specific racial/ethnic groups. The Asian American/ Pacific Islander group alone, for example, has over 43 subgroups with different cultural traditions (DHHS 2001). Rather, this chapter will outline general perspectives of ethnic and cultural considerations in disaster preparedness, the impact of disasters, and the aftermath. Guidelines that will help inform the clinician when working with groups specific to the area of disaster will also be discussed.

Pre-Disaster Issues

Preparation for a disaster involves the perception of the risks of disasters and efforts made to prepare for upcoming disasters. Research shows that ethnic groups' perception of risk was mixed, with some studies suggesting greater perception of risk, whereas others show no difference along ethnic/racial lines. (Fothergill et al., 1999) Evidence does suggest, however, that groups with prior experiences of disaster had heightened perceptions of risk associated with that disaster type. This may be particularly relevant for refugee and immigrant groups that commonly experience pre-migration trauma as a result of natural or man-made disasters. Additionally, individuals from some groups may have a sense of fatalism and feel that they can do little to protect themselves against harm (Fothergill et al., 1999). This can arise from a general sense of helplessness and due to prior disaster experiences, racism, systematic persecution, limited economic and political power, and/or specific cultural/religious beliefs about fate.

Racial and ethnic communities tend to have less formal disaster education than mainstream groups. Some evidence suggest that, in lieu of utilizing formal resources, black and Hispanic families were more likely to be helped by family members in preparing for disaster (Fothergill et al., 1999). Economic factors can also influence preparedness. Structural changes and earthquake insurance, which mitigate the impact of earthquakes, for example, are cost prohibitive to individuals in lower income levels. There are also ethnic differences in during the initial stages of disaster, particularly in the modality of warnings. Many minority groups place greater value on family and social networks as sources of information about disaster and preparedness. This may be due to common language and other culturally congruent methods of communication, in addition to the emphasis on communalism over individualism. In summary, ethnic minorities may have less exposure to and acceptance of formal disaster education, although information may be disseminated in other culturally sanctioned networks such as kinship. Preparation for disaster will vary depending on cultural beliefs and experience of self-determination, as well as socioeconomic and political factors.

Intra-Disaster Issues

The physical and psychological impact of disasters on ethnic minorities can be significant. Physical consequences include mortality, morbidity, injury, and economic hardship. Disaster related mortality appears to be disproportionately higher in ethnic minorities (Fothergill et al., 1999). Due to economic hardship, many minorities live in housing that is older, less structurally sound, and, therefore, more susceptible to damage by disasters. Psychological impacts can also be significant. Again, socioeconomic factors play a major role. Class appears to be associated with risk of mental illness (DHHS, 2001). People with lower incomes appear to be more stressed after a disaster. They were more likely to feel a sense of helplessness and greater indebtedness. Due partly to being poorer, many minority groups also experience greater stress, as with the September 11th terrorist attack on the World Trade Center (Schuster et al., 2002). Special ethnic groups are particularly susceptible to the stress of disasters. These include immigrants and refugees, many of whom left their country of origins due to natural disasters or manmade atrocities. Posttraumatic stress disorder from pre-migration trauma may become exacerbated by new disaster experience (Webster et al., 1995). This study also showed that older immigrants, who had greater difficulties with acculturation and language acquisition, were particularly stressed. Overall, groups in lower socioeconomic levels and at-risk populations such as refugees will experience a greater level of psychological and physical distress from disasters.

Post-Disaster Issues

Following a disaster, ethnic minorities may receive less recovery aid. As discussed earlier, this may be due to lower income and savings, less insurance, and less access to disaster relief information. They may also be ineligible for

disaster benefits due to their immigration status. More acculturated groups will have less difficulty maneuvering through the relief system. Ethnic minority communities, especially in poorer areas, may experience discrimination during the relief effort as well. Media coverage tends to be more active in whiter wealthier communities (Fothergill et al., 1999). Moreover, relief efforts may overtly or inadvertently have bias against ethnic minorities, ranging from being unaware of cultural differences in food preferences and tolerances to preferential treatment for more acculturated, wealthier, or white victims. These inequalities may lead to a worsening of ethnic/racial tensions. Certain populations may become targets of hate crimes as well. This was evident after the September 11th terrorist attack, in which Arab Americans were victimized. The aftermath of a disaster can be a potential time of healing and recovery; however, the evidence suggests that ethnic minorities have poorer access to relief aid and may experience discrimination.

Recommendations

Culturally informed care of ethnic minorities in disaster situations involves planning on a group, as well as an individual, level. In preparation for disaster, clinicians, mental health organizations, and relief organizations should work to identify the ethnic composition of their respective community and strive to understand the traditions and perspectives of each group. The DSM-IV Outline for Cultural Formulation offers guidelines for cultural assessment of the individual. However, it can also be adapted to help conceptualize cultural groups (see Table 1.) The importance to this level of inquiry is to help ascertain vulnerabilities, strengths, and culturally sanctioned treatment modalities that will be essential to mobilizing *effective* disaster aid should the need arise. Clinicians and mental health workers from the respective cultural groups or those who work extensively with these groups should be identified and recruited to assist with this assessment, as they will have insights that an outsider will not. Moreover, these clinicians' experience with their cultural group will be invaluable in helping intervene during and after a disaster. Prior experience suggests that patient who are seen by clinicians from their own ethnic background tend follow up for treatment more than those who do not (DHHS 2001). Individual clinicians are also encouraged to get training in cultural competence and diversity regardless of their ethnic or cultural background.

Table 1 Adaptation of the Cultural Formulation to Groups

1. Characteristics of Cultural Groups • Ethnicity • Age • Gender • Sexual Orientation • Age • SES class • Education Level 2. Group Attitudes towards Mental Illness

- Idioms of distress
- Explanatory model
- Culturally sanctioned interventions

3. Psychosocial Stressors and Supports
   - Housing/Economic factors
   - Family/Community
   - Racism/Discrimination
   - Migration/Immigration history
   - Acculturation Level
   - Language
   - Access to services
4. Cultural Group and Mental Health Services
   - Cultural Group's attitude towards mental health services
   - Mental Health Services' experience with Cultural Group
5. Culturally Informed Disaster Planning

Disaster planning should include interventions which account for the issues that each cultural group will face during the pre-, intra-, and post-disaster phases. Table 2 outlines some of interventions that address issues that may arise during one of these three phases.

Table 2.

Pre-Disaster • Disaster education/warning program that utilize culturally sanctioned networks for communication (i.e. kinship/social/religious networks) • Identify specific populations that may have particular vulnerabilities to disaster (immigrant/refugee populations, disenfranchised populations, lower class) • Community-based interventions to increase feelings of self-efficacy re: disaster preparation
Intra-Disaster • Provide language appropriate treatments • Interventions that target vulnerable populations
Post-Disaster • Social services that assist vulnerable

	population navigate relief system • Anticipate and address exacerbation of PTSD and depression in vulnerable populations (i.e. refugees) • Education of general public about groups that are being a target of racism, and provide mental health support for these groups

Disasters send shockwaves that disrupt entire communities. However, each community is affected and responds to these disruptions differently, depending on its cultural traditions and perspectives. Only by understanding the culture of each community can a clinician or mental health organization anticipate and recognize the distress and intervene effectively in that community.

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Chapter 5

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Medicolegal and Ethical Issues in Disaster Psychiatry

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At first it may seem odd to worry about liability and ethics when discussing disaster psychiatry. After all, it would seem that joining in the response to a disaster represents an act of good will that should be immune from such problems. It is probably true that one's good intentions may predispose a judge, a jury or an ethics board in your favor. However, it is important to consider the legal and ethical pitfalls of this work if for no other reasons than the tremendous stress created by being charged with malpractice or unethical behavior.

Such charges may not be as improbable as they may initially sound. The nature of most disasters in the U.S. is that they create massive litigation (Johnson). When there are more readily identifiably responsible parties for a disaster, such as in crimes, terrorism, and aviation disasters, there is often a belief that litigation is the proper way to recover from a loss. Even for natural disasters, large sums of money may be distributed through insurance companies, the American Red Cross and the Federal Emergency Management Agency, and decisions about these funds often lead to litigation. Thus, every disaster's aftermath should be viewed as a litigious environment. Although the psychiatrist may be an innocent party in all of this, it is not uncommon for psychiatrists to be perceived as "working for" the government, the airlines or some other group and therefore they may be named in a lawsuit. In addition, even if the psychiatrist clearly defines his neutrality in all interactions, he may be perceived as the perfect witness to describe the mental state of individuals who he encountered, even superficially. There may be tremendous pressure to disclose information that may or may not be protected by patient confidentiality or to reveal information in a legal proceeding that may or may not be subject to doctor-patient privilege.

It may be tempting to assume that "Good Samaritan" laws cover psychiatrists responding to disasters, but it is important to review what the laws are in the area where you are practicing. States may define a "Good Samaritan" as someone who fortuitously happens to be at a scene where there is a medical need. If one deliberately journeys to the site of a disaster and if there are other doctors there, your services may be seen as not as fitting the definition of a "Good Samaritan."

These legal expectations can be settled by making sure that you always clarify when you are wearing the hat of a psychiatrist and when you are speaking in a non-professional capacity. Unfortunately, this clarity is often very difficult when doing outreach work at a disaster site. Such work requires the fluid transition from clinical to non-clinical work and attending to the complex issue of knowing when the people you interact with are "patients" or not. Even if it is impossible to define when a casual conversation turned into a psychiatric interview, it is vital that you decide by the end of any encounter whether it is best defined as a doctor-patient encounter. If you engaged in diagnosis or treatment provision, then it is clearly the practice of medicine. Treatment provision would probably include giving advice about how to take medicines that are prescribed by others.

Once you have decided that a specific encounter constitutes the practice of medicine, you should consider the following practices. Not all of these will be feasible in all situations, and it is important to balance your medicolegal defensiveness with good clinical judgement and the humanitarian impulse.

1. Document your encounters. As in other settings, carefully document any discussion of suicidality and any recommendations that you make. If you chose to prescribe medications, you should document exactly what was prescribed or given and all instructions about how to take the medications and what to do if they experience side effects. Document that you recommended that the patient seek follow up if their problems continue or get worse. The inherent chaos of disasters should not be taken as a blanket justification for forgoing sound medico-legal documentation.

2. Be precise in your documentation. There is a tendency to over-use diagnoses such as PTSD or Adjustment Disorder when summarizing a case. If your records are ever used to communicate what you saw to a fellow physician or in a court of law it is important to describe what specific symptoms were reported and what objective signs you saw.

3. Resist the urge to reveal confidential information without permission. A good disaster psychiatrist develops collegial relationships with the various agencies and disciplines at a disaster site, and it may be tempting to discuss a case the way you speak to an interdisciplinary team in a hospital. You may feel that these disclosures are necessary so that you can rally support for the individual who spoke to you. However, in the eyes of the law, these discussions may constitute violations of confidentiality, and you should either get permission from the patient to talk to these other individuals or resist the urge to reveal any confidential information (Gutheil and Appelbaum).

4. Never discuss specific cases with the media. Disasters are media events. Journalists often exert tremendous pressure on psychiatrists to describe not only what kind of problems they saw but the specific cases and stories of individuals. You may have an urge to describe a case in order to inform the public or to make a psychoeducational point. It is best to avoid using specific cases ever. Information you transmit should not be readily linked to any individual patient (American Psychiatric Association Ethics Committee, Section 4 subheadings 3 and 11).

5. Never try to diagnose an individual who you have not examined. Often family members or disaster relief workers may seek advice about a person who is unable or unwilling to see a psychiatrist at this time. It is unethical to diagnose a patient without personally evaluating them(American Psychiatric Association Ethics Committee, Section 7, subheading 3). This includes public figures. Resist the urge to answer questions by the media about your professional opinion of Osama Bin Laden or a specific high-profile victim.

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Chapter 6

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Media and Disaster

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Introduction

At the time of a disaster, the media usually has the attention of the public. There may be large numbers of people who are vulnerable to the emotional impact of what has just happen and will be very attentive to electronic and print media reporting. The information made available to the public at this point can be the starting point of the mental health response to the disaster.

The availability of psychiatrists or other mental health experts to function as resources to the media can shape the reports of the disaster and the aftermath. The ideal situation would be for there to be a preexisting relationship with various editors and reporters who would then call upon their sources for advice and information. In order to establish this type of connection, there are usually previous meetings and the establishment of a record as a resource who will provide expertise and referral to other colleagues to assist the media writing on deadline any story that has a mental health component. District Branch Public Affairs Chairs or Committees often make themselves available to local media. The APA Communication Division makes referral to psychiatrists who can make call backs to assist national and local media. The APA web site, www.psych.org as well as District Branch web sites can also provide pertinent information for the media as well as referral to experts.

Traditional Information Provided by Media

In the past after major disasters in the United States, such as plane crashes, floods, hurricanes and the like, newspapers and electronic media make available information about all support services being provided. This would include not only where victims/survivors can get housing and financial support but also information about counseling and support groups, which are being offered. This can be updated on a daily basis, so therefore it is important that those people organizing such activities know how to provide this information to the media outlets. A phone call to each newspaper and radio and television station can determine if a fax, email or phone call is the preferred vehicle for conveying this information.

The more sophisticated reporters will want to cover the mental health or psychological aspect of the story and may need very little prompting. They will often reach out to their preexisting psychiatric or mental health experts to educate the public about the type of symptoms that people might be experiencing. Where they don't have sources, they will turn to the local societies, medical school or the APA. They will want to give the "warning signs " of Acute Stress or Post Traumatic Stress etc. This is a good opportunity to inform the public that after a major disaster, many people will have difficulty sleeping, anxiety, bad dreams, flashbacks, irritability and other symptoms, which will usually pass within a few weeks. At the same time this is an opportunity to alert

people when they should seek help. People need to be aware that when they see withdrawal, inability to function or feelings of giving up in themselves or others it is time to talk to a mental health professional. Similarly when there is increased drinking and/or drug use, there is a need for a referral. At the time of 9/11 some mental health experts explained the situation to the press as “normal people experiencing an abnormal situation of unprecedented horror, stress and grief and that it was inevitable that many people would have symptoms of anxiety, depression, flashbacks etc. “ Such an approach tends to destigmatize the acknowledgement of psychological symptoms.

There can be very practical advice that can be given by mental health professionals at the time of a disaster which can also help people avoid being overwhelmed by the continued flow of media reports. TV stations were urged not to overdo it by repeatedly showing the planes hitting the WTC on 9/11and in the aftermath. It was suggested that people who found themselves obsessed with watching news reports even when there was no new news (the so called CNN syndrome) “turn off the television set”. It was advised that parents be particularly attuned to whether children were repeatedly watching events on the TV that they could not control instead of doing the things that they can control such as homework, sports and other activities.

In the aftermath of a disaster, the media like everyone else involved, is feeling a great deal of pressure to do their job. The theme of the story that they are writing has often been arbitrarily assigned to them. They are often working on a deadline which is beyond their control. They can be demanding and expect relatively rapid callbacks. They may wish to dispatch a film crew to your office on short notice. They can be abrupt and at times they may not be sensitive to your schedule.

It is common for the media to request to speak directly with someone who is having symptoms. They would prefer to interview real persons and as a second choice would want to hear a detailed description of an actual patient being treated by a mental health therapist. It is generally viewed as unethical for a psychiatrist to ask a patient to participate in a media interview even if the patient would be given the choice to refuse (since it is deemed not a real choice if their doctor asks them to do it.). Similarly it would be questionable ethical behavior for a psychiatrist to describe a patient in any way that he or she could be conceivably be identified. One can make up various scenarios, which of course are drawn from clinical experience. In reality, reporters in these situations, on their own, have little difficulty in finding people who are willing to talk to them or appear on camera. You should be aware it is considered unethical to discuss or analyze a person whom you have not examined, even if the person were a well known celebrity who was making statements in the media. An attempt to do a psychological analysis of that person without actually examining themselves would be unethical behavior. If in fact you had actually examined the person, you would be bound not to reveal what was told to you in confidence.

Media Tips

1. **Do your homework- learn what's "behind the story" prior to an interview.**
2. **Set an objective, develop brief" take home" message points, practice.**
3. **Be able to say your main message in 10-15 seconds.**
4. **"Bridge" to your message points, be positive.**
5. **Avoid using jargon.**
6. **Maintain eye contact with the interviewer.**
7. **Never look at the camera unless told to do so.**
8. **Dress conservatively.**
9. **Be brief.**
10. **Don't be afraid to say, "I don't know."**
11. **Never go "off the record."**
12. **Never speculate on an individual's behavior or diagnosis.**
13. **On call-in programs, never provide advice that sounds like individual diagnosis or treatment.**
14. **Respond promptly to reporter's queries.**

From – Psychiatric Issues –Speaking Points
American Psychiatric Association

Special Circumstances when there is Terrorism

Terrorism is a form of psychological warfare. The terrorists want to frighten large numbers of people. They will strike unexpectedly at civilian populations and attempt to create a climate of fear. The nature of their attack may be suicidal using explosives and/or taking over airplanes, which are blown up or flown into a target. There is the possibility of terrorists using weapons of mass destruction. This can for example include biological weapons such as anthrax, smallpox; chemical weapons with nerve gas such as sarin, or nuclear terrorism, which could be an attack on a nuclear power plant or the setting off of some nuclear device. While a significant attack with any of these agents could cause wide spread anxiety and stress, the threat and possibility of such an attack can also cause great psychological havoc to the public. Therefore the nature of the media

coverage that is provided for any actual or threatened terrorism will greatly influence the psychological response that occurs.

Risk Communication

The threat of continued or new terrorism, produces the possibility of panic behavior, mass exodus from areas and desperation for vaccine or other medication. Large numbers of people may also descend on emergency rooms. Most of these people will have no physical injuries but could be in a panic state with the belief that they have been exposed to a deadly substance.

Tactical decisions have to made by the leaders who are usually elected officials or their designees in regard to what should be publicly stated and how things should be phrased. While giving the informed public the complete truth is usually the most successful approach, there may be times when more people may be endangered by the wrong timing of the release of such information. The best decision in this regard has to be made and the information has to be effectively conveyed.

On the basis of past experiences, the best spokespersons are those who are well known, familiar to the public and believed to be a trusted individual. The presentation of information has to focus on the mission at hand and it needs pay attention to the human and psychological needs of the audience. Whatever the threat, bomb attack, biological agents or potential attack on our nuclear plants, etc., the spokesperson has to put forth a timely, accurate assessment of risks. There then needs to be dialog with the press and the public that neither exaggerates nor downplays the risks. The public needs to see that spokesperson as knowledgeable and caring. Mayor Rudy Guiliani of New York City achieved that position during the 9/11 crisis and Winston Churchill achieved it in another era when London was the focus of daily frightening bomb attacks. Sometimes a well know person in the media will be capable of stepping into that role and have success with it. Water Cronkite a well-respected TV newscaster was one such person who seemed capable of doing that during crisis periods in the 1960's through the 1980's.

Psychological Support for the Media

As discussed above, there is a good case to be made for psychiatrists and other mental health professionals to develop a working relationship with the media, in order to advise, assist and participate in the dissemination of important information that the pubic needs to know during a disaster situation. In the course of working with the members of the working press, it should not be surprising to see that very often they are psychologically impacted by their exposure to the disaster events as much as are other groups such as police, fire, EMTS, and healthcare workers. Reporters and camera people are early on the scene and go to every effort to view all the details of any death and destruction. They will seek

out the victims and their families and explore all gruesome details. The editors and technicians behind the scenes, will view the tapes over and over as they edit them and put them on the air. They keep long hours and rarely take a break during a major even. Most are very competitive and would be reluctant to acknowledge if they had psychological symptoms.

At the time of 9/11, several psychiatrists were asked by local and network groups to hold meetings to help them with the stress and other symptoms that they were feeling. Basic guidelines can be suggested for personnel working a disaster event, such as mandatory rotation off for sleep and meals with periodic days off. Supervisory personnel should be alert for signs and symptoms of workers not handling stress well. Everyone should be aware and expect to have some symptoms due to the impact of working on such a usual and powerful story. Attention should also be paid to the effects on close family members of any group that is directly impacted by a disaster and those who are close to media people are no exception.

The psychiatrist or other mental health professional who might have a working relationship with the media as a resource for psychological issues could be in a position to be a formal or informal consultant to them when they need help with their own psychological needs. As assessment would usually be needed to determine if some group meetings will be helpful or recommendations for any individuals for time off or a referral for psychological care.

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Chapter 7

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Guidance for Parents and Other Caretakers after Disasters or Terrorist Attacks

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"And some kind of help
Is the kind of help
That helping's all about."

From "Helping" by Shel Silverstein

Introduction

Disasters, small and large, affect children, adolescents, parents, and other caretakers for children throughout the United States, Canada, and the entire world. For those in the United States, the terrorist attack of September 11th, 2001 was the most severe disaster the country has recently experienced. Following this event, parents and caretakers were very interested in learning more about how to help children cope with and understand traumatic events, such as disasters and terrorist attacks. For parents, as for others after disasters, prior education and training are associated with more favorable psychological outcomes (Division of Mental Health, W.H.O., 1992). Hurricanes, earthquakes, plane crashes, the Oklahoma City bombing on April 19th, 1995, and the attacks of September 11th, 2001, are leading to improvements in parent education and better support for parents after disasters. These include natural disasters, terrorism, and community violence among others. The mistaken sense that America was invulnerable has been replaced with more realistic appraisals of risk, preparation at many levels to provide timely information and counseling, and when indicated, child and family mental health services. Since the 1974 Disaster Relief Act (Public Law 93-288), U.S. federal relief services have been provided for hundreds of major Federal disasters, and thousands of Federal emergencies which are less severe, and a few state requests for assistance which were denied (Pynoos and Nader, 1989). All states and many communities provide local disaster services, in association with other organizations such as fire fighters and police, hospitals, the American Red Cross, federal agencies, and various psychiatric, mental health, and medical organizations.

Despite the fact that in the wake of a disaster, help will come or is available, adults, particularly parents, are often in a quandry about how to respond to children. The focus should be on providing realistic support and encouraging hope in the face of a traumatic situation. This chapter is intended to provide practical advice and guidance in this area, citing relevant research as appropriate. This practical approach recognizes that *both* children and adults are frightened following a disaster. It is important after a traumatic event, that the adults address their own needs as well. Focusing on their basic necessities, safety and needs for support puts adults in a better position to be available to help their children cope with the situation.

Initially Talking with Children About the Disaster

It is important to spend more time with children, and find time when to talk together (Northern California Psychiatric Society, 1991). While for some, this may seem obvious, this may require special arrangements during the crisis of a disaster, and given the increased occupational and economic time pressures of our society.

Listening to children First, ask what the child knows about the events of the day in order to clarify distortions and help the child have clear information (Massachusetts General Hospital Departments of Pediatrics and Psychiatry, 2001). While acknowledging how this may be scary, support the child asking questions about what is going on, and encourage their curiosity. It may be helpful to ask questions such as "what was the hardest thing about today for you?" or "is there anything else which has been hard to tell me?"

Observing their behavior In the process of listening, a parent can discover the degree of stress, misunderstanding, or worry, which the child is feeling. Nonverbal communications such as worried expressions, avoidance, or being "glued to the TV" may signal that the child is in distress. Some kids may complain of physical symptoms such as a bellyache or sore throat, which could represent the expression of an emotional reaction expressed as a physical complaint. If the child is too distressed, the parent may choose to keep her or him home for part of the day, or to drive the child to school. If the symptoms continue for a prolonged period of time, the child should be evaluated by a health professional. It may be helpful to check in with other parents to learn how their children are responding to the events.

Using knowledge of the child A parent or other caretaker(e.g. grandparent) knows the child best. A child whose favorite activity is doll play may seek that out and need the parent to be with them there in order to talk. A child whose world is computer games or board games may either need a break from that to talk, or need the parent to take an interest if they are to share what they are feeling. A conscientious student may return to their studies, but be keeping secret her or his worries. Children with disabilities, e.g. deafness, blindness, chronic physical or mental illness, a learning disability etc., will likely need extra time for parents to understand and explain.

What should the child be told? It is important to acknowledge the frightening parts of the disaster and not falsely minimize the danger. Realistically state if the threat is far away or nearby—and the stage it is at in being brought under control by rescue teams, police, firemen, military or other workers normally helping in disasters, including terrorist attacks. The degree of detail shared with a child depends on their age – the focus of the discussion should be on what the child wants to know. The goal of the discussion is to assure the child that he/she is safe. The child's response, e.g. further questions or "tuning out" etc. should

guide further continuing communications which will be necessary for weeks and months.

"Debriefing" is a process developed during World War II to assist adult veterans cope with traumatic war neuroses. For children, we do not promote this particular model but encourage the child and family to create their narrative of the experience. Attending to the experience of the traumatic event and working with the child to understand what happened helps the child/family process the episode. As Rabbi Earl Grollman states, "If it's mentionable, it's manageable."

Differences Related to their Developmental Stage and Prior Experiences

How parents can aid their children who have been exposed to, directly affected by, or injured in a disaster or traumatic event derives from developmental psychiatry and "psychological first aid" recommended for clinicians and teachers (Pynoos and Nader, 1987).

Infants (up to 3 years old) reactions and needs are different from verbal children. They may show fearful facial expressions, altered feeding and sleep behaviors, anxious attachment, clinginess, loss of developmental skills(walking, early vocalizations), and possibly depressive withdrawal. The mother may observe that her relationship with her infant has changed in response to the stress of the disaster on herself and her family. Infants require parental or caring adult presence and support, comfort, food, rest, and the opportunity to play. The infant's parents benefits from parenting support which may allow them to become more emotionally available for their infant despite the disaster. Physical nurturance and verbal reassurance are important in their soothing 'feel' and tone as much as content.

From preschool through early school age, children's reactions and needs relate in part to their verbal skills. They may show fear, altered eating and sleep behaviors, anxious attachment, clinginess, loss of developmental skills (walking, speech, toilet training, etc.), and possibly depressive withdrawal. Listening to what they say about their experiences, and providing emotional labels for common feelings is helpful. They require consistent parental caretaking, comfort, food, rest, the opportunity to play, and acceptance that loss of developmental skills, such as toilet training and dressing self, is a common in young children following stressful events.

*In later grade school,(*3rd-5th grade*)* reactions and needs relate in part to their emerging conscience, and sense of responsibility or guilt about what has occurred. They may show generalized fear, anger, altered eating and sleep, and many of the symptoms of younger children. It is helpful to listen to what they say about their experiences—especially their own private imaginings that may be evident in artwork and dreams, and to encourage them not to go beyond the known facts. Like younger children, they require reassurance, comfort, food, rest, play, and acceptance that loss of developmental skills is transient and common

after a stressful event. Some children become irritable or impulsive, and are aided by verbal acknowledgement that “it is hard to feel so angry”. Encouragement of altruistic wishes (drawings, cards, etc) for those who have been injured or died aids their adaptive coping.

Adolescents (middle school and beyond) reactions and needs may resemble those of adults, and include “spacing out” or dissociation, shame or guilt depending on their relationship to the disaster and disaster victims. It is not unusual that early adolescents will regress and have many of the symptoms of younger children. While they may fear disturbing their parents who may also be fearful and upset, it is helpful for parents to listen to the details of what they say about their experience, to verbalize their feelings (fearful, sad, angry etc) and to encourage them not to go beyond the known facts. If they are experiencing “flashbacks” or bad dreams, parents willingness to listen to this and explain that these are reactions after traumatic experiences which can—if shared together—aid coping with the stress of the disaster. Particular risks, associated with anger and vengeful feelings are sudden changes in life plans, acts of revenge, impulsive actions, and abrupt changes in relationships with friends or family. When such risks are identified, it is particularly important that the adolescent has the opportunity to talk about his or her responses to the disaster, and to share their grief rather than acting impulsively (optimally in psychotherapy with a trained therapist). Encouragement of altruistic activities(drawings, sending cards, etc) for those who have been injured, died and their families aids their adaptive coping. It is especially important for the adolescent to identify their positive observations and behaviors after a disaster to mitigate feelings of helplessness, ineffectiveness, guilt and failure. Adolescents will sometimes react by wanting to obtain revenge on the “enemy.” While talking about wanting to kill the “bad guy” is age appropriate, acting or planning out a retaliatory act requires immediate evaluation by a health professional.

Early and Late Post-Disaster Problems to Look for in your Child

Each child has his or her own tempo or rhythm with which they work through upsetting or traumatic feelings or experiences. Bad dreams may have less to do with illness than with working through feelings about the disaster. Some children seem to rapidly dissipate the feelings in activity, while others may retreat, brood, or seem at a distance, and there are many degrees in between. Early problems to look for include new phobias, persistent increased dependency, withdrawal from usual activities, a sudden decline in academic or other performance, new peer or family conflicts, and

It has been discovered that some children’s lives appear to be shaped by being severely traumatized. Their subsequent development may show the effects of those experiences through adolescence by changes in their behavior or personality, e.g. decreased self esteem, feeling more insecure. If a child shows signs of growing or persistent avoidance of communication with parents, social

withdrawal (missing school, coming home late), academic difficulties, severe moodiness, impulsivity, alcohol or substance abuse, professional consultation should be sought.

Coping and Resilience

The stress of a disaster need not, in the long run, "traumatize" a child. Many children become motivated through stressful experiences to help others, or to go into fields of work, which will allow them to help others who have been traumatized or injured. Awareness of or the presence of positive helping role models appears to be one factor, which increases the likelihood of such a positive developmental outcome. Examples of such role models include teachers, coaches, political leaders as well as parents/caretakers.

Factors which seem to "protect" some children, at least to a degree, from the adverse effects of trauma include families which are more supportive than in conflict, economic well-being, and the presence of nonfamilial supports at school, in health care, and in their religious group (Haggerty et.al., 1994). In addition, those children who have found success, and who have stable positive peer relationships may be more buffered against the effects of trauma than those who have not.

Other children, often less traumatized and more able to *adapt to* the full impact of the trauma, seem to be able to "buffer" the effects of the trauma, and cope even better than they might have had it not occurred (Cowan et.al., 1996). These are resilient children who seem to draw strength from adversity.

Guidance for Parents whose Child Has Died in the Disaster

While this topic is too large to be fully addressed here, it is a fact that children as well as adults often die in disasters. Parents, siblings and friends are often strongly affected, suffering "traumatic grief", or a kind of grieving which is mixed with disbelief, shock, irritability, or detachment, as well as active mourning for the lost child(ren). The full impact of the loss may take many months and years to be expressed, but provision of early opportunities to express feelings of sadness, anger, guilt or other feelings may ameliorate the loss somewhat. The funeral, memorials, and anniversaries provide opportunities to share memories and sadness together. After the traumatic death of a child, it is often helpful to consult mental health professionals for help in coping both with the trauma of the event as well as the impact of the loss of the child on the family. Often it is only possible to address one of these at a time.

Adults Need Support Too

As stated by Benedek (1970) "being a parent is at the center of a normal parent's self concept." But, in disaster this parental identity is severely stressed, and very much focussed on the time at hand—"how can I protect my child". This protection is both emotional and physical at the time, but also expresses fear for

the child's future – "I don't want this experience to harm my child later?" This section provides a framework for giving parents and other caretakers tools to respond to and help children in disaster and to lessen their feelings of fear and helplessness. It is also intended to encourage ways of maintaining communication and adult support.

Parents are an important factor in helping children with traumatic events. However adults also need to make certain they address their needs as well as those of the child. Parents who avoid taking care of themselves may be too distressed to notice the suffering of their children. Children respond best if they perceive their parents/caretakers are using available resources to cope with a traumatic situation. Parents educated about normal reactions to trauma are more likely to experience less stress and have increased confidence in their ability to address their children's needs.

The threat of a disaster to the physical and emotional well being of the parent, and to their child, can disrupt a parent's identity and block meaningful with communication with their child. A parent needs time to be alone with their spouse, significant other or friends, and to reduce or recover from disaster stress to the degree possible. Parents, like others in disasters, are at risk of serious stress-related physical or emotional problems, which may interfere with their roles as parents. They may need early medical care for exacerbation of illness, or counseling to reduce disaster-associated anxiety or moodiness. Parents who have had abused alcohol or other substances are at risk of relapse, and should seek appropriate preventive substance abuse services.

In disasters, parents are advised to seek family support services, which are available soon after the event through several public and private agencies, including the state departments of mental health, the Red Cross, and others.

The Media, Their role, and Should Your Child Watch TV?

This is a large topic. What is the media? TV, radio, newspapers, internet, and even telephonic communication such as via cell phone. Our children are "wired". This is true, through peers, even of those who show no interest in watching TV, surfing the internet, or reading a paper. What is a parent to do? Younger children need parental supervision and presence to prevent their seeing traumatic TV images or other media exposure, or when they do(which will happen), to have parental availability to talk about what they have heard or seen. After "911" nearly all children and adolescents witnessed TV replays of the destruction of the World Trade Center towers to the point where many were fearful, and distorted what had happened.

There is no way to shelter children from media portrayals of nearby disasters, or even faraway major terrorist attacks. Parents should do what they are comfortable with—and there is a wide range. Provision of parental physical and emotional presence, guidance and interest in the child's or adolescent's "take" on what is going on is stabilizing for the child. This allows the parent to help even older adolescents cope with what may be one of the worst things they

have ever imagined. Even a “small” disaster at school or faraway, may affect a child directly because of its relation to a peer, a past experience, or a particular interest of that child.

Psychiatrists in all communities may assist the media in ways to support families, with their knowledge of development and stress.

Key Roles of Schools, Churches, Community Agencies, and Businesses

Schools, Churches and other Community agencies act as significant resources for children and parents during times of crises. Schools in particular often serve as “in loco parentis” for many children who spend a huge part of their day in the classroom. In a disaster, school personnel can help the children acknowledge the tragedy and offer the children a safe outlet to discuss their feelings.

In Elementary School, children are focused on their own vulnerability. This age group may act out their feelings – being shy, clumsy or aggressive. Teachers and school personnel can help children by explaining in concrete terms and as accurately as possible the tragedy that occurred. The children benefit from reassurance and a place to express their emotions honestly. Emotions may be expressed orally, in play or artistic work such as drawing, or through writing. Some may need to retell the event multiple times to help understand what happened. School personnel can provide a safe environment to verbalize the feelings, provide consistent caretaking and being an additional resource for the parents. In school, children commonly use familiar class activities such as art, essays or group projects to express their fears and aggressions. School personnel should be on the alert for children having particular difficulties – children expressing somatic complaints, difficulty completing homework due to decreased concentration, or needing constant reassurance. As mentioned earlier, continued reassurance to reestablish feelings of safety are essential, and if the symptoms persist consultation with the school mental health consultant is suggested.

In Middle and High School, children may have more difficulty expressing their feelings openly, especially boys. Teachers can start by asking about how others in the family are coping or trying to have the children express their reactions on paper. Pictures may help the students express themselves and students should be encouraged to talk about the situation. Students may need help deciding how to cope with the loss – what sort of memorial or way to acknowledge the tragedy. Some in this age group are likely to act out their impulses as a way to cope with their anger – this includes possible reckless behaviors, vengeful feelings or plans. School personnel can address these responses realistically and encourage constructive alternatives, particularly those that focus the children’s sense of altruism. Children in this age group commonly turn to peers for support, which can be helpful if there is appropriate available adults and supervision if needed.

For School Administrators, it is helpful to have a Mental Health Consultant, knowledgeable about children's responses to disaster, terrorism, or other stressors available to discuss the event and its sequelae, options for how the school might best respond, and how best to be available for faculty and other school personnel who are likely themselves to be under stress indirectly or directly. Keeping communication open amongst all staff and students, and being sensitive to the impact of the trauma is essential. School Nurses and Counselors should be sensitive to students presenting with physical complaints as a sign of grief. For Teachers, it is important to give them an opportunity to express their reaction to the event and to educate them about the various symptoms children will experience in response to a tragedy.

Traumatic events disrupt the routine and may require early clear interventions if possible, when they occur. Schools can help parents by providing a role model for expressing feelings openly and honestly. Recovery from tragic events takes time and patience and the need for everyone, parents and schools, to be flexible.

Community Organizations, such as churches, businesses and other agencies, are a major source of stability and security for both adults and children. Principles for managing children and families during time apply to these organizations are similar to those outlined above for school personnel. The key components are helping disseminate accurate information, providing a safe environment to understand the event and to allow for adequate expression of the various responses to the event.

What Children May Do to Help Others After a Disaster

Children can benefit from developing altruistic constructive alternatives to assist them in processing a traumatic event and in developing healthy ways of coping with these difficult situations. This can help instill a hopeful attitude despite difficulties encountered in such situations. Examples of constructive alternatives include fundraisers to help those afflicted, volunteering in realistic ways (gathering necessary clothing, food and basic necessities to be sent to individuals), or writing letters directly to those involved. Children who discuss ideas of revenge or other aggressive acts should be refocused on more constructive alternatives to help decrease their sense of helplessness.

Seeking Professional Advice, Information, and Help

Immediate mental health resources for parents following a disaster include nearby schools, hospitals, public mental health agencies, websites sited below and the Red Cross. Telephone hotlines may be available rapidly as well. Experienced professionals are usually available on radio and television with guidance for parents, but it can be difficult for parents to distinguish those who are knowledgeable from those who are not. Within the initial days, additional

resources from state agencies and the Red Cross are available such as trained teams of social workers, psychologists, and psychiatrists who are experienced in disaster situations.

Short-term resources, after the acute disaster has resolved, are available usually from the organizations described above, and also from state or federal agencies. In addition, the primary care pediatrician, as well as child and adolescent psychiatry departments are available to provide consultation, guidance, as well as diagnostic assessment and treatment for children and families.

Long-term resources include both public and private mental health professionals, some of whom specialize in working with families who have been impacted by traumatic experiences and grief. Since post-disaster psychological effects are usually not fully evident until later, these long-term mental health resources are of great importance in preventing long-term problems from worsening.

Ten Points to Guide Parents and Caretakers in Disasters or Terrorism

Mnemonic: Be Patient, Safety First Over All, Children Always Cope with Help.

1. *Be* - **Basic Survival**. Focus on your basic survival. The parent must first organize him/herself –
   Take care of basic necessities, food, clothing, warmth—you cannot help your child unless you take care of yourself first.
2. *Patient* - **Physical health –** take care of the family's needs, both parent and child.
3. *Safety* - **Safe Environment –** Provide a safe environment **-** reassure the child about his/her safety, verbally and with physical nurturing.
4. *First* - **Factual information** – provide factual information to the child about what has occurred, geared to the child's development and ways of communicating
5. *Over* - **Observe -** observe and listen to your child and his/her responses – the child may show feelings nonverbally via increased dependency, withdrawal, acting out.
6. *All* – **Activation -**activate your support systems/networks – family, church, community for help.
7. *Children* - **Children –** those children particularly vulnerable to traumatic events include those with physical injuries, those who have suffered prior losses, those without or with minimal adult support or supervision and those with emotional or behavioral problems,
8. *Always* – **Altruism -** Encourage altruistic responses. These include helping focus the children on realistic and constructive alternatives such as volunteer efforts and fundraisers for those affected. Seek to refocus feelings of aggression and revenge.

9. *Cope* - **Coping –** A parent's ability to help with a disaster is the most predictable measure of a kid's ability to cope with disaster. Kids will minimize their responses if a parent is not coping well to the situation.
10. *with Help* - **Help** – Seek professional help for the child when you are concerned about the child's ongoing responses.

Additional Resources and Websites

Websites with helpful information:
American Psychiatric Association: www.psych.org
American Academy of Child and Adolescent Psychiatry: www.aacap.org
American Academy of Pediatrics: www.aap.org
Red Cross : www.redcross.org.
American Psychological Association: www.apa.org

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