

Disaster Mental Health: A Critical Response

A Training Curriculum for Mental Health and Spiritual Care Professionals in Healthcare Settings

Participant Manual

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Project Director: Jack Herrmann



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Program Introduction

Program Overview

The social, political, and humanitarian pressure to address the psychological and spiritual crises that follow disasters is growing. The importance and value that integrated teams of mental health and spiritual care providers bring to disaster victims, their loved ones, and relief workers are being recognized by those tasked with federal, state, and local disaster planning, preparedness, response, and recovery. The public also expects that a healthcare facility's doors will always be open and that care will be available when it is needed, and that hospital staff will be competent and prepared to handle any threat or disastrous event.¹ While the challenge of providing ongoing services in the aftermath of a catastrophic natural or human-caused disaster may seem like an insurmountable task, a comprehensive disaster plan, which includes the material and human resources needed for implementation of the plan, is a place to start.

You have been invited to participate in a disaster mental health training program developed specifically for New York State. This program is a collaboration among the University of Rochester Medical Center, the New York State Department of Health, and the New York State Office of Mental Health. The production of this curriculum is made possible by a grant from the Health Resources and Services Administration's (HRSA) National Bioterrorism Hospital-Preparedness Program, part of the United States Department of Health and Human Services (HHS), and the New York State Department of Health.

This curriculum will provide you with an overview of how disasters strike, the psychological, psychosocial and psychospiritual impact they have on individuals and communities, and the role of mental health and spiritual care personnel in healthcare settings in disaster planning, response, and recovery.

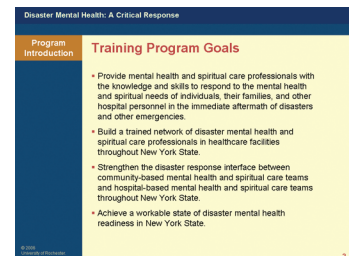
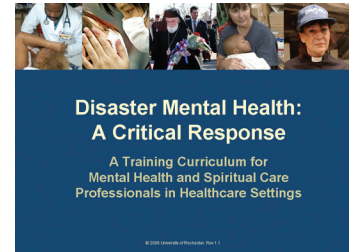
Training Program Goals

Disaster Mental Health: A Critical Response is an important training program that provides essential preparation for mental health and spiritual care professionals employed in healthcare settings. The goals of this training program are to:

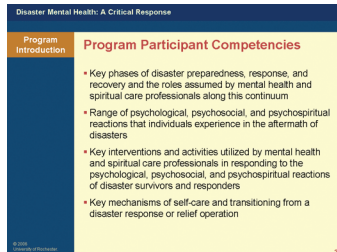
- Provide mental health and spiritual care professionals with the knowledge and skills to respond to the mental health and spiritual needs of individuals, their families, and other hospital personnel in the immediate aftermath of disasters and other emergencies.
- Build a trained network of disaster mental health and spiritual care professionals in healthcare facilities² throughout New York State.

¹ McGlown, K.J. (2004). *Terrorism and Disaster Management: Preparing Healthcare Leaders for the New Reality*. Chicago: Health Administration Press.

² Healthcare facilities include hospitals, urgent care clinics, and community clinics.



- Strengthen the disaster response interface between community-based mental health and spiritual care teams and hospital-based mental health and spiritual care teams throughout New York State.
- Achieve a workable state of disaster mental health readiness in New York State.



Program Participant Competencies

This training program is designed to share information with mental health and spiritual care personnel about the nature of disasters and the ways in which affected populations and disaster relief workers³ respond in healthcare settings and across the impacted community. Ultimately, this information will be translated into workable knowledge⁴ that will help you participate as a member of your facility's disaster response team or provide supplemental support to your county disaster mental health team. Specifically, this means that when you have completed this training program, you should understand the:

- Key phases of disaster preparedness, response, and recovery and the roles assumed by mental health and spiritual care professionals along this continuum
- Range of psychological⁵, psychosocial⁶, and psychospiritual⁷ reactions that individuals experience in the aftermath of disasters
- Key interventions and activities utilized by mental health and spiritual care professionals in responding to the psychological, psychosocial, and psychospiritual reactions of disaster survivors and responders
- Key mechanisms of self-care and transitioning from a disaster response or relief operation

Each module includes a set of *Participant Competencies*. In effect, these serve two primary functions. First, they identify the standard requirement of what is expected from you. Second, these are meant to help you preview and organize the content in meaningful ways.

At the end of each module, you should ask yourself; “Can I say with a comfortable measure of confidence that I have achieved these competencies?” If you feel that you have not to your satisfaction, then you should engage the instructors and other course participants in additional dialogue and seek clarification. It is quite probable that others have similar questions and will value clarification.

³ Disaster relief workers include first responders (e.g., law enforcement, search and rescue, fire departments, and emergency medical personnel) and secondary responders (those who fall into all other categories).

⁴ The achievement of participant competencies indicate increased knowledge, which provides opportunities for reflecting on current attitudes and increasing practical skills.

⁵ Definition: Psychological refers to the emotional characteristics and associated behaviors.

⁶ Definition: Psychosocial refers to the resulting life changes that come about when one's emotions and behaviors affect one's interaction with others.

⁷ Definition: Psychospiritual refers to the resulting changes in one's spiritual belief systems or one's relationships with God or a Higher Power.

Objectives of this Introduction

Within the context of this Introduction, you will be expected to:

- Understand the purpose and goal of the training program.
- Evaluate the match between the course objectives and your personal and professional objectives.
- Introduce yourself, providing a brief background of your personal and professional experience in disaster or crisis work.
- Complete a pre-training questionnaire.

Housekeeping Details

The instructors will provide you with specific information about the facility within which you find yourself for this training program.

Details include information about the following items:

- Time the training will begin and end each day
- Arrangements for breaks and lunch
- Location of restrooms
- Emergency exits
- Use of telephones for emergency calls

As participants, you will also be expected to contribute to a positive and successful learning experience for all who are involved in this training program. Here are some guidelines to keep in mind during this training program.

- Observe start times for training at the beginning of the day, after breaks, and lunch.
- Ask questions and share information; participation is encouraged.
- Turn off laptops and set all cellular phones and pagers to vibrate.
- Stay focused on the topic. Interruptions and side conversations distract the instructors and other training participants.
- Respect the training agenda. If you need extra time to discuss a topic with the facilitator, pursue it after class.
- Maintain professional confidentiality when discussing real-life examples.

Training Program Structure

This training curriculum is designed to provide you with a chronological perspective of how disasters and other public health emergencies unfold at the local level and how mental health and spiritual care professionals play a vital role in providing direct support to those affected by such an event. Whether we are dealing with disaster survivors, disaster responders (including hospital personnel), or the general community, providing professional support and comfort are essential elements to potentially mitigating any long-term adverse psychological, psychosocial, and psychospiritual impact following a disaster.

Disaster Mental Health: A Critical Response	
Program Introduction	Training Program Structure
	Module 1 Facing Disaster: Are You Prepared?
	Module 2 Disaster Planning, Preparedness, and Response in Healthcare Settings
	Module 3 Characteristics and Attributes of Natural and Human-caused Disasters
	Module 4 Reactions to Disaster: The Human Response
	Module 5 Acts of Terrorism, Weapons of Mass Destruction, and Public Health Emergencies: Special Issues and Considerations
	Module 6 Disaster Mental Health and Spiritual Care Team Response
	Module 7 Early Interventions and Other Disaster Mental Health and Spiritual Care Activities
	Module 8 Self-Care and Disengaging from a Disaster Assignment

During this training program, you will be exposed to a great deal of information on disaster planning, response, and recovery from a mental health and spiritual care perspective. In addition to this Introduction and to the Training Program Summary, the subject matter will be presented in the following eight (8) modules:

- Module 1—Facing Disaster: Are You Prepared?
- Module 2—Disaster Planning, Preparedness, and Response in Healthcare Settings
- Module 3—Characteristics and Attributes of Natural and Human-caused Disasters
- Module 4—Reactions to Disaster: The Human Response
- Module 5—Acts of Terrorism, Weapons of Mass Destruction, and Public Health Emergencies: Special Issues and Considerations
- Module 6—The Disaster Mental Health and Spiritual Care Team Response
- Module 7—Early Interventions and Other Disaster Mental Health and Spiritual Care Activities
- Module 8—Self-care and Disengaging from a Disaster Assignment

Disaster Mental Health: A Critical Response	
Program Introduction	Interaction 1
	Participant Introductions
	<ul style="list-style-type: none">• Your name• Where you work and what you do• Previous disaster training experience• Previous disaster response experience• Training expectations

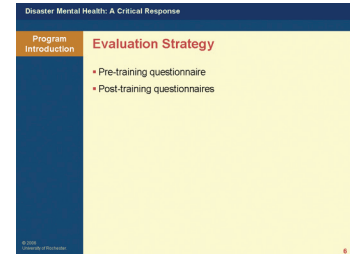
Interaction 1: Participant Introductions

Learning takes place in many ways. Your experiences, background, and insights can provide the impetus for reflection by others who are taking this course. Give some thought as to how you will introduce yourself to the instructors and other training participants. Share information about your clinical experience with respect to these questions:

1. Have you participated in previous disaster mental health training programs?
2. Have you been assigned to a disaster response?
3. Have you been personally involved in a disaster?
4. What are your expectations in taking this course?

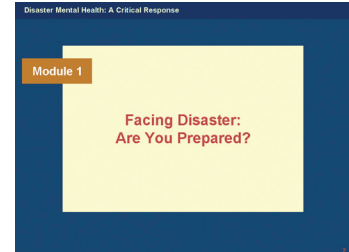
Evaluation Strategy

The evaluation strategy is a mechanism for obtaining feedback that can be used to improve this training program in the future. Essentially, you will be completing pre-training and post-training questionnaires. The pre-training questionnaire focuses specifically on the mental health and disaster preparedness knowledge you have prior to beginning this training program. It will be administered before we move on to Module 1 and will require about 15 minutes to complete. The post-training questionnaires will be administered after you have completed this training program. They will provide you with an opportunity to describe what you have learned, how this training will fit within the context of your day-to-day professional life, and how satisfied you are with this overall training experience. It is also a requirement for you to receive your certification of completion. Your instructors will provide you with more details on how to complete the post-training questionnaires at the end of this training.



Module 1

Facing Disaster: Are You Prepared?



Module Overview

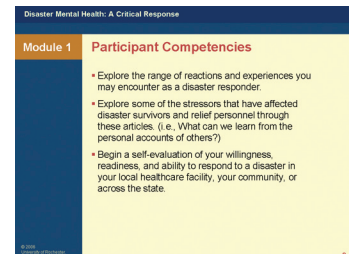
Prior to arriving today, each of you received an invitation packet in the mail that included pre-training materials. You were asked to read three personal accounts from two disaster responders and one disaster survivor. You were also asked to complete the *University of Rochester Disaster Mental Health Personal, Family, and Work Life Inventory*. This first module is dedicated to the review of these materials and sets the stage for the remaining modules.

First, this module is intended to provide you with a glimpse of what you might encounter as a disaster mental health or spiritual care responder in a healthcare setting including both personal and professional challenges. Second, it will encourage you to consider your personal, family, and work life responsibilities and commitments to determine how these responsibilities and commitments support or present challenges for your future as a disaster responder.

Participant Competencies

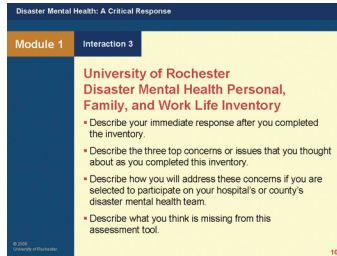
Your objectives for this module will be to:

- Explore the range of reactions and experiences you may encounter as a disaster responder.
- Explore some of the stressors that have affected disaster survivors and relief personnel through these articles. (i.e., What can we learn from the personal accounts of others?)
- Begin a self-evaluation of your willingness, readiness, and ability to respond to a disaster in your local healthcare facility, your community, or across the state.



Personal Accounts

As you recall, there were three articles in your pre-training materials that you were asked to read prior to the training. These articles represent the personal and professional reactions of individuals who have been involved in disasters. The authors' views support the premise that disasters are stressful events for both survivors and responders. Seasoned disaster responders will tell you that no two disasters are alike and that each presents its own unique challenges and rewards. Let us spend some time talking about these articles.



Interaction 2: Reactions to Personal Accounts

Each article provides a perspective from the individual's point of view and his or her reactions to a specific disaster. They are personal; yet they have a universality that speaks to all of us. These are narratives to which you can relate and recognize the possible stressors that you will encounter in similar situations.

As you think about each article, you should consider what it was like for that individual, picture the scene as best you can, and think about how you might have reacted in a similar situation. Consider the following questions:

1. What was each author's primary purpose for writing? Who was he or she writing to and why?
2. What are the compelling messages that each author wishes to share with the audience?
3. What were the images, thoughts, and feelings you had as you were reading these articles?
4. How do these narratives influence you?

University of Rochester Disaster Mental Health Personal, Family, and Work Life Inventory

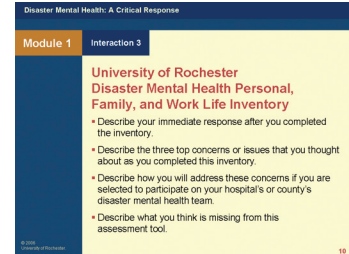
Providing mental health and spiritual care support during times of disaster can be exciting, stimulating, and perhaps, one of the most enriching professional and personal experiences of your life. This work can also be physically and emotionally exhausting. Long hours over many days and weeks coupled with intense environments and interactions can take their toll on those called to provide these services. Clinical training by itself does not prepare you for this type of work. It is often helpful to anticipate the consequences of responding to such events. Disaster relief is not for everyone. The *University of Rochester Disaster Mental Health Personal, Family, and Work Life Inventory* is an assessment tool that is meant to help you see if you are prepared for the range of experiences you will encounter in the aftermath of a disaster.

Interaction 3: Disaster Mental Health Personal, Family, and Work Life Inventory

Having completed the inventory, you are in a better position to comment about your ability to respond to a disaster and the consequences of doing so. Use this opportunity to share your thoughts about what you discovered about yourself and your specific personal, family, and work situations.

1. Describe your immediate response after you completed the inventory.
2. Describe the three top concerns or issues that you thought about as you completed this inventory.
3. Describe how you will address these concerns if you are selected to participate on your hospital's or county's disaster mental health team.
4. Describe what you think is missing from this assessment tool.

This exercise has provided you with an opportunity to entertain the preparations you may wish to make so that you can feel comfortable leaving your regular routine to participate in disaster mental health work.

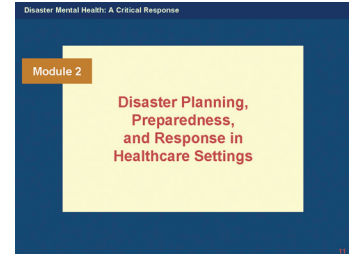


Module Summary

With the completion of this module, you can begin to appreciate the complexity of becoming involved in disaster mental health and spiritual care work. The challenges are both professional and personal. These are unlike what most of you experience in your day-to-day routines. You must become as familiar as you can with what this work involves and how you can contribute to the overall disaster response.

Module 2

Disaster Planning, Preparedness, and Response in Healthcare Settings



Module Overview

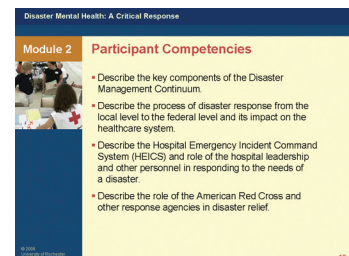
Many of you are taking this course as part of your hospital's efforts to prepare a team of mental health and spiritual care professionals who will be ready to respond during times of disaster. Your main role will be to provide emotional and spiritual support to those affected by disaster, but it is critical for you to understand the context in which you will be providing this support—the bigger picture.

Disaster relief operations are complex systems involving more than just a response mechanism. They require a significant amount of pre-planning. Disaster experts have long known that waiting until a disaster strikes to test a community's or hospital's response procedures can be disastrous. How healthcare systems and communities respond to disaster can even induce more stress on individuals and place them at risk for developing a variety of adverse reactions and psychological consequences. This module takes the first step towards introducing you to the key elements of disaster management and response at multiple levels.

Participant Competencies

The focus of this module is on the framework of disaster planning, preparedness, and response. You will be working as a disaster mental health or spiritual care worker within this structure. It is essential that you are comfortable with the structure that makes disaster response possible. When you have completed this module, you will be able to:

- Describe the key components of the Disaster Management Continuum.
- Describe the process of disaster response from the local level to the federal level and its impact on the healthcare system.
- Describe the Hospital Emergency Incident Command System (HEICS) and role of the hospital leadership and other personnel in responding to the needs of the disaster.
- Describe the role of the American Red Cross and other response agencies in disaster relief.



Disaster Management Continuum¹

All disaster response begins at the local level and, as such, communities must be prepared for whatever happens, no matter how big or small. Healthcare systems play an integral role in a community's disaster response. Therefore, these systems must also be prepared to meet the tremendous challenges that are brought forth by disasters and public health emergencies. Successful disaster response requires a community and its healthcare system to:

- Define and anticipate disaster risks and hazards.
- Prepare the material resources and skilled personnel to respond to these risks and hazards.
- Develop comprehensive plans to deploy the appropriate human and material resources to assist the community and its recovery.
- Learn from disasters and translate these lessons learned into invaluable future preparedness.

Disaster management is the preparation for, response to, and recovery from disaster. It should be viewed as a cycle with the following five key phases:

- Planning and Preparedness Phase
- Mitigation Phase
- Response Phase
- Recovery Phase
- Evaluation Phase



Figure 2–1:
Disaster Management Continuum

¹ Veenema, T.G. (Ed.). (2003). *Disaster Nursing and Emergency Preparedness for Chemical, Biological, and Radiological Terrorism and Other Hazards*. New York: Springer Publishing Company.

Each phase presents opportunities for disaster mental health and spiritual care professionals to be involved. Each of the phases, while written from a community standpoint, can and should be translated into a hospital-based perspective as well.

Planning and Preparedness Phase

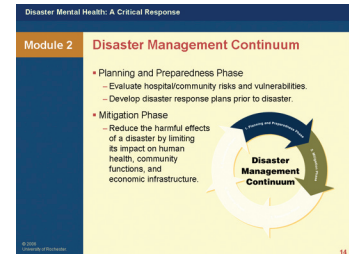
The *Planning and Preparedness Phase* is designed to structure the disaster response prior to the occurrence of a disaster. It is a state of readiness to respond to a disaster or other emergency situation and involves evaluating a community's potential disaster risks, vulnerabilities, and the likelihood for a disaster to occur. This risk assessment process is sometimes referred to as an *All-Hazards Analysis*². An All-Hazards Analysis can be completed at multiple levels, including the:

- Federal, state, and county levels
- Hospital, business, and agency levels
- Personal and family levels

Depending on the disaster, there are some incidents that may present more risk and challenge than others for hospitals. For example, a small house fire may present minimal risk for both a community and a hospital if they have the resources to respond adequately to the needs of the individuals involved. A large structural fire, such as a twenty three-floor office building with multiple people killed or suffering significant burn injuries, may present significant challenges for both the community and the healthcare system no matter how large the city or how many resources they have at hand. Communities and hospital systems must assess the risk of such scenarios and plan accordingly.

The Planning and Preparedness phase also assesses the community's or healthcare system's infrastructure (i.e., availability of backup communications, transportation options, economic viability, etc.) and its capability to respond to the potential risks and vulnerabilities identified in the *All-Hazards Analysis*. An All-Hazards Analysis assesses available mental health and spiritual care personnel and trains them in disaster response; this is an example of a Planning and Preparedness activity.

It is important to note, however, that having the best plan or the most experienced team will not always guarantee a successful disaster response. Some disasters will stress even the most prepared system or team. In these cases, individual flexibility and system flexibility are essential attributes. Developing a plan and response team that is flexible and able to adapt to whatever occurs is extremely important. In many cases, peoples' lives will depend on it.

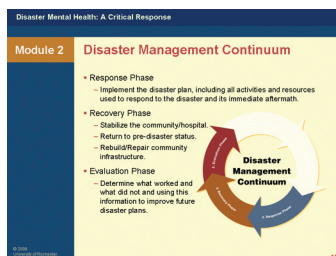


² For more information about *All-Hazards Analysis*, refer to *Mental Health All-Hazards Disaster Planning Guidance*, which can be downloaded from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services web site at <http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA03-3829/All-HazGuide.pdf>.

Consider the scenario where an entire hospital is rendered inoperable because of a flood or contaminated by a biological or chemical agent. A plan and response team that had only considered the provision of services from the usual site quickly will become overwhelmed with how to respond when its site suddenly does not exist.

Mitigation Phase

The *Mitigation Phase*, also known as the Prevention Phase, is characterized by the measures taken to reduce the harmful effects of a disaster to limit its impact on human health, community function, and economic infrastructure. During this phase, steps are taken to prepare a community or hospital for disaster, especially high-risk locations (e.g., hospitals in areas that typically flood) and populations. There is supporting research that suggests individuals, communities, and hospitals are more resilient following disaster when they have anticipated and prepared for disaster outcomes. For example, having a personal or family disaster plan can be a step towards mitigating the effects of disaster when it strikes a particular family. Ensuring that all personnel understand their roles in disaster response and are educated on a department's evacuation plan and other response activities can achieve similar positive outcomes.



Response Phase

The *Response Phase* is the actual implementation of the disaster plan. Disaster response is the organization of activities used to respond to the event and its aftermath. The Response Phase focuses primarily on emergency relief: saving lives, providing first aid, minimizing and restoring damaged systems (communications and transportation), meeting the basic life requirements of those impacted by disaster (food, water, and shelter), providing crisis or acute mental health assistance, and offering spiritual support and comfort. Healthcare systems will be looked to for providing emergent lifesaving care. Mental health and spiritual care professionals in those systems will respond by providing supportive care to those transported to hospitals, the loved ones of those injured, and other hospital personnel.

Recovery Phase

The *Recovery Phase* focuses on the stabilization and return of the community and healthcare system to its pre-impact status or what some describe as "getting back to normal." Activities of the Recovery Phase can range from rebuilding damaged buildings and repairing a community's infrastructure to relocating populations and instituting intermediate and long-term mental health interventions. The Recovery Phase can begin days, or in some cases, months after disaster strikes. In the aftermath of catastrophic disasters such as Hurricane Katrina, the concept of returning a community or healthcare system to its pre-impact status might seem unlikely or impossible. In these cases, the recovery efforts focus on helping communities and systems adapt to a new sense of "normal."

Evaluation Phase

The *Evaluation Phase* of the disaster management continuum often receives the least amount of attention. A timely and thoughtful evaluation process is essential in determining what worked and what failed. This analysis informs future revisions and enhancements to the disaster plan and response system. Communities or healthcare systems that fail to implement an evaluation phase in the context of their disaster management process often find they are no better prepared the next time disaster strikes.

As you can see, each phase presents unique opportunities for communities, hospitals, and individuals to focus on how they will prepare for, respond to, and recover from disaster before the event actually happens.

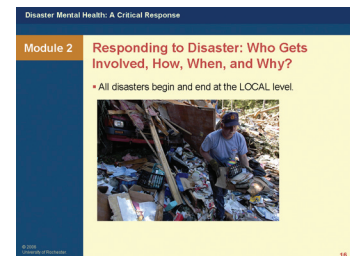
Responding to Disaster: Who Gets Involved, How, When, and Why?

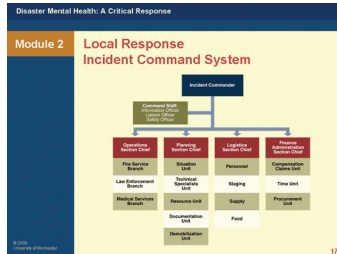
The Local Response

All disasters start at the local level. No matter how large or small, local communities are expected to provide immediate disaster response. On a daily basis, our police officers, firefighters, and emergency medical technicians are our community's first responders. Their primary mission centers on the rescue and recovery of those in harm's way. Whether fire, flood, or acts of terrorism, these individuals are usually the first on the scene.

Others also respond and provide assistance to those impacted in the immediate aftermath of disaster. The community's hospitals, mental health, and spiritual care professionals may also be activated in those early minutes and hours after disaster.

Triage and assessment becomes a significant factor in a community's first response. It is not only the assessment and medical triage of injured victims, but also the assessment of needed human and material resources to respond to the incident. Usually when disaster strikes, there are a number of responding agencies, and the scene of a disaster can quickly become chaotic and confusing. In an effort to avoid some of this unnecessary confusion, there is always someone placed in charge of assessing the situation and evaluating the needs of the response system.





Incident Command System

The *Incident Command System (ICS)*³ is a formalized management structure that lends consistency, fosters efficiency, and provides direction during a disaster or emergency response. ICS is used by all levels of government—federal, state, local, and tribal nations—and by many private sector and nongovernmental organizations. The Incident Command System defines the structure of the incident response as well as the coordination of the responding agencies. The ICS is built around a number of critical components with someone identified as the lead for each component. The illustration that follows provides an overview of the structure.

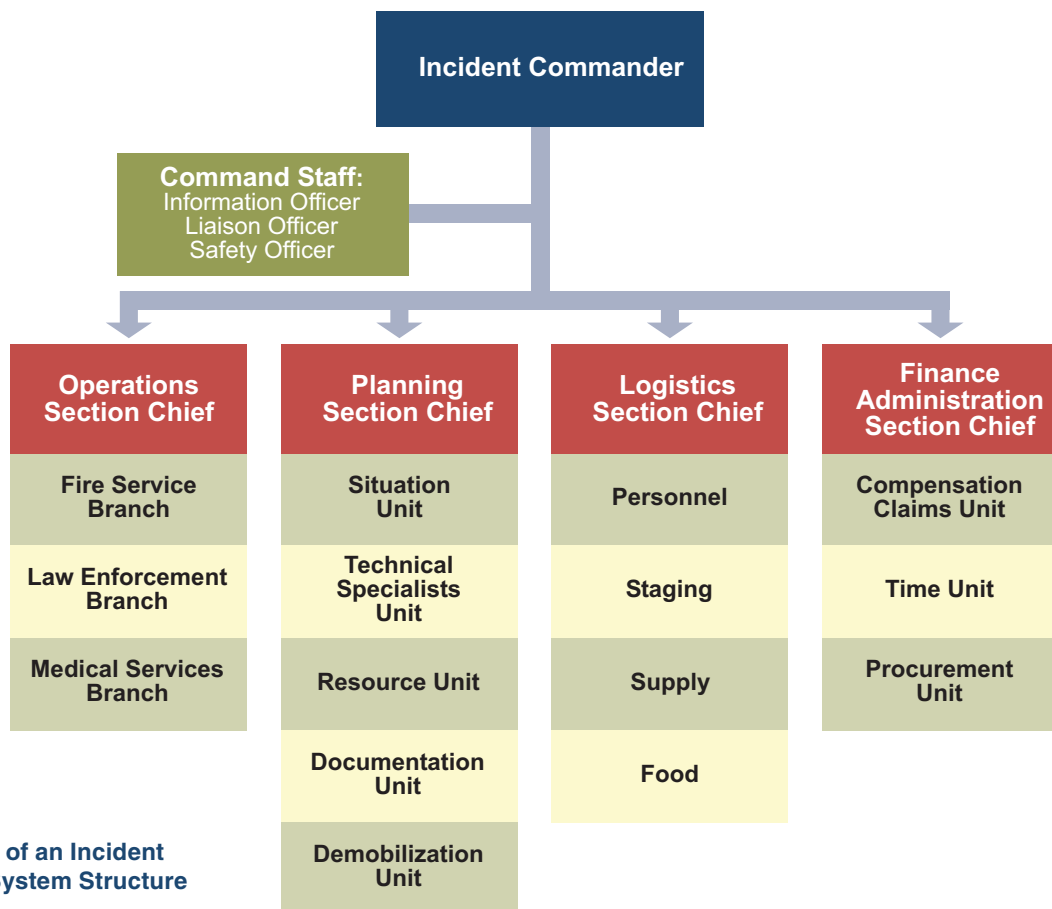


Figure 2–2:
An Example of an Incident Command System Structure

³ This illustration and information provided about the Incident Command Structure has been adapted from several sources, including the *National Incident Management System* document by Homeland Security, March 1, 2004 and the online reference to the *New York State Incident Command System* at www.nysemo.state.ny.us/TRAINING/ICS/explain.htm. For more information on the Incident Command System, refer to the *National Incident Management System* document at http://www.fema.gov/pdf/nims/nims_doc_full.pdf.

Component	Responsibilities
Incident Commander	<ul style="list-style-type: none"> ■ Set objectives and priorities. ■ Assume overall responsibility at the incident or event.
Operations Section	<ul style="list-style-type: none"> ■ Implement the Incident Action Plan (IAP). ■ Manage tactical operations at the incident site with the objectives of: <ol style="list-style-type: none"> 1. Reducing the immediate hazard. 2. Saving lives and property. 3. Establishing situation control. 4. Restoring normal conditions.
Planning Section	<ul style="list-style-type: none"> ■ Collect and evaluate information. ■ Develop Incident Action Plans. ■ Maintain resource status.
Logistics Section	<ul style="list-style-type: none"> ■ Provide support to meet incident needs. ■ Provide resources and all other services needed to support the incident.
Finance and Administration Section	<ul style="list-style-type: none"> ■ Monitor costs related to incident. ■ Provide accounting Procurement Time recording cost analyses.

Table 2–1: Incident Command System High-level Components⁴

Incident Commander

The Incident Commander is the individual in charge of the overall response to the disaster scene. Typically, the local Fire Chief assumes this responsibility; however, in some jurisdictions, the local police chief may be placed in the role of Incident Commander. The Incident Commander ensures that human and material resources are provided to support the needs of the response. Within the Hospital Incident Command System, described later, there is also an identified Incident Commander. This person, typically the Hospital CEO, Senior Administrator, or their designee, will coordinate the health-care system's response to the disaster, ensure the needs of disaster victims and others are being met, and coordinate the provision of the hospital's human and material resources.

County Emergency Manager

At the same time the community's Incident Commander is assessing the response needs at the disaster scene, he or she is determining whether or not the situation justifies alerting the *County Emergency Manager*. The County Emergency Manager is a local governmental representative responsible for overseeing any disaster response where the assets of the county will be required.

Disaster Mental Health: A Critical Response	
Module 2	Local Response
	<ul style="list-style-type: none"> • County Disaster Response <ul style="list-style-type: none"> – Incident Commander – County Emergency Manager – County Emergency Operations Center (EOC) • County Mental Health Response <ul style="list-style-type: none"> – County Department of Mental Health • Local Hospital and Public Health Response <ul style="list-style-type: none"> – County Department of Public Health – Hospital Emergency Incident Command System (HEICS) – Hospital Emergency Operation Center

⁴ An IAP is an oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods. (*National Incident Management System document, March 1, 2004*)

During non-disaster times, the County Emergency Manager is responsible for the overall coordination of the county's disaster planning and preparedness activities. During times of local emergencies or disasters, the County Emergency Manager usually reports to a *County Manager* or *County Executive* and will work in concert with him or her to identify the need to open the *County's Emergency Operation Center*, commonly referred to as the *County EOC*.

Usually the County Emergency Manager oversees the development and implementation of the County's Disaster Plan. A county's disaster plan should clearly articulate how county resources will be managed and delivered during times of disaster and how other county public and private agencies with disaster relief missions will provide supplemental support. While there may be multiple agencies responding to the needs of those affected by disaster, it is the county's responsibility to coordinate disaster relief efforts and ensure and protect the community's well-being.

County Emergency Operation Center

The *County EOC* represents the physical location where the coordination of information and resources to support incident management activities takes place. The County EOC is organized by major functional departments or agencies (fire, law enforcement, medical services, public health, mental health, etc.) or by jurisdiction (city, county, region, etc.), or a combination thereof. The County EOC can also be staffed with representatives from other agencies and organizations such as the American Red Cross, the Salvation Army, the Department of Aging, Agriculture, Transportation, etc. The County EOC is usually directed by the County Emergency Manager in conjunction with the County Manager or County Executive.

County Department of Mental Health

The *County Department of Mental Health* and its director are responsible for developing and implementing the county's mental health disaster plan. The Department has a responsibility to address and respond to the mental health needs of a community during times of disaster. Often the Director, or his or her designee, is located at the County EOC to provide consultation to the County Emergency Manager on mental health issues. The Director coordinates the mental health response through the collaboration of private and public community-based mental health agencies and resources within the county. Therefore, the County Mental Health Director, in large disasters, should be in close contact with whomever is coordinating the mental health services provided by the healthcare and behavioral healthcare agencies in that community.

County Department of Public Health

Disasters place tremendous strain on the public health system of a community. The *County Department of Public Health* and its director are responsible for developing and implementing the county's public health disaster plan. The Department has a responsibility to address and respond to the public health needs of a community during times

of disaster. Often the Director, or his or her designee, is located at the County EOC to provide consultation to the County Emergency Manager and the community's healthcare systems around public health issues. The Director coordinates the public health response through the collaboration of private and public community-based public health agencies and resources within the county.

The Local Hospital Response

Local hospitals are part of a community's public health system and play an integral role in responding to disasters, especially those resulting in mass casualties or public health consequences. All healthcare facilities are required to develop and maintain a written emergency management plan describing the process of disaster readiness and emergency management, and know how to implement that plan when appropriate. These plans must also include provisions for responding to the acute healthcare needs of a community in the event the disaster directly affects the hospital itself. The importance of hospital disaster planning received significant visibility following the devastating impact Hurricane Katrina had on the healthcare facilities in Louisiana and its neighboring states. Because of the critical role hospitals and other acute care facilities play in responding to a community disaster, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)⁵ has set in place a more focused process to review hospital disaster plans during scheduled site visits. This additional performance measure makes healthcare facilities more accountable and ensures that hospitals will be able not only to provide the human and material resources necessary during times of disaster, but to sustain that effort as well.

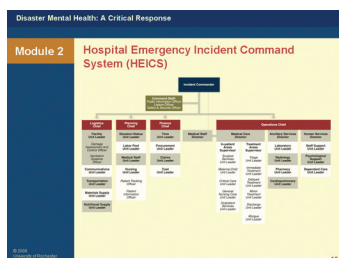
The Hospital Emergency Incident Command System (HEICS)

In an effort to respond in a timely and efficient manner to acute healthcare needs of disaster victims, many hospitals have adopted a command structure for disaster response similar to the community's Incident Command System. This specific healthcare response structure is known as the *Hospital Emergency Incident Command System* (HEICS)⁶, also referred to as HICS-Hospital Incident Command System. HEICS is an emergency management system that describes a logical management structure, defined responsibilities, and reporting channels for hospital disaster managers and responders, and common terminology to help unify hospitals with other emergency responders. The illustration that follows provides an overview of the HEICS structure.

⁵ For more information on the JCAHO's disaster planning and response guidelines, refer to the JCAHO Web site at <http://www.jcaho.org/about+us/public+policy+initiatives/emergency.htm>.

⁶ For more information about HEICS, refer to the Hospital Emergency Incident Command Web site at www.heics.com. Consider downloading http://www.gnyha.org/eprc/general/ics/2003_NSLIJ_HEICS_Module1.pdf from the Greater New York Hospital Association Web site.

Module 2—Disaster Planning, Preparedness, and Response in Healthcare Settings



Mental health and spiritual care workers play an integral role in providing supportive care to disaster victims and hospital personnel within the hospital's incident command system. Hospital social workers, psychiatric nurses, clergy, and other mental health and spiritual care staff may be deployed to emergency departments, family reception centers, ambulatory care facilities, or other acute healthcare delivery sites to address the mental health and spiritual care needs of victims of disaster and hospital personnel. The roles of these workers and other mental health and spiritual care activities will be more fully described later in this manual.

When disaster strikes, depending upon the size and magnitude of the disaster, hospitals will respond by engaging their disaster plans. Human and material resources are deployed to meet the needs of the disaster along with a process to continually assess and evaluate these needs. In the event the hospital's material or human resources face the risk of being depleted or severely compromised, early communication with the County EOC, the County Public Health Director, and other area healthcare resources must occur to avoid the disruption of critical healthcare services.

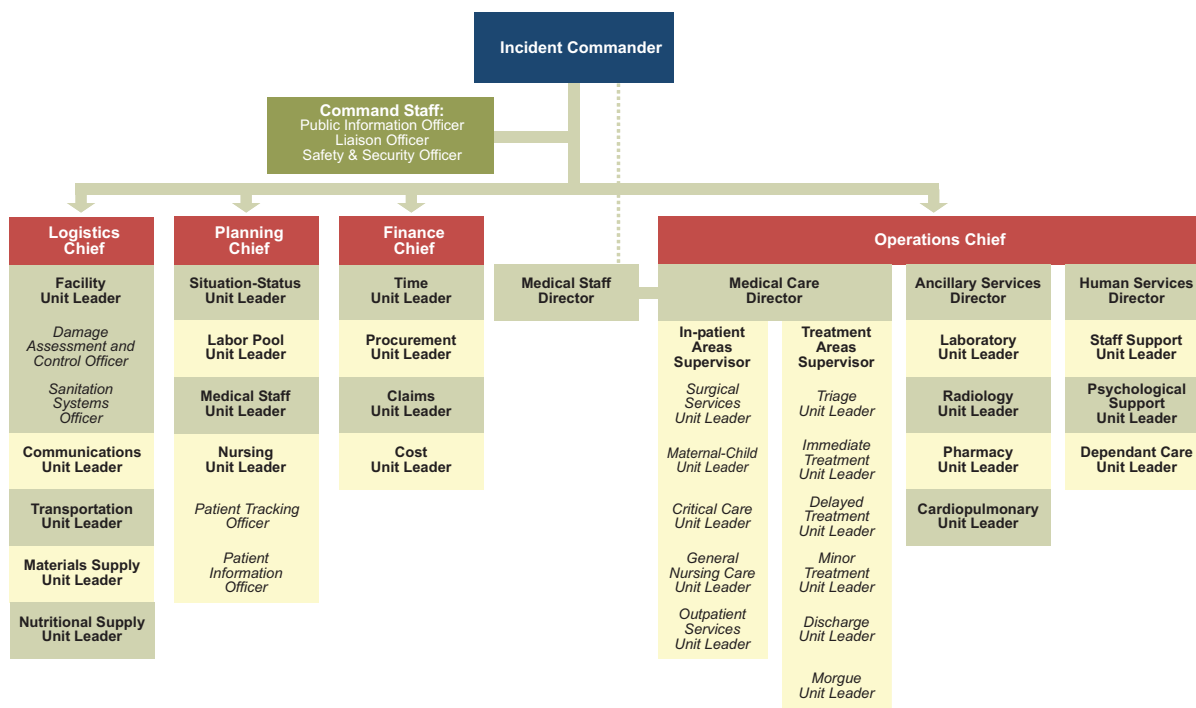


Figure 2–3:
An Example of a Hospital
Emergency Incident
Command System Structure

Hospital Emergency Operation Center

The hospital's *EOC* represents the physical location where the hospital's coordination of information and resources to support incident management activities takes place. As seen in the HEICS flow chart, the hospital EOC is organized by major functional areas (Operations, Logistics, Planning, Finance, etc.). Hospital administrators and other personnel serving in these roles ensure that adequate material and human resources are available to meet the needs of the disaster. Communication with the County's EOC and the County's Director of Public Health and Director of Mental Health is critical in coordinating the disaster response efforts of the local healthcare system.

The Regional and State Response

In some situations, a community or healthcare facility may not be able to fully initiate or sustain its disaster response due to the scope and magnitude of a disaster and the resources required to bring the incident under control. In those circumstances, communities and their healthcare facilities may need additional assistance and the incident response is raised to the next level.

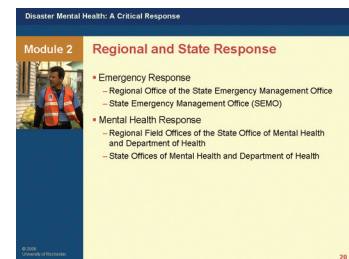
When the incident requires resources that exceed what the community can expend, the Incident Commander or County Emergency Manager will look to the resources of neighboring communities or the state for assistance.

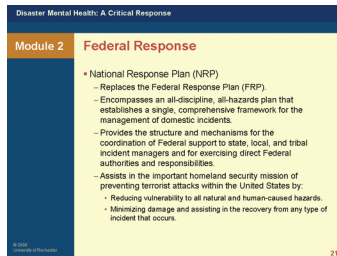
When resources from the State are requested, the *State Emergency Management Office* (SEMO) will activate the *State Emergency Operation Center*. Typically, the County EOC has been in close communication with its regional SEMO representative and this individual is a conduit between the County EOC and the *State EOC*. The regional SEMO representative provides the State with the necessary information to determine when and if State resources will be needed.

State Office of Mental Health and Department of Health

During large-scale disasters, the County Mental Health and Public Health Directors continually evaluate and monitor the mental and public health of the community and advise County officials when additional mental health and healthcare resources are needed.

When a healthcare facility determines that its mental health or public health resources have been depleted, additional resources may be requested from the County Mental Health or Public Health Directors. Should such county mental health or public health resources become depleted or unsustainable, the County Mental Health or Public Health Directors work in collaboration with their respective *Regional Field Offices and State Offices* to evaluate and request additional resources.



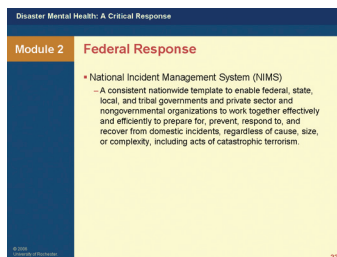


The Federal Response

There are some disasters that are so large they warrant a massive rescue and recovery response, which under most circumstances would exceed any given community's or state's resources. With these situations, the disaster response must be raised to a national level, and the state may request assistance from the Federal government. The next several pages offer an overview of the available assistance and the process by which it is provided. For more detailed information, refer to the *Disaster Process and Disaster Aid Programs* in *Appendix B: Additional Information and Checklists* on page B-2.

The National Response Plan

The National Response Plan (NRP)⁷ provides a framework for incident management at all jurisdictional levels. It establishes protocols and forms the basis for how the federal government coordinates with state, local, and tribal governments and the private sector during disasters.



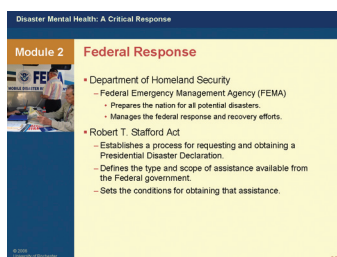
The National Incident Management System

This National Incident Management System (NIMS)⁸ provides a consistent nationwide template to enable federal, state, local, and tribal governments and private sector and nongovernmental organizations to work together effectively and efficiently to prepare for, prevent, respond to, and recover from domestic incidents, regardless of cause, size, or complexity, including acts of catastrophic terrorism.

The NIMS represents a core set of doctrine, concepts, principles, terminology, and organizational processes that enable effective and collaborative incident management at all levels. It is not an operational incident management or resource allocation plan. By September 30, 2006, federal, state, local, tribal, private sector, and non-governmental first responders and disaster workers (including Emergency Medical Service personnel, firefighters, hospital staff, law enforcement personnel, public health personnel, public works/utility personnel, skilled support personnel, and other emergency management response, support, and volunteer personnel) will be required to complete a series of courses offered by the Federal Emergency Management Agency (FEMA). These courses will describe in more detail the NIMS, the Incident Command System, and the National Response Plan as they relate to disaster response.

The Federal Emergency Management Agency

The Federal Emergency Management Agency (FEMA)⁹, a federal agency since 1979, became part of the new Department of Homeland Security (DHS) on March 1, 2003. FEMA's mission within the DHS is to lead the effort to prepare the nation for all potential disasters and



⁷ For more information about the *National Response Plan*, refer to the Web site http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml

⁸ For more information about NIMS, refer to the Web site <http://www.fema.gov/nims/> and select the "Frequently Asked Questions" link.

⁹ For more information about FEMA, refer to the Web site <http://www.fema.gov>.

to manage the federal response and recovery efforts following any national incident—whether natural or human-caused.

The Robert T. Stafford Act

In 1974, the *Robert T. Stafford Disaster Relief and Emergency Assistance Act*¹⁰ was enacted to support state and local governments and their citizens when disasters overwhelm them. This law:

- Establishes a process for requesting and obtaining a *Presidential Disaster Declaration*.
- Defines the type and scope of assistance available from the federal government.
- Sets the conditions for obtaining that assistance.

FEMA is tasked with coordinating the national response to disaster under both the NIMS and the Stafford Act.

Presidential Declaration

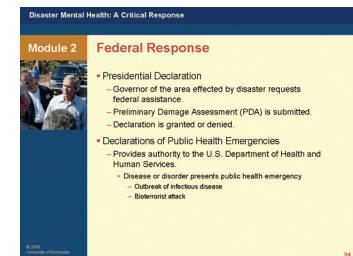
In order for federal assets to be released to a disaster-affected state, a *Presidential Declaration* must be requested and approved. The Robert T. Stafford Act establishes a process by which States can request federal assistance. The Stafford Act requires that all requests for a *Presidential Declaration* be made by the governor of the affected state. Based on the Governor's request and the supporting documentation regarding the extent of the damage, the President may declare that a major disaster or emergency exists and activate an array of federal programs to assist in the response and recovery effort. More information on the *Disaster Process and Disaster Aid Programs* can be found in *Appendix B—Additional Information and Checklists* on page B-2.

Declarations of Public Health Emergencies

The Public Health Service Act provides broad authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to declare a public health emergency at the federal level. Upon consultation with public health officials, the Secretary may declare a public health emergency under the following circumstances:

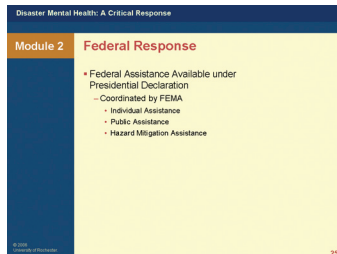
- A disease or disorder presents a public health emergency; or
- A public health emergency, including significant outbreaks of infectious diseases or bioterrorism, otherwise exists.

The Secretary of HHS may take such action as may be appropriate to respond to the public health emergency, including making grants, providing awards for expenses, entering into contracts, and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder.¹¹



¹⁰ For more information about the *Stafford Act and disaster declaration*, refer to the FEMA Web site at <http://www.fema.gov/library/stafact.shtm>.

¹¹ *Hurricane Katrina: The Public Health and Medical Response*. Prepared by Sarah A. Lister for the Congressional Research Service, The Library of Congress. September 21, 2005. Retrieved electronically on December 29, 2005. <http://www.au.af.mil/au/awc/awcgate/crs/r133096.pdf>.

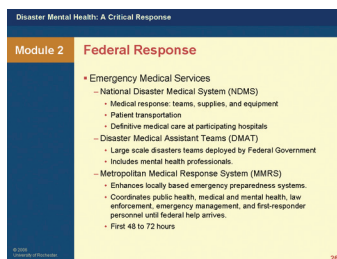


Federal Assistance¹²

Not all federal programs are activated for every disaster. The determination of which programs are activated is based on the needs found during the *Preliminary Damage Assessment* and any subsequent information that may be discovered.

The federal assistance coordinated by FEMA falls into three general categories.

- *Individual Assistance* provides aid to individuals, families, and business owners.
- *Public Assistance* provides aid to public (and certain private non-profit) entities for certain emergency services and the repair or replacement of disaster-damaged public facilities.
- *Hazard Mitigation Assistance* provides funding for measures designed to reduce future losses to public and private property.



Emergency Medical Services

The *National Disaster Medical System* (NDMS)¹³ is a section within the U.S. Department of Homeland Security, Federal Emergency Management Agency, Response Division, Operations Branch and is responsible for supporting federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters. There are three (3) primary components of the NDMS:

- Medical response to a disaster area in the form of teams, supplies, and equipment;
- Patient transport from a disaster site to unaffected areas of the nation; and
- Definitive medical care at participating hospitals in unaffected areas.

In the event of a large-scale disaster, teams of healthcare professionals may be deployed by the federal government to supplement the personnel of the local community and healthcare system. These teams, known as the *Disaster Medical Assistance Teams* (DMAT)¹⁴, include mental health professionals trained to respond during large, catastrophic events.

The *Metropolitan Medical Response System* (MMRS)¹⁵ was established to develop or enhance existing locally based emergency preparedness systems. This system coordinates public health, medical and mental health, local law enforcement, emergency management, and first-responder personnel to respond more effectively in the first 48 to 72 hours of a public health crisis and until federal assets arrive.

¹² For more information on the *Federal Assistance* available in disasters, refer to the FEMA Web site at http://www.fema.gov/pdf/rrr/dec_proc.pdf.

¹³ For more information about the *National Disaster Medical System*, refer to the NDMS Web site at <http://www.oep-ndms.dhhs.gov>.

¹⁴ For more information about the *Disaster Medical Assistance Team*, refer to the Web site <http://www.oep-ndms.dhhs.gov/dmat.html>.

¹⁵ For more information about the *Metropolitan Medical Response System*, refer to the Web site <http://www.mmrs.fema.gov/default.aspx>.

Mental Health Counseling Services

Under federally declared disasters, immediate and short-term mental health financial assistance to states may also be available from the federal government. Only the state (as a governmental unit) has the authority to apply for such federal assistance. This assistance is known as the *Crisis Counseling Assistance and Training Program* (CCP).

FEMA/Center for Mental Health Services Crisis Counseling Assistance and Training Program

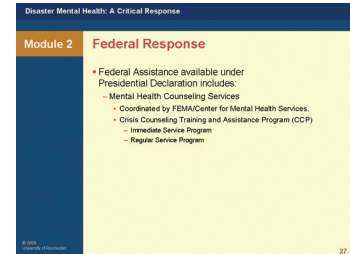
The *Crisis Counseling Assistance and Training Program*¹⁶ authorized by the Stafford Act and administrated by FEMA and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS), is designed to provide supplemental funding to states for short-term crisis counseling services to people affected in a *presidentially declared disaster*.

Two separate portions of the CCP can be funded: *Immediate Services* and *Regular Services*. A state may request either or both types of funding.

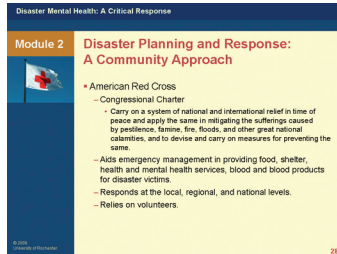
- The *Immediate Services Program* is intended to enable the state or local agency to respond to the immediate mental health needs of disaster survivors with screening, diagnostic, and counseling techniques, as well as outreach services such as public information and community networking.
- The *Regular Services Program* is designed to provide up to nine months of crisis counseling, community outreach, and consultation and educational services to people affected by a *presidentially declared disaster*. Funding for this program is separate from the immediate services grant.

To be eligible for crisis counseling services funded by the CCP, the disaster survivor must be a resident of the designated area or must have been located in the area at the time the disaster occurred. The survivor also must be experiencing psychological distress that was caused or aggravated by the disaster or its aftermath.

During times of disaster, the process by which a *Presidential Declaration* is approved can take days, weeks, or even months. As you can see, a wide range of services that might be significantly helpful to individuals relies on a Presidential Declaration. The period between when a disaster declaration is requested and when it is approved can be an extremely stressful time for both disaster relief workers and disaster survivors. Further, rejection of a Presidential Declaration or limiting the services offered by the Presidential Declaration can pose significant challenges for mental health professionals who are caring for disaster survivors.



¹⁶ For more information about the SAMHSA Crisis Counseling Assistance and Training Program, refer to the SAMHSA Web site at <http://www.mentalhealth.samhsa.gov/cmhs/emergencyservices/progguide.asp>.



Disaster Planning and Response: A Community Approach

While local, state, and federal agencies have the responsibility and the burden of preparing for and responding to disasters, during times of large-scale disasters, it is important to recognize that most communities will never have enough governmental resources to meet the immediate needs of disaster survivors. With this in mind, it is critical that a county's and a healthcare facility's disaster plan include a collaboration and partnership with multiple agencies (both public and private) that can assist in meeting the needs of disaster survivors. The following agencies or groups play key roles in disaster response.

The American Red Cross (ARC)

The *American Red Cross* is a humanitarian organization of volunteers that provides relief to survivors of disaster. The *Red Cross* helps people prevent, prepare for, and respond to emergencies and provides such services consistent with its *Congressional Charter* and under the principles of the *International Red Cross and Red Crescent Movement*.

In 1905, the Red Cross was chartered by Congress to “carry on a system of national and international relief in time of peace and apply the same in mitigating the sufferings caused by pestilence, famine, fire, floods, and other great national calamities, and to devise and carry on measures for preventing the same.”

This Charter is not only a grant of power, but also an imposition of duties and obligations to the nation, to disaster survivors, and to those donors who support its work.

Red Cross disaster relief focuses on meeting an individual's immediate disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, and health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently. The Red Cross also feeds emergency workers, handles inquiries from concerned family members outside the disaster area, provides blood and blood products to disaster victims, and helps those affected by disaster access other available resources.

What is most important to remember about the role of the Red Cross in disaster relief is that the Red Cross supplements the resources and services of the local, state, and federal government and does not override or substitute for the local, state, and federal governments' responsibilities in times of disaster.

American Red Cross at the Local Level

Most counties across the country have active Red Cross Chapters, which meet the day-to-day needs of individuals affected by community emergencies such as single-family house fires and small floods. These needs typically include short-term shelter, food, and clothing and the provision of mental health and physical health services.

American Red Cross at the State and National Level

When a disaster exceeds the human and material resources of a given Red Cross Chapter, the affected chapter can look to neighboring chapters or other chapters within the state for assistance.¹⁷ In situations where the incident exceeds that which the state can accommodate, the Red Cross may deploy resources from within its service area (e.g., the Northeast Region) or from across the country.

American Red Cross and Disaster Mental Health

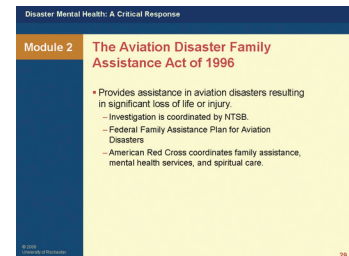
In 1992, the American Red Cross developed a disaster mental health component to its disaster relief branch. Licensed mental health practitioners, acting as volunteers, are trained to recognize a disaster's emotional impact on survivors and disaster workers and provide appropriate interventions to mitigate or resolve such reactions. On a local level, disaster mental health volunteers may respond and support individuals involved in house fires or other community emergencies. On large-scale disasters, mental health professionals may be deployed to hurricanes, floods, tornados, forest fires, incidents involving weapons of mass destruction or other disasters.

In most cases, the local governmental authority in the disaster area coordinates the disaster response and relief efforts. There are instances, however, in which the authority of the American Red Cross in disaster response supersedes that of the local governmental unit. This occurs in the coordination of mental health and spiritual care services following aviation and other transportation disasters.

The Aviation Disaster Family Assistance Act of 1996 (ADFAA)

In 1996, the National Transportation Safety Board (NTSB) was assigned the role of integrating the resources of the federal government with those of local and state authorities and the airlines to meet the needs of aviation disaster victims and their families. As a result, the ***Federal Family Assistance Plan for Aviation Disasters*** was developed and implemented. This plan describes the airline and federal responsibilities in response to an aviation crash involving a significant number of passenger fatalities and/or injuries.

In addition, the ADFAA mandates that the NTSB identify a human service organization to coordinate family assistance and mental health services to surviving victims and the families of the deceased and to coordinate a non-denominational memorial service. The NTSB, in turn, has named the American Red Cross to oversee the coordination of these services. In the event an aviation disaster meets the above criteria and the ADFAA is enacted, the national headquarters of the American Red Cross will deploy a *Critical Response Team* to engage the ***Federal Family Assistance Plan for Aviation Disasters***.¹⁸ This team will work with local, state, and federal resources to meet the mental health and spiritual care needs of those involved.



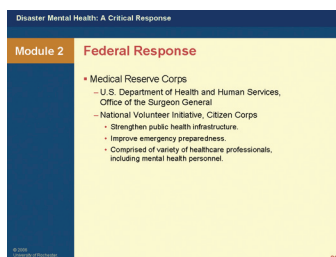
¹⁷ For information on the *Statement of Understanding between the New York State Office of Mental Health, the New York State Conference of Local Mental Hygiene Directors, and All New York Chapters of the American Red Cross*, refer to the following Web site: <http://www.omh.state.ny.us/omhweb/sou/>.

¹⁸ For more information on the *Federal Family Assistance Plan for Aviation Disasters*, refer to the NTSB Web site at <http://www.ntsbn.gov/publicn/2000/spc0001.pdf>.

American Red Cross and Disaster Spiritual Care

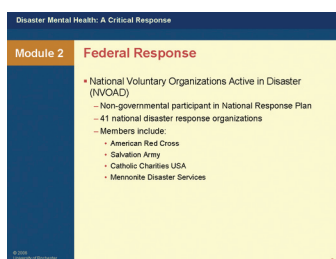
The American Red Cross recognizes the importance of spiritual care support during times of disaster, especially in those events resulting in mass casualties and fatalities. While the American Red Cross does not specifically provide spiritual care support directly through its volunteer resources, Red Cross chapters across the country are encouraged to collaborate with faith-based organizations in their communities to ensure that spiritual care services are offered and provided to those requesting and requiring such support.

In the event of an aviation disaster, where the ***Federal Family Assistance Plan for Aviation Disasters*** is engaged, the American Red Cross will deploy specially trained disaster spiritual care professionals. While it is not the role of these individuals to provide direct spiritual care assistance, these individuals will assist the community in organizing the provision of spiritual support to disaster victims, their family members, and the general community using community faith-based organizations.



The Medical Reserve Corps¹⁹

The Medical Reserve Corps, founded in 2002, is a specialized component of a national volunteer initiative called Citizen Corps and is housed under the U.S. Department of Health and Human Services, Office of the Surgeon General. The program was developed to strengthen the public health infrastructure and improve emergency preparedness. While initially conceived to be a local community response organization, the Florida hurricanes of 2004 and Hurricanes Katrina and Rita in 2005 further defined this group's role in the national response system. While most MRCs are comprised of a variety of healthcare professionals, there are some MRCs that are specifically comprised of mental health professionals. During times of catastrophic disaster, these teams are deployed to work along such public and private relief organizations like the DMATs and the American Red Cross.



National Voluntary Organizations Active in Disaster (NVOAD)²⁰

The *National Voluntary Organizations Active in Disaster* is composed of forty-one national disaster response organizations from religious denominations and mental health organizations. Along with the American Red Cross, a NVOAD member, NVOAD is the other non-governmental participant named in the National Response Plan. Local, state, and national VOADs are essential partners with local, state, and government partners in disaster response. (i.e., Florida VOADs worked diligently with FEMA and state and local government, including ARC to provide services to those impacted by the four catastrophic hurricanes of 2004). NVOAD is increasing in importance as the federal government is seeking public partnerships for disaster

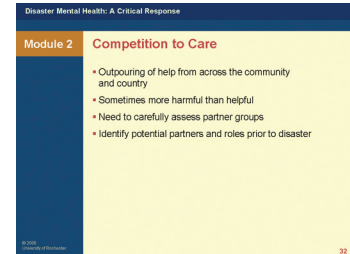
¹⁹ For more information on the *Medical Reserve Corps*, refer to the Web site <http://www.medicalreservecorps.gov>.

²⁰ For information on the *National Voluntary Organizations Active in Disaster*, refer to the Web site <http://www.nvoad.org>.

response. Examples of participating organizations in NVOAD include the Salvation Army, Catholic Charities USA, and Mennonite Disaster Services.

The Competition to Care

Depending upon the size and magnitude of the disaster, there may be an outpouring of assistance from the local community and, quite possibly, from around the state and country as well. Given the challenges resulting from the disaster, communities and healthcare systems may eagerly accept this assistance as a way to supplement their human resources. While many of the individuals and groups offering this assistance have good intentions, extreme caution should be used when assessing the role these individuals and groups will play in the disaster response. In some cases, their assistance could be more harmful than helpful, create financial and legal liabilities, and present administrative challenges. Effective disaster planning includes identifying potential community partners that may be able to supplement already existing resources. In addition, protocols, policies, and procedures for recruiting and utilizing spontaneous volunteers should be developed before disaster strikes.



Exercise 1: First on the Scene of a Disaster

Exercise Overview

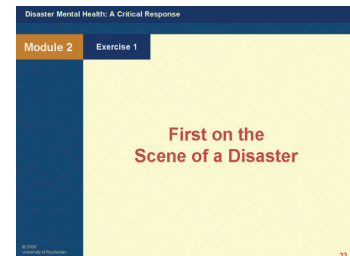
It is a Saturday afternoon. You are in your car running errands and listening to the local news radio station. The newscaster is warning drivers to avoid a particular state highway because of a serious bus crash. The out-of-state bus was transporting a group of adults on their way home from a casino. The news report does not provide specific details, except that the bus appears to have skidded out of control over an embankment, rolled several times, and landed on its side.

Exercise Purpose

The purpose of this exercise is to explore this disaster scene from the time of the crash, as first responders arrive, and through the first few hours as the situation is being addressed. You should think about what the scene looks like, who is on the scene, and what is happening.

Exercise Mode

Each of you will respond to the questions first. Then you will share your responses with the entire group in the context of a discussion about what this particular scene may look like. Your instructors will guide you through this exercise. Use Exercise 1 handout in Appendix A: Exercises on page A-2.



Module Summary

Prior to a disaster, coordination of the agencies and organizations described in this module should be of primary interest. Identifying specific roles and relief procedures for each agency and organization could prevent some of the unnecessary challenges communities and healthcare facilities have faced in times of disasters.

Module 3

Characteristics and Attributes of Natural and Human-caused Disasters

Module Overview

In the previous module, you were introduced to the phases of disaster management and how communities and healthcare systems prepare, respond, and recover from disaster. We also reviewed the important mitigation and response evaluation activities where mental health and spiritual care workers can play a role.

In this module, you will explore the different kinds of disaster and the similar and unique characteristics of each disaster type. This information will provide the necessary background for understanding and appreciating the psychological, psychosocial, and psychospiritual implications that result from certain types of disasters, which are topics more fully covered in Modules 4 and 5.

Participant Competencies

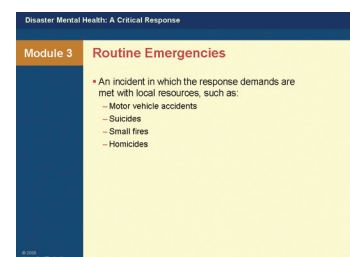
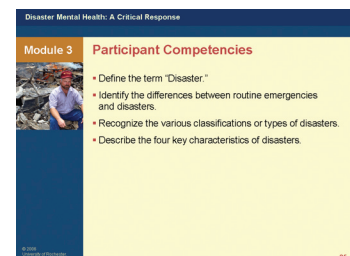
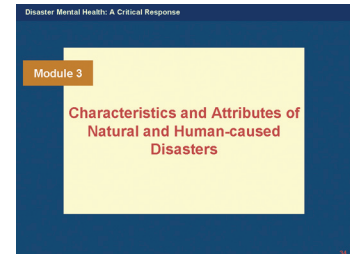
It is important for you to understand how disasters are defined and characterized. At the end of this module, you will be able to:

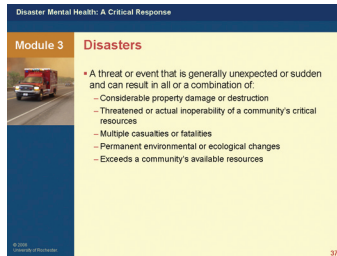
- Define the term disaster.
- Identify the differences between routine emergencies and disasters.
- Recognize the various classifications or types of disasters.
- Describe the four key characteristics of disasters.

Defining a Disaster versus a Routine Emergency

There are incidents that occur in communities that are tragic and stressful; however, these may not meet the technical definition of disaster. These incidents are better known as *routine emergencies*. Routine emergencies differ from disasters and are typically situations in which the response demands are successfully met with local resources. Examples of routine emergencies might include:

- Motor vehicle accidents
- Suicides
- Small fires
- Homicides



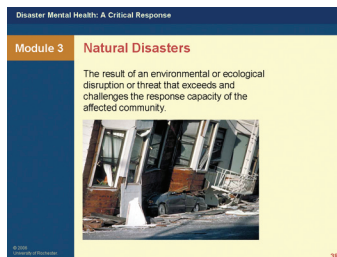


There may be times in which situations like these turn into disasters. For example, multiple homicides, mass suicides, or a series of small fires resulting from arson may necessitate bringing in other resources from outside the community for assistance or support.

Let us begin to draw some specificity around the definition of disaster to understand when and how community disaster relief services are activated. Many definitions of disaster exist in the literature. For our purposes, a disaster is a threat or event that is generally unexpected or sudden and can result in all or a combination of:

- Considerable property damage or destruction
- Threatened or actual inoperability of a community's critical resources (e.g., healthcare system, businesses, schools)
- Multiple casualties or fatalities
- Permanent environmental or ecological changes
- A demand for human and material resources that exceeds what the community can provide

One must also consider that an incident that may be defined as a disaster in one setting may not be defined as such in another. To see this we might compare a multi-family fire in a rural community to the same fire in an urban community. The urban community may have sufficient human and material resources available to successfully respond and fight this large fire. As a result, this may not “technically” be defined as a disaster. In a rural community, where fire response equipment and volunteer personnel are limited, such incidents might necessitate reaching out to neighboring communities for assistance. The demand for human and material resources, in this particular example, defines this incident as a disaster for that community.



Disaster Classifications

Disasters are typically classified into two main types: *natural disasters* and *human-caused disasters*. With some basic understanding of these two groups and their unique characteristics, the role of planning and response in the aftermath of such events can be further defined.

Natural Disasters

A *natural disaster* is the result of an environmental or ecological disruption or threat that exceeds and challenges the response capacity of the affected community. Natural disasters can occur in many forms (hurricanes, floods, tornadoes, etc.) and have diverse characteristics that will be addressed later in this module.

The Impact of Natural Disasters

It is suggested that individuals may fare better in coping with natural disasters than they do with disasters that are human-caused. However, recent research indicates that natural disasters and human-caused disasters may have more in common, especially when they reach catastrophic levels. Natural disasters and the causal agent is typically seen as beyond human control and without evil intent.

Survivors affected by natural disasters typically struggle with property loss and damage, the need to relocate to temporary or permanent housing, the financial stress associated with the loss of possessions or time away from their jobs, and the daily challenges of negotiating with insurance companies and disaster relief agencies. These are valid stressors and ones that should not be minimized when considering the emotional toll on those impacted by such disasters.

We also know, all too well, that natural disasters can result in significant loss of life or injuries. Under these catastrophic conditions, their impact on those affected may look similar to those resulting from human-caused disasters.

Human-caused Disasters

Human-caused disasters are those events in which the principle, direct causes are identifiable human actions, deliberate or otherwise.¹ Human-caused disasters can be divided further into three categories:²

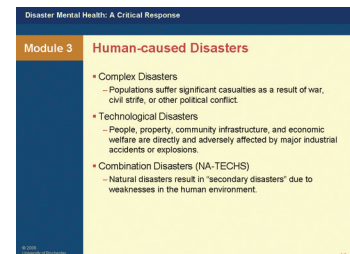
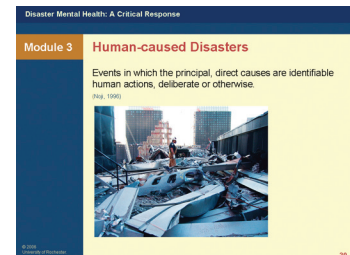
- Complex Disasters
- Technological Disasters
- NA-TECHS (*pronounced Nay Tek's*) or combination disasters

Complex Disasters

Complex disasters involve situations where populations suffer significant casualties because of war, civil strife, or other political conflict. Some disasters are the result of a combination of forces such as drought, famine, disease, and political unrest, resulting in the displacement of millions of people from their homes. While the United States does not typically experience these types of disasters, public health emergencies, like a pandemic influenza would be considered an example of a Complex Disaster and are an increasing concern among disaster preparedness experts.

Technological Disasters

Technological disasters, such as industrial accidents, fires, or explosions from hazardous materials, or nuclear power plant accidents, affect large numbers of people and their economic welfare as well as property and the community infrastructure. Hospitals will be faced with issues of surge (exceeding their already crowded emergency rooms) and treating large numbers of individuals with potentially complex injuries resulting from explosions and burns. Hospital personnel skilled in treating these injuries and a shortage of supplies may be other challenges faced by healthcare systems following these events.



¹ Noji, Erik K. (1996) *Disaster Epidemiology. Emergency Medicine Clinics of North America*. 14(2), pp. 289–300.

² Veenema, T.G. (2003) *In Disaster Nursing and Emergency Preparedness for Chemical, Biological, and Radiological Terrorism and Other Hazards*. p. 4.

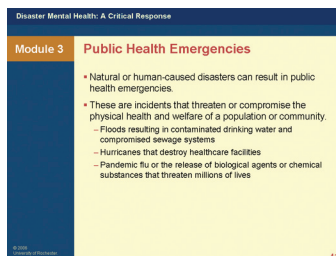
Combination Disasters (NA-TECHS)

Combination disasters, otherwise referred to as NA-TECHS, occur when a natural disaster results in a secondary disaster that is the result of weaknesses in the human environment. An example of this is an earthquake triggering a nuclear power plant explosion. In this case, healthcare systems will be faced not only with those injured in the earthquake, but have the additional challenge of potentially caring for those critically injured and suffering from radiation exposure.

The Impact of Human-caused Disasters

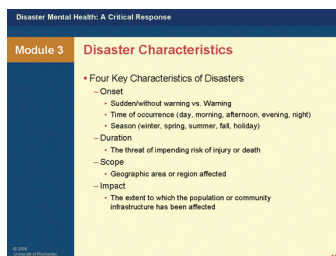
Human-caused disasters can stem from a number of reasons that, for many, may seem senseless and incomprehensible, making recovery from such events significantly challenging. Whether such actions result from perceived evil intentions, political, sociological, or religious beliefs, hate or bias against an individual or group, or mental illness, the perception that the event was preventable or avoidable and the sense of human betrayal can produce significant psychological and spiritual challenges for those exposed to human-caused acts.

Individuals exposed to human-caused disasters are confronted with the reality that bad things can happen to good people. They lose their illusion of invulnerability and realize that anyone can be in the wrong place at the wrong time. Their basic assumptions about humanity may be shattered, and they no longer feel that the world is secure, fair, and orderly. They may also be faced with the palpable realization that even their government cannot guarantee their safety and protection or that of their family and loved ones. They may question their beliefs, and their spiritual life and practices may be altered.



Public Health Emergencies

Public health emergencies can also be disasters, either natural or human-caused, and are incidents that threaten or compromise the physical health and welfare of a population or community. Examples include floods that result in contaminated drinking water and inoperable sewage systems, devastating hurricanes that destroy healthcare facilities and severely curtail the availability of physical health resources like emergency supplies and medications, and pandemic influenza, the release of a biological agent or chemical substance that can potentially threaten millions of lives. We will learn more about public health emergencies and their impact in Module 5.



Disaster Characteristics

From all accounts, disasters are complex phenomena. The classification of an event as either natural or human-caused is not the only factor that accounts for how disaster survivors and others will react in their aftermath. Because disasters are not all uniform events it is also important to appreciate the specific characteristics of a disaster and how these characteristics can vary from disaster to disaster and in turn, produce a host of reactions for those in their path.

There are four key characteristics of disaster that can contribute to the range of reactions individuals will experience. These key characteristics of a disaster include:

- Onset
- Duration
- Scope
- Impact

Onset of Disaster

The *onset* of a disaster can be sudden and without warning. Others may be accompanied by minimal advance notice. Others still may evolve over an extended period of time, slowly, yet progressively affecting the infrastructure of a community or healthcare facility. Consider the timing of these disasters and their resulting effect on those individuals and communities in their path:

- An earthquake that occurs late at night when everyone is asleep
- A tornado that strikes in the middle of the day when people are at work
- The detonation of a bomb during a crowded public event
- A hurricane that gradually moves its way through the Atlantic to strike a large coastal city

Duration of Disaster

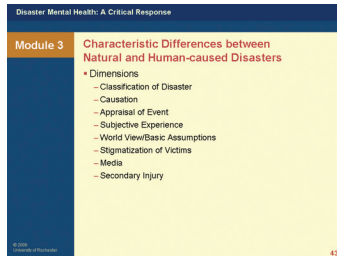
The *duration* of a disaster is measured from the time it starts (for example, when the tremors from an earthquake begin) to the time the immediate crisis has passed (when the tremors from an earthquake cease). Some disasters begin and end quite quickly, and the time from beginning to end may be seconds or minutes. Other disasters are much more prolonged (occurring over hours, days, or months), such as hurricanes, slow rising floods, wildfires, and public health emergencies such as pandemic influenza. Of key importance is the length of time (or duration) someone is exposed to the threat of injury, harm, or other adverse effect. Research strongly suggests there is a correlation between the levels of exposure with the amount of psychological distress they are likely to experience.

Scope of Disaster

The *scope* or magnitude of a disaster involves the geographic area or region that is affected by the disaster. A disaster can be limited to a concentrated area, such as a small neighborhood or town. Alternatively, it can cover a large geographic region (e.g., the coastline communities of five states).

Impact of Disaster

The fourth characteristic, the *impact* or intensity of the disaster, addresses more specifically the extent to which the population or community infrastructure has been affected. Disasters can strike rural areas in which very few people or community resources are



impacted, or they can strike areas that are heavily populated and where a majority of a community's critical infrastructure may be damaged or destroyed. Examples include loss of telecommunications or the shutting down of major highways, bridges, or tunnels. Of note, the number of injuries or deaths experienced as a result of the disaster can contribute to the intensity of the impact. Consider, for example, an aviation disaster. The amount of community infrastructure damage may be minimal (i.e., a plane crashing into the ocean), but the number of associated deaths will add to the intensity of the resulting impact on survivors and the community where it happens.

Characteristic Differences between Natural and Human-caused Disasters

Some disaster research has attempted to distinguish the differences in characteristics between natural and human-caused disasters such that one may better understand the resulting psychological, psychosocial, and psychospiritual consequences. Recent literature suggests that no one classification of disaster is any worse than another, challenging a long-time myth that human-caused disasters result in greater psychological impact than natural disasters. Instead, it is more important to understand the unique characteristics of each disaster and its potential impact on those in its path.

The U.S. Department of Health and Human Services' *Mental Health Response to Mass Violence and Terrorism: A Training Manual* offers some insight of these characteristic differences and their impact on survivors and their family members. Let us take a few minutes to review some of these dimensions in the following table.³

Dimension	Human-caused Disasters	Natural Disasters
Examples	<ul style="list-style-type: none"> ■ Mass riots ■ Hostage taking ■ Arson ■ Terrorist bomb ■ Mass shooting ■ Bioterrorism ■ Aircraft hijacking 	<ul style="list-style-type: none"> ■ Hurricane ■ Earthquake ■ Tornado ■ Flood ■ Volcanic eruption ■ Wildfire ■ Drought
Causation	<ul style="list-style-type: none"> ■ Includes evil human intent, deliberate sociopolitical act, human cruelty, revenge, hate or bias against a group, mental illness. 	<ul style="list-style-type: none"> ■ Is an act of nature; severity of impact may result from interaction between natural forces and human error or actions.
Appraisal of Event	<ul style="list-style-type: none"> ■ Event seems incomprehensible, senseless. ■ Some view as uncontrollable and unpredictable, others view as preventable. ■ Social order has been violated. 	<ul style="list-style-type: none"> ■ Expectations defined by disaster type. ■ Awe expressed about power and destruction of nature. ■ Disasters with warnings increase sense of predictability and controllability. ■ Recurring disasters pose ongoing threat.

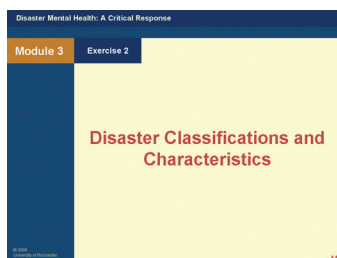
³ Adapted from: U.S. Department of Health and Human Services. (2004). *Mental Health Response to Mass Violence and Terrorism: A Training Manual*. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. pp. 9–10. You may download this document from <http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA-3959/MassViolenceAndTerrorism.pdf>.

Dimension	Human-caused Disasters	Natural Disasters
Subjective Experience	<ul style="list-style-type: none"> Victims are suddenly caught unaware in a dangerous, life-threatening situation. They may experience terror, fear, horror, helplessness, and sense of betrayal and violation. Resulting distrust, fear of people, or being “out in the world” may cause withdrawal and isolation. Outrage, blaming the individual or group responsible, desire for revenge, and demand for justice are common. 	<ul style="list-style-type: none"> Separation from family members, evacuation, lack of warning, life threat, trauma, and loss of irreplaceable property and homes contribute to disaster stress reactions. Anger and blame expressed toward agencies and individuals responsible for prevention, mitigation, and disaster relief.
World View/Basic Assumptions	<ul style="list-style-type: none"> Assumptions about humanity are shattered; individuals no longer feel that the world is secure, just, and orderly. Survivors confronted with the reality that evil things can happen to good people. People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time. 	<ul style="list-style-type: none"> Spiritual beliefs may be shaken (e.g., “How could God cause this destruction?”). Loss of security in “terra firma” that the earth is “solid” and dependable. People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.
	<ul style="list-style-type: none"> Some victims may come to feel humiliation, responsibility for others’ deaths, survivor guilt, self-blame, and unworthy of assistance, thus assigning stigma to themselves. The larger community, associates, friends, and even family may distance themselves to avoid confronting the idea that crime victimization can happen to anyone. Well-meaning loved ones may urge victims and bereaved to “move on,” causing them to feel rejected and wrong for continuing to suffer. Hate crimes reinforce the discrimination and stigma that targeted groups already experience. 	<ul style="list-style-type: none"> Disasters tend to have greater impact on people with fewer economic resources due to living in lower-cost, structurally vulnerable residences in higher-risk areas. Survivors from cultural, racial, and ethnic groups, single-parent families, people with disabilities, and the elderly on fixed incomes experience greater barriers to recovery causing double jeopardy and potential stigma.
Media	<ul style="list-style-type: none"> The media shows more interest in events of greater horror and psychological impact. Excessive and repeated media exposure puts people at risk for secondary traumatization. Risk of violations of privacy. 	<ul style="list-style-type: none"> Short-term media interest fosters sense in community that “the rest of the world has moved on.” Media coverage can result in violations of privacy; there is a need to protect children, victims, and families from traumatizing exposure.
Secondary Injury	<ul style="list-style-type: none"> Victims’ needs may conflict with necessary steps in the criminal justice process. Steps required to obtain crime victim compensation and benefits can seem confusing, frustrating, bureaucratic, and dehumanizing and trigger feelings of helplessness. Bias-crime victims may suffer prejudice and blame. Victims may feel that the remedy or punishment is inadequate in comparison to the crime and their losses. 	<ul style="list-style-type: none"> Disaster relief and assistance agencies and bureaucratic procedures can be seen as inefficient, fraught with hassles, impersonal Disillusionment can set in when the gap between losses, needs, and available resources is realized. Victims rarely feel that they have been “made whole” through relief efforts.

Table 3–1: Characteristic Differences between Human-caused and Natural Disasters

The Meaning behind the Disaster

As you will notice from this chart, some of the most significant differences between natural disasters and those that are human-caused result from one's appraisal or attribution of the event, the person's overall subjective experience, and his or her resultant change in the view of the world and humanity. Human-caused disasters, such as what we saw on September 11, tend to increase our sense of vulnerability and, more importantly, shake our natural and spiritual belief systems. On the other hand, natural disasters, such as Hurricane Katrina, can present similar challenges. More specific information about psychological, psychospiritual, and psychosocial reactions that individuals experience following human-caused disasters will be discussed in Module 5.



Exercise 2: Disaster Classifications and Characteristics

Exercise Overview

This exercise will provide you with an opportunity to integrate what you have learned in Module 3 and expand on it a little more specifically with respect to your own community. Although there are similarities among natural and human-caused disasters and public health emergencies, there are important differences that yield logistical challenges for each community and, therefore, influence how the community is able to respond. This exercise is designed to provide you and your group members with an opportunity to discuss the various similarities and differences among disaster classifications/types with respect to:

1. Onset of the disaster
2. Duration of the disaster
3. Scope of the disaster
4. Impact of the disaster

Exercise Purpose

The purpose of this exercise is to explore the characteristics of natural disasters, human-caused disasters, and public health emergencies that may happen in your community and to identify the potential impact these will have and the challenges inherent in responding to these occurrences.

Exercise Mode

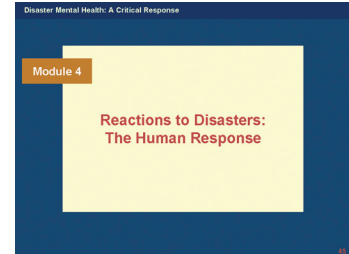
This is a small group exercise. Your instructors will organize you into small groups. Each group will be assigned a specific scenario. In these groups, you will discuss your responses to a series of questions among group members. When you have completed your group work, you will share your observations with the rest of the group. Use Exercise 2 handout in **Appendix A: Exercises** on page A-4.

Module Summary

You may have noticed that we have spent a considerable amount of time discussing how disasters unfold at the local, state, and national level, and more specifically the various classifications, characteristics, and attributes of disasters. The hope is that you have gained a greater understanding of how extremely important these issues are when considering how individuals and healthcare systems react in times of disaster. Whether you are working with disaster survivors, relief workers, or other hospital personnel, the type of disaster, the unique characteristics of how it strikes, and the actions of those who help all have considerable influence on how those affected will respond psychologically and spiritually and how they will eventually recover.

Module 4

Reactions to Disasters: The Human Response



Module Overview

In this module, we will focus on the human response to disaster and more specifically on the range of associated reactions individuals experience in their aftermath. Please note that the disaster mental health literature is continually evolving with a growing understanding of how people react and recover following disasters. The information in this module has been accumulated from what is available at the time of the writing of this module. As disaster mental health and spiritual care professionals, you have an obligation and responsibility to continue your education independently.

The field of disaster mental health is relatively young and has been particularly shaped over the last years by the following events:

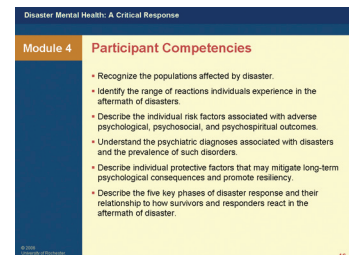
- 1995 Oklahoma City bombing
- September 11, 2001 acts of terrorism
- 2004 and 2005 hurricane seasons, including the devastating effects of Hurricane Katrina
- 2004 Southeast Asia Tsunami and other international disasters
- Workplace and school shootings

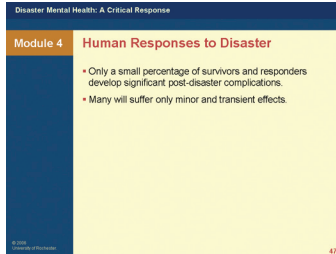
Each disaster provides us with an opportunity to learn more about how individuals and their communities are affected and how they recover.

Participant Competencies

The focus of this module is the human response to disaster. When you have completed this module, you will be able to:

- Recognize the populations affected by disaster.
- Identify the range of reactions individuals experience in the aftermath of disasters.
- Describe the individual risk factors associated with adverse psychological, psychosocial, and psychospiritual outcomes.
- Understand the psychiatric diagnoses associated with disasters and the prevalence of such disorders.
- Describe individual protective factors that may mitigate long-term psychological consequences and promote resiliency.
- Describe the five key phases of disaster response and their relationship to how survivors and responders react in the aftermath of disaster.



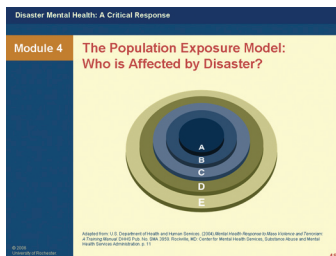


Human Responses to Disaster

As mental health and spiritual care professionals, it is important to understand that most people who are exposed to disasters do not develop major psychopathology, lifelong psychological problems, or spiritual crises. In fact, only a small percentage of disaster survivors and responders develop such significant complications. Many others, however, will suffer minor and transient post-disaster effects.

Disasters produce a range of psychological, psychosocial, and psychospiritual consequences in their aftermath. When we talk about the psychological impact of disaster, we mean specifically the emotional characteristics and associated behaviors of those individuals affected. Psychosocial impacts are the resulting life challenges that come about when these emotional characteristics and associated behaviors affect individuals' interactions with others. Psychospiritual impacts involve the resulting changes in individuals' spiritual belief systems or their relationships, including those with God or a Higher Power.

For those exposed to disaster, the aftermath can feel like an emotional roller coaster. Many find themselves flooded with various feelings and thoughts that can affect the way they respond and recover from disaster. As we addressed in the previous module, an individual's reaction to and recovery from disaster may be influenced by a number of factors such as the specific characteristics of the disaster and the meaning an individual attributes to the event. Equally important and potentially influencing are an individual's personal characteristics and his or her experience of the specific phases of the disaster response itself. Let us first talk about who is typically affected by a disaster.



Who is Affected by Disaster?

Many educators, researchers, and other contributors to the field of disaster mental health have attempted to define those individuals who are most likely to be affected by disaster. One such approach,

the Population Exposure Model, takes a macroscopic view of the entire community and the gradations of effects and needs across population groups.

This model shows a series of concentric circles depicting the various affected populations following a disaster.

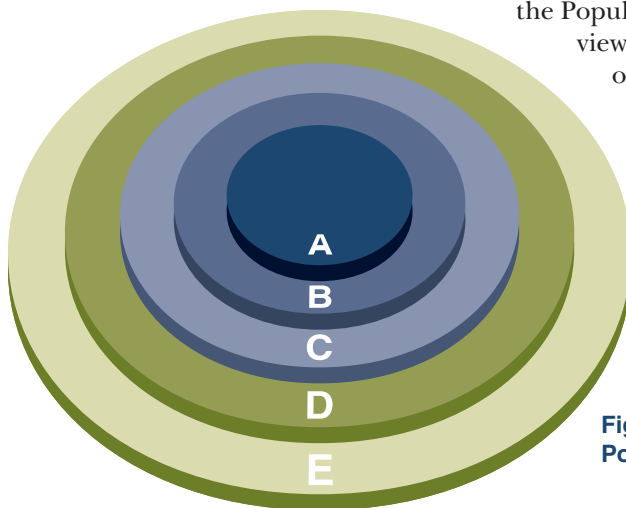


Figure 4-1:
Population Exposure Model

The following table provides a description of each population.

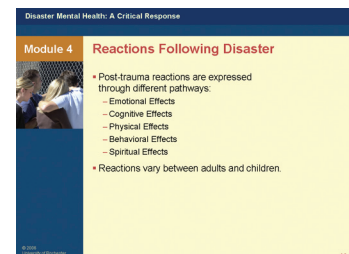
Designation	Population Description
Population A	<ul style="list-style-type: none"> ■ Community victims killed and seriously injured ■ Bereaved family members, loved ones, close friends
Population B	<ul style="list-style-type: none"> ■ Community victims exposed to the incident and disaster scene, but not injured
Population C	<ul style="list-style-type: none"> ■ Bereaved extended family members and friends ■ Residents in disaster zone whose homes were destroyed ■ First responders, rescue and recovery workers ■ Medical examiner's office staff ■ Service providers immediately involved with bereaved families, obtaining information for body identification and death notification
Population D	<ul style="list-style-type: none"> ■ Mental health and crime victim assistance providers ■ Clergy, chaplains, other spiritual care providers ■ Emergency healthcare providers, hospital personnel ■ Government officials ■ Members of the media
Population E	<ul style="list-style-type: none"> ■ Groups that identify with the target-victim group ■ Businesses with financial impacts ■ Community-at-large

Table 4–1: Population Descriptions of the Population Exposure Model¹

The underlying principle of this model is that the individuals who are more intimately exposed to trauma and the disaster scene are likely to be affected the most. Numerous research studies support the finding that the closer the populations are to the epicenter of the disaster, the more directly they may be impacted psychologically, psychosocially, or psychospiritually. It is important not to assume, however, that those individuals on the “outer” layer of the model will only suffer minimal impact. In fact, there are individuals within each category who may suffer severe reactions requiring intensive mental health assistance. Many of these individuals are at risk because of pre-existing vulnerabilities. These are issues that will be addressed later in this module.

Reactions Following Disaster

Post-trauma reactions are expressed through different pathways: physical, behavioral, emotional, cognitive, and spiritual. Any or all of these may be reflected in psychological, psychosocial, or psychospiritual consequences. Research and other anecdotal experiences suggest that some of the reactions individuals may experience following a disaster are contained in the following tables:



¹ Adapted from: U.S. Department of Health and Human Services. (2004). *Mental Health Response to Mass Violence and Terrorism: A Training Manual*. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. p. 11. You may download this document from <http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA-3959/MassViolenceAndTerrorism.pdf>.

Emotional Effects	<ul style="list-style-type: none"> ■ Shock, despair, hopelessness ■ Rage, anger, irritability, resentment ■ Anxiety, fear, terror ■ Emotional numbing, apathy ■ Grief, sadness, guilt 	<ul style="list-style-type: none"> ■ Helplessness, loss of control ■ Feelings of insignificance ■ Loss of interest ■ Variability in mood (“mood swings”) ■ Feelings of being overwhelmed
Cognitive Effects	<ul style="list-style-type: none"> ■ Difficulty concentrating and thinking ■ Difficulty making decisions ■ Memory impairment, forgetfulness ■ Disbelief ■ Confusion ■ Distortion of sense of time 	<ul style="list-style-type: none"> ■ Decreased self-esteem ■ Decreased self-efficacy ■ Self-blame ■ Intrusive thoughts, memories, flashbacks ■ Worry ■ Dissociation or a sense of being cut off from reality
Physical Effects	<ul style="list-style-type: none"> ■ Fatigue, insomnia, sleep disturbance ■ Agitation ■ Physical complaints (e.g., headaches, GI problems) ■ Decreased or increased appetite, weight gain/loss ■ Decreased or increased sex drive 	<ul style="list-style-type: none"> ■ Startle response ■ Increased cravings/use of caffeine, nicotine, sweets, alcohol, illicit substances ■ Difficulty breathing or rapid breathing ■ Lightheadedness ■ Weakness
Behavioral Effects	<ul style="list-style-type: none"> ■ Crying spells ■ Outbursts and acts of aggression ■ Social withdrawal and avoidance ■ Relationship conflict 	<ul style="list-style-type: none"> ■ School and work impairment ■ High risk behaviors (driving erratically, multiple sexual partners, unsafe sex) ■ Decreased concern with personal hygiene, self care
Spiritual Effects	<ul style="list-style-type: none"> ■ Change in relationship with or belief about God or a Higher Power ■ Abandonment of prayer, ritual, scripture, devotions, sacraments ■ Questioning the tenets of their faith or beliefs ■ Struggle with questions about reality, meaning, justice, fairness, afterlife 	<ul style="list-style-type: none"> ■ Rejection of spiritual care providers ■ Loss of familiar spiritual supports ■ Loss or weakening of faith

Table 4–2: Common Symptoms or Stress Reactions Following Disaster in Adults²

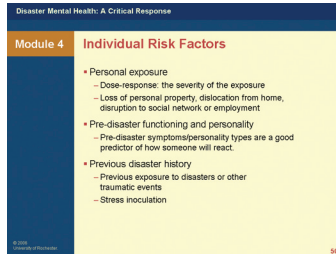
² Adapted from: Raphael, B., Newman, L., Silove, D., Bryant, R., Boman, B., Sprague, T., et al. (2000). *Disaster Mental Health Response Handbook: An Educational Resource for Mental Health Professionals Involved in Disaster Management*. New South Wales, Australia: Center for Mental Health, NSW Health and NSW Institute of Psychiatry. State Health Publication No: (CMH) 00145. You may download this document from the Web site http://www.nswiop.nsw.edu.au/Resources/Disaster_Handbook.pdf.

Emotional Effects	<ul style="list-style-type: none"> ■ Concern about re-occurrence of the disaster ■ Increased clinginess in young children* ■ Concern about separation from parents* ■ Preoccupation with death, suicidal ideation (adolescents) ■ Terror 	<ul style="list-style-type: none"> ■ Grief, sadness, guilt ■ Irritability ■ Helplessness and loss of control ■ Loss of interest ■ Variability in mood (“mood swings”)
Cognitive Effects	<ul style="list-style-type: none"> ■ Difficulty concentrating and thinking ■ Difficulty learning new information ■ Difficulty making decisions ■ Self-blame 	<ul style="list-style-type: none"> ■ Intrusive thoughts, memories, and flashbacks ■ Regression in developmental skills ■ Worry about safety of self and others
Physical Effects	<ul style="list-style-type: none"> ■ Fatigue, insomnia, sleep disturbance, including nightmares ■ Agitation ■ Increased activity level/hyperactivity* ■ Physical complaints (e.g., headaches, GI problems) 	<ul style="list-style-type: none"> ■ Decreased or increased appetite ■ Startle response ■ Incontinence/bed wetting*
Behavioral Effects	<ul style="list-style-type: none"> ■ Crying spells ■ Aggressive behavior* ■ Social withdrawal and avoidance ■ Relationship conflict ■ Work impairment (adolescents) ■ School impairment ■ Increased difficulty getting along with siblings and parents ■ Increase in high-risk behaviors (e.g., substance abuse) 	<ul style="list-style-type: none"> ■ Re-living events through play (young children) ■ Increased questions and story-telling related to event ■ Increased temper tantrums (young children)* ■ Increased deviance and delinquency (adolescents)* ■ Refusing to sleep alone*

Table 4–3: Reactions of Children, Pre-Adolescents, and Adolescents

** These reactions represent those often cited in the literature*

These reactions, when experienced by disaster survivors, their families, or relief workers can be quite disturbing and uncomfortable. Experiencing any of these reactions, however, does not necessarily signal an impending psychiatric illness or even warrant the need to implement major psychiatric interventions. Any of these reactions can be considered “anticipated” reactions as they are typically experienced by many individuals faced with similar circumstances. While some may choose to call them “normal” reactions, care should be given not to overly “normalize” them as their overall impact could be minimized and detection of a more serious, underlying mental health problem may be overlooked.



Individual Risk Factors³

Clinicians have long struggled with why disaster survivors, when exposed to identical trauma and tragedy, respond with considerable variability. Some individuals are able to incorporate the experience into their lives and move on relatively soon. Other individuals continue to feel devastated and overwhelmed for longer periods of time. Some individuals suffer lasting consequences that prevent them from moving on in healthy and positive ways from the event, thus causing significant problems in their personal, family, and work lives. There are some individual risk factors that may contribute to more severe psychological reactions in those exposed to disaster. While the research around these risk factors is limited, the literature suggests these characteristics may present heightened risk and warrant further study.

Personal Exposure

The most studied risk factor for negative outcomes following disaster events is the severity of the exposure to the event. Dose of exposure is a strong predictor of who will likely be most affected. This includes situations where the individual was exposed to the death of a family member, other loved one, or pet, was at risk of physical injury or harm to self or family, or was exposed to massive fatalities or injuries, especially the death or injury of children. Personal exposure is also a factor assessed by some population-based mental health triage systems, such as PsySTARTTM⁴, which will be discussed in Module 7.

The loss of personal property, dislocation from home, disruption to their social network or employment, or having to relocate to new surroundings can present significant risk factors, as well for survivors.

Pre-Disaster Functioning and Personality

Pre-disaster symptoms are usually among the best predictors of post-disaster symptoms. Survivors with previous psychiatric histories may be at an increased risk for developing post-disaster stress. Even so, disaster responders should make it a point to remember that many of these individuals have the same need for social and psychological support as those in the general population.⁵ Moreover, when housing, medication, and case management services remain stable, most people with mental illness will function reasonably well following disasters. Whatever reactions they are experiencing should not be automatically interpreted as an exacerbation of their pre-existing illnesses, but instead may be expectable reactions to the disaster itself.

³ Adapted from: Norris, F.H., Friedman, Byrne, C.M., Diaz, E., & Kaniasty, K. (Fall 2002). 60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature. 1982–2001. *Psychiatry*. 65(3), pp. 207–239.

⁴ For more information on PsySTARTTM, refer to the Web site at <http://www.psystart.org>.

⁵ Speier, T., (1996). *Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster*. U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. DHHS Pub. No. SMA96–3077. You may download this document from the Web site <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA96–3077/default.asp>.

Previous Disaster History

Individuals previously exposed to disasters or other traumatic events may be more at risk for developing psychological symptoms in the aftermath of disaster. Conversely, several studies have reported on the stress inoculation effect of prior exposure and a strengthening of protective factors through mastery of previous traumatic events.

Age

Research suggests that age presents unique risks across the life span. Each age group presents its own set of factors.

Children

Children are a particularly vulnerable group and require special attention. At considerable risk will be those who suffered significant exposure to threats of death or injury to themselves or their parents, those who were separated from their parents in the aftermath of disaster (e.g., evacuation), or those who experienced a significant delay in the reunification with their parents or family members. In addition, the loss of their possessions, such as favored toys or pets, can present particular challenges. Young children will experience a full range of emotions following a disaster, but may not have the words or means to express their internal experience. School-age children may also manifest their anxiety through regressive behavior such as irritability, whining, clinging, fighting with friends and siblings, competing with their younger siblings for their parents' attention, or refusing to go to school. Bedtime and sleep problems are common due to nightmares and fearfulness about sleeping alone or in the dark.

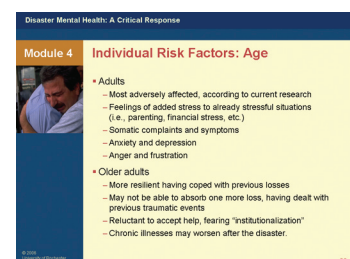
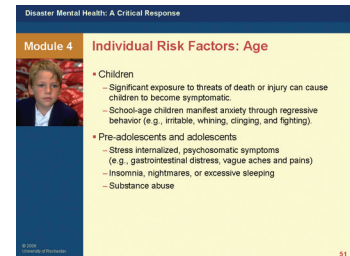
Sometimes children's behaviors can be "super good" at home, because they are afraid of further burdening their parents or causing more family disruption. They may show distress at school through concentration problems, decline in academic performance, aggression towards classmates, or social withdrawal. Some children may complain of physical illnesses as well.

Pre-adolescents and Adolescents

For this population, disaster stress may be internalized and expressed through symptoms such as gastrointestinal distress, headaches, or vague aches and pains. Sleep problems such as insomnia, nightmares, or sleeping excessively should be a red flag. Adolescents may turn to alcohol or drugs to cope with their anxiety and loss. They may become focused on death and dying increasing a concern about their suicide risk.

Adults

Adults, particularly middle-aged adults, may experience significant stress reactions following disaster. In many research studies, this age group tended to be the most adversely affected. This may be more a result of the burdens and additional stresses associated with this phase in life. Examples include parental stress (either the stress of



being responsible for the care of their own children or the stress of caring for their aging parents), financial stress, and occupational stress. Over time, this stress overload can be manifested through physical symptoms of headaches, increased blood pressure, gastrointestinal problems, and sleep difficulties. Anxiety and depression are common as adults struggle with both anxiety about future threats and grief about the loss of home, lifestyle, or community. As noted earlier, anger and frustration about relief efforts may emerge sometimes reflecting a displacement of the less rational anger that the disaster happened to them and was out of their control.

Older Adults

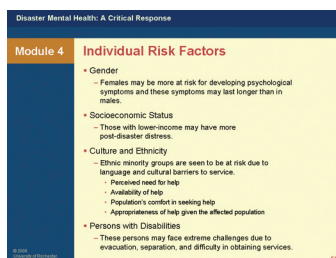
Older adults have typically coped with many losses prior to the disaster. They may have successfully adjusted to losses of employment, family, home, loved ones, or their own physical capabilities. Coping with these losses, for some, has strengthened their resilience and as a result, it should not be generalized that older adults are always at risk of developing significant psychological reactions following disaster. For some older adults, especially the physically and emotionally “frail”, the prior losses may have worn down that resiliency and made them less likely to be able to cope in the aftermath of a disaster. The loss of generations of memorabilia or a long-time companion or pet may increase the vulnerability of older adults. In addition, because of financial limitations and age, they may not be able to afford making repairs to their homes. Depending on the extent of the damage, they may also be forced to leave their homes and familiar surroundings, which can result in more cognitive impairments such as disorientation and forgetfulness.

Many older adults fear that if their diminished physical or cognitive abilities are revealed, they risk loss of independence or being institutionalized. As a result, they may under report the full extent of their problems and needs. Chronic illnesses may also worsen in the aftermath of a disaster.

While older adults may be more in need of multiple services for recovery, they are often especially reluctant to accept help or “handouts.”

Gender

Research suggests that females are affected more adversely by disasters than males. These studies further indicate that psychological effects were not only stronger among women, but more lasting as well. The psychological effects were strongest for Post-Traumatic Stress Disorder, where women’s rates exceeded men’s rates by a ratio of 2 to 1.⁶



⁶ Norris, F.H., Friedman, M.J., Watson, P.J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I, an empirical review of the empirical literature, 1981–2001. *Psychiatry: Interpersonal & Biological Processes*. 65(3) pp. 207–239.

Socioeconomic Status

In studies looking at the *socioeconomic status* (SES) of disaster survivors, lower SES was consistently associated with greater post-disaster distress. In fact, the effect of SES has been found to grow stronger as the severity of exposure to the disaster increases.

When thinking about a survivor population, mental health and spiritual care professionals will also need to consider the socioeconomic groups with whom they will be working. Survivors with a higher SES will undoubtedly have more resources. They will have insurance to help rebuild. They may have more traditional cognitive and social skills to help them deal with the myriad details involved in coping with trauma and accessing medical and mental health professionals. However, they might also find they have difficulty dealing with the shock of the disaster in ways that people who have had more difficulties in their lives do not have. The response, “I have so much more than others; I should not be so upset,” may be common. Mental health and spiritual care responders can help normalize the reactions of these individuals as they assist them in mobilizing their resources.

Lower socioeconomic groups tend to have fewer resources and have typically dealt with more challenging situations in their past. This may provide them with greater resilience or may increase their trauma reactions. They may express a passive attitude in the face of disaster. Disaster workers can help empower individuals in these groups to become more active in their recovery. Certainly, assisting in problem-solving activities becomes important with low SES survivors. Respecting and supporting their survival skills and facilitating their own support systems are also good strategies.

Culture and Ethnicity

Disaster mental health and spiritual care professionals may be particularly challenged in responding to and providing support for diverse populations. Culture and ethnicity may be influencing factors in determining the reaction of individuals affected by disaster, although the research in this area is both limited and deficient. In a paper by Norris and Alegria⁷, the authors highlight the complexity of responding to diverse populations, especially those from various ethnic and cultural backgrounds, due to such issues as the population’s perceived need for help, the availability of help, the population’s comfort in seeking help, and whether that help is appropriate given the population affected. Language as a barrier to applying for disaster relief services, inability to adhere to burial rituals, and the overall lack of cultural social supports following disaster may also place some ethnic and cultural minority groups at risk.

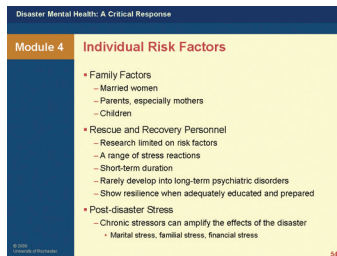
Individuals from minority cultural and ethnic populations who may be disenfranchised (real or perceived) during non-disaster times, may feel even more so in the aftermath of disaster, especially if disaster

⁷ Norris, F.H., & Alegria, M. (February 2005). Mental Healthcare for Ethnic Minority Individuals and Communities in the Aftermath of Disasters and Mass Violence. *CNS Spectrums*. 10(2), pp. 132–140.

relief and recovery efforts are delayed or are perceived to arrive quicker to majority populations. More information and resources related to cultural and ethnic issues related to disaster can be found in *Appendix C: References and Resources* on page C-1.

Persons with Disabilities⁸

Millions of Americans suffer from some type of physical, psychological, or cognitive disability. In the aftermath of disaster, these individuals can face extreme challenges placing them at risk for suffering subsequent psychological crises. Issues related to evacuation, separation or relocation from family and peers, health, mental health, and spiritual care resources, and difficulty obtaining disaster recovery services may contribute to individuals' experiences of post-disaster psychological sequelae.



Family Factors

Married status is a risk factor for women. Moreover being a parent also adds to the stressfulness of disaster recovery. Mothers are especially at risk for substantial distress, and children are highly sensitive to post-disaster distress and conflict in the family. More information and resources related to Family Factors can be found in *Appendix C: References and Resources* on page C-2.

Rescue and Recovery Personnel

The research on risk factors in rescue and recovery personnel is quite limited. While it is inherently true that exposure to situations warranting quick action to save the lives of those involved in disasters can be quite stressful, the limited research that is available to date suggests that reactions by this group tend to be of short-term duration and rarely develop into long-term psychiatric disorders. Rescue and recovery personnel are more likely to show resilience when they have been adequately educated and prepared for their life-saving responsibilities and are part of a well-functioning team.

Post-disaster Stress

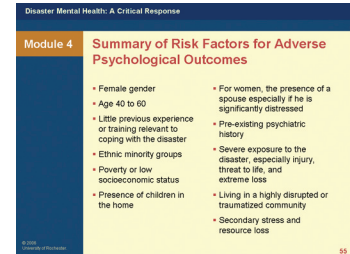
Some research suggests that acute stressors amplify psychological distress by intensifying or otherwise negatively affecting chronic stressors such as marital stress, financial stress, and ecological stress. Mental health professionals and local government must pay attention to the stress levels of a stricken community long after the disaster has happened and passes. While it is not the focus of this particular curriculum, healthcare professionals and hospitals should expect that once the immediate needs of disaster survivors have been met, these individuals may seek out assistance for their ongoing physical and psychological stress reactions creating a potential surge issue in the affected community.

⁸ For more information, download the document *Disaster Preparedness for People with Disabilities* from the American Red Cross Web site at <http://www.redcross.org/services/disaster/beprepared/disability.pdf>.

Summary of Risk Factors for Adverse Psychological Outcomes⁹

The individuals at greatest risk include those that have the following characteristics:

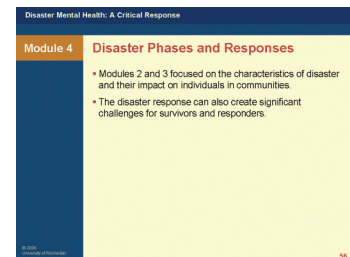
- Severe exposure to the disaster, especially injury, threat to life, and extreme loss
- Female gender
- Age in the middle years of 40 to 60
- Little previous experience or training relevant to coping with the disaster
- Ethnic minority group membership
- Poverty or low socioeconomic status
- The presence of children in the home
- For women, the presence of a spouse especially if he is significantly distressed
- Psychiatric history
- Living in a highly disrupted or traumatized community
- Secondary stress and resource loss



The Disaster Response as a Risk Factor

On a macroscopic level, how a community responds to the disaster and the specific life cycle or phases of disaster response can also have profound effects on those involved.

While the literature does not support universally accepted nomenclature to describe the phases of disaster, there is consensus that each phase presents unique challenges for disaster survivors and relief workers. Each of these phases is associated with a relative time frame within the disaster response and certain anticipated and expected reactions. Depending upon the population you are addressing, you may see distinctly different reactions. Individuals and communities progress through these phases at different rates depending on the type of disaster and the degree and nature of disaster exposure. The progression may not be linear or sequential because each person and community brings unique elements to the recovery process. Individual variables, such as psychological resilience, social support, and financial resources, influence a survivor's capacity to move through the phases.



⁹ Risk Factors for Adverse Outcomes in Natural and Human-Caused Disasters: A Review of the Empirical Literature. A National Center for PTSD Fact Sheet. Retrieved from http://www.ncptsd.va.gov/facts/disasters/fs_riskfactors.html.

Module 4—Reactions to Disasters: The Human Response

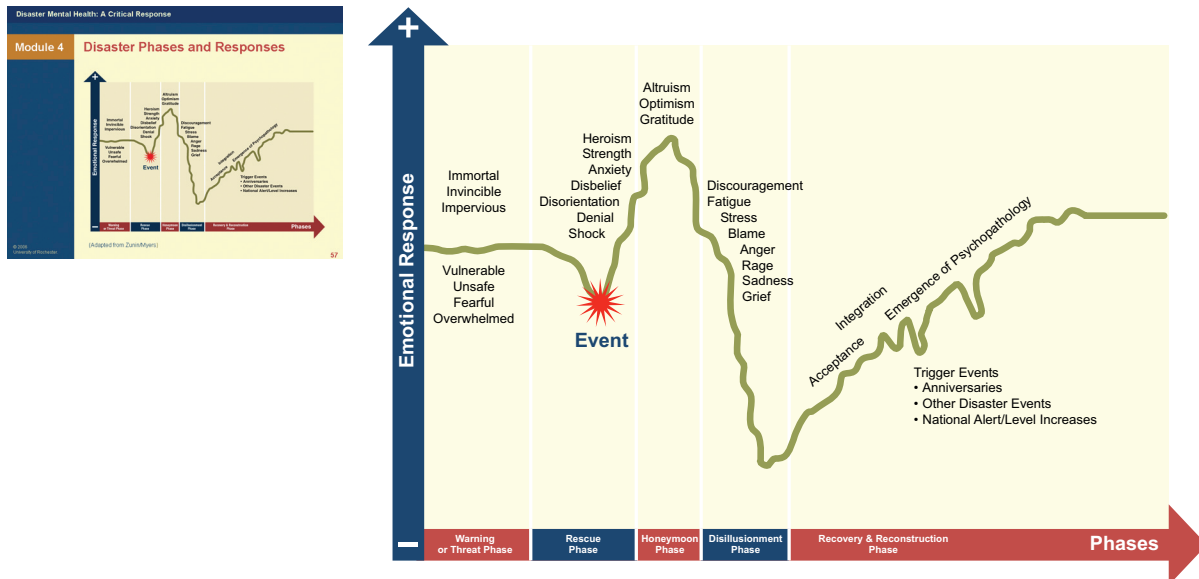


Figure 4-2: Disaster Phases and Responses Graphic¹⁰

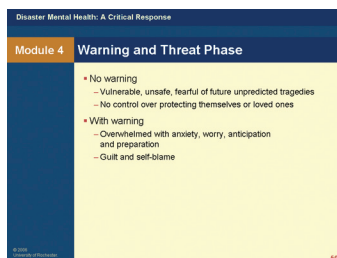
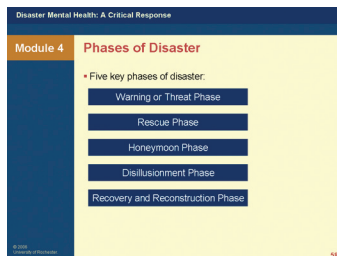
Here are the five key phases of disaster:

- Warning or Threat Phase
- Rescue Phase
- Honeymoon Phase
- Disillusionment Phase
- Recovery and Reconstruction Phase

Warning or Threat Phase

The first phase of disaster response is usually referred to as the *Warning or Threat Phase*. Depending upon the type of disaster, the amount of warning a community receives about an impending strike can vary. When there is no warning, survivors may feel more vulnerable, unsafe, and fearful of future unpredicted tragedies. The feeling that they have no control over protecting themselves or their loved ones can be particularly distressing.

Even in those situations where there may have been warning of an impending event, the anticipation and preparation may be overwhelming for some. Conversely, for those individuals who did not heed the warning and, as a result, suffered personal losses or ultimately placed someone else at risk (such as a police officer, firefighter, neighbor, or family member), feelings of guilt or self-blame may emerge. They may also feel a sense of responsibility for what has occurred, especially if there were negative outcomes.



¹⁰ This illustration has been adapted from two published illustrations. One is representative of a theoretical model developed by Zuning and Myers. The other is an illustration published in *Mental Health Response to Mass Violence and Terrorism: A Training Manual*, (2004), U.S. Department of Health and Human Services. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. p. 20.

Rescue Phase

In the *Rescue Phase*, a disaster can vary from the slow, low-threat buildup associated with some types of floods or slow-moving wildfires to the violent, dangerous, and destructive outcomes associated with tornadoes and explosions. The greater the scope, community destruction, and personal losses associated with the disaster, the greater the psychological, psychosocial, and psychospiritual effects.

The reactions of disaster survivors during this phase can be quite strong and intense. These reactions range from feeling stunned and shock-like responses to overt expressions of panic, hysteria, or mass aggression. While the literature in this area suggests that you do not see these reactions quite often, it is important to note that the research on these reactions is quite limited. There are also certain risk factors for such responses that will be discussed further in Module 5.

Survivors, during this phase, can also react with surprising clarity, strength, and cooperation. They may place themselves at risk taking heroic actions as they reach out to help others, especially in situations where they or their loved ones are threatened with severe injury or death.

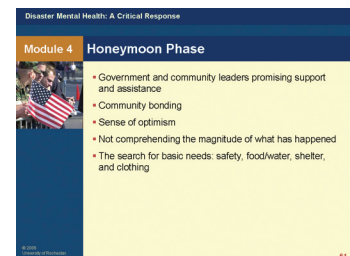
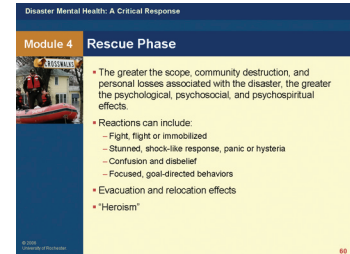
When family members are separated from each other during the disaster (e.g., children at school, adults at work), they are likely to experience considerable anxiety until reunited with their loved ones. If evacuations to shelters, motels, or other homes are necessary, survivors may experience disorientation. This is especially true with older adults. They may become confused and agitated, thereby presenting considerable challenges for shelter staff and others looking after their care.

For many, household pets may be just as important as their family members are. Individuals asked to leave their pets behind during an evacuation may experience an overwhelming sense of anxiety and concern about their pet's safety. In fact, some survivors may even refuse to evacuate if their pets are not able to join them.

Honeymoon Phase

Once the impact of the disaster strikes and the immediate risk of injury or death has passed, the community is usually saturated with disaster-response personnel. These workers respond to meet the needs of the individual survivors and community.

During the period following the direct impact of a disaster, governmental, public, and private assistance may also be readily available. Community leaders are promising support and assistance, and planning is underway to get the community back to where it was prior to the disaster. Community or survivor bonding occurs through the sharing of the catastrophic experience and the giving and receiving of community support. Survivors may experience a sense of optimism that the help they will receive will make them whole again. Families are reunited and for those who escaped injury or death, a sense of relief is found.



Also during this phase, survivors are beginning to comprehend the magnitude of what has happened and may become overwhelmed with many different emotions. Most are focused primarily on attending to their basic needs—food, shelter, clothing, and the safety and security of their family members. They may have unrealistic expectations about their recovery and deny the extent the emotional impact has had on them and their family members.

For those who have lost loved ones or whose homes have been destroyed, feeling thankful of the disaster relief services available to them pales in comparison to the profound sense of sadness and desperation they feel upon learning of their losses. They may be unable to accept the support available to them and even disregard encouragement to take care of their own personal needs.



Disillusionment Phase

Over time, survivors begin to recognize the limits of available disaster assistance and the reality of the impact the disaster has had on their lives. This is when community disillusionment sets in. The *Disillusionment Phase* may realistically only take a day or two to set in after the disaster. The initial optimism experienced in the *Honeymoon Phase* gives way to feelings of discouragement and fatigue. Because of multiple demands, financial pressures, and the stress of relocation or living in a damaged home or community, survivors become exhausted—physically and emotionally. Eventually, many of the initial responding disaster relief agencies and volunteer groups begin to pull out leaving survivors feeling abandoned and resentful.

The media has left, and the visibility of the affected community's plight has diminished. Financial and human resources are no longer available at the level found during the Honeymoon Phase.

Stressors such as family discord, bureaucratic hassles, time constraints, home reconstruction, and lack of recreation or leisure time emerge. Health problems and exacerbations of pre-existing conditions also emerge due to ongoing, unrelenting stress and fatigue. Many stress-related psychological symptoms also begin to emerge.

If the scope of the disaster affected only a portion of the community, the non-impacted area of the community has often returned to “business as usual,” which can be typically discouraging and alienating for survivors who continue to be impacted. Ill will and resentment may surface in neighborhoods as survivors receive unequal monetary amounts for what they perceive to be equal or similar damage. Divisiveness and hostility among neighbors undermines community cohesion and support.

For those who suffered injury to self or family members or for those family survivors who experienced the death of a loved one, they may progress directly into the Disillusionment Phase, skipping the Honeymoon Phase, entirely. The psychological reactions experienced during this phase can vary. They will not experience the disaster response in the same way as those who emerged unharmed.

The catastrophic aftermath of Hurricane Katrina in 2005 brought an entirely new dimension to the Disillusionment Phase. Because of the scope and magnitude of the disaster and the resulting challenges faced by local, state, and federal agencies in responding to the immediate needs of those in the hurricane's path, many survivors expressed extreme outrage at these governmental and non-governmental relief agencies for not providing the needed services and personnel in a quick and efficient manner. The psychological aftermath for survivors resulting from these response issues are likely to have long-lasting effects that will present challenges for the mental health and faith-based providers and organizations in those affected areas.

Reconstruction and Recovery Phase

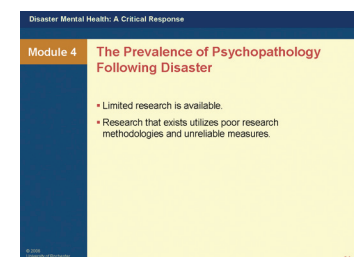
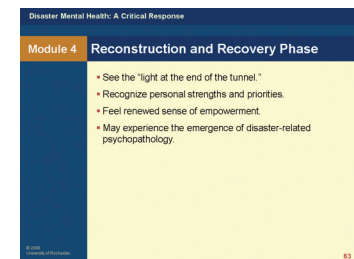
The *Reconstruction and Recovery Phase* usually represents a community on its way to healing. Most survivors can see the light at the end of the tunnel. However, the reconstruction of physical property and recovery of emotional well-being may continue for years following the disaster. Survivors have realized that they will need to solve the problems of rebuilding their own homes, businesses, and lives largely by themselves and have gradually assumed the responsibility for doing so. For many, they are beginning to put the disaster behind them and have a renewed feeling of empowerment.

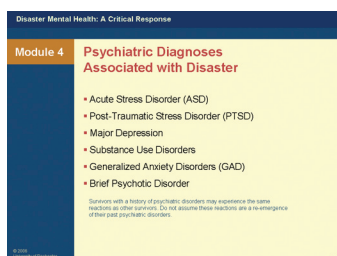
With the construction of new residences, buildings, and roads, another level of recognition of losses surfaces. Survivors are faced with the need to readjust to and integrate new surroundings as they continue to grieve their losses. Social support from friends and family may be worn thin, though these individuals may have found new social supports through the disaster experience.

For many, disasters bring profound life-changing losses, as well as the opportunity to recognize personal strengths and to re-examine life's priorities. For others, they represent disruptive life events that yield significant consequences. During the *Reconstruction and Recovery Phase*, mental health and spiritual care professionals may encounter a subset of survivors who experience significant dysfunction in their personal, family, or work life. This distinction quite possibly represents the emergence of disaster-related psychopathology that may require higher levels of mental health treatment or spiritual care intervention.

The Prevalence of Psychopathology Following Disaster

There is emerging evidence on the psychiatric outcomes following disasters. This data should be accepted cautiously as most disaster mental health research up to the present does not adhere to rigorous methodological standards. Many studies consist of small, unrepresentative samples and utilize poor or unreliable measures.





Psychiatric Diagnoses Associated with Disaster

While it has been continually emphasized throughout this manual that most individuals who experience a disaster or traumatic event will not develop major psychopathology, there will be, however, a small minority of individuals who will develop psychiatric syndromes.

The research of psychiatric disorders following disaster often focuses solely on Post-Traumatic Stress Disorder (PTSD); however, this is not the only psychiatric disorder associated with disasters. It may not even be the most common. Acute Stress Disorder, Post-Traumatic Stress Disorder, Major Depression, substance use disorders, Generalized Anxiety Disorder, and Brief Psychotic Disorder have all been noted in the literature as potential psychiatric disorders following disaster. Your knowledge of these disorders and their diagnostic criteria will help you to predict future development of these disorders in disaster survivors. A brief description of each follows. However, for more detail, refer to the DSM-IV-TR Criteria in **Appendix B: Additional Information and Checklists** on page B-6.

Acute Stress Disorder (ASD)

In 1994, DSM-IV introduced the Acute Stress Disorder diagnosis to describe stress reactions in the initial month after a trauma.¹¹ A growing body of evidence suggests that specific stress symptoms may occur almost immediately following a disaster and may predict the development of Post-Traumatic Stress Disorder (PTSD). *Acute Stress Disorder* (ASD) is conceptually similar to PTSD and shares many of the same symptoms. Approximately 6% to 33% of individuals will experience Acute Stress Disorder in the aftermath of a disaster or traumatic event. The variation in prevalence rates is closely associated with the type of traumatic event (e.g. industrial accident vs. mass shooting) experienced by the individual.

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder is the most commonly studied diagnosis after disaster, though it should not be considered the normal response to traumatic events and disasters. Following a disaster, most individuals will not develop PTSD. Further, having PTSD-like symptoms, which are commonly experienced by individuals after a disaster, does not always yield a full-blown diagnosis of Post-Traumatic Stress Disorder. The research also suggests that most people who display PTSD-like symptoms in the immediate aftermath of a disaster actually recover in the following few months. Disaster research exploring the prevalence of PTSD suggests that anywhere from 4% (natural disasters) to 34% (terrorist attack) of individuals will develop PTSD.

¹¹ Bryant, R. A. (2004). Acute Stress Disorder. Course, Epidemiology, Assessment, and Treatment. In: *Early Intervention for Trauma and Traumatic Loss* (Brett T. Litz, Editor). New York: The Guilford Press.

Major Depression

Depression, especially *Major Depression*, can pose a significant risk for some individuals after a disaster. This is especially true if the individual has suffered significant personal losses or injuries. It is worth noting that the incidence of depression following disaster can be very high ranging from 17% to 45% in some studies. The co-occurrence of PTSD and depression is also very common (35% to 68%) and acute depression is a strong predictor of severity of subsequent impairment. Acute depression can follow a distinct course after disaster that is independent of PTSD. Of particular note, disaster survivors and responders can exhibit depressive symptoms without meeting the diagnostic criteria for major depression. In fact, such symptoms (sadness or irritability, sleep disturbance, and loss of energy or appetite) may be quite common following disaster and usually are resolved within a relatively short time.

Substance Use Disorders

Recent studies have looked at the prevalence of *Substance Use Disorders* in individuals exposed to disaster. While these diagnoses have been identified in disaster survivors and responders, there is some indication that pre-existing disorders may have been exacerbated by the disaster as opposed to new diagnoses resulting after the disaster. Increases in alcohol or drug consumption may or may not necessarily lead to the development of a diagnostic substance use disorder. Attention should be given to those showing increased substance use so that further assessment and treatment, if necessary, can be provided.

Generalized Anxiety Disorder (GAD) and Brief Psychotic Disorder

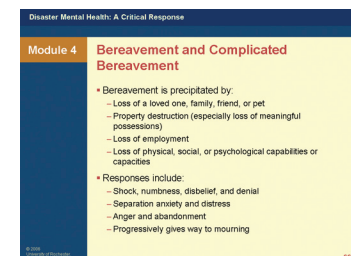
Distress and anxiety are common reactions to disaster. Not so common are situations in which disaster survivors experience disruptions in their ability to distinguish from what is real versus what is not real. Both *Generalized Anxiety Disorder (GAD)* and *Brief Psychotic Disorder* are mentioned occasionally throughout the literature.

Bereavement and Complicated Bereavement

In situations of traumatic or catastrophic loss, a survivor may demonstrate both traumatic stress reactions and bereavement. These may have been precipitated by the following occurrences:

- Death of a loved one, family member, friend, or pet
- Destruction of one's property or personal possessions
- Loss of employment
- Loss of one's physical, social, or psychological capabilities or capacities
- Loss of community and community support

An individual's reaction to loss is typically referred to as grief or bereavement. It is characterized by a brief period of shock, numbness, disbelief, and to a degree, denial. Intense separation distress



and anxiety may also be experienced. The bereaved person is highly aroused, yearns for the lost loved one or object, and may also engage in searching behaviors, particularly if it is not certain, in the case of the loss of a loved one, that the person is dead or the body has not been found or identified.

Individuals may also express a sense of anger and abandonment. This anger may be recognized as irrational by the bereaved person, but it amounts to anger towards the deceased for not being there or for being among those who died. Anger, rage and blame may also be directed towards those individuals (or one's Higher Power) who are seen as having caused or been associated with the death of a loved one or pet.

Most grief reactions progressively give way to mourning where the bereaved person is focused more on the memories of the relationship and experiences painful reminders of the absence of the person. The bereaved person begins to accept the death, although with ongoing feelings of sadness and loss. The direction and expression of "normal" bereavement vary considerably among different cultural groups. Depending on one's spiritual perspective, the person may be comforted by his/her belief that the person's soul or spirit lives on in some way.

The acute grief reaction usually settles in the early few weeks or months after the loss, but more intense emotions and preoccupations may occur sporadically during the first year and into the years that follow.

It has, however, been shown that about 9% of a normal community sample of bereaved people may develop *chronic or complicated grief*¹². This is a more significant grief reaction where the initial acute distress continues with other manifestations for six months or more, and often for many years.

Risk factors for complications of bereavement have been identified by a number of researchers¹³. These include:

- Perceived lack of social support
- Other concurrent crises or stressors
- High levels of ambivalence in relation to the deceased
- An extremely dependent relationship
- Circumstances of death that are unexpected, untimely, sudden, or shocking
- Personality vulnerabilities
- Past history of losses

It has also been shown that an inability to see the body of the deceased may further contribute to the risk of adverse outcomes.



¹² For more information regarding traumatic grief in adults, refer to *The International Society for Traumatic Stress Studies Web site* at http://www.istss.org/terrorism/sudden_traumatic_loss.htm.

¹³ *Effects of Traumatic Stress in a Disaster Situation: A National Center for PTSD Fact Sheet*. (2005). Electronic source: http://www.ncptsd.va.gov/facts/disasters/fs_effects_disaster.html.

Child Traumatic Grief¹⁴

Childhood Traumatic Grief is distinct from the normal bereavement process and PTSD; however, it shares features of both. The distinguishing feature of Childhood Traumatic Grief is that trauma symptoms interfere with the child's ability to navigate the typical bereavement process. A mental health professional with experience in Childhood Traumatic Grief may be needed to distinguish between the sometimes-overlapping symptoms of uncomplicated bereavement and traumatic grief.

Psychiatric Reactions Resulting from Chemical and Biological Agents

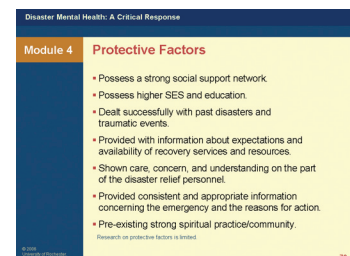
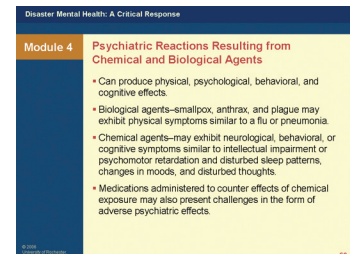
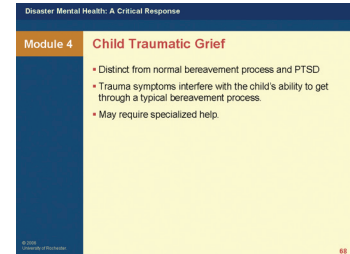
Some chemical and biological agents used as weapons of mass destruction can produce physical, psychological, behavioral, and cognitive effects and thus cause confusion in diagnosis. Individuals exposed to such biological agents as smallpox, anthrax, plague, and tularemia might exhibit physical symptoms that may be often confused with those of flu or pneumonia. Individuals exposed to chemical agents may present with neurological, behavioral, or cognitive symptoms such as intellectual impairment, psychomotor retardation, and disturbed sleep patterns. They may also suffer changes in mood and disturbed thoughts. Even medications administered to counter the effects of chemical agents can also elicit adverse psychiatric effects. For example, atropine, a commonly used antidote to address the physical health effects from chemical agents, has the most potential for serious alterations in mental status resulting in side effects ranging from drowsiness to hyperactivity, hallucinations, and coma. Many biological weapons can also cause delirium. For specific information, refer to the section entitled *Chemical, Biological, Radiological, Nuclear, and Explosive Agents Used in Acts of Terrorism* in *Appendix B: Additional Information and Checklists* on page B-12.

Protective Factors

As described earlier, many survivors and others affected by disaster are likely to experience a range of reactions, while uncomfortable, are transient. These individuals go on to lead productive lives, and their disaster experiences are successfully integrated and result in no adverse outcome. Unfortunately, not much research to date has explored what protects these people from developing more significant post-disaster stress or pathology and makes them resilient in the face of such extreme adversity. The existing research does suggest that individuals who have the following protective factors may have increased resiliency in the face of traumatic events.

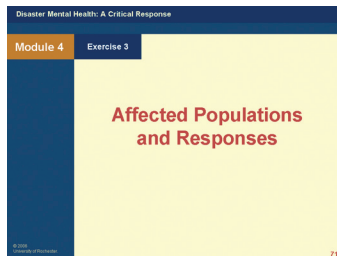
- Have a strong social support network
- Enjoy a higher income and education
- Have shown mastery of past disasters and traumatic events

¹⁴ For more information on Child Traumatic Grief, refer to the document entitled *Child Traumatic Grief Educational Materials* from the *National Child Traumatic Stress Network* Web site at http://www.nctsn.org/nctsn_assets/pdfs/reports/childhood_traumatic_grief.pdf.



- Were provided with information about expectations and availability of recovery services and resources
- Were shown care, concern, and understanding on the part of the disaster relief personnel
- Were provided with consistent and appropriate information concerning the emergency and the reasons for action

Have a pre-existing strong spiritual practice/community¹⁵



Exercise 3: Affected Populations and Responses

Exercise Overview

A serious bus crash has occurred in your community. The passengers will be transported to your healthcare facility. Essentially, this is the same bus crash that you explored in Exercise 1. This bus crash has happened on a Saturday afternoon on a major highway. However, for the purposes of this exercise, you will explore four different scenarios related to the purpose of the bus trip and passengers on the bus. These scenarios are as follows.

1. Bus 1 was transporting high school football and cheerleading teams on the way to a regional competition in another part of New York State; the accident occurs 50 miles from the team's home.
2. Bus 2 was transporting a senior citizens' tour group from Pennsylvania on its way home from a Canadian casino.
3. Bus 3 was transporting immigrant farm workers to employment in a rural community.
4. Bus 4 was transporting a Mormon Church group returning home from a Toronto weekend of cultural events; the crash occurred 150 miles from their home.
5. Law enforcement and rescue personnel have been deployed. Information about the bus passengers is being verified. The details appear within the context of the instructions.

Exercise Purpose

The purpose of this exercise is to explore how these different populations may respond to the disaster situation in which they find themselves.

Exercise Mode

This is a small group exercise. You will work with several others as determined by your instructors. Use the Exercise 3 handout in Appendix A: Exercises on page A-7.

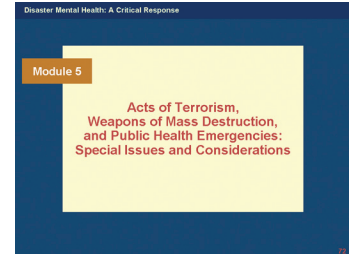
¹⁵ Richards, P.S. & Bergin, A. E. (1997). A theistic, spiritual view of personality and mental health. In *A Spiritual Strategy for Counseling and Psychotherapy*. American Psychological Association: Washington, DC.

Module Summary

In this module, you have come to understand the range of reactions individuals experience in the aftermath of disaster and throughout the phases of the disaster response. At this point in the training, no doubt you have come to appreciate that many populations are affected by disaster. Members of each population respond in their own way, depending on the circumstances under which the disaster occurred, how they and their friends and families were personally affected by the disaster, and what their individual characteristics were at the time of the disaster. With all these variables in play, you can understand the complexity and challenges of providing disaster mental health and spiritual care services in the immediate aftermath of a disaster. However, the more prepared you are, the more effective you will be in the role of a disaster mental health or spiritual care professional.

Module 5

Acts of Terrorism, Weapons of Mass Destruction, and Public Health Emergencies: Special Issues and Considerations



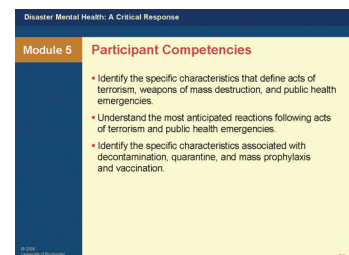
Module Overview

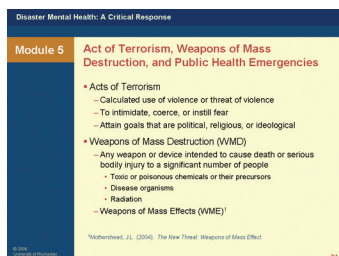
The threat of acts of terrorism, weapons of mass destruction, and diseases that can create public health consequences affecting millions of Americans have raised national, state, and local agendas on how to prepare and respond to such potentially cataclysmic events. These threats are underscored by the real life events of multiple school shootings, the attacks on September 11, 2001, the emergence of SARS and Avian Flu, and Hurricane Katrina. All of these events left an indelible mark in our minds of how important this agenda is to preparing our nation to respond to the simultaneous and urgent needs of communities struck by such disasters. Because of the resultant psychological effects from terrorist acts, weapons of mass destruction, and public health emergencies, mental health and spiritual care professionals play a critical role in responding to the affected communities and assisting in their recovery. This module will provide you with more specific information on the unique characteristics of human-caused disasters, particularly acts of terrorism, weapons of mass destruction, and public health emergencies, and how these characteristics can affect the way disaster survivors and responders react and recover from such events.

Participant Competencies

At the end of this module, you will be able to:

- Identify the specific characteristics that define acts of terrorism, weapons of mass destruction, and public health emergencies.
- Understand the most anticipated reactions following acts of terrorism and public health emergencies.
- Identify the specific characteristics associated with decontamination, quarantine, and mass prophylaxis and vaccination.





Acts of Terrorism

An act of terrorism is defined as the calculated use of violence (or threat of violence) against individuals or communities to intimidate, coerce, or instill fear in order to attain goals that are political, religious, or ideological in nature. Other motivations (psychological, etc.) may also be at the root of such acts. For example, the 2002 sniper shootings in the Washington, DC area and a number of school shootings across the country may also be defined as acts of terrorism since they were calculated and instilled fear in those closely affected by them.

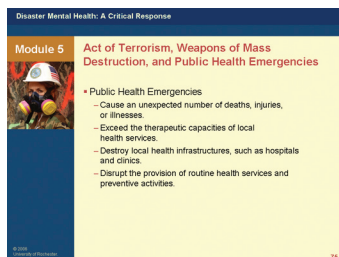
Weapons of Mass Destruction (WMD)¹

A weapon of mass destruction, as defined by the U.S. Congress (1996), is any weapon or device that is intended, or has the capability, to cause death or serious bodily injury to a significant number of people through the release, dissemination, or impact of any of the following:

- Toxic or poisonous chemicals or their precursors
- Disease organisms
- Radiation

Actually, the term weapons of mass effect² may be a more appropriate term given the range of weapons considered to be used in acts of terrorism result in varying degrees of “destruction” while their effects, regardless of weapon choice, will be far-reaching in a community.

The Department of Homeland Security (DHS) and the Department of Defense (DOD) have identified a number of agents that may potentially be used as WMD or WME. More specific information on these agents can be found in *Appendix B: Additional Information and Checklists* on page B-12.



Public Health Emergencies

As you learned in Module 3, public health emergencies are incidents that threaten or compromise the physical health and welfare of a population. This can be the spread of disease, the intentional release of a chemical or biological agent, or a small community’s only hospital rendered inoperable by a devastating tornado.

Specific characteristics of potential public health emergencies or disasters include those incidents that:

- Cause an unexpected number of deaths, injuries, or illnesses.
- Exceed the therapeutic capacities of local and regional healthcare services.

¹ CBRNE-Chemical, Biological, Radiological, Nuclear, and Explosives are synonymous with WMD (Weapons of Mass Destruction).

² Mothershead, J.L. (2004). The New Threat: Weapons of Mass Effect. In *Terrorism and Disaster Management: Preparing Healthcare Leaders for the New Reality* (K.J. McGlown, Ed.). Chicago, IL: Health Administration Press.

- Destroy local healthcare infrastructures, such as hospitals, clinics, and private practice offices.
- Disrupt the provision of routine health services and preventive activities, which in turn may lead to long-term health consequences resulting in increased morbidity and mortality.

Pandemic Influenza

A flu pandemic is a global outbreak that occurs when a new *influenza A virus* causes serious human illness and spreads easily from person to person. An influenza pandemic will place a huge burden on the U.S. healthcare system. Published estimates based on extrapolation of the 1957 and 1968 pandemics suggest that there could be 839,000 to 9,625,000 hospitalizations, 18 to 42 million outpatient visits, and 20 to 47 million additional illnesses, depending on the attack rate of infection during the pandemic.³

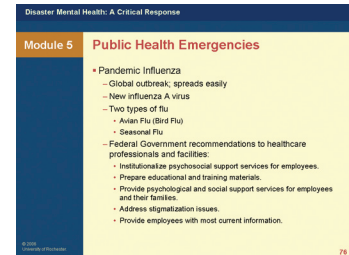
There are two types of flu that are of current concern.

- *Avian Flu* (also called bird flu) is an illness caused by avian influenza viruses, which occur naturally among birds.
- *Seasonal Flu* is a contagious respiratory illness caused by influenza viruses

The real or perceived threat of a flu pandemic presents significant challenges for communities and especially their healthcare facilities and healthcare professionals. In the face of these challenges, national experts and the federal government are encouraging healthcare professionals and facilities to do the following⁴:

- Institutionalize psychosocial support services for employees who participate in or provide support for the response to public health emergencies such as influenza pandemics.
- Prepare educational and training materials on psychosocial issues for distribution to employees during an influenza pandemic.
- Provide psychological and social support services for employees and their families.
- Address stigmatization issues that might be associated with participation in such services.
- Provide employees with ongoing access to up-to-date information on healthcare and training issues, as well as on the national and local status of the pandemic.

It is also important to provide spiritual care services to those affected by the illness or involved in the response to the outbreak.



³ Centers for Disaster Control Pandemic Influenza Web site, accessed on January 31, 2006. For more information, refer to the Web sites <http://www.cdc.gov/flu/pandemic/healthprofessional.htm> and <http://www.cdc.gov/flu/professionals/background.htm>.

⁴ Centers for Disaster Control Pandemic Influenza Web site, accessed on January 31, 2006. For more information, refer to the Web site <http://www.hhs.gov/pandemicflu/plan/pdf/S11.pdf>.

Populations Affected by Acts of Terrorism and Public Health Emergencies

The psychological impact resulting from acts of terrorism, including the use of WMD, and large scale public health emergencies can be far reaching. Take for example the events of September 11, 2001. Telephone and internet surveys conducted shortly after September 11 found widespread effects that spanned the nation. From New York to California and Washington, DC to Texas, individuals described a range of psychological and physical reactions. In addition to Ground Zero, the Pentagon, and areas nearby, disaster mental health and spiritual care professionals were called to schools, businesses, and community centers across the country to help people cope with the emotional and spiritual impact of this national tragedy.

As described in the discussion about the Population Exposure Model in Module 4, individuals who have the most exposure—personally, physically, and psychologically—to the disaster scene are likely to be the most affected, while those farthest away may be the least affected.⁵

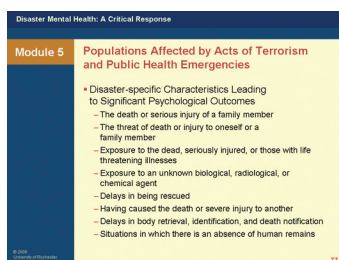
For those who were directly exposed to the disaster, there are specific characteristics that may increase the likelihood of developing significant psychological outcomes. These include:

- The death or serious injury of a family member
- The threat of death or serious injury to oneself or a family member
- Exposure to the dead, seriously injured, or those with life-threatening illnesses
- Exposure to an unknown biological, radiological, or chemical agent
- Delays in being rescued
- Having caused the death or severe injury to another
- Delays in body retrieval, identification, and death notification
- Situations in which there is an absence of human remains

Public Responses to Acts of Terrorism, WMD, and Public Health Emergencies

The Institute of Medicine, in a 2003 publication entitled *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy*, indicates that, “Terrorism and the threat of terrorism will have psychological consequences for a major portion of the population, not merely a small minority...”

When death and destruction are deliberately planned and caused by other persons, survivors, family members, and the larger community are horrified by the tragedy, evil intent, and the unnecessary losses. Survivors feel confused, out of control, frightened, and unable to make sense of an act that seems incomprehensible.⁶



⁵ Refer to the *Population Exposure Model* in Module 4.

⁶ Butler, A.S., Panzer, A.M., & Goldfrank, L.R. (Eds.). (2003). *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy*. Washington, D.C. The National Academies Press.

Victims of mass violence experience terror, fear, horror, helplessness, and a sense of betrayal that you do not typically find following natural disasters (unless they are catastrophic natural disasters such as the Southeast Asia Tsunami or Hurricane Katrina).

Depending upon who claims responsibility for such acts, disaster survivors may also feel distrust of certain individuals or groups and extreme outrage at the perpetrators of the violence. The desire for revenge and justice is common. Many survivors of human-caused disasters also describe a change in their worldview. They no longer feel their world is secure, just, or orderly. Their basic assumptions about humanity are shattered, leaving them disillusioned and ungrounded. Terrorism and mass violence shake our inner core and all that we have come to know and understand especially from a cross-cultural perspective. Take for example the people of Israel and Palestine. Unfortunately, acts of terrorism are commonplace for their regions. Their worldview has been shaped differently from those of Americans given this frequent phenomenon. This may correlate, in fact, with the extent of psychological impact they experience.

Many of the stress reactions individuals experience following acts of terrorism or the threat of such an event are similar to those seen in the immediate aftermath of other types of disasters.⁷ However, the following reactions may be more prominent following acts of terrorism or from catastrophic natural disasters where significant loss of life and destruction of property occur.

- Shock and denial
- Hopelessness and helplessness
- Anxiety and fear
- Feelings of guilt or blame
- Grief and feelings of loss
- Recurring and intrusive thoughts or images
- Disruption of usual activities

Mass Panic

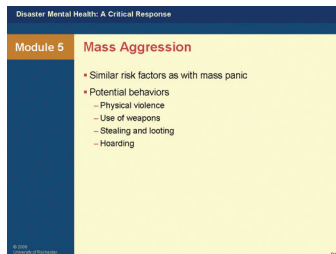
The commonly held assumption that mass panic automatically follows a terrorist event is relatively unfounded in the literature. Even so, the limitations in current research in this area should not result in minimizing the potential for panic in communities or populations following disaster. Panic is primarily a group phenomenon characterized by intense and contagious fear causing people to think only of themselves. Many disaster survivors will be able to assess the dangers, formulate a plan, and carry that plan out. Others will remain stunned, though still able to function towards self-preservation. A small percentage will become hysterical or confused in the face of disaster and paralyzed by fear or anxiety. Risk factors for group panic include:

Disaster Mental Health: A Critical Response	
Module 5	Common Psychological Consequences of Acts of Terrorism and Catastrophic Natural Disasters
<ul style="list-style-type: none">• Shock and denial• Hopelessness and helplessness• Anxiety and fear• Feelings of guilt or blame• Grief and feelings of loss• Recurring and intrusive thoughts or images• Disruption of usual activities	
© 2006 University of Rochester	78

Disaster Mental Health: A Critical Response	
Module 5	Mass Panic
<ul style="list-style-type: none">• Group phenomenon, characterized by intense and contagious fear, rarely occurs following disaster• Risk factors include:<ul style="list-style-type: none">– Belief that there is a small chance of escape– Perception that one is at high risk of becoming ill or infected– Limited or inadequate availability of needed resources or supplies– Perceived lack of effective management of the catastrophe	
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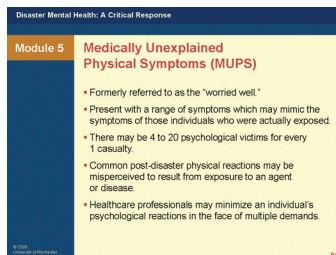
⁷ Refer to the *Individual Reactions and Characteristics* table in Module 4.

- The belief that there is a small chance of escape
- Seeing oneself as being at high risk of becoming ill or infected
- Limited or inadequate availability of needed resources or supplies
- Perceived lack of effective management of the catastrophe



Mass Aggression

While most disaster survivors do not react in an aggressive or violent manner, the risk factors described above for mass panic may induce, in fact, such behaviors. If we take Hurricane Katrina as an example, some residents of the disaster stricken area went without water, food, and other relief supplies for a number of days. As time went by and human and material resources were presumed to be inadequate or efforts to evacuate populations at risk of harm or death were delayed, disaster relief personnel and government officials were confronted with extremely dangerous situations, including physical violence, the use of weapons, stealing and looting, and hoarding behaviors.



Medically Unexplained Physical Symptoms (MUPS)

In reality, when you look at many of the terrorist events that have occurred in the last decade or so, most resulted in few, if any deaths, but held more significant psychological impact. For example, the 1995 Tokyo subway Sarin gas attacks resulted in a dozen deaths, but the psychological effects were exponential. Over 5,500 people arrived at 280 medical facilities on the day of the attack and in the following days. Of those who presented for medical care, many were unexposed to the chemical agent. These individuals still presented with psychosomatic symptoms that led them to believe they were in danger. In this attack, those with multiple unexplained, physical health symptoms outnumbered physically affected victims by a margin of 4 to 1. There is some literature to suggest that a more accurate estimate may be 4 to 20 psychological victims for every one physical casualty.⁸ It is also expected that during public health emergencies, such as a pandemic flu, individuals who may not have been exposed to the illness might believe they have and present for care.

Even common post-disaster physical reactions such as hyperarousal and intense anxiety may produce multiple somatic symptoms such as heart racing, shortness of breath, flushing in the face or neck, nausea, and headaches. Acutely traumatized, frightened individuals may easily attribute these physical sensations to exposure to chemical, biological, radiological, or nuclear agents following an act of terrorism or to exposure to a lethal disease in the event of a public health emergency.

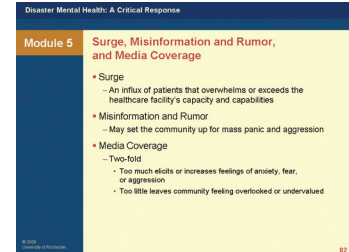
Healthcare facilities, and in particular disaster mental health professionals, must be prepared to respond to the emotional needs of those with *Medically Unexplained Physical Symptoms* (MUPS), more commonly known as the “worried well.” Healthcare professionals may be tempted to minimize their symptoms in light of the multiple demands placed on them by individuals with documented symptoms requiring

⁸ Warick, M.C. (2002). Psychological Effects of Weapons of Mass Destruction. *Missouri Medicine*. 99 (1), pp. 15–16.

urgent care. Unfortunately, if the needs of those with MUPS are not addressed, they will place considerable demands on the healthcare systems.

Surge

Surge, from a public health perspective, is an influx of patients to a healthcare facility that can or has the potential to overwhelm or exceed that facility's capabilities (human and material resources) to respond to the healthcare needs of those patients. These patients may be suffering from real or perceived physical health issues resulting from an act of terrorism or other potentially life threatening public health incident, such as influenza. While healthcare systems across the country have been focused on how to prepare for such events, their efforts have centered on such issues as increasing the amount of medical supplies, ventilators, and medications on hand. Few are prepared for the resulting psychological challenges these events will present. It is expected that emergency rooms, clinics, and even primary care offices will be overrun with individuals, some of whom are truly symptomatic, but most of whom believe they have been exposed to the agent or virus when in fact they have not. These individuals are also likely to present with their family members making an already crowded emergency room or doctor's office more crowded. Mental health and spiritual care professionals will be utilized to support these treatment areas and provide emotional and spiritual comfort to those with real or perceived illnesses.



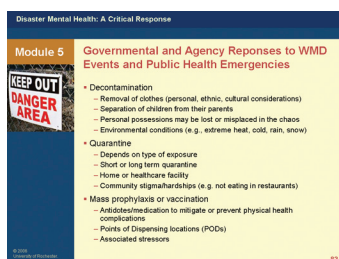
Misinformation and Rumors

In the chaos that follows a disaster, accurate information about both the disaster and the resources and services available to survivors is paramount in attending to the basic needs of these individuals. This information, given in a clear and concise manner, can greatly mitigate or alleviate reactions experienced by those impacted by a disaster. On the contrary, it is very common to hear about rumors that are not accurate making their way through a community or specific disaster population. This misinformation may set the community up to experience mass panic or aggression.

Media Coverage

Media coverage of an event, typically of large-scale disasters, may also elicit or increase feelings of anxiety, fear, or aggression in disaster survivors, their families, or the general community. It is common for people to want as much information as possible. Thus, they turn to the media to keep them informed. The media, especially televised media, tend to look for the stories that involve strong emotions or dramatic effects. Pictures of planes flying into buildings, terrorists holding hostages at gunpoint, and people walking into buildings dressed in protective clothing and gas masks leave lasting impressions on viewers, especially young children.

Continuous media coverage of a relatively localized event could lead to public fear in places that are far removed from the threat.⁹ There are situations, though, where lack of media coverage may leave a community feeling overlooked or undervalued. This often occurs when the media turns to the next “big story” leaving the previously affected community to pick up the pieces of what may be a long recovery process. These feelings may also be fueled by the simultaneous departure of rescue and recovery workers and disaster relief personnel who see their jobs as completed and now must return home to their day-to-day jobs and personal lives. More information on how mental health and spiritual care professionals can mitigate the reactions following dramatic media coverage of an event can be found in Module 7.



Governmental and Agency Responses to WMD Events and Public Health Emergencies

In the event that an act of terrorism involves a weapon of mass destruction, namely a biological, chemical, radiological, nuclear agent or explosive device, or upon the emergence of a public health situation or threat, the need to conduct activities to preserve the public health may be warranted. These activities might include decontamination activities, quarantine, or mass vaccination and prophylaxis. Depending upon the agent used or disease identified, there may be significant individual and public health implications. Wide spread anxiety and fear are likely to be felt by those directly exposed or presumed to be exposed. Public health officials may require individuals potentially exposed to a chemical or radiological agent to be decontaminated before being treated. Other agent or disease exposure may require populations to be quarantined in their homes, worksites, or special holding facilities, and/or given antidotes that can counter the resultant physical health effects from these agents or diseases.

Decontamination

Decontamination involves physically removing a lethal agent from the skin, clothes, and other potentially exposed areas. This is usually accomplished by washing the individual down with water or a special decontamination agent. The local fire department or Hazardous Materials (Haz-Mat) Team is usually responsible for the decontamination process. In most cases, individuals will be instructed to remove their clothing, jewelry, and other personal possessions before passing through a showering apparatus. In immediate situations, individuals may be hosed off with a regular garden hose or the hose from a fire truck. Depending on the nature of the incident and the surrounding resources, the decontamination process may present many of the following challenges for individuals that may have mental health implications:

⁹ *A Community Response to Managing Trauma in Times of Disaster and Terrorism*. (2004). Evans, G.D., Wiens, B.A. (Eds.). University of Florida, National Rural Behavioral Health Center.

- Individuals may be stripped of their clothing while others are watching (Notes: some religious faiths disallow individuals disrobing in front of others).
- Children may be separated from their parents or guardians as they go through the decontamination process.
- Personal possessions relinquished prior to decontamination may be lost, misplaced, or stolen in the chaos.
- Environmental conditions, such as extreme cold, may make the decontamination process extremely uncomfortable.

Individuals refusing to go through the decontamination process may be subject to law enforcement action depending on the public health risks.

Healthcare systems are also currently challenged to look at ways to identify individuals who may have been exposed to certain agents before those individuals actually enter their facility. Unfortunately, once that happens, the facility is deemed ‘contaminated’, which may in turn require the facility to close and divert care to other facilities in or outside the community.

Quarantine

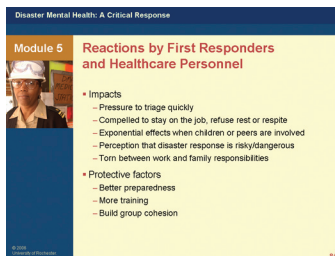
Exposure to particular biological or chemical agents or diseases may require isolation or quarantine to reduce the risk of spreading the disease to others. Isolation means to separate individuals known or potentially “infected” from those who are healthy. Quarantine is the mandatory restriction of potentially exposed individuals to a designated area. In the face of an immediate risk of exposure to a chemical agent, communities may be required to “shelter-in-place” to await the passing threat. Upon exposure or suspected exposure to other agents or disease, populations may be quarantined at home or in a healthcare facility, depending on the physical health status of those exposed or the public health risk to others. The need to establish quarantine conditions will result in high stress not only for those individuals intimately involved, but also for healthcare workers at the quarantine facility and for others in the general community as well. Those individuals quarantined may be highly stigmatized and the communities where they reside may experience significant economic hardships. As above, individuals refusing to abide by mandatory quarantine may be subject to law enforcement action, depending on the public health risks.

Mass Prophylaxis or Vaccination

Some disasters present significant public health risks to the larger community. These risks can result from exposure to biological agents such as anthrax, plague, smallpox, and other deadly pathogens or more common diseases such as influenza or the not so common *Severe Acute Respiratory Syndrome* (SARS). In the event of such a public health emergency, there may be a need to administer specific anti-dotes or medications that can prevent or mitigate the physical health complications associated with these agents or diseases.

Many local public health departments and healthcare facilities are preparing for such events by identifying locations where they might mass distribute medications or vaccinations to the community. These sites, known as *Points of Dispensing* locations (PODs) will be discussed more specifically in the next module.

As expected, the need to distribute mass medications or vaccinations can present both logistical and mental health challenges. Concerns about resulting short- and long-term health effects can typically be expected. These concerns may induce fear and anxiety in those who are believed to be infected and in those at lowest risk. Depending upon the location of the dispensing site, individuals may encounter long lines that are further complicated by extremes in temperature. The process of registering, disclosing one's health history, and completing the necessary paperwork can be tedious and frustrating as well. Further stress might be exhibited by those without obvious physical symptoms when standing in line with individuals who are perceived to be symptomatic. Inadequate supplies of medication can present significant community reactions, including panic and outrage. Disaster mental health and spiritual care professionals should be utilized as consultants when discussing and developing public health messaging around the need to open a POD.



Reactions by First Responders and Healthcare Personnel

Responding to acts of terrorism and public health emergencies can be particularly stressful for healthcare providers, emergency responders, and other disaster personnel. Typically, these events result in mass fatalities and injuries that exceed local personnel resources. There may be significant pressure to quickly triage and leave aside those who are severely injured so that critical resources can be preserved for those that have the best chance to live. In addition, disasters such as the Oklahoma City Bombing, the events of September 11, 2001, and the response to the SARS epidemic involved long and protracted rescue, recovery and treatment efforts lasting over the course of many hours and, in some cases, many days, or weeks. In the case of events involving mass casualties, emergency response and healthcare personnel involved feel compelled to stay on the job until the last survivor or body is found. They may dismiss or minimize their own physical and psychological needs and refuse any effort to provide a rest period or respite from their work. When children, family members, or their own colleagues and peers are the victims, the mental health effects on first responders and other personnel can be exponential.

Many times, acts of terrorism and public health emergencies can be risky and dangerous as well to first responders, disaster personnel, and healthcare workers. It may not be known initially that they are responding to a situation involving a weapon of mass destruction or that they are faced with an emerging public health emergency. Local responders and healthcare professionals might find themselves well into the rescue and recovery phase or treating individuals before the origin of the disaster and the presence of a deadly agent or disease

is identified. Given the huge physical and psychological ramifications that stem from these types of disasters, communities across the country are making further efforts to better prepare and train first responders and their healthcare counterparts—secondary receivers who are healthcare professionals in hospitals where victims are transported. As an example and to illustrate this issue, one may need only look at the most recent SARS outbreak in Canada. Most of those infected with SARS were healthcare workers who, in some cases, transmitted the disease to their family members. Healthcare workers treating colleagues and even family members and friends may be under extreme stress during these public health emergencies.

However, in some cases, better preparedness and more training may not be sufficient. Some recent research suggests that healthcare resources may be scarce in the immediate aftermath of WMD or public health disasters. Preliminary surveys conducted with healthcare professionals and emergency response personnel indicate a reluctance or refusal to show up or stay at work if they perceive that exposure to a lethal agent or disease is likely. That reluctance is exacerbated if there is no identifiable means to obtain an antidote or appropriate therapy for themselves or their family members.

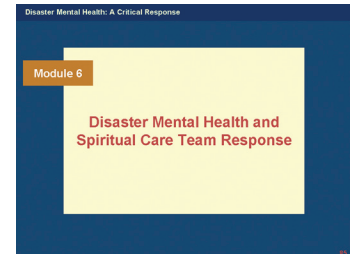
Disaster response workers and healthcare personnel also face significant personal and professional challenges in responding to these large-scale, catastrophic disasters. Many are caught between their dedication to help relieve the suffering of those affected by such events and the concern of their family members who may worry about the dangers their loved ones will encounter.

Module Summary

In this module, you have explored the specific challenges that you will face as a disaster mental health and spiritual care responder following acts of terrorism and public health emergencies. With the increasing attention given to preparing for these potentially catastrophic events, it is critical that healthcare facilities, their personnel, and other community responders work together to address and meet the potential mental health and spiritual care needs of those impacted.

Module 6

Disaster Mental Health and Spiritual Care Team Response



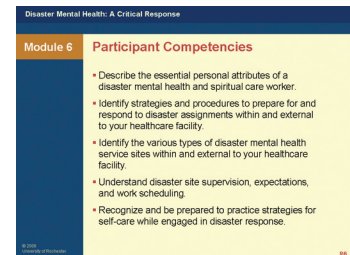
Module Overview

Throughout this course, there has been considerable emphasis on the stressors related to disaster assignments. Mental health and spiritual care professionals are not immune from these stressors. Working long hours in physically and emotionally challenging conditions will have an impact on you and those around you. Examining ahead of time your readiness to engage in this type of work and recognizing some of the personal attributes that contribute to a less frustrating experience can help prepare you for the demands of disaster response.

Participant Competencies

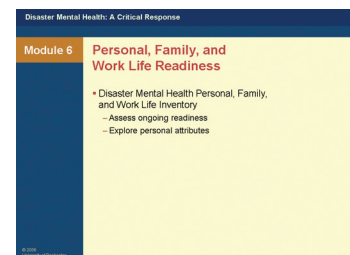
This module is particularly important to you because it will provide you with the personal details of the who, what, where, when, and why questions. When you have completed this module, you should be able to:

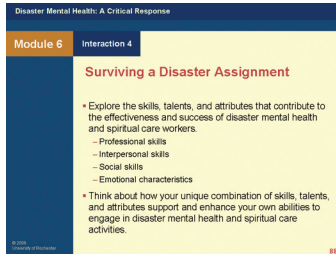
- Describe the essential personal attributes of a disaster mental health and spiritual care worker.
- Identify strategies and procedures to prepare for and respond to disaster assignments within and external to your healthcare facility.
- Identify the various types of disaster mental health service sites within and external to your healthcare facility.
- Understand disaster site supervision, expectations, and work scheduling.
- Recognize and be prepared to practice strategies for self-care while engaged in disaster response.



Personal, Family, and Work Life Readiness

Prior to attending this training program, you were provided with the *University of Rochester Disaster Mental Health Personal, Family, and Work Life Inventory*. This tool has encouraged you to consider the stressors associated with disaster mental health and spiritual care response and if you are fully prepared to engage in such work. This tool can and should be used in an ongoing way as one's readiness to respond can change at any time. In the event that you decide personal, family, or other commitments preclude you from being able to respond to a disaster, notify your supervisor. From an organizational preparedness perspective, it is critical to know what human resources can be relied on at any given time.





Personal Attributes: Surviving a Disaster Assignment

Some people are just naturally adept at responding in the midst of highly stressful environments with a sense of calmness and confidence. They are able to flex their time and attitude around meeting the demands of the job and require very little direction or oversight. Others find it more difficult to be spontaneous and work in environments without clear order and direction. Not knowing where they are going, how they are getting there, and what they will be confronted with when they arrive inflicts a certain amount of anxiety and personal discomfort. There are some basic personal attributes and skills which tend to contribute to having an overall positive disaster experience. Let us spend a few minutes to explore what these attributes and skills might be.

Interaction 4: Surviving a Disaster Assignment

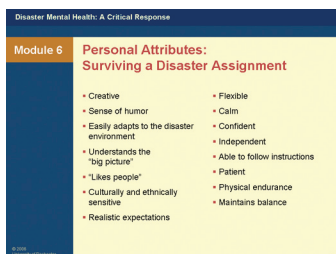
As a disaster mental health or spiritual care professional, you will have to consider the qualities and skills that you possess that will make you a more effective disaster worker. This interaction provides you with the opportunity to think about the attributes in a disaster worker that will enable that individual to perform effectively in providing early interventions to disaster survivors.

The circumstances of disasters vary from situation to situation. The same is true for individual responses to disaster; they vary as well. It is essential for disaster mental health and spiritual care providers to possess a variety of skill sets, behaviors, and personal characteristics. Take this opportunity to explore the attributes that are needed to support an effective disaster assignment. Consider the following categories:

1. Professional skills include your breadth of professional knowledge, experience in applying that knowledge, and effectiveness in getting results.
2. Interpersonal skills include your ability to interact with individuals one-on-one via the many channels of communication.
3. Social skills include your ability to work in socially complex environments with groups of individuals with diverse backgrounds.
4. Emotional characteristics include your ability to regulate your own emotions in challenging and stressful situations.

These are not necessarily discrete categories. The purpose of providing them is to get you thinking more specifically about the kinds of skills, attributes, qualities, and characteristics that a disaster mental health or spiritual care worker should possess in order to be effective in the context of a disaster assignment. In relation to these categories:

1. Explore the skills, talents, and attributes that contribute to the effectiveness and success of disaster mental health and spiritual care workers.
2. Think about how your unique combination of skills, talents, and attributes support and enhance your own abilities to engage in disaster mental health and spiritual care activities.



Hospital Disaster Mental Health and Spiritual Care Teams

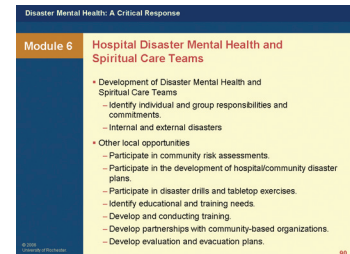
The New York State Department of Health is strongly encouraging that all hospitals prepare and train mental health and spiritual care personnel to respond to the mental health needs of the affected population in the aftermath of a disaster. Each healthcare facility around the state is encouraged to develop a disaster mental health and spiritual care team. This team can be utilized to respond to disasters affecting their facility or local community. Under some circumstances, healthcare facilities may also allow their teams or certain team members to respond to disasters outside their facility or community. Typically, this will occur upon invitation from the impacted community.

Many of you are participating in this training as a prerequisite to joining your hospital's Disaster Mental Health and Spiritual Care Team. Upon completing this course, please clarify with your Supervisor or Team Leader your responsibilities and commitment level pertaining to your response for both internal and external disasters.

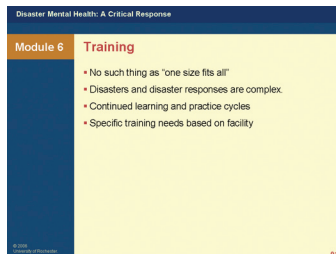
In addition to joining your hospital Disaster Mental Health and Spiritual Care Team, there may be other opportunities for you to participate in disaster mental health activities on a local level, especially from a hospital and county planning and preparedness perspective. These activities include:

- Participating in community and hospital risk assessments (identifying special needs populations).
- Participating in the development of hospital and community disaster plans.
- Participating in disaster drills and tabletop exercises.
- Identifying educational and training needs for mental health and spiritual care professionals as well as other hospital personnel.
- Developing and conducting training that meets these training needs.
- Developing partnerships with community-based organizations that can provide important services during times of disaster.
- Developing evaluation and evacuation plans for all components of a disaster mental health and spiritual care response.

As we mentioned earlier, a sophisticated mental health plan is the first key to addressing and mitigating the potential psychological, psychosocial, and psychospiritual consequences following disaster. Of equal or greater importance is the availability and deployment of human resources to respond to the disaster needs of an impacted community. These resources need to be highly trained and oriented to the experiences they will encounter during a disaster response and specifically trained in skill sets related to meeting the needs of those impacted by disaster. Sometimes the community response to disaster results in what is called the second disaster where the response has resulted in not meeting the perceived or expected needs of a community.



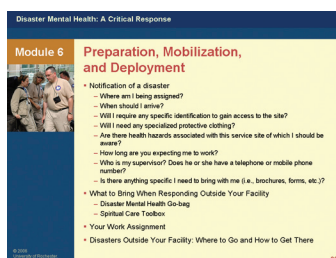
The risk of invoking a second disaster is more likely in communities where advance planning and preparedness is not a priority and disaster responders have not been adequately trained in disaster response at both the macro- and micro-levels.



Training

Your participation in this training may be the first step in your preparation as a disaster mental health or spiritual care responder. It is critically important to remember that neither this training nor others you have received in the past or will receive in the future prepare you for every situation or experience you will encounter. There is no such thing as a “one size fits all” training curriculum. Disasters and disaster response are complex phenomenon. Your success as a disaster responder and your facility’s success in being able to respond to the needs of disaster victims and their families are contingent upon a continued learning and practicing cycle. The more you learn and take opportunities to drill and enhance your plans, procedures, and support skills, the more likely it is that you will be an effective disaster worker.

While there are certain services and functions that all healthcare facilities must perform in the event of a disaster, the initiation and application of these services and functions will be unique to your specific hospital, community, or disaster situation. Specific trainings will need to be developed and implemented to better prepare you and your disaster response colleagues for the roles you will take on during a disaster and the mechanisms for how you and your team will respond and engage in such work. The following are general guidelines and instructions for how you and your team will provide disaster mental health and spiritual care services either in a health-care facility or in the general community.



Preparation, Mobilization, and Deployment

In the pre-training materials you were encouraged to put together your own personal disaster plan. This plan addresses any personal, family, or other commitments that may preclude you from participating on your hospital’s disaster mental health team or may compromise your ability to respond in a timely manner. In some cases, you may be asked to respond immediately to a disaster. Under other circumstances, you may have some advance notice, but not much (24 hours). Negotiating in advance how you will resolve any personal, family, and other matters will ensure a timely response when necessary.

Notification of a Disaster

Your hospital’s emergency preparedness director, your department, and your supervisor should have a plan for how you will be contacted in the event of a disaster. Typically, when disaster strikes your community and it is serious enough to require the coordination of multiple relief services, including the activation of your healthcare system, your county’s disaster plan and disaster mental health plan will be engaged as we discussed in Module 2. At that time, your healthcare

facility will engage its own disaster plan and prepare its personnel for incoming victims of disaster, their family members, and others from the community. Your hospital's disaster preparedness director, department supervisor, or disaster mental health and spiritual care team supervisor will contact you to request your availability and inform you of where to report for duty. In most cases, you will be asked to report to a volunteer staging area for registration and assignment to a specific service site.

In the event that you are not being sent to a pre-assignment staging site and are being deployed directly to the Emergency Department or other hospital service site, you might want to ask the following questions.

- Where am I being assigned and when should I arrive?
- Will I require any specific identification to gain access to the site?
- Will I need any specialized protective clothing?
- Are there health hazards associated with this service site of which I should be aware?
- How long are you expecting me to work (i.e., shift, number of days)?
- Who is my supervisor? Does he or she have a telephone or mobile phone number?
- Is there anything specific I need to bring with me (i.e., brochures, forms, etc.)?

If you are assigned to a staging area, you will be given an orientation to the circumstances of the disaster and many of these questions and issues will be addressed and answered. This may not always happen in the immediate aftermath of disaster however, your flexibility to respond without knowing this information is essential.

What to Bring When Responding Outside Your Facility

It is also important that you have any personal items or professional supplies prepared ahead of time. Having a Go-bag packed and/or a Spiritual Care Toolbox assembled ensure that you have not forgotten important items that invariably are left behind in the chaos of responding to a disaster assignment. Refer to **Appendix B: Additional Information and Checklists** on page B-19 and B-20 for more information on preparing your **Disaster Mental Health Go-bag** or **Spiritual Care Toolbox**.

Depending upon the location of your assignment and the circumstances of the disaster, there may be a number of personal items you may wish to bring in addition to the items you prepared ahead of time in your disaster Go-bag. These items may differ depending upon whether or not you will be assigned to a service site within your facility, in your local community, or other part of the region or state. For example, if you are assigned away from your home community, having sufficient clothing, medication, and other supplies will be essential.

Your Work Assignment

Once you arrive at your work site be sure to check in with the site supervisor and receive any specific instructions for your work assignment. Depending upon the nature of the disaster and your facility's or county's response, you may be assigned to more than one work site. In the case of a prolonged disaster, you may receive a different assignment each day.

Disasters Outside Your Facility: Where to Go and How to Get There

Depending upon the situation, you and your team members may be requested to respond to a disaster service site outside your facility. Under those circumstances, there are some important details you should consider. You may be asked to use your own transportation or car-pool with another disaster responder to a central staging area where all disaster relief volunteers are registered and provided with the appropriate credentials. It is here that you may also be assigned to your service site. Depending upon the nature of the disaster and who is coordinating the disaster personnel response, the registration process may be lengthy. In all likelihood, it will include identifying your emergency contact information and assessing your physical health status, which will influence where you are assigned. You should also be prepared to have some pertinent information on hand for the registration process. This would include having a copy of your professional license, your driver's license, next of kin contact information, and healthcare insurance information.

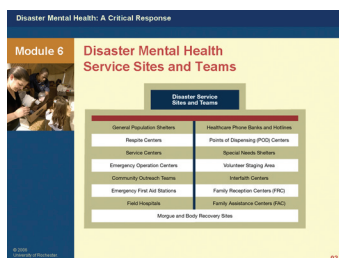
In the early stages of a disaster relief operation, this staging area may seem chaotic and disorganized. It is usually at this phase that various disaster relief personnel are being contacted and deployed and initial reports on the extent of damage and possible needs for various services are being identified and coordinated.

Coping with what may be a chaotic and seemingly disorganized process calls for extreme patience and flexibility. In fact, you may spend the better part of a day or a significant number of hours in this staging area just preparing to be assigned to a service site. Your ability to tolerate this environment may be the first test of how you will succeed in your newfound position as a disaster mental health or spiritual care professional.

Once you have completed the registration process, you will be assigned to a service site by a disaster mental health supervisor.

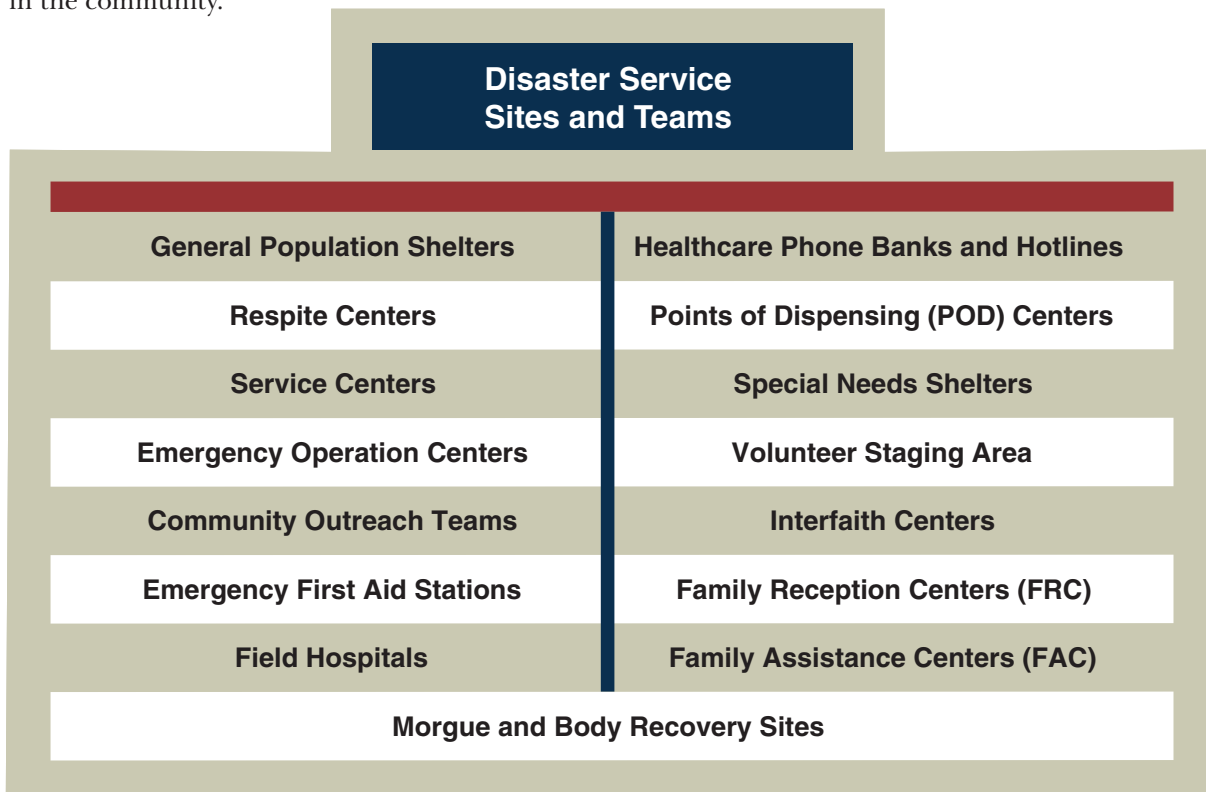
Disaster Service Sites and Teams

Providing disaster mental health and spiritual care services typically involves fieldwork. You may not have the option of meeting with people in a quiet, private location. Often your interactions may involve comforting someone in a large, noisy room, outside in a parking lot, or in line as individuals wait for disaster-related services.



In the aftermath of a disaster, hospital administration, county officials or other community leaders will identify the various locations for disaster relief services. These sites will often evolve over the course of the immediate disaster response. They will be located based upon the needs of the affected population or be placed where disaster survivors and responders congregate. It is important for you to understand that you will be assigned to a service site where you are needed most. While you may have a preference for one site over another, the response needs will require you to be flexible. Survivors and relief personnel are equally important in our response to providing mental health and spiritual care.

Let us consider some of the sites and teams where you may be deployed. Some of these sites can be set up both within a facility and in the community.



General Population Shelters

When it is determined that a community or area of the community must be evacuated because of dangerous or threatening conditions, *General Population Shelters* are opened for the temporary housing of individuals. General Population Shelters are usually located in schools, community and recreation centers, or in other large facilities. Shelters usually have limited space for people to sleep and eat as well as an area for meals to be served.

Figure 6–1:
Disaster Service Sites and Teams

Respite Centers

Respite Centers are locations where first responders can rest and obtain food and clothing and other basic support services. The decision to open a Respite Center is usually determined by evidence that prolonged rescue and recovery efforts are necessary. Respite Centers are usually located in close proximity to the direct impact of a disaster.

Service Centers

Service Centers may be opened by a local or federal governmental agency or by disaster relief organizations to meet the initial needs of disaster survivors. These centers typically offer assistance with locating temporary housing or providing for the immediate personal needs of disaster survivors such as food, clothing, and clean-up materials.

Emergency Operation Centers

On-going mental health support services may also be requested at the county's *Emergency Operation Center* (EOC). In the aftermath of a large-scale disaster, the EOC is a chaotic and stressful environment as county and other organizational disaster planners and managers are preparing the disaster relief response.

Community Outreach Teams

Community Outreach Teams are usually established in the event of disasters that affect a large geographic area and/or a significant percentage of the population. These teams are often necessary to avoid long lines at Service Centers or when transportation services for the general population are limited. The teams are usually comprised of two or more individuals that can provide comprehensive services to disaster survivors. For example, a disaster mental health or spiritual care professional may be teamed up with a representative from the American Red Cross who can provide assistance in meeting the survivors' food, clothing, and shelter needs.

Emergency First Aid Stations

Emergency First Aid Stations provide basic medical services to disaster survivors as well as responders who may suffer minor injuries in the rescue and recovery efforts following a disaster. They are usually located in close proximity to the direct impact of a disaster. In the event of a disaster resulting in mass casualties, makeshift emergency first aid stations may be set up in close proximity of your healthcare facility in an effort to relieve the burden on emergency room services and ensure that such high-level care is available to the seriously injured.

Field Hospitals

A field hospital may be set up by a local, state, or federal public health authority in the event of a mass casualty incident or those incidents that result in an increase in a surge of patients to local healthcare facilities, such as in the event of a pandemic. Federal personnel may be deployed to these sites to supplement the affected community's healthcare resources. Mental health and spiritual care professionals may also be deployed to a field hospital to address the mental health and spiritual needs of patients, their families, or workers.

Morgue and Body Recovery Sites

In the event of a disaster resulting in mass fatalities, a separate area, or multiple areas, may be established by the local medical examiner to hold and identify the deceased. Mental health and spiritual care professionals may be deployed to these sites to support “body handlers,” law enforcement staff, and other professionals responsible for attending to the deceased. At times, mental health and spiritual care professionals may be called upon to support family members and others who spontaneously present to these sites or who arrive there for the identification process.

Phone Banks and Hotlines

Communities and healthcare systems may wish to set up a *Phone Bank* to address and respond to numerous calls with questions that typically arise after a disaster. These Phone Banks are likely to be overwhelmed in the first few hours or days with many questions or concerns regarding such issues as locating missing or injured family members or healthcare concerns or issues. Community hotlines may encounter similar questions and address additional information such as the availability of shelter locations, mass food distribution sites, and other disaster relief services.

Points of Dispensing (POD) Centers

As described previously in Module 5, *PODs* might be established by local, state, or federal public health agencies in the event of a public health emergency. These centers may be established to provide mass distribution of medications or vaccinations in an effort to prevent or mitigate the spread of any communicable disease or other public health risk. Healthcare facilities may also open *PODs* with the goal of vaccinating or distributing necessary medications to its own personnel or to reduce the burden on the community *POD* sites.

Special Needs Shelters

Special Needs Shelters are typically set up for populations that require special attention due to their physical health needs and when these needs cannot be accommodated in a general population shelter. Under most circumstances, special needs shelters are opened by the local public health entity. Mental health and spiritual care professionals may be assigned to such shelters to assist shelter residents and staff in meeting their mental health and spiritual care needs.

Volunteer Staging Area

In the event of large-scale disasters requiring significant volunteer resources, a *Volunteer Staging Area* may be established by a particular disaster relief agency, by a local, state, or federal government agency, or by a healthcare system for its own personnel. Typically, activities in the Volunteer Staging Area include the registering of volunteers for duty and the credentialing of those involved in duties requiring specific skill sets such as mental health or health services.

Interfaith Centers

A separate interfaith center may be established within a hospital or in the community to provide family members and others with a quiet and serene setting for prayer, meditation, or other reflective practices. Spiritual care professionals may be assigned to such settings to provide support and comfort for those who use this center or to conduct services for members of various faith traditions. Approved spiritual resources may be made available at these centers for those of various faith traditions.

Family Reception Centers (FRC)

Family Reception Centers are typically opened in the immediate aftermath of a disaster involving mass casualties or fatalities. There is a common recognition that after such disasters individuals may be trying to locate family or other loved ones specifically involved in the disaster or separated during the evacuation process. Often these are temporary holding sites until a more structured and operational Family Assistance Center can be opened. Family Reception Centers may be established in close proximity to the immediate disaster scene where individuals arrive in search of family and other loved ones involved in the incident or in healthcare facilities where the injured have been transported.

Family Assistance Centers (FAC)

Family Assistance Centers are commonly opened in the event of a disaster involving mass casualties or fatalities. These centers usually offer a range of services in an effort to meet the needs of individuals affected by the disaster. These services include mental health and spiritual care, crime victims and law enforcement services, and catering services. Additional space for coroner/medical examiner staff, disaster relief agencies, and other local, state, and federal agencies will also be necessary. Family Assistance Centers are usually located away from the immediate disaster site. It is important to note, however, that many times family members will request visits or wish to conduct memorial services close to the affected site. For these reasons, the FAC should be close enough to facilitate those activities.

Setting Up a Family Reception Center

As mentioned earlier, in the event of a disaster involving mass casualties or fatalities, or under circumstances of a public health emergency, it is extremely likely that your healthcare facility will need to open a Family Reception Center. In the aftermath of disaster, families of disaster victims will search for their loved ones in local hospitals, especially if they believe they were transported to such facilities or if the families were not able to gain access to the disaster scene. Opening hospital-based family reception centers is critical to preventing emergency rooms from becoming overwhelmed with family members while still allowing them to be in close proximity to their loved ones.

Great care should be taken in designing the layout of the Family Reception Center and choosing the appropriately trained personnel to staff the center. Family Reception Centers can be extremely chaotic and stressful environments, especially in the early aftermath of disaster. Pre-planning the opening and operation of this center is critical to preserving the mental health and well-being of the families of disaster victims and the personnel working in the center. Here are some important issues to consider when preparing and opening a Family Reception Center.

- Identify an area that is sufficiently large enough (or expandable) to accommodate the number of expected families. Depending upon the culture or ethnicity of the affected population, there may be 6 to 10 family members per victim who arrive at the FRC. The FRC should be within relatively close proximity without compromising direct care to disaster victims and should also be accessible to those with disabilities.
- Ensure the availability of audio equipment sufficient for large spaces so that general announcements or special messaging can be heard by all occupants.
- Ensure the adequate availability of phones, restrooms, seating, and other items based upon the number of expected FRC occupants.
- Ensure adequate security personnel are available to contain the flow and safety of the FRC, but more importantly to keep those not affiliated with the families away from the center (e.g., media, general community). An identification system for family members and other loved ones should be instituted to ensure a secure flow into and out of the center.
- Identify a private area, away from the general milieu, where family members can go for respite or receive medical updates on their loved ones.
- Identify an area (chapel, quiet area) where families and responders can go to observe spiritual practices such as prayer and meditation.
- Identify a safe area for children, either within or in very close proximity to the FRC. Security procedures should be developed to ensure that children are released from the play area only to authorized adults.

Disaster Mental Health: A Critical Response	
Module 6	Setting Up a Family Reception Center (FRC)
	<ul style="list-style-type: none">• Identify an area that is large enough (6-10 family members per survivor).• Ensure availability of audio equipment, phones, restrooms, comfortable seating, etc.• Ensure adequate security personnel.• Identify a private area away from media.• Identify a private area for spiritual practices.• Identify a safe area for children.• Identify an area for food/beverage service.• Ensure the quick availability of medical personnel, interpreters and translators.• Identify a separate area for staff.

- Identify an area within the FRC for canteen or catering services. In addition to periodic hot meals, beverages and snacks should be available at all times.
- Ensure the quick availability of medical personnel in the event of a medical emergency.
- Ensure the availability of interpreters and translators for the deaf and hearing impaired or for those whose primary language is not English.
- Identify a separate area where FRC personnel can take breaks, rest, or eat.

Use the following illustration to help guide you in setting up a Family Reception Center.

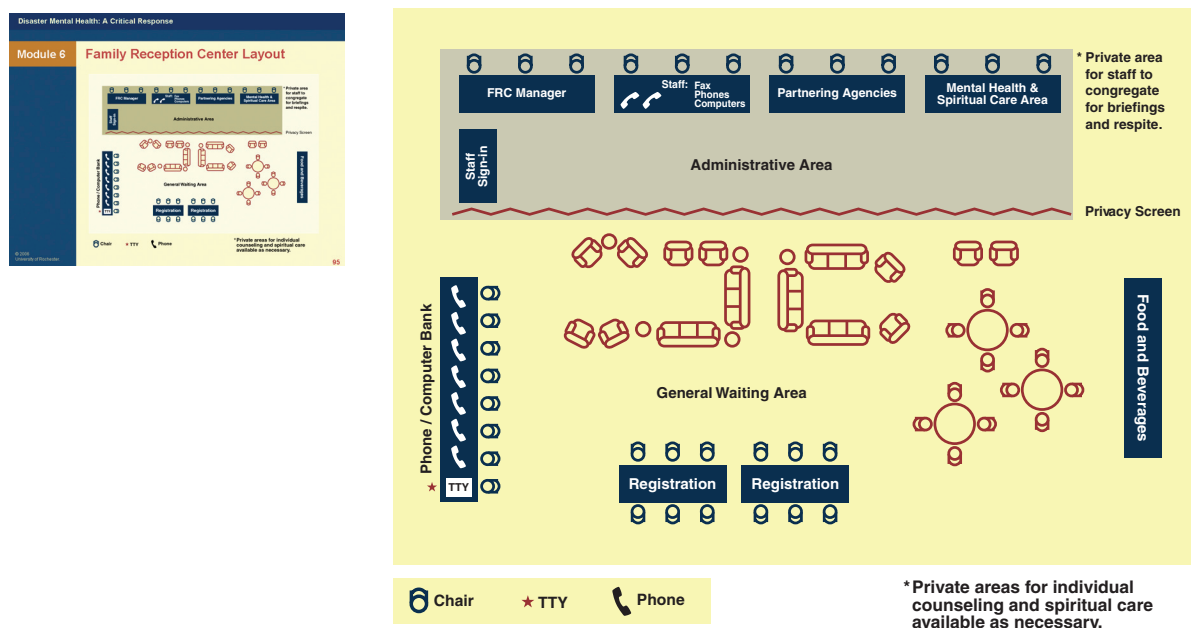
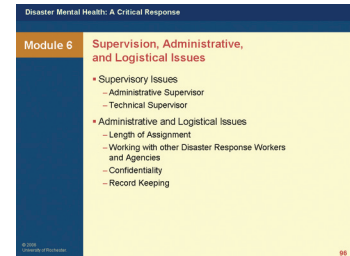


Figure 6-2: Family Reception Center Layout

It should also be noted that at times family and other loved ones will not be able to travel to or be present at a Family Reception Center. In such cases, provisions must be made to provide consistent and updated information to individuals, wherever they may be. Domestic partners and close friends of a disaster survivor may also request to be present in a FRC. While traditionally, healthcare information and next-of-kin death notification might be withheld and protected from such individuals; healthcare facilities should be prepared to address these circumstances with flexibility and compassion.

Your Supervision

Depending upon where you are assigned, you are likely to have a supervisor. In fact, you may have more than one supervisor. The level of supervision within a disaster service site may vary depending on the size and magnitude of the disaster and the individual characteristics of that supervisor. Keep in mind that service delivery sites can be extremely chaotic, especially in the early aftermath of disaster. It is often assumed and even expected that mental health and spiritual care professionals called upon in disaster will be self-motivated and able to work independently with minimal supervision.



Administrative Supervisor

Some sites will have an *Administrative Supervisor*. The Administrative Supervisor, also known as a *Site Supervisor*, will be that individual who is ultimately in charge of the service site where you are assigned. It is likely that this individual will not be a mental health or spiritual care professional, but you will still be required to take direction from this person and respond to his or her requests. In the event that you are not able to effectively work with your Administrative Supervisor, please see your Technical Supervisor.

Technical Supervisor

Your *Technical Supervisor*, a mental health or spiritual care professional, will be the person who oversees your provision of *mental health or spiritual care services*. It is important to remember that this person may or may not have more clinical, pastoral, or disaster-related experience than you have. It is equally important that you follow the direction of your Technical Supervisor. If you are not able to effectively work or communicate with your Technical Supervisor, identify and contact the person in the organization's structure that he or she reports to. Your Technical Supervisor may or may not be located in the site in which you are assigned. When you are assigned to a work site, please be sure to ask who your Technical Supervisor will be for that assignment. If this person is not on-site, ask how you can contact him or her if needed.

Administrative and Logistical Issues

In Module 7, you will explore the range of disaster mental health and spiritual care interventions available to you in working with disaster survivors and responders in the initial aftermath of disaster. Two areas of immediate concern include the length of time you are expected to perform your duties and your team assignment.

Length of Assignment

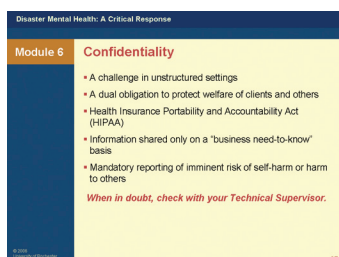
Depending upon the size, scope, and magnitude of disaster, the disaster response and recovery may last hours, days or, in some cases, months. Your assignment length will be predetermined between you and your facility's team leader. Again, you will need to consider personal and family responsibilities when negotiating your assignment.

Working with Other Disaster Response Workers and Agencies

Whether you are assigned to a service site within your facility or one in the community, you may likely be working with other relief agencies and personnel.

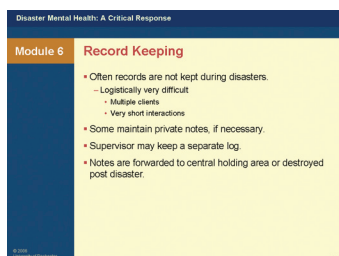
During the initial phases of disaster response these agencies may request or be invited to be present in the various service sites set up around the community or within your hospital. The coordination of these agencies and services may vary from community to community. Disaster-prone communities with a history of collaborative disaster response, resulting in clear sets of agency roles and responsibilities, may be more organized than communities who have not experienced disasters. In the early aftermath of a large-scale disaster, it is crucial to remember that there is usually sufficient work for all involved and no one agency can and should have the sole responsibility for meeting all survivor needs.

Effective collaboration can significantly enhance the mental health outcomes of a particular community. Identifying the opportunities, roles, and responsibilities for all disaster response organizations before disaster strikes will significantly reduce or mitigate those challenges that present themselves when multiple agencies show up to provide disaster relief.



Confidentiality

Maintaining the confidentiality of those with whom you work with in disaster settings can be a challenge given the lack of privacy and other extenuating factors. Even so, we are obligated to adhere to the highest level of confidentiality to protect those with whom we interact. Information should be released only on a “business need to know” basis. As licensed or certified mental health professionals, you should already be aware of the mandated reporting laws for New York State and should abide by those laws. As spiritual care providers, you also have similar ethical and legal standards to uphold. It is important to be aware of the **Health Insurance Portability and Accountability Act (HIPAA)**, though in some cases of disaster, compliance with this legislation is somewhat relaxed. If you have questions concerning the release of information on someone with whom you are working, please discuss the information release requirements with your Technical Supervisor.



Record Keeping

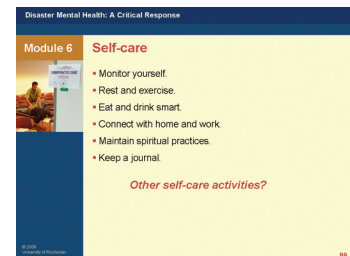
Typically, you will not be charting your interactions with disaster survivors, their families, or relief personnel. The logistics for tracking the numbers of individuals you will see and the non-traditional ways you will intervene with them precludes disaster mental health and spiritual care professionals from maintaining a client case record. It is also unreasonable to think that you could maintain clinical or contact notes on individuals especially since you may be interacting with hundreds of survivors or relief workers over the course of your assignment. It is also important to remember that you are not

engaged in long-term therapy with these individuals; therefore, your interactions with most of them will be of a short-term, supportive nature. However, please confirm if there are any record or note-taking requirements with your Technical Supervisor prior to arriving at your assignment.

There may be situations in which you may want to keep private notes on individuals. In the instance where someone has been identified as being of imminent risk to himself/herself or others and requires referral for a more extensive psychiatric intervention, you may want to note the circumstances and actions taken around this situation. This note can be maintained in a separate notebook kept by your Technical Supervisor. Most notes will be destroyed or forwarded to a central holding area following the closure of the disaster relief operation.

Self-care

Self-care is important on all disaster assignments. However, it is especially important when the assignments last a week or more or involve severely stressful situations, such as mass fatality incidents. Many of the tips and suggestions we will discuss relate to long and protracted disaster assignments. Even so, you need to know how to take care of yourself no matter how long your assignment as a disaster mental health or spiritual care worker lasts.



Monitor Yourself

There are three “occupational hazards” common to disaster workers: burnout (working too hard and too long); compassion fatigue (overextending one’s capacity for selflessness); and vicarious traumatization (experiencing trauma reactions due to empathizing with trauma victims). All helpers working with trauma victims are susceptible to these reactions. The most important strategy to use while on disaster assignment is that of self-monitoring. Pay attention to your own reactions.

- Are you more upset than usual when hearing a survivor’s story?
- Are you identifying too closely with the survivors?
- When you hug someone is it more for your benefit than for his or hers?

You can expect to be emotionally impacted by the work that you are doing. However, you should also be aware of when that emotional impact is impairing your ability to stay focused and express compassion.

Your colleagues will be your most useful support system while on assignment. Usually people pair up when they arrive at a disaster; however, this does not happen naturally. Make efforts to find other mental health or spiritual care professionals with whom you can spend time. Often sharing meals together is one of the best ways you can engage in self-care. This time gives you a chance to share what your day was like, what challenges you faced, and what went well.

It helps to hear what others are doing to give you a benchmark on your own functioning. Your colleagues also may be the first to notice when you are beginning to suffer from compassion fatigue (See Module 8). Pay attention to them! Also, keep in mind that when you talk about your work among yourselves, you need to be sure to maintain the confidentiality of those whom you interacted with as you would in any professional situation.

Rest and Exercise

Just as you advise others that you counsel to pay attention to basic self-care, you need to model it yourself. It is often difficult to get enough sleep, and you may need to function on less than your particular optimum. So take advantage of every opportunity to rest that you can find. In addition, you may find that you are not able to engage in your normal exercise routine (if you have one!). Find ways to introduce exercise into your day. It will significantly enhance your mental and spiritual health. Exercise will not only help relieve stress, it will give you a few minutes to think and clear your mind. Know where you hold stress in your body and give those areas extra attention. For example, slow deliberate stretches engage muscles and help relax the nervous system.

Eat and Drink Smart

Pay attention to your diet. Food and beverage choices often are limited in disaster situations. The more you can eat a healthy diet—lots of fresh fruits and vegetables—the better you will feel. Use moderation when eating food or drinking beverages containing caffeine products, sugar or alcohol. If you have any food restrictions, let your supervisor know and take whatever steps are necessary to make sure you have the nutrition you need.

Connect with Home and Work

Depending upon the length of your disaster response, you may want to call home or work frequently. Even if it is just a two-minute phone call, it is important to be in contact with your loved ones and colleagues at work to let them know you are okay and that you are thinking of them. Remember that there is another world that you belong to and to which you will be returning.

Maintain Spiritual Practices

If you have a spiritual practice, give yourself time to engage in it. A few minutes of meditation or prayer each morning or evening will also help you to maintain emotional balance. If you would like to attend twelve-step meetings or weekly faith services while you are on assignment, you should let your supervisor know that you need transportation and the time to attend these meetings or services.

Keep a Journal

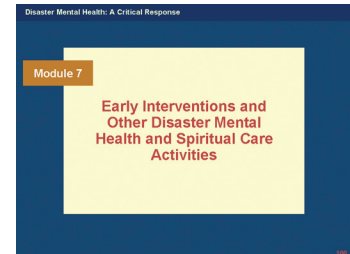
Many people maintain a journal during disaster assignments. Reflecting on the activities and thoughts you documented often leads to a sense of accomplishment and fulfillment in the work you are doing. It also helps to vent those emotional reactions that may not be appropriate to express in public.

Module Summary

Now take some time to consider what you have just reviewed in this module. You have looked at many of the attributes and skills that are important for disaster mental health and spiritual care workers and some of the logistical issues and questions you may have concerning your role as a disaster responder. In addition, you have also reviewed a range of potential services sites where you may be assigned during times of disaster as well as ways to maintain good self-care while you are on assignment.

Module 7

Early Interventions and Other Disaster Mental Health and Spiritual Care Activities



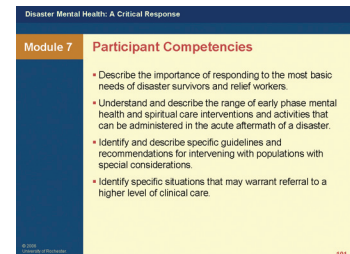
Module Overview

In the previous module, you explored some of the more practical questions and issues about being a disaster mental health and spiritual care worker. In this module, you will examine the range of interventions and activities that you can use to support disaster survivors and responders during a crisis or relief operation. We will also review some of the practical reminders that are important when working with populations of special consideration. At the end of this module, you will be able to practice some of these interventions and skill sets.

Participant Competencies

When you have completed this module, you will be able to:

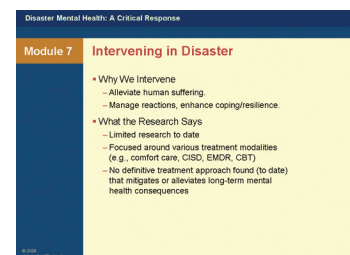
- Describe the importance of responding to the most basic needs of disaster survivors and relief workers.
- Understand and describe the range of early phase mental health and spiritual care interventions and activities that can be administered in the acute aftermath of a disaster.
- Identify and describe specific guidelines and recommendations for intervening with populations with special considerations.
- Identify specific situations that may warrant referral to a higher level of clinical care.



Intervening in Disaster

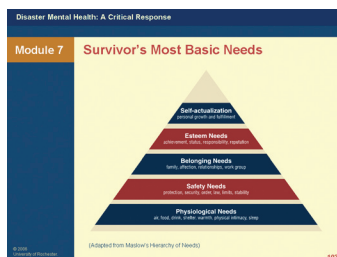
In Module 4, you learned that most individuals who experience a disaster will not develop significant psychopathology. Yet there is evidence to suggest these individuals will experience a wide range of distressing reactions. The purpose of implementing mental health and spiritual care interventions in the early aftermath of a disaster is to focus on the reduction or alleviation of human suffering. Early mental health interventions have long been considered the conduit to helping people through these traumatic experiences.

Current disaster mental health research, although limited in its scope, has explored various interventions used in the immediate, intermediate, and long-term phases of disaster response and recovery. With the growth of the disaster mental health field, considerable



controversy has arisen as to how, when, and with whom these interventions should take place. For example, psychological debriefing, especially *Critical Incident Stress Debriefing (CISD)*, had long been the preferred intervention for first responders exposed to a traumatic event. Research findings in CISD and psychological debriefing have significantly pointed to concerns about the efficacy and purpose of these interventions. Further, many experts in the field have issued a message of caution in its use and have called for raising the priority of further research in this area. We will talk more about this later in this module.

What can be said with certainty is that there is no research to date that clearly and definitively points to one recommended acute treatment intervention for survivors and response personnel who are impacted by a disaster. Instead, there are a number of studies, which have looked at various forms of treatment, and interventions that experts in the field believe show promising results and others that have shown potentially harmful or, at best, no positive benefits at all. In this module, you will explore those early phase interventions that appear to have the most support from the field and specific guidelines for intervening with special populations. You may also refer to the document, *Key Components of Early Intervention*, in *Appendix B: Additional Information and Checklists* on page B-21.



Meeting a Survivor's or Worker's Most Basic Needs

Many disasters leave those in their path stunned, frightened, anxious, and feeling overwhelmed. Some become frustrated, angry, and exasperated with the ensuing recovery process. For those who have been displaced from their homes, have been injured or become ill, or who have lost family members in the disaster, the psychological and psychospiritual aftermath of a disaster can be exponentially devastating. No matter what one has experienced, most survivors appear to have, at least initially, similar needs and expectations that are consistent with what is more commonly known as Maslow's Hierarchy of Needs.

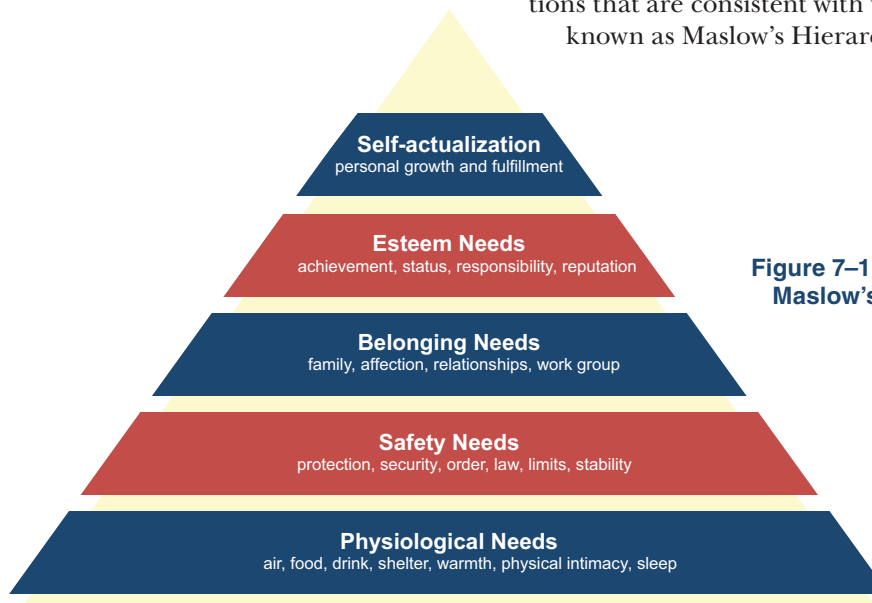


Figure 7-1:
Maslow's Hierarchy of Needs

These needs include:

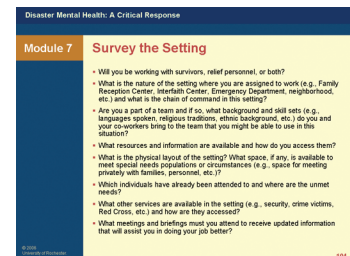
- **Physiological Needs:** These include basic needs such as air, water, food, sleep, etc. If these needs are not satisfied, they may feel physical illness, discomfort, and pain, which will then motivate them to alleviate these feelings to establish homeostasis or psychological balance.
- **Safety Needs:** These include the desire, in a chaotic environment, to establish consistency and stability in a safe environment with the security of a home and family, structure, order, and limits.
- **Belonging Needs:** These include the desire to belong, to be accepted, and to have a sense of community. This is also known as “social connectedness.”
- **Esteem Needs:** These include the need to experience competence or mastery of a task and the need for recognition and attention of others.
- **Self-Actualization:** This is the desire to become everything that one is capable of becoming.

Our role as mental health and spiritual care professionals is to assist and support individuals towards achieving these needs. We help survivors with their most basic needs first and move up Maslow’s Hierarchy. Only when basic needs are met and there is a clinical need or desire from the individual, do we attempt to implement more intensive psychiatric or spiritual intervention.

Survey the Setting

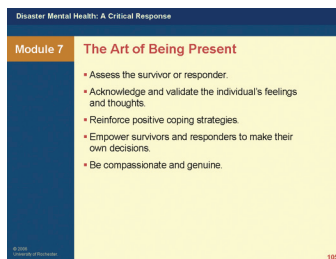
How you intervene can depend on “when” in the disaster response you arrive. The phases discussed in Module 4 suggest that emotional reactions and particular needs may be different during the impact phase compared with those in the recovery phase (e.g., the need for shelter in the early phase). How you interact with survivors and responders and the context in which you do so will be somewhat dependent on your assigned setting. In the last module, we introduced you to some of these settings. Upon your arrival, you will need to survey the setting to understand the particular nuances and dynamics of that setting. The following are some of the questions you need to consider.

- Will you be working with survivors, relief personnel, or both?
- What is the nature of the setting where you are assigned to work (e.g., Family Reception Center, Interfaith Center, Emergency Department, neighborhood, etc.) and what is the chain of command in this setting?
- Are you a part of a team and if so, what background and skill sets (e.g., languages spoken, religious traditions, ethnic background, etc.) do you and your co-workers bring to the team that you might be able to use in this situation?
- What resources and information are available and how do you access them?



- What is the physical layout of the setting? What space, if any, is available to meet special needs populations or circumstances (e.g., space for meeting privately with families, personnel, etc.)?
- Which individuals have already been attended to and where are the unmet needs?
- What other services are available in the setting (e.g., security, crime victims, Red Cross, etc.) and how are they accessed?
- What meetings and briefings must you attend to receive updated information that will assist you in doing your job better?

Your assigned setting, in some manner, will dictate your approach.



The Art of Being Present

Most disaster survivors and relief personnel respond favorably to a warm and compassionate manner. They will find great comfort in someone that is approachable and willing to help them through their experiences. Most often, it is not what you do but how you do it that counts. If you take a hard-core “I need to diagnose your problem” approach, chances are you will not be successful in getting people to engage with you. Conversely, if you take the opposite approach and just sit there waiting for someone to come up to you or to be told what to do, the chances are the same that no one will seek you out. Mental health and spiritual care professionals are most successful when they can “blend” into the setting and accomplish their work in a minimally intrusive manner.

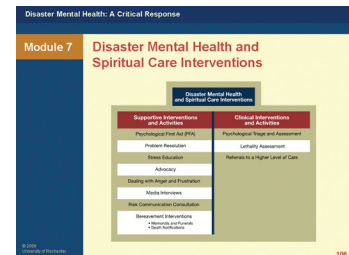
Being able to do so involves a certain amount of flexibility in the disaster mental health and spiritual care worker. You most certainly will not have an office within which to conduct your intervention. Instead, you may have to find a quiet spot under a tree, in a car, or in the corner of a shelter. Remember that providing mental health and spiritual care interventions on a disaster relief operation can be very different from what you do on a day-to-day basis for your job. Do not attempt to superimpose your daily clinical structure or format onto the disaster setting.

Once you have engaged with the survivor or responder, you need to assess the level of intervention that is warranted and appropriate. Most of us by now have learned how to conduct a thorough assessment in clinical settings of our clients. Based upon that evaluation, we typically form a comprehensive treatment plan. Many times this assessment is completed and the plan is implemented over a number of sessions. In disaster relief settings, that level of assessment, planning, and treatment is just not feasible or practical, and is often not necessary. Disaster mental health and spiritual care workers must have the skill and capability to rapidly assess a disaster survivor or responder and recognize if that individual is experiencing common or anticipated stress reactions or if that individual’s symptoms indicate more significant psychopathology. In many disaster situations, you may only have brief interactions with an individual before having to move on to the next person. Disaster mental health, by nature, is intended to be short-term, solution-focused, and targeted to meet the survivors’ initial needs. In the immediate aftermath of disaster, we are not there to uncover all the hidden pathologies. Instead, we must:

- Assess the survivor or responder.
- Acknowledge and validate the individual's feelings and thoughts.
- Reinforce positive coping strategies in survivors and responders who seem to be exhibiting expectable stress reactions.
- Empower survivors and responders to make decisions that will lead to their recovery.

It is relatively uncommon that we would have to engage in any intense psychotherapeutic modality or direct someone to a local psychiatric emergency facility. Most people, barring some time-limited stress reactions, will do just fine with or without our help.

Once you have been assigned a setting, assessed the environment in which you are working, and have a better feel for the needs of those with whom you will be working, there are a range of supportive interventions and activities that you use in order to provide disaster mental health and spiritual care assistance.



Disaster Mental Health and Spiritual Care Interventions

The information that follows consistently makes reference to your work with survivors. It should be generally understood that the interventions and activities listed are also appropriate to use with disaster responders and other workers with whom you interact.

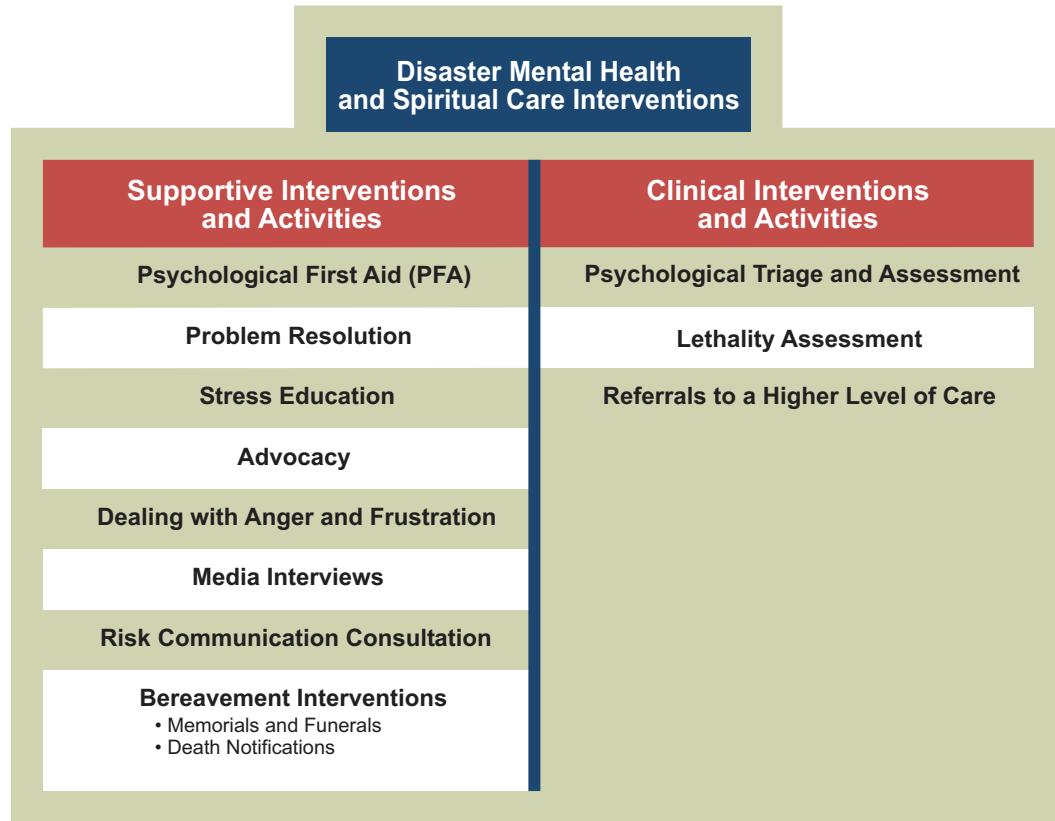
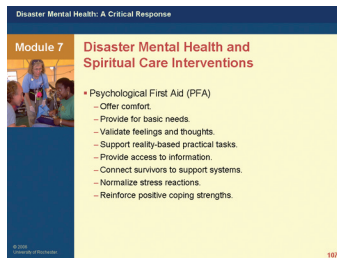


Figure 7-2: Disaster Mental Health and Spiritual Care Interventions and Activities



Supportive Interventions and Activities

Psychological First Aid (PFA)

Psychological First Aid (PFA) is currently considered by disaster mental health experts as the intervention of choice in the immediate aftermath of a disaster. Although there is no evidence-based literature at this time supporting the overall efficacy of this intervention, many components of PFA are based in crisis intervention and stress management approaches, which are areas that have long been studied.

The concept of PFA is similar to medical first aid in that we are trying to sustain life, promote safety and survival, comfort and reassure, and provide protection to those who have experienced a traumatic event. It also involves assessing and referring individuals to the appropriate services should they need a higher level of care.

PFA helps people get through the immediate phase of the disaster by building on their existing resources and helping them to develop a sense of safety and empowerment. Some basic components of PFA are described in the following paragraphs.

Offering Comfort

Provide reassurance to the survivor that he or she is not alone and that you and others around him or her will provide support through this crisis. Provide a safe and quiet environment, one that is relatively free from environmental stimuli. The individual can take advantage of periods of rest and recuperation, which are ultimately critical to reaching both physical and emotional balance.

Providing for Basic Needs

Referring to Maslow's Hierarchy of Needs, think about how you or other disaster relief personnel can assist survivors in meeting their needs for safety, shelter, food, water, and clothing. You may need to facilitate the provision of these needs by identifying and linking these individuals with agencies that provide these goods and services and by helping survivors feel empowered to take advantage of the aid that is being offered. It also can be as easy as handing someone a bottle of water or placing a warm blanket around his or her shoulders.

Validating Feelings and Thoughts

Many disaster survivors have a story to tell and listening to that story is important for their recovery process. Their recounting of the circumstances around the disaster and the expression of associated feelings and thoughts are part of a normal reaction to a sudden event. Allowing survivors to express their feelings and thoughts can help reduce heightened states of emotions that paralyze individuals and impair their decision-making skills. Listening to survivors share their feelings and thoughts and validating these reactions can help individuals move through a process towards identifying their next steps and regaining a sense of control over their environments. You may also have to assist other disaster relief personnel with their listening skills. Often, they are so intent on meeting a specific need for the

disaster survivor that they do not take time to listen to what the individual perceives his or her needs to be. They want to get right down to the facts and give the survivor something so they can move on to the next person. However, if a survivor does not want to talk about the experience, he or she should not be pressed to do so.

Supporting Reality-based Practical Tasks

Survivors may be quickly overwhelmed with the realization of what it will take to put their lives back together again after a disaster. Encourage survivors to take one step at a time and empower them to take action on those tasks that can be accomplished at that place and time. Oftentimes, these tasks are related to addressing and resolving their most basic needs and questions.

- Where are we going to sleep tonight?
- How are we going to get there?
- Will it be safe?
- Where will I get food for my family?
- Where can I get my medicine?

Remember, the anxiety, fear, and frustration they may experience around some of these tasks are normal reactions and should be anticipated as such. For most, not being able to organize their thinking around these tasks is common as well. Your role as a disaster relief worker is to assist survivors in exploring their options and encouraging them to make decisions and to follow through.

Providing Access to Information

Most individuals impacted by disaster have an overwhelming need for as much information as possible about what happened and what will happen. Some may not have access to a television, radio, newspaper, or computer, therefore, consistent information provided at routine intervals will assist disaster survivors in making decisions, while enhancing their ability to cope. As a mental health and spiritual care worker, you can encourage the disaster relief operation personnel to provide consistent information quickly. It is best to over-communicate, so long as what you communicate is accurate. It is also critical that you know what information you can and cannot disseminate. At times, mental health and spiritual care professionals are in a position to receive information that has not yet been vetted or released to the public. During those situations, it is important that you do not disclose information that has not been approved or extends beyond your area of responsibility or expertise.

Connecting Survivors to Support Systems

Our inherent need to belong ensures that most survivors had some sort of support system in place prior to the disaster. In some disaster situations, survivors may be separated from family members, or in more extreme cases, family members may have been reported missing, injured, or killed. Identify and utilize already existing support systems by exploring who and where these supportive individuals are and help the survivors re-connect with them. Disaster survivors should be linked with their support systems as quickly as possible.

Having loved ones around them can enhance survivors' abilities to endure and cope with the stressors commonly resulting from disaster. Their support systems may also include their faith community or representatives of the effected community including pastors, rabbis, imams, etc. When possible, facilitate these connections, as well, either at their request or with their permission.

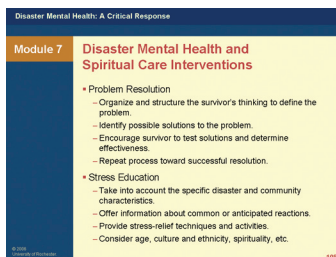
Normalizing Stress Reactions

As described in Modules 4 and 5, individuals experience a range of stress reactions following disaster; many of these are foreign and distressing to them. Normalizing these reactions by letting survivors know these are anticipated reactions that usually get resolved in a short time frame can be tremendously helpful in enhancing the survivor's ability to cope in the aftermath of a disaster. Some expected reactions may be warning signs of impending psychological or psychiatric crisis. More information on these symptoms and reactions can be found later in this module.

Reinforcing Positive Coping Strengths

Reinforcing a survivor's positive coping strategies can reduce his or her sense of helplessness and hopelessness and enhance resiliency, which ultimately leads to recovery. Consider the following:

- Explore how survivors have coped with adverse conditions or situations in the past.
- Encourage survivors to do things that have worked for them during other stressful periods in their lives.
- Encourage survivors to utilize the spiritual resources that are important to them including, prayer, ritual, meditation, spiritual reading, etc.



Problem Resolution

At times, the survivor or responder will come to you for emotional and problem-solving support. Problem solving can help survivors to develop a sense of self-efficacy and offer you an opportunity to provide emotional support and establish rapport. It is common, especially in the early aftermath of a disaster, that one's decision-making skills are compromised. The ability to identify options is clouded by an overwhelming sense of anxiety, fear, helplessness, and hopelessness. In these situations, it is best to help structure the individual's thinking.

- What options are open to the individual for resolving his or her particular problem or issue?
 - Which option does the individual feel most comfortable exploring?
- Encourage the individual to take one step at a time, to explore one option at a time and to evaluate his or her progress. Try not to make decisions for the individual; however, be advised that you may need to be more directive than you may normally be comfortable with.

Stress Education

Oftentimes, mental health and spiritual care professionals find themselves in the role of educator. Typically, offering information about the common or anticipated reactions to a disaster, how to take care of children or other loved ones, and the availability of various disaster relief services in the area can be helpful and therapeutic interventions. A number of booklets and pamphlets have been written about response to trauma, many of which can be available for survivors and responders following a disaster. Material should be oriented specifically to the actual event and locale and adapted to each survivor or responder group taking into consideration age, culture and ethnicity, spirituality, and other important community demographics. Be aware that, typically, these brochures and pamphlets are not readily available in the immediate aftermath of disaster, and they may take some time to arrive at your location. It is helpful if you identify such materials and include copies in your Disaster Mental Health Go-bag or Spiritual Care Toolbox Refer to *Appendix B: Additional Information and Checklists* on page B-19 and B-20.

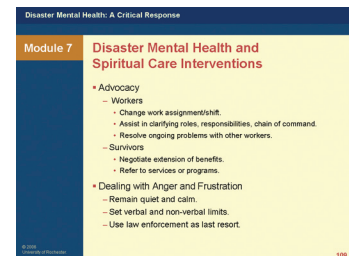
Advocacy

Disaster mental health and spiritual care workers may often find themselves advocating on behalf of survivors and other relief personnel. Such advocacy efforts may aid in alleviating or mitigating disaster stress. Examples might include talking with a relief worker's supervisor to give him a day off, encouraging the operation's management to procure healthier meals and snacks for workers, or speaking with a community agency to request additional assistance for a survivor. It may also be important to advocate on behalf of survivors and workers so that spiritual, mental health, or other needs may be met. For example, you may need to advocate for a time and place for religious services or twelve-step meetings (e.g., AA or NA) meetings. You may also need to advocate for having a prayer room or other location available where people can have the privacy to engage in their religious practices or come together to offer prayer for the survivors, victims, and rescue personnel in the midst of the disaster.

Effectively advocating may increase our credibility in the eyes of survivors and workers. However, it may also hamper their abilities to effectively cope with or recover from their disaster experience. In most cases, it is best to encourage the survivor or disaster worker to first attempt advocating on their own behalf. When such efforts fail, the disaster mental health or spiritual care worker may intervene.

Dealing with Anger and Frustration

At times, survivors and other relief personnel who are under a great deal of stress erupt with anger and frustration. As disaster mental health and spiritual care workers, we will be called upon to de-escalate potentially aggressive situations. We are expected to be able to defuse the situation and assist the individual or individuals to find more adaptive ways of dealing with each other and the situation at hand. This is when it will be important to draw upon our clinical skills so that we can remain detached, not take whatever the person



says personally, and hear their issues in an empathetic way. Two strategies to employ when dealing with angry or frustrated survivors or responders include:

- Remaining quiet and calm.
- Setting verbal and non-verbal limits.

Remain Quiet and Calm

Disagreeing with an individual may only make the person feel discounted and think that his or her feelings are being invalidated. Your goal is the opposite, and it is important for you to:

- Lower your voice rather than giving in to the temptation to match the angry or frustrated person's tone of voice.
- Validate the individual's feelings by acknowledging his or her anger and frustration.
- Avoid patronizing the individual and find areas of agreement.
- Use "yes, and ..." statements rather than "no, but..." statements.

Set Verbal and Non-verbal Limits

If necessary, politely tell the person that verbal abuse is not acceptable. Set non-verbal limits—do not let the aggressive person encroach on personal space or physically threaten you in any way. Ask for help from security personnel, or other personnel, if necessary.

If the individual continues to make verbal or non-verbal advances, advise him or her of appropriate and enforceable consequences. Make sure you know which options are available. If you are in a shelter or other service site, the person can be asked to leave.

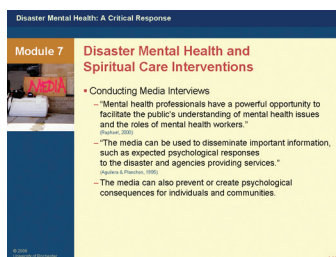
If law enforcement personnel are nearby and available to assist you, let the person know that as well. Do not threaten arrest if police are not readily available.

Finally, keep yourself safe and out of harm's way. Do not go into a room alone with a person threatening violence without a clear way out of the room. If you feel the potential is there to be physically overpowered, make sure someone else is there to help protect you.

Conducting Media Interviews

Most homes in the United States have both a television and a radio, and many Americans have come to rely on broadcast media to bring them the most up-to-date information on current world events. Many times, news media are the first to arrive on the scene following a disaster. The type, intensity, and duration of media coverage can affect people in various ways.

Mental health and spiritual care professionals have a powerful opportunity to facilitate the public's understanding of mental health and spiritual issues and the roles of disaster mental health and spiritual care workers. The media can be used to disseminate important information, such as expected psychological and psychospiritual responses to the disaster, as well as agencies that are providing disaster relief, mental health, and faith-based services.



Messages should address the normalcy of reactions and emphasize that recovery will occur for the majority of those affected.¹ Carefully constructed descriptions of expectable reactions, such as sleep difficulty, irritability, difficulty concentrating, and questioning one's faith provide a framework for survivors to understand and anticipate likely reactions. These descriptions may help to decrease fear about emotional responses and may help survivors identify friends or family members who may be in need of professional help.

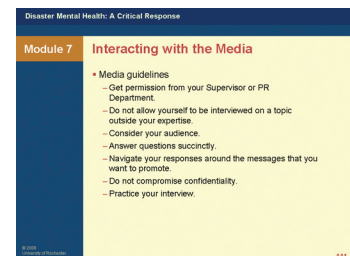
Sound and thoughtful information can also assist in preventing ineffective, fear-driven, and potentially damaging public responses to disaster events.

Most often following disaster, the media will be looking for information related to what has happened, who was involved, how these individuals feel about what has happened, and how they are going to be helped. Many times, they will want to hear from the survivors themselves for their personal reactions. They may wish to utilize disaster mental health or spiritual care professionals when they are looking for information on the impact such events have on those involved or what to expect in regards to reactions in the hours, days, and weeks after the event.

While not everyone feels comfortable talking with the media, the experience can be less stressful if you follow these guidelines.

- Get permission from your Administrative or Technical Supervisor or Public Relations Department before conducting any media interviews.
- Do not allow yourself to be interviewed on a topic outside of your expertise.
- Consider your audience. Is this a local newspaper, radio or television station, or are you speaking in front of national or international media?
- Try to answer the reporter's questions succinctly. Do not go into long elaborations or offer more details than what was requested.
- Navigate your responses around the issues that you think are most important to convey.
- Do not use situations or examples that compromise a survivor's or a responder's confidentiality.
- Practice your interview with a colleague ahead of the scheduled interview time.

There are also some important cautions to be noted when in the presence of the media. As mentioned earlier, there are times when mental health and spiritual care professionals are in the position to receive information that has not yet been released to the public.



¹ Raphael, B., Newman, L., Silove, D., Bryant, R., Boman, B., Sprague, T., et al. (2000). *Disaster Mental Health Response Handbook: An Educational Resource for Mental Health Professionals Involved in Disaster Management*. New South Wales, Australia: Center for Mental Health, NSW Health and NSW Institute of Psychiatry. State Health Publication No: (CMH) 00145. You may download this document from the Web site http://www.nswiop.nsw.edu.au/Resources/Disaster_Handbook.pdf.

During these situations, it is important that you do not disclose information that has not been approved or extends beyond your area of responsibility. A very sad example of this comes from the West Virginia Mining Accident in 2006. Prior to the families of those trapped being officially notified, information came out in the media that one miner perished with the fate of the other 12 left unknown. This caused extreme distress in the families who were left wondering whether their loved ones were alive or dead. Shortly thereafter, information was released to the families by officials informing them that all of their loved ones were discovered alive. Unfortunately, while family members were rejoicing, it was discovered by officials that this information was inaccurate and in fact, 12 of the miners were deceased and only one survived. As you can see from this example, misinformation can potentially create life-long psychological challenges for those receiving it.

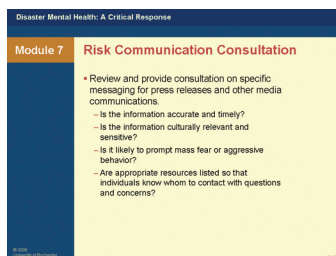
In addition, there may be occasions when the media requests your professional opinion concerning a specific situation or individual. For example, they may look to you to hypothesize about the motivations of the alleged perpetrators of a human-caused disaster or comment on the efficacy of a response organization or public official. The circumstances around what motivates individuals to conduct horrific acts or what procedures individuals or organizations use to respond to the needs of disaster survivors are often complex. It is advised that you refrain from commenting on such information or refer it to your supervisor or other disaster management official.

Risk Communication Consultation

There may be other times when your mental health or spiritual care expertise is requested from hospital administrators (e.g., Public Relations Directors), public health officials, or disaster response managers. In these situations, you may be asked to review and provide consultation on specific messaging for press releases or other print media being disseminated related to the disaster. These messages should be reviewed carefully with the following mental health issues in mind.

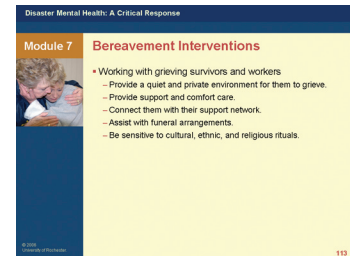
- Is the information accurate and timely?
- Is the information culturally relevant and sensitive?
- Is it likely to prompt mass fear or aggressive behaviors?
- Is the information free of jargon or overly technical terms?
- Are appropriate resources listed so that individuals know whom to contact with questions and concerns?

These are just a few of the tips you might find helpful in preparing for media interviews or providing mental health consultation during disaster. For more information, refer to ***Communicating in a Crisis: Risk Communication Guidelines for Public Officials*** available at www.riskcommunication.samhsa.gov.



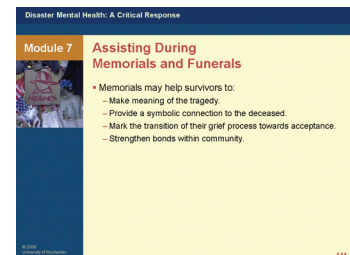
Bereavement Interventions

At times, you will be confronted with survivors and relief personnel who have lost loved ones or colleagues as a result of the disaster. For mental health or spiritual care workers not familiar with working with the bereaved, these situations can be uncomfortable and stressful. It is important to remember that in the early aftermath of a disaster, you are there to provide support and comfort to those newly bereaved. Grief counseling and other therapeutic modalities are best left to those who will establish on-going professional relationships with individuals. What you can offer is someone with whom the bereaved person can talk or pray. You can also try to provide a comforting environment where individuals can express their sorrow and grief. The newly bereaved may also need assistance locating other loved ones or connecting with their support network. Providing access to a telephone or arranging for the individuals to be transported home or loved ones to them may be helpful. Survivors may also need help with funeral arrangements or completing other cultural, ethnic, and spiritual rituals. It is important to ask individuals how you may be helpful instead of assuming that there is nothing you can do, or doing something that is not needed at that time. At the very least, the survivors or workers may just need someone to sit with them awhile and hold their hands before taking the next step towards living without their loved ones.



Assisting During Memorials and Funerals

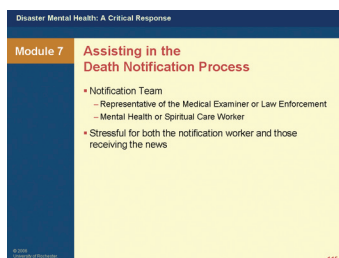
A site for memorializing victims of disaster often spontaneously appears within hours of a mass tragedy where significant fatalities have occurred. Community members bring flowers, photographs, mementos, and messages. The site, often close to the location where the disaster occurred, becomes a place for remembering, honoring, grieving, praying, and giving and receiving support.² In large-scale disasters, we may also be asked to assist in developing memorial rituals to honor the dead and provide closure for the survivors. These memorial rituals may typically extend beyond the immediate phase of disaster response.



As mental health and spiritual care professionals, we may also be asked to provide support to those attending such memorial services. Being sensitive to the community and organizing a culturally and religiously appropriate ritual may help survivors to:

- Make meaning of the tragedy.
- Feel a symbolic connection to the deceased.
- Mark the transition in their grief process towards greater acceptance.
- Strengthen bonds within the community.

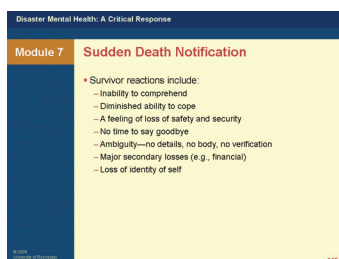
² U.S. Department of Health and Human Services. (2004). *Mental Health Response to Mass Violence and Terrorism: A Training Manual*. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. You may download this document from <http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA-3959/MassViolenceAndTerrorism.pdf>.



For more information about memorial rituals, you may wish to review the book *In Memoriam: A Guide to Modern Funeral and Memorial Services* by Edward Searl.

Assisting in the Death Notification Process

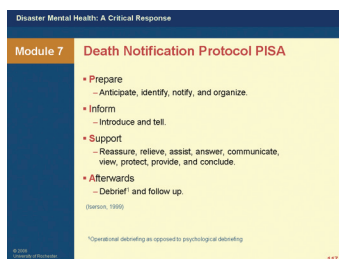
Mental health and spiritual care professionals in community or hospital settings typically do not deliver information regarding deaths, but may participate on death notification teams or be present when medical personnel are delivering such information to survivors. Your role would be to support survivors as this information is being provided by officials. Death notifications can be extremely difficult for those giving and receiving the news.



Survivor Reactions

The most traumatic moment for many people is the notification of a sudden death. There is often a feeling of shock and disbelief leaving the survivor uncertain about what to do next. Without an opportunity to say goodbye, the survivor is left feeling incomplete and empty. In the absence of a body or verification of the death, there is also the feeling of unreality and the expectation that the deceased will be back any minute.

A properly conducted notification process can assist survivors in processing their grief in a healthy manner.



Active listening, sensitivity, and good communication skills are key components to the notification process. Individuals responsible for death notification may not be skilled in or aware of the standard protocols used for notifying survivors of a sudden death. While you may not be in the position to provide death notification, you can support and instruct others who may have such responsibility. The PISA model, recommended by Kenneth Iserson in his book *Grave Words: Notifying Survivors about Sudden, Unexpected Deaths*, provides a worthwhile guide for the notification process.

Prepare

- Anticipate
- Identify
- Notify
- Organize

In this stage, Notifiers should provide a place to make the notification with enough chairs, a phone and phone book, tissues, water, paper and pencil, and a mechanism for summoning help. They should anticipate expected reactions and be prepared with contact information for follow-up services. Notifiers need to identify the deceased and the appropriate survivors who need to be told, contact those survivors, and organize the notification team.

Inform

- Introduce
- Tell

During this stage, the Notifiers will introduce themselves, using their professional titles, and confirm the identity of the survivors and the deceased using formal language to address the survivors. The news should be delivered quickly, with as much accurate information surrounding the death as the family requests. The Notifier should arrange for enough time so that the news is not rushed, the survivors have time to absorb and react to the news, and they have time to ask questions. Using "D" words such as death, died, or deceased is important to avoid confusion and ambivalence.

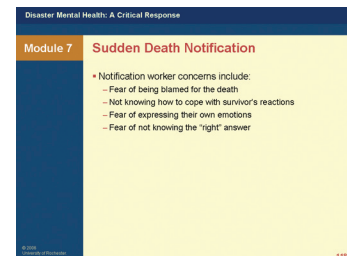
Support	<ul style="list-style-type: none"> ■ Reassure ■ Relieve ■ Assist ■ Answer ■ Communicate ■ View ■ Protect ■ Provide ■ Conclude 	<p>In this stage, the Notifier provides as much emotional support as possible by reassuring the survivors, relieving their guilt and anguish, assisting them in providing for their basic needs, protecting their privacy, and communicating as many details about the event as can be accurately provided. Notifiers will need to pay attention to the special needs of children. The survivors may need to view the body or a photograph of the face for identification. The survivors may need to describe their version of events. Written materials with information that will be needed later may be provided. Finally, letting the survivors know that the process has concluded and what steps are to be taken next will provide a sense of closure for the survivors and a sense of direction.</p>
Afterwards	<ul style="list-style-type: none"> ■ Debrief ■ Follow up 	<p>After notification, the notification team should conduct an operational debriefing to improve on subsequent notifications, release public information if appropriate, and provide support for each other.</p>

Table 7–1: The PISA model³

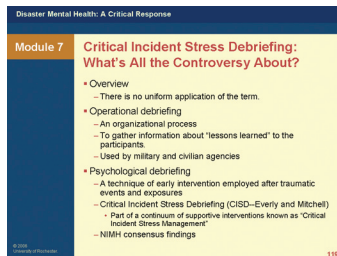
Notifier Reactions

Those who are responsible for death notification may experience a range of reactions. Knowing these reactions and how they may unfold will help us as mental health and spiritual care professionals support survivors through this process. We may also feel some of these emotions ourselves and thus need to be aware of our own responses to the situation. Typical feelings and reactions include:

- Fear of being blamed for the death
- Discomfort with not knowing how to cope with a survivor's reactions
- Fear of expressing one's own emotions or not being able to contain one's emotions
- Fear of not knowing the "right" answers to questions asked by the survivor



³ Adapted from: Iserson, K.V. (1999). *Grave Words: Notifying Survivors about Sudden, Unexpected Deaths*. Tucson, AZ: Galen Press, Ltd. Iserson recommends CISD as an appropriate protocol for the notification team. He suggests debriefing with emergency personnel only; debriefing is not recommended for survivors, and some research suggests it should not be used at all (with survivors or responders) in the acute aftermath of disaster.



Critical Incident Stress Debriefing: What is All the Controversy About?^a

Overview

Debriefing can mean many things. Even in emergency services and disaster operations, there is no uniform application of the term. It is extremely important to understand these different meanings to ensure that we are communicating the correct message and providing appropriate care for those exposed to traumatic events, including victims, families, and response personnel.

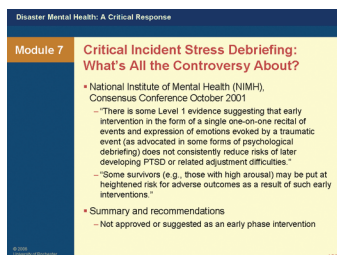
Operational Debriefing

Operational Debriefing is an organizational process implemented after a major event or training exercise to review the process of the response and focus on successes and failures of an operation. The primary intent of operational debriefing is to gather information about the event for leadership and to convey important "lessons learned" to the participants. It has been used by military and civilian agencies extensively for intelligence gathering and informational purposes, providing an evaluative or quality improvement component to response activities and field operations.

Psychological Debriefing

Although there are many variant applications, *Psychological Debriefing* is a technique of early intervention employed after traumatic events and exposures with the intent of helping an individual process the event and its linked emotional content.

The most widely used form of psychological debriefing in emergency services is *Critical Incident Stress Debriefing (CISD)* developed by Jeffrey Mitchell and George Everly. Their strategy has evolved into more of a toolbox of responses known as *Critical Incident Stress Management or CISM*, where a structured format of debriefing may be part of the package. Mitchell and Everly have reportedly acknowledged that one of the difficulties "is the confusion over terms and the failure of methodologies to evaluate their specific model of debriefing in the situation for which it was developed (e.g., emergency services) and as part of a comprehensive stress management/crisis intervention framework."^b



In October of 2001, the National Institute of Mental Health held a consensus conference on disaster mental health in an attempt to clarify some of the controversies and provide guidance in the area of mental health in relation to mass violence.^c Their findings in relation to debriefing suggested that early intervention in the form of a single one-on-one recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties. Some survivors (e.g., those with high arousal) may be put at heightened risk for adverse outcomes because of such early interventions. Moreover, for these reasons, the use of single session recital of events is not suggested.

Summary and Recommendations

Additional literature has since evolved out of the psychological debriefing and CISD controversy that continues to support the position that such interventions must be approached with significant caution and in fact, might not be the most appropriate interventions in the acute phase of disaster response. In light of the former and current research findings, we have chosen not to include critical incident stress management and, particularly, critical incident stress debriefing among those approved or suggested early phase interventions. We acknowledge that some communities may continue to utilize such interventions with emergency services personnel, but we believe these interventions should be delivered with caution, if they are to be administered at all.

- ^a The paragraphs under this heading were originally submitted in a paper entitled *Debriefing: Confusion and Controversy* by Edward M. Kanter and Jack Herrmann and presented at the 2004 Medical Reserve Corps Annual Conference.
- ^b Raphael, Beverly, et. al. (Eds). (2000). Chapter 5: Critical Incident Stress Management and Critical Incident Stress Debriefings: Evolutions, Effects and Outcomes. In *Psychological Debriefing, Theory, Practice and Evidence*. (pp. 71-90) London: Cambridge University Press.
- ^c National Institute of Mental Health. (2002). *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence, A Workshop to Reach Consensus on Best Practices*. Washington, D.C.: U.S. Government Printing Office. NIH Publication No. 02-5138. You may download this document from <http://www.nimh.nih.gov/publicat/massviolence.pdf>.

Clinical Interventions and Activities

Some survivors and responders will need more than just a compassionate touch or a supportive environment to resolve their states of crisis. Their exposure to the disaster and its aftermath can result in their need for a higher level of mental health involvement. These needs can include rapid assessment of their physical, cognitive, psychological, and behavioral reactions and referral to additional community-based resources. In these situations, specially trained mental health and spiritual care professionals must engage a more advanced skill set. If you do not have such a skill set or advanced education to conduct these activities, please reach out to your Technical Supervisor or to other professionals who may have such skills.

Triage and Assessment

Through observation, asking questions, and reviewing the impact of survivors' or workers' exposure to the disaster and their resultant concerns, the mental health or spiritual care worker develops an impression of each individual's capacity to address his or her current challenges related to the disaster. Most disaster survivors and relief workers respond positively to words of reassurance and hope. Those individuals who are not easily comforted and reassured may be at risk for developing significant psychological reactions. Specially trained disaster mental health and spiritual care workers must assess the intensity of the symptoms and reactions exhibited by the individual, the impact on his or her functioning, and the efforts the individual is making to attend to and resolve these issues.

Disaster Mental Health: A Critical Response	
Module 7	Clinical Interventions and Activities
	<ul style="list-style-type: none">• Triage and Assessment<ul style="list-style-type: none">– PlaySTART™<ul style="list-style-type: none">• Mental health triage and incident management system• Rapid triage questions• Link between at risk individuals and appropriate levels of care– Lethality Assessment<ul style="list-style-type: none">• Includes context in which lethal statement is made• Accessibility to a weapon or other means• Availability and willingness to use social support network• Mobile Crisis Team or other crisis intervention team• Referrals to a Higher Level of Care<ul style="list-style-type: none">– Know what is available locally if a referral is necessary<ul style="list-style-type: none">• Mental Health Centers• Skilled individual practitioners• Voluntary vs. involuntary assessment or treatment
	121

In order to conduct an accurate individual risk assessment, a specially trained mental health or spiritual care professional must be aware of the risk factors that may contribute to the development of more significant psychological consequences following disaster and factor these into his or her assessment. In addition to the assessment evaluation skills you may have learned in the context of your academic and clinical training, PsySTART™ is another tool that mental health and spiritual care professionals can utilize to identify at-risk disaster survivors and responders.

PsySTART™

PsySTART™⁴ is a mental health triage and incident management system that promotes the rapid sorting and linkage of individuals who may be at risk for developing severe or extended mental health consequences resulting from disaster to appropriate levels of care. By assessing the response of an individual to a series of questions relating to high-risk situations, a worker with clinical experience can potentially identify those individuals who may be at risk for extended distress and impairment and who may warrant a referral for more focused mental health assessment or treatment. There is evidence to suggest that if those at risk are matched with definitive care early on, long-term impact can be reduced. These triage questions include the following:

- Does the individual have a pre-existing disability? (e.g., physical, emotional, developmental, etc.)
- Did the individual experience the death of a parent, sibling, family friend, peer, pet or other significant person?
- Did the individual witness (or hear) the death or serious injury of another person?
- Did the individual or family member feel a direct threat to his or her life?
- Was the individual evacuated from his or her usual residence?
- Did the individual experience being trapped, or if evacuated, was there a delay in evacuation?
- Is the individual's home habitable?
- Did the individual or family member sustain a physical injury or illness?
- Was the individual separated from his or her parent/child during the event?
- Was the individual exposed (confirmed) to a chemical, biological, or other potentially life-threatening agent?
- Did the individual require decontamination due to exposure (potential exposure) to a chemical, biological, or other potentially life-threatening agent?

⁴ Schreiber, M. (2000). Proposal developed for HHS/Emergency Medical Services for Children Targeted Issues. *Managing the Consequences of Mass Casualty Events for Children: Rapid Triage and Disaster Systems of Care*.

- Did the individual receive medical treatment (e.g., antibiotic, antidote, etc.) for exposure to a chemical, biological, or other potentially life-threatening agent?
- Did the individual experience any health concerns as a result of his or her exposure to a chemical, biological, or other potentially life-threatening agent?

An affirmative answer to any one or more of these questions suggests the need for further assessment, continued monitoring, or warrants potential referral to a higher level of mental health intervention.

Lethality Assessment

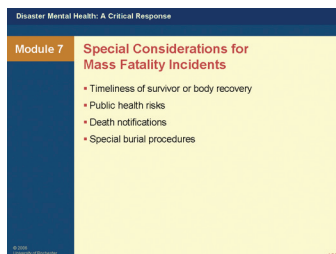
There are also situations in which individuals may express thoughts of self-harm or harming others, especially in disasters that have resulted in the severe injury or death of a family member or other loved one or the loss of meaningful personal possessions. Specially trained mental health and spiritual care workers must possess the ability to make a quick and thorough lethality assessment at such times so that the appropriate life sustaining interventions can be implemented in an expeditious manner. This lethality assessment must include the context in which the lethal statement (against oneself or others) is being made, the individual's accessibility to a weapon or other means, and the availability and willingness of the individual to utilize his or her social support network. If in doubt, seek consultation immediately.

In the event that a disaster survivor or other relief worker requires a higher level of assessment or intervention, disaster mental health and spiritual care workers must be aware of the resources within that community or facility to engage this referral. Some communities or facilities in New York State have a Mobile Crisis Team or other crisis intervention team that can respond on-scene and perform a psychiatric evaluation of the individual. Others require individuals to report to a local emergency room or acute psychiatric care facility. If responding to a disaster outside your facility, know what crisis resources are available in that community and verify that community's emergency psychiatric evaluation procedures and protocols.

Referrals to a Higher Level of Care

Most individuals will respond positively to the minimal levels of support offered by disaster mental health and spiritual care workers and other relief personnel. Most of your referrals will be to other disaster relief agencies or resources where assistance can be provided to meet that individual's disaster-related needs. However, there may be an occasion where a disaster survivor or responder will require more non-emergent, advanced levels of mental health intervention than that which can be provided in a disaster setting such as those who have one or more positive responses to the PsySTART™ rapid triage questions. In these circumstances, it is important to know which mental health resources are available in the area you are working.

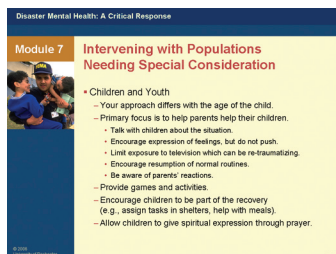
Mental health referrals may be made to local community mental health centers or individual practitioners skilled in working with disaster survivors or responders. In extreme situations, you may need to refer an individual to another local hospital or emergency clinic for immediate assessment and evaluation. In these cases, it is optimal if the individual volunteers to go to such a facility for treatment and is transported by a family member or other loved one. In cases where involuntary assessment or treatment is necessary, mental health and spiritual care workers must work with their supervisors and within local guidelines to engage this level of referral.



Special Considerations for Mass Fatality Incidents

Incidents involving mass fatalities can be quite traumatic for those who have lost loved ones and relief workers who are called to the scenes of these events. The circumstances concerning the suspected cause of these fatalities can also be a major factor. For example, the delay in recovering the bodies of those exposed to chemical, biological, or radioactive agents or those that are missing or not easily recoverable (e.g., swept away by floods or buried under debris) may be particularly stressful to survivors. It may concern relief workers as they worry about what personal health risks they assume in body recovery activities. In the case where the deceased are recovered, it is typically the local medical examiner or coroner that has jurisdiction and authority in deciding how the physical remains of the deceased will be handled. This can include requiring the need for an autopsy or the implementation of special burial procedures (i.e., mass burial). The requirement of an autopsy or special burial procedures can have a significant psychological and psychospiritual impact on some ethnic, cultural, or religious populations. Mental health and spiritual care professionals must take special note of these circumstances so that they can effectively support survivors in these situations.

In mass fatality incidents, limited human resources may also mean that notification workers are continually stressed by having to conduct the death notification process over and over again. Under these circumstances, providing ongoing supportive interventions to notification workers will be helpful. These individuals may also require reduced shifts and opportunities to perform other disaster-related jobs to balance the stressful work of death notification.



Intervening with Populations Needing Special Consideration

In disaster situations, you will find yourself working with different populations, including children, older adults, and individuals with cultural, religious, or ethnic backgrounds different from yours. Within this section, you will note key considerations when intervening with these populations.

Youth

Interventions will differ according to age group and developmental stage: preschoolers, school age, and adolescents. Child trauma experts also suggest that in addition to providing individual support to children and youth in the aftermath of disaster support and education must also be provided to a child's parents or guardians. Youth, especially young children, tend to react and respond to trauma based upon the reactions and responses of the adults around them. Therefore, providing supportive interventions to alleviate or calm the concerns of adults can be beneficial to their children. The following is a list of guidelines that you can consult when you are working with individually with children.

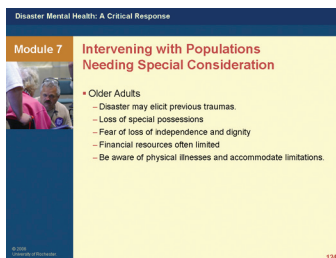
General Guidelines for Working with Children and Adolescents⁵

1. Assess the developmental level of the child/adolescent or seek consultation from professionals who can assess the child/adolescent's developmental level.
2. Do not be afraid to talk with the children about the events in an honest, clear, and accurate manner. Do not make up answers to questions if you do not know the answers; it is okay to say you do not know. Let children take the lead on how much to talk about and when to talk. Answer their questions, but do not overload them with information. Give them time to process what you have already told them before giving them more information. Be sensitive to their developmental stages when providing complex concepts or information. Simplify as much as possible without distorting.
3. Let the children talk about their feelings as much as they want to, but do not coerce them to talk. Reassure children, not with false expectations, but realistic positive interpretations of the situation (e.g., not, "don't worry, this will never happen again," but "we're safe now, and we expect to be safe in this building"). Depending on the disaster, inform the child about what you expect the future to hold (e.g., more rain, another attack, aftershocks). The goal is for parents and recovery workers to foster a soothing environment for the child.
4. Limit the child's exposure to media coverage, especially if it is a terrorist attack or some other catastrophic single event. Young children, especially, may exaggerate the scope or frequency of the event. Seeing it repeatedly on TV may suggest to them that it is actually happening repeatedly.
5. Encourage resumption of normal routines. Ask parents and children how they did things before the disaster, and help them get back to their routines as soon as possible. Routine helps children feel safe.
6. The parents' reactions will influence the child's reactions. When you help the parents, you will be ultimately helping the child.

⁵ For more information about working with children and adolescents after disaster, refer to the *National Child Traumatic Stress Network* Web site at www.nctsn.org

At times, you may need to provide another voice and another perspective to the child when their parents are upset. Reassure the child that the adults will be okay, and then provide some distance from the parent, if possible. Be sure to reunite children and parents when the parents are more in control. Children need to know it is okay to be upset and that strong feelings can be handled and dealt with. Be a backup to the parent so that the parent can regain his or her composure.

7. Facilitate access to safe recreational activities for children according to their developmental stage, and ethnic, cultural, and religious backgrounds. Often, children will feel more comfortable talking about their reactions while they are in the midst of a game. These will also give parents space to deal with their problems, issues, and emotions.
8. If possible, get children, especially older children and adolescents, to help provide assistance to others. Have them clean the shelter, or distribute drinks or meals, or engage in any other activity that will allow them to feel useful and in control.
9. If children ask to pray for what has happened or the people involved, allow them to use their own words or familiar prayers from their tradition. They may want to draw or write their prayers.



Older Adults

By the time one reaches older adulthood, it is likely one has experienced many of life's challenges and stressors. Often older adults have been through previous traumas and have coped successfully. In this case, reminding them of how they coped previously, what worked then, and why, may be helpful. Many elders have excellent coping and resiliency skills. As mental health and spiritual care workers, we need to respect and honor their strengths and wisdom.

On the other hand, some may not have grieved or healed from previous traumas and may be more vulnerable in this disaster. They may appear especially frail, emotionally and physically. Acknowledging the previous trauma and being witness to the grief of their previous losses may be the most healing intervention.

Being aware of physical limitations is especially important when working with older survivors. Knowing how to replenish medication supplies or replacing damaged or lost personal items such as canes, wheelchairs, etc., can alleviate their anxiety and fear. Be sure that you advocate for assistance in whatever way they might need, such as help up the stairs to the assistance center, comfortable chairs to wait in, easy access to bathrooms, etc., without calling special attention to their limitations or physical disabilities.

Many elderly survivors are afraid to leave their homes during evacuations. They fear that if they are evacuated from their homes and placed in a senior living facility, they will never be allowed to return home. They may also be fearful of leaving pets behind, which they consider their companions. Talking with their families about their fears, reassuring older adults of their safety, and ensuring the safety

of their pets are important interventions. Help both the family and the survivor make agreements that will provide for the individual's safety without compromising his or her independence and dignity.

Older adults are often living on fixed incomes and any disaster-related losses can be devastating. Seniors may lack the resources to recover and rebuild. It is important to recognize that feelings of pride and reluctance to take “handouts” may be a factor when dealing with some older adults. Acknowledge their contributions during their working lives, and stress that it is okay for their families and society to help them now; after all, they have already contributed for so many years. Emphasize how they have provided for their families and have played an important part in their communities, and now it is time for their communities to give back to them. Honor their roles in their families and communities and offer them respect as you encourage them to take whatever assistance they may need.

Finally, be aware that they may have experienced losses of family photos, pets, gardens, or homes; these items have sentimental value and are irreplaceable. Acknowledge the grief related to these losses.

Letting them tell you about their homes, their pets, etc., and reminding them that they still have these memories in their hearts can be comforting.

Cultural, Ethnic, and Religious Groups

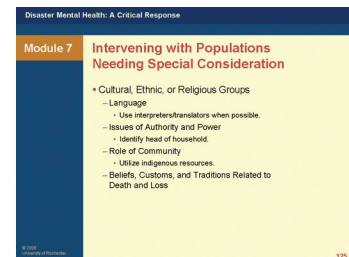
While it is impossible in a training curriculum such as this to address issues related to every cultural, ethnic, or religious group that you might encounter in a disaster, some issues and dynamics need to be considered whenever you are dealing with individuals that differ from your own cultural, ethnic, or religious background.

Language

When people are dealing with the stress of a disaster, cognitive processing is impaired, and even those people who may have been able to get by with limited English skills before the disaster may find they are more challenged with their English speaking and processing abilities after the disaster. Optimally, translators should be provided when possible. In the absence of a translator, utilize a family member or other loved one who may be able to translate for you. Exercise caution when utilizing children as translators; depending on the age and maturity of the child, he or she may be unable to translate sophisticated or complicated concepts and might simplify the conversation such that it distorts the information being transmitted. Having children act as translators may also put them needlessly into the position of being responsible for their parents, and this may have other implications. If possible, find an adult to translate.

Issues of Authority and Power

When working with a family of another culture, you may need to determine who is considered the head or decision-maker of the family. Be sensitive to the roles of the various family members.



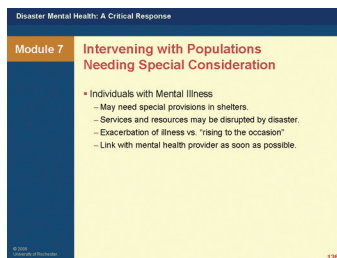
At times, this may be confusing and very different from the way you are accustomed to working with people, but it may be crucial for providing effective intervention.

Role of Community

The role of the community is also different from culture to culture. In some cultures, outsiders are viewed with suspicion and distrust, and support is expected to come only from their own community. If the community's resources are strained, support from other sources may be needed. Helping survivors accept such help may be quite difficult, but crucial. Whenever possible, working with community support providers, such as religious or civic groups, is the best option.

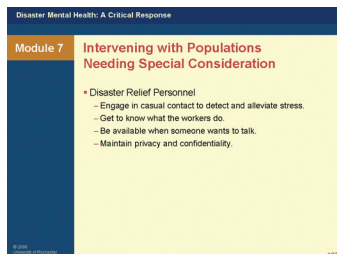
Beliefs, Customs, Traditions Related to Death and Loss

Religious and cultural beliefs are important to survivors as they experience a range of emotions and other reactions in the aftermath of traumatic events. Beliefs may influence their perceptions of the causes of traumatic experiences as well as their ways of coping with the consequences. Their beliefs may also affect their receptivity to assistance and influence the type of assistance that they will find most effective. Different cultural groups also handle grief in different ways. Family customs, beliefs, and the degree of acculturation affect expressions of grief. Disaster mental health and spiritual care workers must recognize that grief rituals, although diverse in nature, can help people return to a reasonable level of functioning. Cultural norms, traditions, and values determine the strategies that the survivors use to deal with their losses. At a time of crisis and in the midst of a disaster, it may be important for mental health and spiritual care professionals to assist individuals in finding creative and meaningful ways to honor their dead and mourn their losses when traditional ways and means cannot be realized due to the circumstances of the disaster.



Individuals with Mental Illness

Disaster mental health and spiritual care workers may find that survivors with pre-existing mental illness are able to cope and deal with the disaster in effective and productive ways. For others, they may find their symptoms exacerbated by the disaster and the services they rely on every day to maintain their mental health needs disrupted and unavailable. Those individuals with pre-existing mental illness may need special provisions in shelters or other disaster relief settings so as not to further exacerbate their symptoms. Linking them quickly with their ongoing mental health provider or spiritual advisor may be important to their recovery as well.



Disaster Relief Personnel

At times, you may be approached by or asked to work with other disaster relief personnel. Many of the same interventions that are used with disaster survivors can also be used with disaster workers.

Your job is to observe the other workers and be on the lookout for disaster-related reactions. Often workers will deny that they are reacting to the disaster or their assignments, and it is our job to intervene early to help them find better ways to cope with their stress when you see some of these symptoms beginning to appear.

By far, the most important way for mental health and spiritual care workers to connect with other disaster workers is through casual interactions. Just hanging out with the other workers, talking with them, laughing with them, listening to their concerns, and appreciating their roles in the disaster operation are incredibly helpful interventions. Mental health workers are on call 24/7 to help other disaster workers deal effectively with the stress of being on a disaster assignment. It helps to know the activities and responsibilities of the various workers on your site so that you can ask knowledgeable questions and gently probe for signs of stress. No matter how much you know, however, simply asking questions about what and how people are doing is usually a good intervention, so long as it does not interfere with them actually doing their job.

Sometimes, workers will want to speak with you directly, and you will need to be available for such conversations. Having a private place to talk where you can maintain privacy and confidentiality is even more crucial when talking with other workers, since most of them do not want to be seen as “weak” or not able to “handle it.” In addition, the stresses that workers want to discuss have to do with other workers or the organization, and they need to be guaranteed confidentiality in their discussions.

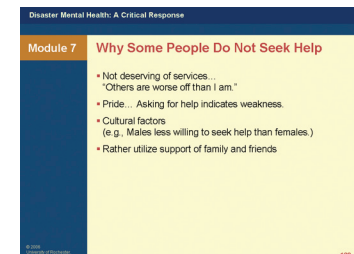
Educating workers about typical stress reactions, encouraging them to advocate for themselves in their work environments, and advocating for them, when necessary, are helpful interventions.

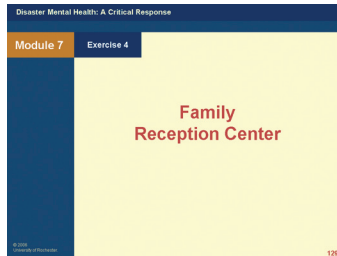
Why Some People Do Not Seek Help

Some survivors do not seek help because they prefer to work things out by themselves or with help from family and friends. However, it is also possible that survivors do not seek help because they may be both proud and humble. They believe that those who are worse off than they are should be getting help, instead of themselves. They also may believe they “shouldn’t” be so upset if others were affected more than they were. For some, being in distress indicates being weak.

These are all typical reasons why people do not seek help, and it is important that we do not take their rejections personally. Instead, we may look for other approaches that are more palatable or are more effective in getting the point across or message out to those who need it. Many times, if we just let individuals know we are there and do not try to pressure them to disclose their most personal and intimate thoughts, they will seek us out.

We spent a considerable amount of time reviewing some of the skill sets and interventions that mental health and spiritual care professionals use in the aftermath of disaster. We are now going to take the opportunity to let you practice these skills, and experience what it may be like in a typical disaster service setting.





Exercise 4: Family Reception Center

Exercise Overview

The Family Reception Center (FRC) Exercise draws upon the raw emotions of family and worker dynamics in the context of a bus crash disaster. The scenario focuses on the families of the victims and how they are processed through the information gathering process. The exercise mingles the emotional pain of waiting for information about a loved one with the kindness of mental health and spiritual care professionals offering unconditional support. The scenario includes several individual interactions as well as team interactions with the family groups. The family role descriptions are carefully profiled using a contrast of dysfunctionality with functional cohesiveness. The exercise is emotionally intense and clearly plays upon the basic emotions of anxiety, love, impatience, fear, anger, and sorrow.

Exercise Purpose

The intention of the exercise is to prepare mental health and spiritual care professionals for the range of reactions they will encounter in the aftermath of a mass casualty event. The participants have an opportunity to assess and check their own personal reactions in light of providing mental health and spiritual care services to families impacted by disaster.

Exercise Mode

Participants assume the roles of the victims' families, Family Reception Center (FRC) workers, and observers. Everyone in the training session has a part and thereby contributes to the learning process at the conclusion of the exercise. The write-up that includes the scenario and instructions will be provided by your instructor.

Module Summary

In this module, you have devoted a considerable amount of time to understanding the types of specific interventions that you may find effective in your role as a disaster mental health or spiritual care worker. The most important aspect of this module has been the Family Reception Center exercise. Within the context of this exercise, you have been able to experience a service site and engage in a role-play scenario that closely approximates what an actual Family Reception Center will be like and the process and interactions that take place as families and others try to get information about their loved ones.

Module 8

Self-care and Disengaging from a Disaster Assignment



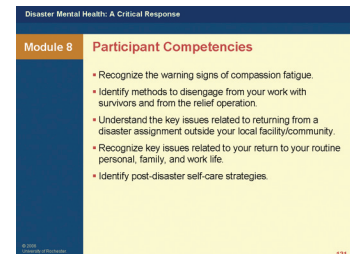
Module Overview

As you may have surmised by now, disaster mental health and spiritual care work can be stressful and disruptive to those who answer the call for help. As mental health and spiritual care providers, it is important that you prioritize taking care of yourself both during and after a disaster response. Failing to do so can have significant impact on your work with survivors or in the transition back to your day-to-day personal, family, and work life. This module addresses some of the unique aspects of transitioning from a disaster assignment back to one's day-to-day routine. Information has also been provided on the issues faced by mental health and spiritual care workers providing disaster relief outside their local facility or community.

Participant Competencies

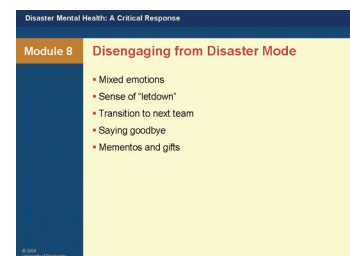
After completing this module, you will be able to:

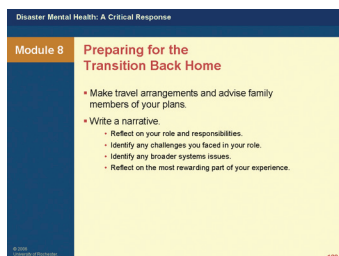
- Recognize the warning signs of compassion fatigue.
- Identify methods to disengage from your work with survivors and from the relief operation.
- Understand the key issues related to returning from a disaster assignment outside your local facility or community
- Recognize key issues related to your return to your routine personal, family, and work life.
- Identify post-disaster self-care strategies.



Disengaging from Disaster Mode

Even though the long hours and fast pace of disaster response is stressful, it can be both rewarding and fulfilling. At some point, though, the work of a responder must end. Some disaster responders can find the transition from “disaster mode” back to the day-to-day routine of one’s personal, family, and work life to be filled with difficulties and challenges. As the disaster response winds down or you are making arrangements to return home from a disaster assignment outside of your community, it is important for you to consider the following issues and suggestions.





Preparing for the Transition Back Home

If you have been assigned to a disaster outside of your local community, you should have some idea of the length of your assignment before you even depart. In most cases, you will know your departure date ahead of time as well. Depending upon when you were recruited and deployed, provisions will have been made to identify the date you will be leaving the assignment so that another mental health or spiritual care worker can be brought in to replace you. It is important to remember that in the event of a long and protracted disaster response it is common to routinely rotate staff off the assignment and replace them with “fresh” disaster workers. Prepare those around you for this transition and try to welcome the new workers in such a way that they can begin to feel comfortable in the work assigned to them as quickly as possible.

Upon signing out or out-processing from a disaster relief operation, there are some arrangements and tasks that will need to be completed before you depart. The first task is to make or confirm travel arrangements, especially if you did not arrive with your own transportation. Your supervisor can assist you with your travel options. Alert people at home once these arrangements have been confirmed so that they can welcome you upon your return. It always feels nice to know that you were missed and that people appreciated the work in which you have been engaged.

If you were assigned to work under a specific disaster relief organization, that organization may have specific procedures for out-processing. Familiarize yourself with these procedures ahead of time and allow enough time to out-process with respect to your travel arrangements. Be sure to check with your Technical or Administrative Supervisor should you have any questions about these procedures.

You may also be asked (or given the option) to write a narrative about your disaster relief experience. Your narrative gives you a chance to:

- Reflect on your role and responsibilities of your disaster response experience.
- Identify any challenges you faced in your role.
- Identify any broader system issues for which you have recommendations or suggestions.
- Reflect on the most rewarding part of your experience.

For many, taking the time to write this narrative either before or shortly after arriving home is a very cathartic experience. Remember to respect the confidentiality of those with whom you worked, especially if your narrative is to be shared with the general public.

A *Returning Home from a Disaster Assignment* checklist can be found in *Appendix B: Additional Information and Checklists* on page B-22.

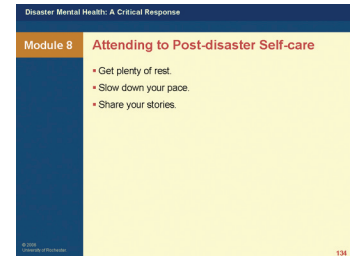
Attending to Post-disaster Self-care

Most likely, the first thing you will need to do when you complete your disaster-related duties is to rest. It is quite unlikely that you will have been able to maintain your normal sleep pattern or schedule during the disaster response. If it is possible to put off going back to work for a day or two, do it. Give yourself time for your body and your mind to reorient and simply rest.

You may also need to transition to a different, possibly slower, pace when you return. Many disaster assignments are fast-paced and intense. A more relaxed pace may feel odd or disquieting, and you may want people to speed up their pace to match yours. Let your pace slow down. Give your body and mind time to recover.

Sharing your stories lets people share your disaster experience, but it is important to remember that their lives went on while you were gone. Listening to their concerns and stories is important as well. Because of the disparity in your experiences, it may be difficult to relate to those around you for a while, but this will ease as time goes on.

If your experiences are still significantly bothering you after two weeks or more and impacting your personal, family, or work functioning, you may want to find a disaster mental health colleague or other professional with whom you can discuss your feelings and thoughts.

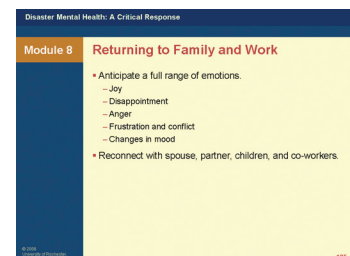


Returning to Family and Work

For those of you who may have responded to disasters out of town, there is often an array of emotions upon returning to family and friends. Besides happiness and joy at the reunion, there are difficult feelings as well. You may be disappointed that some family members or friends do not want to hear all of your stories, or they have no comprehension of what it is you have been doing for the past couple days or weeks. They may be angry that you left during very busy times for them, or that you were not there to handle your responsibilities when they needed you. You may come home exhausted from long days and stressful work and all you want to do is sleep. Yet, your spouse or significant other may expect you to pick back up your normal routine.

Variability in one's mood is common upon transitioning or returning from a disaster assignment. Emotions such as sadness, grief, or anger, which you may have suppressed while you were on assignment, may begin to surface. These emotions may alternate quickly and without warning with feelings of happiness and calm. As you become adjusted to your normal routine again, your mood shifts should abate.

Sometimes children will have difficulty understanding why you were away from home. Explaining to your children what you were doing, without frightening them with scary stories, will help. It will also help if you have been calling home regularly to speak with them while you were away. Depending on the ages of your children, you may find that they are unable to appreciate and comprehend the importance of what you were doing. They will want you to hear their stories about

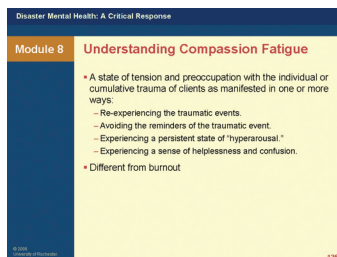


school and other activities you have missed while you were away. Taking the time to listen to your children and letting them share in your experience is a wonderful way to transition home.

When you return to your normal work routine, you may be faced with a desk piled with work that has been collecting since you have been gone. While it all seems quite trivial to you compared with your disaster assignment experiences, it is quite important to your employer and to the people you serve. You may also get a mixed response from your co-workers upon your return. Many colleagues will recognize the importance of your disaster work, but others may feel resentful that they were not given the same opportunity, especially if they had to cover your responsibilities while you were away.

Understanding Compassion Fatigue

Charles Figley, best known for his work on the stress effects of trauma, describes a phenomenon known as “compassion fatigue,” also referred to as secondary traumatic stress.¹ Compassion fatigue can be particularly problematic for mental health and spiritual care workers on disaster assignments. Working long hours and hearing many stories of loss, grief, anger, and devastation can take its toll on even those well experienced in the field.



Recognizing the Warning Signs of Compassion Fatigue

While the symptoms of compassion fatigue may come on suddenly, the good news is that you can recover quickly as well. Individuals who are experiencing compassion fatigue may find themselves:

- Re-experiencing the traumatic event.
- Avoiding the reminders of the traumatic event.
- Experiencing a persistent state of “hyperarousal.”
- Experiencing a sense of helplessness and confusion.

With compassion fatigue, you may identify too closely with survivors rather than distancing yourself from them as experienced with burnout.

You may not recognize that your symptoms of distress are related to the stories you have been hearing, or that there is any connection with your own past or current traumatic experiences. Warning signs² of compassion fatigue include those listed in the following table.

¹ *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. (1995) Figley, C. (editor). New York: Brunner/Mazel, Inc.

² Pfifferling, J., & Gilles, K. (April 2000). Overcoming Compassion Fatigue: When practicing medicine feels more like labor than a labor of love, take steps to heal the healer. *Family Practice Management*. 7(4). Retrieved from <http://www.aafp.org/fpm/20000400/39over.html>.

Emotional	Physical
<ul style="list-style-type: none"> ■ Anger ■ Blaming ■ Depression ■ Diminished sense of personal accomplishment ■ Exhaustion ■ High self-expectations ■ Hopelessness ■ Inability to maintain balance of empathy and objectivity ■ Increased irritability ■ Less ability to feel joy ■ Low self-esteem 	<ul style="list-style-type: none"> ■ Abusing drugs, alcohol, or food ■ Exhaustion ■ Frequent headaches ■ Gastrointestinal complaints ■ Sleep disturbances ■ Workaholism

Table 8–1: Warning Signs of Compassion Fatigue

Monitoring Yourself and Asking for Help

Many of the self-care techniques we discussed in Module 6 can be used towards preventing or mitigating compassion fatigue. It is extremely important that you continually self-monitor for the warning signs and ask others around you to let you know if they are seeing these same signs or reactions. If you or they see that your personal, family, and work life is disrupted because of these warning signs, then that should be your red flag to reach out and ask for help and support.

After Relief Work³

Expect a readjustment period upon returning home. You may need to make personal reintegration a priority for a while. Make every effort to engage in the following activities:

- Seek out and utilize social support.
- Check in with other relief colleagues to discuss disaster experiences.
- Increase supervision, consultation, and collegial support.
- Schedule time for a vacation or gradual reintegration into your normal life.
- Prepare for worldview changes that may not be mirrored by others in your life.
- Participate in formal help to address your response to relief work if stress persists for greater than two to three weeks.
- Increase leisure activities, stress management, and exercise.
- Pay extra attention to health and nutrition.
- Pay extra attention to rekindling close interpersonal relationships.
- Practice good sleep routines.
- Make time for self-reflection.

Disaster Mental Health: A Critical Response					
Module 8	Recognizing the Warning Signs of Compassion Fatigue				
	<table> <tr> <th>Emotional</th><th>Physical</th></tr> <tr> <td> <ul style="list-style-type: none"> • Anger • Blaming • Depression • Diminished sense of personal accomplishment • Exhaustion • High self-expectations • Hopelessness • Inability to maintain balance of empathy and objectivity • Increased irritability • Less ability to feel joy • Low self-esteem </td><td> <ul style="list-style-type: none"> • Abusing drugs, alcohol, or food • Exhaustion • Frequent headaches • Gastrointestinal complaints • Sleep disturbances • Workaholism </td></tr> </table>	Emotional	Physical	<ul style="list-style-type: none"> • Anger • Blaming • Depression • Diminished sense of personal accomplishment • Exhaustion • High self-expectations • Hopelessness • Inability to maintain balance of empathy and objectivity • Increased irritability • Less ability to feel joy • Low self-esteem 	<ul style="list-style-type: none"> • Abusing drugs, alcohol, or food • Exhaustion • Frequent headaches • Gastrointestinal complaints • Sleep disturbances • Workaholism
Emotional	Physical				
<ul style="list-style-type: none"> • Anger • Blaming • Depression • Diminished sense of personal accomplishment • Exhaustion • High self-expectations • Hopelessness • Inability to maintain balance of empathy and objectivity • Increased irritability • Less ability to feel joy • Low self-esteem 	<ul style="list-style-type: none"> • Abusing drugs, alcohol, or food • Exhaustion • Frequent headaches • Gastrointestinal complaints • Sleep disturbances • Workaholism 				

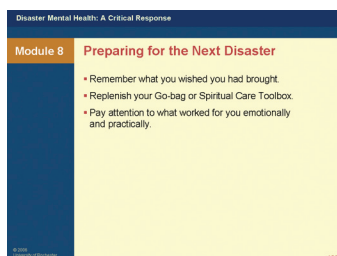
Disaster Mental Health: A Critical Response	
Module 8	Monitoring Yourself and Asking for Help
	<ul style="list-style-type: none"> • Monitor yourself for signs of compassion fatigue. • Ask for help. • Engage in healthy activities while avoiding those that may be destructive.

³ *Provider Self-care During Relief Work*. Retrieved from the National Center for Post-Traumatic Stress Disorder Web site at http://www.ncptsd.va.gov/pfa/Self_Care_for_Providers.pdf.

- Practice receiving from others.
- Find things to make you laugh.
- Try at times not to be in charge or the “expert.”
- Increase experiences that have spiritual or philosophical meaning to you.
- Anticipate that you will experience recurring thoughts or dreams, and that they will decrease over time.
- Keep a journal to get worries off your mind.
- Ask for help in parenting if you feel irritable or are having difficulties adjusting to being back at home.

Make every effort to avoid:

- Using alcohol, illicit drugs, or excessive amounts of prescription drugs, all of which interfere with sleep cycles and prolong recovery.
- Making any big life changes for at least a month.
- Assessing negatively your contribution to relief work.
- Worrying about the difficulties you face in readjusting (unless they are still present after a month).
- Engaging in obstacles to better self-care.
- Keeping too busy.
- Making care of others more important than self-care.
- Withdrawing and not talking about relief work experiences with others when appropriate.



Preparing for the Next Disaster

There will be another disaster. Your experience with each disaster can help you to prepare for the next assignment. If this is the type of work you find satisfying, make your preparations for future assignments immediately following each completed disaster assignment.

- Remember what you wished you had brought with you and make a note of it somewhere.
- Replenish your Go-bag and Spiritual Care Toolbox so that you are prepared for the next disaster assignment.
- Pay attention to what worked for you emotionally and practically, and plan to include these factors in your next assignment.

It is important not to minimize the amount of energy it will take to transition back home from a disaster relief assignment. It is not as easy as picking up where you left off. For some, their disaster assignments have been life-changing events that they will not soon forget. Celebrate the contributions that you have made in people's lives and be aware of the changes that this opportunity has made in you and those around you.

Interaction 5: Revisiting Your Disaster Mental Health Personal, Family, and Work Life Inventory

Now that you have completed this training program, you have an opportunity to review your Disaster Mental Health Personal, Family, and Work Life Inventory once again. You know much more about disasters and the consequences to a community and the individuals who are directly affected by a disaster.

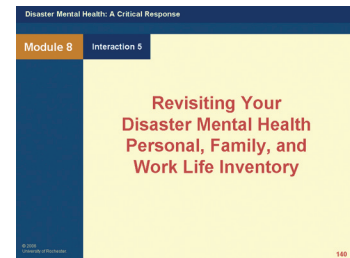
The purpose of this exercise is to revisit your Disaster Mental Health Personal, Family, and Work Life Inventory to clarify any of your responses now that you know more about the challenges of providing disaster mental health on a disaster relief operation. In addition, you may wish to revise your ideas about what you need to do to be better prepared prior to being deployed on a disaster assignment.

Take a few minutes to review your ***Disaster Mental Health Personal, Family, and Work Life Inventory***. Now consider the following questions.

1. What would you change with respect to your readiness under the Personal category? Why?
2. What would you change with respect to your readiness under the Health category? Why?
3. What would change with respect to your readiness under the Family category? Why?
4. What would change with respect to your readiness under the Work Life category? Why?
5. How would you revise your responses to the open-ended questions under the category of Other Considerations?
6. How would you revise your plan so that you are better prepared to respond to a disaster assignment?

Module Summary

With the completion of this module, you have explored many aspects and challenges of transitioning from a disaster assignment back to life as you know it. In addition, you were provided with an opportunity to revisit your ***Disaster Mental Health Personal, Family, and Work Life Inventory*** and review your responses now that you are more familiar with the demands of disaster mental health and spiritual care work.



Program Summary

Summary Overview

During this training program, you have devoted considerable time and energy to attend this training program.

- By the end of this training, you should have acquired the knowledge and skills to respond adequately to the mental health and spiritual needs of individuals and responders during times of disaster.
- This training has also prepared you to become part of a trained network of disaster mental health and spiritual care professionals throughout New York State, increasing your facility, county, and State's readiness and ability to deploy disaster mental health and spiritual care professionals to disaster sites.

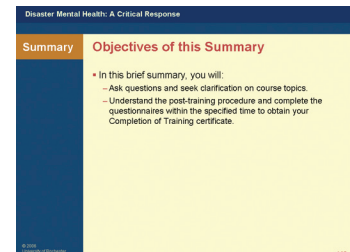
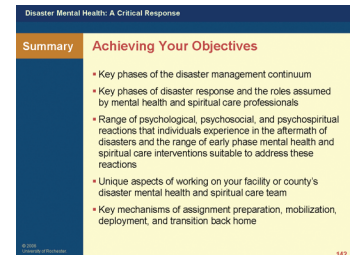
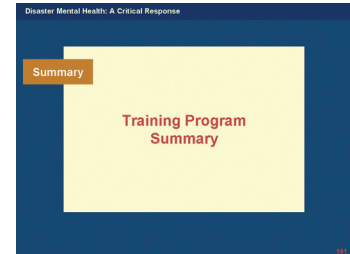
This training program has provided you with important information that you will translate into workable knowledge that will help you to be effective in providing the necessary support to the populations who are affected by disasters. You will be an asset to your facility or county's disaster mental health and spiritual care team because you now have a better understanding of the:

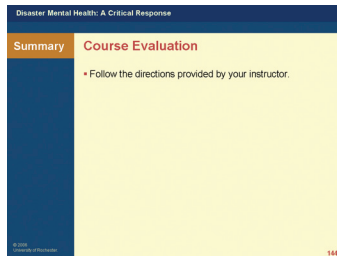
- Key phases of the disaster management continuum
- Key phases of disaster response and the roles assumed by mental health and spiritual care professionals
- Range of psychological, psychosocial, and psychospiritual reactions that individuals experience in the aftermath of disasters and the range of early phase mental health and spiritual care interventions suitable to address these reactions
- Unique aspects of working on your facility or county's disaster mental health and spiritual care team
- Key mechanisms of assignment preparation, mobilization, deployment, and transition back home

Objectives of this Summary

This is your opportunity to raise any issues you have or to clarify any concepts or information that have been presented in this training program. In this brief summary, you will:

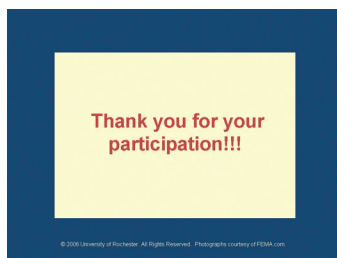
- Ask questions and seek clarification on course topics.
- Understand the post-training procedures and complete the questionnaires within the specified time to obtain your Completion of Training certificate.





Course Evaluation

At the beginning of this training program, you completed a pre-training questionnaire. Now that you have completed this training program, we ask you to complete three post-training questionnaires as well. These questionnaires will provide you with an opportunity to describe what you have learned, its impact on your day-to-day work life, and how satisfied you are with this training experience. Once you have completed the post-training questionnaires, you will receive your Completion of Training certificate from your instructors. This certificate is a requirement for those of you who will be joining your local facility's or county's disaster mental health team. Your instructors will provide more details about completing the post-training questionnaires and receiving your Completion of Training certificate.



Appendix A: Exercises

**Exercise 1: First on the Scene of a Disaster
(Module 2)**

**Exercise 2: Disaster Types and Characteristics
(Module 3)**

**Exercise 3: Affected Populations and Responses
(Module 4)**

Note: A description and handouts for the final exercise, Exercise 4: Family Reception Center (Module 7), will be provided by the instructors.

Exercise 1: First on the Scene of a Disaster

Exercise Overview

It is a Saturday afternoon. You are in your car running errands and listening to the local news radio station. The newscaster is warning drivers to avoid a particular state highway because of a serious bus crash. The out-of-state bus was transporting a group of adults on their way home from a casino. The news report does not provide specific details, except that the bus appears to have skidded out of control over an embankment, rolled several times, and landed on its side.

Exercise Purpose

The purpose of this exercise is to explore this disaster scene from the time of the crash, as first responders arrive, and through the first few hours as the situation is being addressed. You should think about what the scene looks like, who is on the scene, and what is happening.

Exercise Mode

Each of you will respond to the questions first. Then you will share your responses with the entire group in the context of a discussion about what this particular scene may look like. Your instructors will guide you through this exercise.

Exercise Duration

Take approximately 15 minutes to think about and jot down ideas in response to the questions.

Exercise Instructions

Your objective is to think about all the aspects of the accident scene, including what it looks and sounds like and how the chaos of the scene is being addressed. Refer to the information in Module 2 and use the following questions to guide your exploration of who is first on the scene and what they are doing.

-
1. Before anyone arrives on the scene, what is happening with the bus passengers who have escaped the bus with minor injuries?

-
2. Who are the first responders and what are they doing? Who else is on the scene?

-
3. Who is in charge and how are the various organizations working together?

-
4. What are you hearing from rescue personnel and from bus passengers? (Orders, directives, pleading, and crying, etc.)

-
5. What services will be offered away from the scene? Who will be providing them?

Exercise 2: Disaster Types and Characteristics

Exercise Overview

This exercise will provide you with an opportunity to integrate what you have learned in Module 3 and expand on it a little more specifically with respect to your own community. Although there are similarities among natural and human-caused disasters and public health emergencies, there are important differences that yield logistical challenges for each community and, therefore, influence how the community is able to respond. This exercise is designed to provide you and your group members with an opportunity to discuss the various similarities and differences among disaster classifications/types with respect to:

- Onset of the disaster
- Duration of the disaster
- Scope of the disaster
- Impact of the disaster

Exercise Purpose

The purpose of this exercise is to explore the characteristics of natural disasters, human-caused disasters, and public health emergencies that may happen in your community and to identify the potential impact these will have and the challenges inherent in responding to these occurrences.

Exercise Mode

This is a small group exercise. Your instructors will organize you into small groups. Each group will be assigned a specific scenario. In these groups, you will discuss your responses to a series of questions. When you have completed your group work, you will share your observations with the rest of the class. Use this exercise handout to guide your interactions with group members.

Exercise Duration

Take approximately 15 minutes to work through this exercise with group members.

Exercise Instructions

Review the following disaster scenarios. Your instructor will assign one in particular for each group to address in more detail.

1. A Category 3 hurricane has struck the south shore of Long Island on May 14. The worst hit areas have included the coastline communities. Warnings were issued 24 hours in advance advising residents to evacuate from shoreline properties, especially those at the most Eastern parts of Long Island. The worst of the storm occurred at 2:00 AM, producing a storm surge. The damage to the shoreline and property is immediately apparent. Flooding and debris have resulted in limited access and egress.

2. It is 11:00 AM on a Tuesday in October, and children at an elementary school in a rural community are beginning the normal lunch routine. It has been a windy, rainy day, but not unlike others. Without warning, the north end of the building is struck by what appears to be a tornado or microburst. The cafeteria, which has a wall of windows, is on this side of the building.
3. In a medium-sized city in Western New York State at 3:00 PM, an explosion occurs at a chemical company. The explosion was heard and felt for miles around. The smoke and flames color the sky. Initially, the explosion is assumed to be an act of terrorism, especially since this company works on classified projects for the U.S. Government.
4. Western New York State, especially along the New York State Thruway, offers harsh winter weather and challenging driving conditions. On a Sunday evening in February, a Pennsylvania-licensed bus is returning home from a Canadian casino in Niagara Falls. Bus passengers are retired seniors, many of whom reside in Pennsylvania counties in and around Scranton and Wilkes-Barre. About 6:00 PM, somewhere in between exit 47 (Batavia) and exit 46 (Henrietta/Rochester), the bus skids, breaks through barriers along the right shoulder, careens down a hill, and lands on its side.
5. Influenza tracking and information have been prominently featured in many new journals and Web sites. The threat of a pandemic is real. It is the middle of January and a significant outbreak has occurred in a large metropolitan city in New York State. A public health warning has been issued by city, state, and federal government agencies, including the CDC.

Although you will be tempted to discuss the psychological implications around disaster characteristics, you should focus your discussion primarily around *community and healthcare logistics*. For example, consider the following challenges.

- With sudden, unanticipated disasters, communities might not have the opportunity to prepare for evacuation or other safety or security measures.
- Disasters that occur in rural communities may be challenged by inaccessibility of response equipment or personnel.
- Disasters that occur at rush hour may cause more injuries or present transportation challenges.
- Disasters during the day may pose logistical challenges for family members who are separated and need to be reunited (this may also be a basis for psychological reactions).

Now address the following questions specifically in relation to your group's assigned disaster scenario.

1. What kinds of challenges in particular about the time of day, time of year, and location of the disaster do you think the community will face?
2. What are some of the obvious logistical challenges of dealing with the populations that are most affected by the disaster?
3. What can you say about the magnitude (scope and impact) of the disaster in terms of the level and complexity of the emergency response and the resources that are needed?

Exercise 3: Affected Populations and Responses

Exercise Overview

A serious bus crash has occurred in your community. The passengers will be transported to your healthcare facility. Essentially, this is the same bus crash that you explored in Exercise 1. This bus crash has happened on a Saturday afternoon on a major highway. However, for the purposes of this exercise, you will explore four different scenarios related to the purpose of the bus trip and passengers on the bus. These scenarios are as follows.

- Bus 1 was transporting high school football and cheerleading teams on the way to a sectional competition in another part of New York State; the accident occurs 50 miles from the team's home.
- Bus 2 was transporting a senior citizens' tour group from Pennsylvania on its way home from a Canadian casino.
- Bus 3 was transporting immigrant farm workers to employment in a rural community.
- Bus 4 was transporting a Mormon Church group returning home from a Toronto weekend of cultural events; the crash occurred 150 miles from their home.

Law enforcement and rescue personnel have been deployed. Information about the bus passengers is being verified. The details appear within the context of the instructions.

Exercise Purpose

The purpose of this exercise is to explore how these different populations may respond to the disaster situation in which they find themselves.

Exercise Mode

This is a small group exercise. You will work with several others as determined by your instructors. Use this exercise handout to guide your interactions with group members.

Exercise Duration

Take approximately 15 minutes to work through this exercise with group members.

Exercise Instructions

Reconvene in your small groups. Each group will be assigned a scenario. As a group, identify the various issues and responses faced by the passengers, their families, and those called to the scene to assist in this disaster response. This exercise will build on the knowledge you have gained from Modules 2, 3, and 4. Consider that you are a mental health or spiritual care professional who is called to the scene of this accident or are in the emergency room when these passengers arrive. Consider the passenger profiles provided on the following pages. These details should provide you with enough information to think about the responses of affected populations and the issues that may arise.

Appendix A: Exercises

Scenario	Passenger Profiles	Injuries and Casualties
Bus 1: High school football team and cheerleading team (Total # of passengers = 42)	<ul style="list-style-type: none"> 30 male students 8 female high school students 45-year old male head coach 37-year old male assistant coach 33-year-old female cheerleading coach 48-year old female bus driver 	<p>Fatalities include:</p> <ul style="list-style-type: none"> 33-year-old female cheerleading coach 2 football players 3 cheerleaders 48-year old bus driver <p>All surviving passengers were transported to area hospitals:</p> <ul style="list-style-type: none"> 1 cheerleader, 1 football player, and the assistant coach were air lifted to emergency facilities able to handle severe trauma 4 cheerleaders, 27 football players, and the head coach were transported to local hospitals with minor injuries (Two of the survivors have siblings who died in the crash.)
Bus 2: Senior citizens' tour group (Total # of passengers = 41)	<ul style="list-style-type: none"> 26 elderly female passengers 14 elderly male passengers 38-year old male bus driver 	<p>Fatalities include:</p> <ul style="list-style-type: none"> 6 women 3 men <p>All surviving passengers were transported to area hospitals:</p> <ul style="list-style-type: none"> 3 women and 2 men were air lifted to emergency facilities able to handle severe trauma Bus driver and remaining passengers (26) were transported to local hospitals with minor injuries (3 of the male survivors have spouses who died in the crash. 2 of the female survivors have siblings who died in the crash.)
Bus 3: Immigrant farm workers (Total # of passengers = 44)	<ul style="list-style-type: none"> 20 middle-aged male passengers 7 young adult male passengers between the ages of 16 and 30 13 middle-aged female passengers 3 older adult female passengers 55-year-old male bus driver 	<p>Fatalities include:</p> <ul style="list-style-type: none"> Grandmother, her son (45), and her grandson (16) from one family (wife, who is the daughter-in-law, survived) 3 women between the ages of 30 and 45 1 male, aged 60 (wife survived) <p>All surviving passengers were transported to area hospitals:</p> <ul style="list-style-type: none"> Bus driver and remaining passengers (37) were transported to local hospitals with minor injuries.
Bus 4: Mormon Church group (Total # of passengers = 42)	<ul style="list-style-type: none"> 8 families, including 16 adults and 20 children ranging from 5 to 16 years of age 60-year old male Mormon Bishop and his 55-year old wife 3 older adult female church staff members 48 year-old male bus driver 	<p>Fatalities include:</p> <ul style="list-style-type: none"> Wife of the Bishop Mother and father from one family (children survive, age 12, 14, and 16) 2 children from one family (parents survive) 1 5-year old (7 year-old sibling and parents survive) 1 mother (father and 3 children survive) 1 father (mother and 2 children survive) <p>All surviving passengers were transported to area hospitals:</p> <ul style="list-style-type: none"> 3 children were air lifted to emergency facilities able to handle severe trauma Bus driver and remaining (30) passengers were transported to local hospitals with minor injuries.

For each of the populations (passengers, family members of bus passengers, and disaster responders), discuss the range of reactions that you could encounter as a mental health or spiritual care worker. Think about the logistical challenges that might exacerbate the reactions from those involved in the bus crash. Consider using the following table to organize your responses.

Population	Range of Reactions	Logistical Challenges
Passengers		
Family Members of Bus Passengers		
Disaster Responders		

Appendix B: Additional Information and Checklists

**The Disaster Process and Disaster Aid Programs
(Module 2)**

**Diagnostic and Statistical Manual of
Mental Disorders-IV (DSM-IV-TR Criteria) (Module 4)**

**Chemical, Biological, Radiological, Nuclear,
and Explosive Agents Used in Acts of Terrorism
(Module 4 & 5)**

**Disaster Mental Health Professional Go-bag Checklist
(Modules 6 & 7)**

Spiritual Care Toolbox (Modules 6 & 7)

Key Components of Early Intervention (Module 7)

**Returning Home from a Disaster Assignment Checklist
(Module 8)**

The Disaster Process and Disaster Aid Programs

Information about the disaster process and aid program has been compiled from a number of Web sites, including <http://www.fema.gov/library/dproc.shtm>.

Response and Recovery

First *Response* to a disaster is the job of local government's emergency services with help from nearby municipalities, the state, and volunteer agencies. In a catastrophic disaster, and if the governor requests, federal resources can be mobilized through the Federal Emergency Management Agency (FEMA) for search and rescue, electrical power, food, water, shelter and other basic human needs.

It is the long-term *Recovery* phase of disaster that places the most severe financial strain on a local or state government. Damage to public facilities and infrastructure, often not insured, can overwhelm even a large city.

A governor's request for a major disaster declaration could mean an infusion of federal funds, but the governor must also commit significant state funds and resources for recovery efforts.

A *Major Disaster* could result from a hurricane, earthquake, flood, tornado, or major fire that the President determines warrants supplemental federal aid. The event must be clearly more than state or local governments can handle alone. If declared, funding comes from the President's Disaster Relief Fund, which is managed by FEMA, and disaster aid programs of other participating federal agencies.

A *Presidential Major Disaster Declaration* puts into motion long-term federal recovery programs, some of which are matched by state programs, and designed to help disaster victims, businesses, and public entities.

An *Emergency Declaration* is more limited in scope and without the long-term federal recovery programs of a Major Disaster Declaration. Generally, federal assistance and funding are provided to meet a specific emergency need or to help prevent a major disaster from occurring.

The Major Disaster Process

A Major Disaster Declaration usually follows these steps.

1. The *local government responds*, supplemented by neighboring communities and volunteer agencies. If overwhelmed, the local government turns to the state for assistance.
2. The *State responds* with state resources, such as the National Guard and state agencies.
3. The *damage assessments* conducted by local, state, federal, and volunteer organizations determine losses and recovery needs.
4. A *Major Disaster Declaration* is requested by the governor, based on the preliminary damage assessment (PDA), and an agreement to commit state funds and resources to the long-term recovery.
5. FEMA *evaluates the request* and *recommends* action to the White House based on the disaster, the local community and the state's ability to recover.
6. The *President approves* the request or FEMA informs the governor it has been denied. This decision process could take a few hours or several weeks depending on the nature of the disaster.

Disaster Aid Programs

There are two major categories of disaster aid.

- *Individual Assistance* addresses damage to residences and businesses or personal property losses.
- *Public Assistance* addresses repair of infrastructure, public facilities, and debris removal.

Individual Assistance

Immediately after the declaration, disaster workers arrive and set up a central field office to coordinate the recovery effort. A toll-free telephone number is published for use by affected residents and business owners to register for assistance. Disaster Recovery Centers also are opened where disaster victims can meet with program representatives and obtain information about available aid and the recovery process.

Disaster aid to individuals generally falls into the following categories:

- *Disaster housing* may be available for up to 18 months, using local resources, for displaced persons whose residences were heavily damaged or destroyed. Funding also can be provided for housing repairs and replacement of damaged items to make homes habitable.
- *Disaster grants* are available to help meet other serious disaster related needs and necessary expenses not covered by insurance and other aid programs. These may include replacement of personal property, and transportation, medical, dental, and funeral expenses.
- *Low-interest disaster loans* are available after a disaster for homeowners and renters from the U.S. Small Business Administration (SBA) to cover uninsured property losses. Loans may be for repair or replacement of homes, automobiles, clothing, or other damaged personal property. Loans are also available to businesses for property loss and economic injury.
- *Other disaster aid programs* include crisis counseling, disaster-related unemployment assistance, legal aid, assistance with income tax, and Social Security and Veteran's benefits. Other state or local help may also be available.

Assistance Process

After the application is taken, the damaged property is inspected to verify the loss. If approved, an applicant will soon receive a check for rental assistance or a grant. Loan applications require more information and approval may take several weeks after application. The deadline for most individual assistance programs is 60 days following the President's major disaster declaration.

Audits are done later to ensure that aid went to only those who were eligible and that disaster aid funds were used only for their intended purposes. These federal program funds cannot duplicate assistance provided by other sources such as insurance.

After a major disaster, FEMA tries to notify all disaster victims about the available aid programs and urges them to apply. The news media are encouraged to visit a Disaster Recovery Center, meet with disaster officials, and help publicize the disaster aid programs and the toll-free tele-registration number.

Public Assistance

Public Assistance is aid to state or local governments to pay part of the costs of rebuilding a community's damaged infrastructure. Generally, public assistance programs pay for 75% of the approved project costs. Public Assistance may include debris removal, emergency protective measures and public services, repair of damaged public property, loans needed by communities for essential government functions, and grants for public schools.

Hazard Mitigation

Disaster victims and public entities are encouraged to avoid the life and property risks of future disasters. Examples include the elevation or relocation of chronically flood-damaged homes away from flood hazard areas, retrofitting buildings to make them resistant to earthquakes or strong winds, and adoption and enforcement of adequate codes and standards by local, state, and federal government. FEMA encourages and helps fund damage mitigation measures when repairing disaster-damaged structures.

Small Business Administration (SBA) Disaster Loans

The U.S. Small Business Administration (SBA) can make federally subsidized loans to repair or replace homes, personal property or to businesses that sustained damages not covered by insurance. The Small Business Administration can provide three types of disaster loans to qualified homeowners and businesses.

- *Home Disaster Loans* are available to homeowners and renters to repair or replace disaster-related damages to home or personal property.
- *Business Physical Disaster Loans* are available to business owners to repair or replace disaster-damaged property, including inventory and supplies.
- *Economic Injury Disaster Loans* provide capital to small businesses and to small agricultural cooperatives to assist them through the disaster recovery period.

For many individuals the SBA disaster loan program is the primary form of disaster assistance.

Disaster Unemployment Assistance

The Disaster Unemployment Assistance (DUA) program provides unemployment benefits and re-employment services to individuals who have become unemployed because of major disasters. Benefits begin with the date the individual was unemployed due to the disaster incident and can extend up to 26 weeks after the Presidential Declaration date. These benefits are made available to individuals not covered by other unemployment compensation programs, such as self-employed, farmers, migrant and seasonal workers, and those who have insufficient quarters to qualify for other unemployment compensation.

All unemployed individuals must register with the State's Employment Services Office before they can receive DUA benefits. However, although most States have a provision that an individual must be able and available to accept employment opportunities comparable to the employment the individual held before the disaster, not all States require an individual to search for work.

Legal Services

When the President declares a disaster, FEMA/EPR, through an agreement with the Young Lawyers Division of the American Bar Association, provides free legal assistance to disaster victims. Legal advice is limited to cases that will not produce a fee (i.e., these attorneys work without payment). Cases that may generate a fee are turned over to the local lawyer referral service.

The assistance that participating lawyers provide typically includes:

- Assistance with insurance claims (life, medical, property, etc.)
- Counseling on landlord and tenant problems
- Assisting in consumer protection matters, remedies, and procedures
- Replacement of wills and other important legal documents destroyed in a major disaster

Disaster legal services are provided to low-income individuals who, prior to or because of the disaster, are unable to secure legal services adequate to meet their needs as a consequence of a major disaster.

Special Tax Considerations

Taxpayers who have sustained a casualty loss from a declared disaster may deduct that loss on the federal income tax return for the year in which the casualty actually occurred, or elect to deduct the loss on the tax return for the preceding tax year.

Mental Health Counseling Services

Under federally declared disasters, immediate and short-term mental health financial assistance to States may be available from the Federal government.

FEMA/Center for Mental Health Services Crisis Counseling Assistance and Training Program

The Crisis Counseling Training and Assistance Program (CCP), administrated by FEMA and CMHS and authorized by the Stafford Act, is designed to provide supplemental funding to States for short-term crisis counseling services to people affected in *Presidentially Declared Disasters*. There are two separate portions of the CCP that can be funded: immediate services and regular services. A State may request either or both types of funding.

- The *immediate services* program is intended to enable the State or local agency to respond to the immediate mental health needs with screening, diagnostic, and counseling techniques, as well as outreach services such as public information and community networking.
- The *regular services* program is designed to provide up to nine months of crisis counseling, community outreach, and consultation and education services to people affected by a *Presidentially Declared Disaster*. Funding for this program is separate from the immediate services grant.

To be eligible for crisis counseling services funded by this program, the person must be a resident of the designated area or must have been located in the area at the time the disaster occurred. The person must also have a mental health issue that was caused by or aggravated by the disaster or its aftermath.

Diagnostic Information from the DSM-IV-TR Criteria

This information represents excerpts from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington, DC: American Psychiatric Association (2000).

Anxiety Disorders

Diagnostic Criteria for Panic Attacks

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias (numbness or tingling sensations)
- Chills or hot flushes

Diagnostic Criteria for Acute Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present.
 - The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - The person's response involved intense fear, helplessness, and horror.
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
 - A subjective sense of numbing, detachment, or absence of emotional responsiveness
 - Reduction in awareness of his or her surroundings (e.g., "being in a daze")
 - Derealization
 - Depersonalization
 - Dissociative amnesia (i.e., inability to recall important aspects of the trauma)
- C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience, or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, and people).

- E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, and motor restlessness).
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G. The disturbance last for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

Diagnostic Criteria for Post-Traumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present.
 - The person experienced, witnessed, or was confronted with an event or events that involved actual threat of death or serious injury, or a threat to the physical integrity of self or others.
 - The person's response involved intense fear, helplessness, and horror.
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
 - Recurrent distressing dreams of the event
 - Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
 - Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - Efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - Efforts to avoid activities, places, or people that arouse recollections of the trauma
 - Inability to recall an important aspect of the trauma
 - Markedly diminished interest or participation in significant activities
 - Feeling of detachment or estrangement from others
 - Restricted range of affect (e.g., unable to have loving feelings)
 - Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - Difficulty falling or staying asleep
 - Irritability or outbursts of anger
 - Difficulty concentrating
 - Hypervigilance
 - Exaggerated startle response
- E. Duration of the disturbance is more than one month.
- F. The disturbance causes significant distress or impairment in social, occupation, or other important areas of functioning.

Diagnostic Criteria for Generalized Anxiety Disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past six months).

Note: *Only one item is required in children.*

- Restlessness or feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Mood Disorders

Diagnostic Criteria for Major Depressive Episode

- A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either

- Depressed mood or
- Loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, mood-incongruent delusions, or hallucinations.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

Note: In children and adolescents, can be irritable mood.

- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day

Note: In children, consider failure to make expected weight gains.

- Insomnia or Hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or a specific plan for committing suicide

- B. The symptoms do not meet criteria for a Mixed Episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, (i.e., after the loss of a loved one) and the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Appendix B: Additional Information and Checklists

Diagnostic Criteria for Major Depressive Disorder, Single Episode

- A. Presence of a single Major Depressive Episode.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. Determine Severity/Psychotic/Remission Specifiers (for current or most recent episode):
 - Chronic
 - With Catatonic Features
 - With Melancholic Features
 - With Atypical Features
 - With Postpartum Onset

Bereavement

This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (i.e. feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as “normal,” although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of “normal” bereavement vary considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present two months after the loss. However, the presence of certain symptoms that are not characteristic of a “normal” grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode. These include:

- Guilt about things other than actions taken or not taken by the survivor at the time of the death
- Thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person
- Morbid preoccupation with worthlessness
- Marked psychomotor retardation
- Prolonged and marked functional impairment
- Hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person

Psychotic Disorders

Diagnostic criteria for Brief Psychotic Disorder

- A. Presence of one (or more) of the following symptoms:
 - delusions
 - hallucinations
 - disorganized speech (e.g., frequent derailment or incoherence)
 - grossly disorganized or catatonic behavior

Note: Do not include a symptom if it is a culturally sanctioned response pattern.

- B. Duration of an episode of the disturbance is at least one day but less than one month, with eventual full return to premorbid level of functioning.
- C. The disturbance is not better accounted for by a Mood Disorder with Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Specify if:
 - *With Marked Stressor(s) (brief reactive psychosis)*: if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture
 - *Without Marked Stressor(s)*: if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture
 - *With Postpartum Onset*: if onset within four weeks postpartum

Chemical, Biological, Radiological, Nuclear, and Explosive Agents Used in Acts of Terrorism

The following information was compiled from *Disaster Nursing and Emergency Preparedness for Chemical, Biological, and Radiological Terrorism* (2003), edited by Tener Goodwin Veenema. (New York: Springer Publishing Company)

Chemical Agents

Blister Agents

Blister agents are known to cause blisters, but also cause damage to the eyes. Two common blister agents are mustard gas (Sulfur Mustard) and Lewisite.

Mustard gas is a chemical that can come in various forms, a vapor, a liquid or a solid.

As a liquid, it has an oily texture and the color is yellow to brown. In cold conditions, it can last for weeks or even months. This agent was used during World War I for chemical warfare, and although it was not a fatal weapon, its effects were long lasting.

When it is a vapor, it can spread easily and be breathed in, get on the skin or in the eyes. Vapors will settle in low-lying areas because it is denser than air. As a liquid or a solid, it could be added to water and enter the body after it is consumed.

The symptoms of this agent include an initial redness of the skin followed by a yellow blistering. The eyes will become irritated and begin to water. In some severe cases, it has been known cause temporary blindness for up to ten days.

A person will also face a runny or bloody nose, shortness of breath, sinus pain, and cough. Digestive problems may occur with abdominal pain, nausea, diarrhea, vomiting and a fever.

Long-term effects may include permanent blindness, burns and scarring, respiratory disease, and a greater risk of cancer. The treatment includes supportive medical care.

This means that first the person must leave the area as quickly as possible. If it was inhaled, a person should get fresh air. If in the eyes, it should be flushed out as soon as possible. If on the skin, it should be washed off. If swallowed, the person should drink milk and call 9-1-1.

Blood Agents

Blood agents enter into the blood stream and prevent the absorption of oxygen in cells so that they die. They do this by inhibiting oxygen-receiving enzymes. Most notably among these agents is cyanide.

Cyanide is a very dangerous chemical that can be a colorless gas or a crystal solid. It is most often odorless. Cyanide exists in the daily life and can be found in cigarette smoke or when plastic burns. It is also used in the development of photographs. Exposure happens when it is breathed in or when someone eats something that is contaminated. In its aerosolized form, it is less dense than air and thus it rises, making it a minimal threat in this form.

Cyanide prevents oxygen from entering into cells, and even if exposed to small amounts, the symptoms will be rapid breathing, gasping for air, dizziness, headache, nausea, rapid heart rate, and bluish skin. If an individual is exposed to large amounts, in addition to the symptoms already mentioned, other symptoms can include convulsions, low blood pressure, a slow heart rate, and unconsciousness. The individual eventually stops breathing and then death occurs.

The treatment protocol is similar for blood agents as it is for blister agents and includes supportive medical care. The one addition for blood agents is that there is an antidote that can be taken to alleviate the symptoms.

Pulmonary Agents

A *pulmonary agent* causes breathing problems that lead to organ damage. *Chlorine gas* is an example of a pulmonary agent. It is a widely used product that can be found in water and bleach cleaner. However, as a gas it is poisonous and when it comes in contact with tissue it creates an acid that damages these tissues.

An individual can be affected by drinking or eating large amounts of chlorinated liquids or food, or by inhaling the poisonous gas. The gas is yellow-green and has the familiar smell of bleach. Like mustard gas, chlorine gas is dense and stays close to the ground.

Symptoms related to being exposed to chlorine depend on the amount of the exposure. Exposure typically includes a burning pain, redness that develops into blisters on the skin, a burning feeling in the eyes, a burning feeling in nose and throat, tightness in chest, trouble breathing, and fluid will then fill up the lungs. Symptoms may also include vomiting and nausea.

If it is chlorine liquid in high concentration, the only difference is that the skin will become white and numb and develop frostbite-like blisters as opposed to the red and burning when exposed to gas. A pulmonary agent can be produced commercially, and thus use by a terrorist agency is not out of the realm of possibilities.

Psychoincapacitating Agents

Psychoincapacitating agents disrupt the central nervous system (CNS) and lead to confusion, short-term memory loss, and immobility. LSD is a well-known incapacitating agent. Another incapacitating agent is called BZ. This agent can be spread with a bomb or aerosolized with a spray. The effectiveness of putting it in the air is not known.

Symptoms related to BZ do not just depend on how a person is exposed, but it also varies by the person. Essentially, there will be symptoms of confusion, hallucinations, dilation of the pupils, slurred speech, loss of motor skills, and a slower heart rate that can last for more than 24 hours. This agent can be treated with an antidote that reverses symptoms for an hour, but as can be found with LSD, the effects are long lasting and repeat doses of the antidote may be necessary. LSD is potentially a lethal drug in high doses. It is likely that if it is used it could be contaminated in food or drinking water. However, the likelihood of incapacitating agents being used is minimal, unless terrorists were primarily interested in causing large disruptions.

Nerve Agents

Nerve agents are considered to be the most toxic of the chemical agents. These agents can contribute to significant respiratory and cardiovascular problems. A person exposed to a nerve agent can no longer control the muscles and glands from twitching and as a result, the body goes into convulsions. *Sarin* is a well-known nerve agent and has previously been used on the public in a Tokyo subway attack about a decade ago. As was seen in that case it was released through the air, but it can also be released through the water or the soil.

Breathing the vapors, drinking the agent, or eating something contaminated can infect a person. This agent can also get on an individual's clothing and can remain on that clothing for half an hour or more after being exposed. Touching someone or his or her clothing can transfer the agent resulting in infection.

Symptoms of *Sarin* do not vary with the medium through which someone is exposed. The symptoms can show up within seconds if it is in vapor or gas form or within 18 hours if it is liquid.

Symptoms include a runny nose, drooling or excess spittle, headache, watery eyes and blurred vision, fast rapid breathing, coughing, confusion, drowsiness, abdominal pain, vomiting, diarrhea, and nausea. In very small amounts, one drop of liquid, can cause sweating and muscle twitching. In large amounts, it can cause convulsions, paralysis, and blackouts and may lead someone to stop breathing, which in turn causes death.

The treatment of *Sarin* is with an antidote and supportive medical care to decontaminate affected areas as quickly as possible.

Biological Agents

“Biological agents are those pathogens used deliberately to infect persons, as well as toxins normally derived from plants or animals” (Croddy and Ackerman). Their affect on humans can vary depending on the agent.

The three groups of biological agents are bacteria, virus and toxin. These agents, for the most part, enter into the body through inhalation, absorption through the skin, or when eating contaminated foods.

- *Bacterial agents* are small living organisms that can be fought with antibiotics.
- *Viral agents* are not necessarily living organisms and in fact, it is difficult to classify them. However, they use living cells in bodies to multiply and cause disease. They are harder to kill off as antibiotics do not work, and only on occasion do antiviral drugs help.
- *Toxins* are poisonous substances that are found in plants and animals and can be extracted to harm humans. These substances can be treated with antitoxin drugs.

The Centers for Disease Control lists biological agents by priority, and they give the highest priority to anthrax, botulism, ricin, tularemia, smallpox, viral hemorrhagic fever, and the plague.

Anthrax

Anthrax was the notorious biological agent that crept its way into news agencies and federal buildings following the September 11 attacks in 2001.

As a biological agent it can enter the skin in three ways: inhalation (known as inhalation anthrax), through a cut (known as *cutaneous anthrax*) or by ingestion (known as *gastrointestinal anthrax*). With each form, the symptoms are different.

Inhalation anthrax is the most serious and following interaction with the agent a person can develop flu-like symptoms. The long-term effects include gradual respiratory problems, shock, and even death.

Cutaneous anthrax is characterized by a painful blister that forms where it enters the skin and then a black scab forms at that point.

Those that suffer from gastrointestinal anthrax will most likely suffer from nausea, loss of appetite, vomiting, fever, and eventually severe abdominal pain and diarrhea.

Anthrax is treatable with antibiotics. Most popular is ciprofloxacin, and this is the drug that during the attacks was being hoarded by the public.

A few other drugs including doxycycline are also known to combat anthrax.

Anthrax is considered an ‘ideal’ bioterrorism agent because of its prevalence in nature. The *Bacillus anthracis* spore is “not terribly difficult to isolate and grow.” Furthermore, this spore is capable of withstanding stresses brought on by the environment allowing it to maintain its virulence.

Botulism

Botulism is a disease that paralyzes muscles. It is caused by a toxin that is released by a bacterium called *Clostridium botulinum*.

It can be found in animals, water, and the soil; therefore, it can contaminate foods or crops. To spread botulism it must either be foodborne, or enter through a wound (wound botulism). If it is, a man-made version it can be inhaled (inhalation botulism)

Symptoms of these various forms of botulism include double vision, blurry vision, drooping eyelids, difficulty speaking or swallowing, dry mouth, and fatigue. Eventually, muscle weakness begins to set in and nerve damage leads to paralysis of the face, head, throat, chest, arms, and legs.

- *Foodborne*: Symptoms show between 6 to 36 hours
- *Wound*: Symptoms show in 4 to 8 days
- *Inhalation*: Symptoms show within 72 hours

Ricin

Ricin is a toxin that can be processed from the castor-bean plant. Ricin enters a human body through inhalation of powder or mist, by eating or drinking something with the toxin (ingestion), and through injection of the toxin into one's body.

Symptoms vary based on the manner in which it enters the human body and the quantity of Ricin inhaled. Ricin in large amounts can cause death within 36 to 48 hours.

Inhalation of Ricin produces symptoms such as tightness of breath, coughing, nausea and aching muscles. These symptoms progress to include inflammation of the airways, excess fluid secreting into the lungs; the skin may turn blue from lack of oxygen due to trouble breathing.

Ingestion of Ricin leads to internal bleeding of the stomach or intestines. This causes vomiting and bloody diarrhea. Eventually this may lead to liver, spleen, or kidney failure, all of which may result in death.

Injection of Ricin will lead to immediate death of the muscles and lymph nodes in the area, and a cascade effect from there affecting the organs in the body and leading to massive internal bleeding in the stomach and intestines thus causing death.

Groups such as Al Qaeda have referred to toxins such as Ricin and Botulism as possible agents, however, most of this has not centered on a mass casualty attack.

Tularemia

Tularemia is a disease caused by the bacteria *Francisella tularensis*. It is found in wild animals and insects. It is especially found in rabbits and thus it is given the name *Rabbit Fever*.

There are three ways in which to contract Tularemia: through the skin, through ingestion (stomach Tularemia) or through inhalation (lungs Tularemia).

As in other diseases, the way in which it is contracted is a determining factor for the symptoms. However, for the most part all forms of Tularemia may include fever, chills, joint pain, and overall weakness. If someone is bitten by animal or insect, or handles a diseased carcass, the person can contract the disease. In addition to these symptoms, the infected individual will have a bump or ulcer on the bite, and swollen and painful lymph glands.

If the bacteria is ingested a person may suffer the characteristic symptoms as well as a sore throat, abdominal pain, ulcers in or on the mouth, diarrhea, and vomiting.

If someone inhales dust from contaminated soil, then other symptoms may include a dry cough, chest pain, bloody spittle, trouble breathing or a victim may even stop breathing.

Immediate medical attention must be sought so that antibiotics can be most effective against the bacterium. Tularemia is considered to be highly infectious. It can be put into the air and inhaled. Tularemia may be fatal, and during the Cold War, it was the focus of Soviet and American forces attempting to create biological agents (316).

Smallpox

Smallpox is caused by the variola virus. It is highly contagious from person to person and is known to cause death. Through years of research and vaccinations, smallpox was eradicated and there have been no known cases since 1977. However, the variola virus does still exist in two government controlled laboratories; one controlled by the Americans in Atlanta, and one controlled by the Russians in Siberia.

Smallpox spreads from person to person by droplets that are inhaled in close contact. Coming into contact with bodily fluids of someone that is infected can also lead to the spreading of the disease.

Only humans can transmit smallpox. There is no evidence that it can be contracted through contact with an insect or an animal.

Infection from the variola virus only requires that a person be close enough, about two meters, to inhale the droplets of fluid from an infected person; a person may never even have to touch the infected person.

Following infection there is an incubation period of 7 to 17 days before symptoms appear. After the incubation period ends, (it can be one week to two and a half weeks), the symptoms appear first with a fever, malaise feelings, head and body aches, and vomiting sometimes. This may take between two and four days.

In the next stage, there will be small red spots on the tongue. These spots turn into sores that break open and spread the virus into the mouth and throat. The infected person is very contagious.

This is followed by a rash that covers the body, which starts near the mouth and works its way down the body. By the third day, the rashes turn into raised bumps. On the fourth day, the bumps fill in with a clear fluid. After this stage, a fever returns, and the bumps start to feel as if there is something hard inside. These are called pustules.

After about five days, the pustules begin to turn into scabs. This period lasts another five days, about two weeks after the first rash appears. After a period of six days, the scabs fall off. A scar or dent in the skin remains where each scab was. After all scabs are gone, the individual is no longer contagious.

As you can imagine, this is a very painful, unpleasant disease that is easily transmittable. Vaccinations have prevented its existence today, but there is no telling if the same vaccines will be useful in the future. This is why an outbreak of smallpox is a concern for all medical personnel. Understanding its pathology is critical. If someone is suspected of having smallpox, avoid close contact unless you are wearing appropriate protective gear. Close contact with no precautions may lead that individual to become infected.

Viral Hemorrhagic Fevers

Viral Hemorrhagic Fevers (VHF) is a group of diseases caused by viruses. They include well-known viruses such as Ebola and the Hantavirus. These diseases are characteristically highly contagious and associated with bleeding. Some cases of VHF cause the organs to shut down because there is damage to the vascular system. VHFs originate in many animals, especially rodents, and insects like mosquitoes.

VHFs differ significantly depending on what type it is. Thus, some only spread from a bite, from coming into contact with an infected animal's bodily fluid, or from being bitten by an insect. Other VHFs can spread between humans when close contact with body fluids occurs.

Symptoms include a high fever, fatigue, dizziness, weakness, and headache. Other symptoms may include a sore throat, abdominal pain, vomiting, and diarrhea. In the most severe cases, there can be signs of bleeding under the skin from internal organs or from the mouth, eyes, or ears. Blood loss leads to fainting, shock, coma, seizures, and organ failure.

There are no known cures outside of supportive medical attention.

Plague

Plague is caused by the bacteria *Yersinia pestis*. It is found in rodents and their fleas. It can be transmitted to humans when they are bitten by infected fleas or when they touch materials infected with bacterium in a cut in the skin. This form is called *bubonic*. If the bacterium is spread in the air, it can be inhaled and then contracted (*pneumonic*). A new form of the disease can be created when bubonic or pneumonic forms of the disease multiply in the blood (*septicemic*).

The various forms of plague contain some similar symptoms. They all include a fever, headache, weakness, chills, and possibly vomiting and diarrhea. This lasts one to ten days after being exposed.

Bubonic plague also includes swollen lymph glands known as buboes.

Pneumonic is the most deadly and brings on pneumonia, chest pain, coughing, and sometimes bloody or watery spittle. It can cause respiratory failure, shock, or death. This form of plague can be passed from person to person through inhaling droplets through the air, such as fluids from a sneeze. Fortunately, this form of plague is significantly hampered by its exposure to sunlight, which hampers its ability to spread rapidly.

The symptoms of the last form, septicemic plague, include abdominal pain, shock, and bleeding into skin and other organs. This form is not transmittable.

All forms of the plague can be treated with antibiotics, but as in the case of Tularemia, this medical attention should be immediate.

As you can see, the dangers in these biological agents are very significant. Many of these diseases have an incubation period, which prevents people from knowing if they have the disease. By the time an outbreak occurs, many people may have been exposed.

It is clear, however, that as information about the outbreak is slowly revealed mass panic may result. A phenomenon we rarely see in natural disasters.

Although it is difficult to attend to survivors because the infection may be readily transmitted, which would then put your life and other lives in danger, there will exist a very strong need to support the family of the individual as well as provide community psychological support in an effort to alleviate or mitigate overall anxiety and stress.

Radiological/Nuclear Agents

The threat of a radiological or nuclear device is very serious. Although an attack by a small backpack nuclear arm is possible, or perhaps a large-scale interballistic missile, it is most likely that any attack involving radiation will come in the form of a dirty bomb, also known as a *Radiation Dispersion Device* (RDD).

These kinds of bombs use an explosive device to spread radioactive material that is bundled up and upon explosion is dispersed as powder or pellets across an area.

Low-level radioactive materials are pretty easy to attain seeing that they are readily available in such industries as agriculture and medicine.

RDDs pose many issues mostly because there is very little evidence about what will happen. Potential spreading of radiation may be minimal, or it may be large enough to effect large areas.

The thought is that any use of low-level radiation will not be significant enough to cause severe illnesses, and thus the actual blast itself is considered the primary threat. However, the possibility that high-level radiation is used, or a nuclear bomb is set off could lead to catastrophic consequences. Radiation burns and long-lasting effects would undeniably plague society for many years.

It is important to note that radiation is a normal occurrence in everyday life. Every year a person is exposed to approximately low levels of radiation from various sources. However, acute radiation exposure can cause skin lesions and blistering.

Radiation exposure can also lead to nausea, and a host of radiation syndromes that include *Prodromal Syndromes*, *Hematopoietic Syndromes*, *Gastrointestinal Syndromes* and *Cerebrovascular Syndromes*.

Prodromal Syndrome depends on the amount and intensity of exposure, but symptoms usually begin at low levels and will lead to fatigue and vomiting. At higher levels, this will lead to fever, diarrhea, and hypotension.

Hemotopoietic Syndrome appears following moderate levels of radiation exposure. This syndrome is characterized by killing off precursor blood cells. Thus, when the old blood cells die out, they are not replaced, and there is an overall reduction in blood cell count. This leads to an individual suffering from chills, hair loss, ulceration of the mouth, bleeding, immune system depression, and other symptoms because of the loss of blood cells. Treatment for this requires a blood transfusion.

Gastrointestinal Syndrome is even more serious and begins at higher levels of radiation exposure. This syndrome involves the killing off the villi that line the walls of the small intestine, which are critical in metabolism. This will lead to bloody diarrhea, circulatory collapse, and severe damage to the intestinal tract. Death will likely occur within three to ten days of exposure. Treatment includes attempts to replace fluids and fight infection. This treatment is meant to keep people alive longer.

Cerebrovascular Syndrome results from high levels of radiation exposure and causes damage to the central nervous system. Death usually results within a few hours of exposure.

Those contaminated by radioactivity pose no threat to emergency responders; although, it is suggested that simple precautions be taken. What remains a threat would be the affected area as there will be significant amounts of radiation still in the area that can contaminate responders.

Explosives

According to the FBI Bomb Data Center (BDC), it is estimated that 70 percent of all terrorist attacks worldwide involve explosives. Fragmentation can be the most destructive characteristic of a bomb. Pure blast can create craters and blow down walls and buildings, but the concentrated power of a fragment can force penetration deeply into a target, tearing and shredding as it goes. Some of the more common types of explosive devices include:

- Incendiary devices
- Letter bombs
- Pipe bombs
- Briefcase bombs
- Car and truck bombs

Bombs can be constructed to look like almost anything and can be placed or delivered in any number of ways. Most explosive devices are homemade and are limited in their design only by the imagination of, and resources available to, the maker. Secondary explosive devices are employed for the purpose of injuring or killing response personnel who arrive to render aid in the aftermath of the primary explosion.

Disaster Mental Health Professional Go-bag Checklist

This checklist provides a guideline for what to pack for a disaster assignment should you be called outside your local community. You should consider luggage with wheels and an integrated and removable backpack.

- Use this checklist each time you pack your Go-bag. Include items that you feel are essential.
- Check the items that you have included.
- Place the completed checklist inside your Go-bag.

Professional Materials	Work Supplies
<input type="checkbox"/> Copy of professional license <input type="checkbox"/> Copy of driver's license <input type="checkbox"/> Other professional identification <input type="checkbox"/> Phone numbers of professional contacts at home <input type="checkbox"/> Forms, e.g., release of confidentiality <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Business cards <input type="checkbox"/> Steno pad of paper <input type="checkbox"/> Pens and pencils <input type="checkbox"/> Envelopes for expense receipts <input type="checkbox"/> Crayons <input type="checkbox"/> Paper for drawing <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Clothing	Personal Items
<input type="checkbox"/> Easycare clothing (enough for 10 days without laundry) <input type="checkbox"/> Casual slacks (no jeans, as these may not be appropriate for memorial services or funerals) <input type="checkbox"/> Casual shirts or tops <input type="checkbox"/> Wrinkle-free clothes <input type="checkbox"/> One set of dress clothes <input type="checkbox"/> Jacket <input type="checkbox"/> Sweater <input type="checkbox"/> Rain gear <input type="checkbox"/> Comfortable shoes <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Toilet articles <input type="checkbox"/> Antibacterial hand wipes <input type="checkbox"/> Facial tissues <input type="checkbox"/> Extra pair of glasses <input type="checkbox"/> Sunglasses <input type="checkbox"/> Hand fan or hand warmer <input type="checkbox"/> Inexpensive watch <input type="checkbox"/> Clothes pins and retractable clothes line <input type="checkbox"/> Leisure time materials (books, swimsuit, camera, music, workout clothes) <input type="checkbox"/> Comfort foods and list of special dietary restrictions <input type="checkbox"/> Water bottle <input type="checkbox"/> Personal or traveler's checks <input type="checkbox"/> Limited amount of cash (in case ATMs or credit card machines are not working) <input type="checkbox"/> Credit card <input type="checkbox"/> Photos of family and friends <input type="checkbox"/> Journal <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Equipment	Healthcare and Medical Items
<input type="checkbox"/> Flashlight and batteries <input type="checkbox"/> Portable radio <input type="checkbox"/> Extra batteries <input type="checkbox"/> Sewing kit <input type="checkbox"/> Travel alarm clock <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Spiritual Care Toolbox

This list of books, pamphlets, and materials may be included in a “Spiritual Care Toolbox.”

Bahá'í

Pamphlets

- ❑ The Hidden Words of Baha 'U'Llah
- ❑ The Gift of Prayer: Embracing the Sacred in the Everyday
- ❑ Death: The Messenger of Joy
- ❑ Bahá'í Prayers

Books

- ❑ The Power of Divine Assistance
- ❑ The Kita-I Aquos
- ❑ The Open Door
- ❑ Beads (bone and wood)
- ❑ Words to Comfort, Words to Heal

Other Resources

- ❑ Bahá'í banner
- ❑ Abdu'l Baha picture

Buddhist

Books

- ❑ The Teaching of Buddha (In ten languages)
- ❑ The Lotus Sutra
- ❑ Good Question, Good Answer
- ❑ The Seeker's Glossary of Buddhism
- ❑ The Major Writings of Nichiren Daishonin

Catholic

Pamphlets

- ❑ The Lord is My Shepherd
- ❑ The Way of the Cross
- ❑ Praying for the Dead

Books

- ❑ Holy Bible

Other Resources/Materials

- ❑ Holy Cards
- ❑ Rosary Beads
- ❑ Crucifix
- ❑ Large candle

Hindu

Books

- ❑ Bhagavad-Gita “As it is”

Other Resources/Materials

- ❑ Indian Fabric Rug

Jaina

Books

- ❑ Jaina Religion and Community

Jewish

Books

- ❑ Paths of Faith: The New Jewish Prayer Book for Synagogue and Home : For Weekdays, Shabbat, Festivals & Other Occasions
- ❑ The Book of Shiva
- ❑ Hebrew Scriptures

Mormon

Books

- ❑ The Book of Mormon: Another Testament of Jesus Christ

Muslim

Books

- ❑ The Janaaz: Easy Directions for the Preparation of the Muslim Deceased and the Funeral
- ❑ The Story of Mary and Jesus
- ❑ Reliance of the Traveller: The Classic Manual of Islamic Sacred Law Umdat Al-Salik
- ❑ The Holy Qur'an: Text, Translation & Commentary

Other Resources /Materials

- ❑ Prayer Rugs
- ❑ Compass
- ❑ Wooden Qur'an holder
- ❑ Prayer Beads

Protestant

Books

- ❑ Book of Common Prayer
- ❑ Holy Bible
- ❑ Hymnal
- ❑ The Faith We Sing: Pew—Cross & Flame

Other Resources/Materials

- ❑ Communion Plate
- ❑ Chalice
- ❑ Wooden Cross

Sikh

Books

- ❑ Sacred Sukhmani
- ❑ Sacred Nitnem
- ❑ The Sikh Prayer

Other Resources /Materials

- ❑ Wooden Wall Hanging

Additional Resources and Materials

- ❑ How to be a Perfect Stranger: A Guide to Etiquette in Other People's Religious Ceremonies
- ❑ Rainbow pins
- ❑ Spiritual care vests
- ❑ Care notes (many varieties)
- ❑ Reflective music: tapes , CD's, etc. and a portable stereo with batteries
- ❑ Bibles and hymnals from various traditions/denominations

Web site Resources

- ❑ National Selected Independent Funeral Homes provides information about religious ceremonies performed during a funeral or memorial service at www.nsm.org/information/guides/religions.html.

Key Components of Early Intervention

The following is a description of the key components of early intervention.¹ Mental health professionals would provide some of these components, while service providers other than mental health professionals would deliver other components with mental health implications.

Basic Needs

- Provide survival, safety, and security.
- Provide food and shelter.
- Orient survivors to the availability of services and support.
- Communicate with family, friends, and community.
- Assess the environment for ongoing threats.

Psychological First Aid

- Protect survivors from further harm.
- Reduce physiological arousal.
- Mobilize support for those who are most distressed.
- Keep families together and facilitate reunions with loved ones.
- Provide information and foster communication and education.
- Use effective risk communication techniques.

Needs Assessment

- Assess the current status of individuals, groups, and/or populations and institutions/systems.
- Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed.

Rescue and Recovery Environment Observation

- Observe and listen to those most affected.
- Monitor the environment for toxins and stressors.
- Monitor past and ongoing threats.
- Monitor services that are being provided.
- Monitor media coverage and rumors.

Outreach and Information Dissemination

- Offer information/education and “therapy by walking around.”
- Use established community structures.
- Distribute flyers.
- Host Web sites.
- Conduct media interviews and programs and distribute media releases.

Technical Assistance, Consultation, and Training

- Improve capacity of organizations and caregivers to provide what is needed to:
 1. Reestablish community structure.
 2. Foster family recovery and resilience.
 3. Safeguard the community.
- Provide assistance, consultation, and training to relevant organizations, other caregivers and responders, and leaders.

Fostering Resilience and Recovery

- Foster but do not force social interactions.
- Provide coping skills training.
- Provide risk assessment skills training.
- Provide education on stress responses, traumatic reminders, coping, normal versus abnormal functioning, risk factors, and services.
- Offer group and family interventions.
- Foster natural social supports.
- Look after the bereaved.
- Repair the organizational fabric.

Triage

- Conduct clinical assessments, using valid and reliable methods.
- Refer when indicated.
- Identify vulnerable, high-risk individuals and groups.
- Provide for emergency hospitalization.

Treatment

- Reduce or ameliorate symptoms or improve functioning via:
 1. individual, family, and group psychotherapy,
 2. pharmacotherapy, and
 3. short-term or long-term hospitalization.

¹ National Institute of Mental Health. (2002). *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices.*

Returning Home from a Disaster Assignment Checklist

Use the following checklist as a reminder for the activities that you will engage in as you prepare to return home from each assignment.

Preparing for the Transition Back Home from a Disaster Assignment Outside Your Community

- Make travel arrangements.
- Alert people at home once arrangements have been made.
- Return any extra supplies and/or vehicle.
- Settle your financial accounts including reimbursements.
- Write a narrative about your disaster experience.
 - Reflect on your role and responsibilities.
 - Identify any challenges you faced in your role.
 - Identify any broader systems issues for which you have recommendations or suggestions.
 - Reflect on the most rewarding part of your experience.

Disengaging from “Disaster Mode”

- Brief the arriving (or replacement) team.
- Prepare documents the new team may need.
- Help the new team make a smooth transition.
- Say goodbye to everyone with whom you have developed a connection.
- Decide on whether or not bringing home gifts is appropriate.

Returning to Family and Work

- Anticipate that not everyone at home will want to hear your stories or comprehend what you have done.
- Expect sudden changes in emotions (mood shifts).
- Listen to your children and let them share in your experiences.
- Anticipate piles on your desk when returning to work.
- Expect mixed responses from co-workers on your absence and the importance of what you have done.

Attending to Post-Disaster Self-care

- Rest, rest, and rest.
- Give yourself time for your body and mind to reorient.
- Adjust pace downward to those around you.
- Assess how much information sharing should take place.
- Be sensitive to the lives of those who stayed at home.
- Seek help if unable to settle back in; discuss your feelings and thoughts with another mental health professional

Appendix C: References and Resources

Planning Tools and Technical Resources

Risk Communication

**Disaster Relief Organizations, Agencies,
and Programs**

Intervention Resources

Issues and Populations of Special Interest

Training Resources

Planning Tools and Technical Resources

A Guide to the Disaster Declaration Process and Federal Disaster Assistance

Department of Homeland Security, Emergency Preparedness and Response Directorate, Office of Legislative Affairs, 202-646-4500.

http://www.fema.gov/pdf/rrr/dec_proc.pdf

American Red Cross Statement of Understanding (New York State)

Statement of Understanding Among New York State Office of Mental Health, New York State Conference of Local Mental Hygiene Directors, and All New York Chapters of the American National Red Cross.

<http://www.omh.state.ny.us/omhweb/sou/>

An ADA Guide for Local Governments: Making Community Emergency Preparedness and Response Programs Accessible to People with Disabilities

U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 2005.

<http://www.usdoj.gov/crt/ada/emergencyprep.htm>

CDC Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors

Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

<http://www.bt.cdc.gov/planning/pdf/cdcresponseguide.pdf>

Community Guidelines for Developing a Spontaneous Volunteer Plan

Illinois Terrorism Task Force Committee on Volunteers and Donations

<http://www.illinoisohomelandsecurity.org/pdf/spontvol.pdf>

Crisis Counseling Assistance and Training Program

<http://www.mentalhealth.samhsa.gov/cmhs/emergencyservices/progguide.asp>

Disaster Nursing and Emergency Preparedness for Chemical, Biological, and Radiological Terrorism and Other Hazards

Veenema, T.G., (editor). New York: Springer Publishing Company, Inc., 2003.

http://www.springerpub.com/prod.aspx?prod_id=21438

Disaster Technical Assistance Center

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services

<http://www.mentalhealth.samhsa.gov/dtac>

Disaster Mental Health Training: Guidelines, Considerations, and Recommendations

Young, B.H., Ruzek, J.I., Wong, M., Salzer, M.S., and Naturale, A.J. In *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice*. Edited by Elspeth Cameron Ritchie, Patricia J. Watson, and Matthew J. Friedman. New York: Guilford Publications, 2006.

<http://www.istss.org/guilfordDMH.pdf>

Federal Family Assistance Plan for Aviation Disasters

Prepared by the National Transportation Safety Board, August 1, 2000.

<http://www.nts.gov/publictn/2000/SPC0001.pdf>

Mental Health All-Hazards Disaster Planning Guidance

U.S. Department of Health and Human Services. DHHS Pub. No. SMA 3829. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

<http://media.shs.net/ken/pdf/SMA03-3829/All-HazGuide.pdf>

Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence

National Institute of Mental Health. NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office, 2002.

<http://www.nimh.nih.gov/publicat/massviolence.pdf>

National Center for Post-Traumatic Stress Disorder (NCPTSD)

<http://www.ncptsd.org>

National Incident Management System

Published by the U.S. Department of Homeland Security, March 1, 2004.

http://www.fema.gov/pdf/nims/nims_doc_full.pdf

National Institute of Mental Health

<http://www.nimh.gov>

National Memorial Institute for the Prevention of Terrorism

<http://www.mipt.org>

National Response Plan

http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml

New York State County Disaster Mental Health Planning and Response Guide: A Guide for County Directors of Mental Health and Community Services

Herrmann, J., University of Rochester, 2005.

<http://www.omh.state.ny.us/omhweb/countyguide/>

New York State Education Department, Office of the Professions, Online Verification

<http://www.op.nysed.gov/opsearches.htm>

New York State Office of Alcoholism and Substance Abuse Services

<http://www.oasas.state.ny.us/www/home.cfm>

New York State Pandemic Influenza Plan

Published by the New York State Department of Health, February 2006.

http://www.health.state.ny.us/diseases/communicable/influenza/pandemic/docs/pandemic_influenza_plan.pdf

Pandemic Influenza

<http://pandemicflu.gov/>

Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy

Butler, A.S., Panzer, A.M., & Goldfrank, L.R., (editors). Washington, DC: The National Academies Press, 2003.

<http://books.nap.edu/catalog/10717.html>

Appendix C: References and Resources

Robert T. Stafford Disaster Relief and Emergency Assistance Act

United States Code, Title 42. The Public Health and Welfare, Chapter 68. Disaster Relief (As amended by Pub. L. 103-181, Pub. L. 103-337, and Pub. L. 106-390) Pub. L. 106-390, October 2000, 114 Stat. 1552-1575.

<http://www.fema.gov/library/stafact.shtm>

State Mental Health Authorities' Response to Terrorism

National Association of State Mental Health Program Directors, (NASMHPD) Medical Directors Council, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314, February 2004.

http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Med%20Dir%20Terrorism%20Rpt%20-%20final.pdf

Surge Hospitals: Providing Safe Care in Emergencies

Published by the Joint Commission on Accreditation of Healthcare Organizations, 2006.

http://www.jcaho.org/about+us/public+policy+initiatives/surge_hospital.pdf

Terrorism and Disaster Management: Preparing Healthcare Leaders for the New Reality

McGlow, K. J., (editor). Published by the Foundation of the American College of Healthcare. Chicago: Health Administration Press, 2004.

Trauma and Disaster: Response and Management

Ursano, R., & Norwood, A.E. (editors). Review of Psychiatry Series, Volume 22, Number 1; Oldham, JM & Riba, M.B., (series editors). Washington, DC: American Psychiatric Publishing, 2003.

Risk Communication

Communicating in a Crisis: Risk Communication Guidelines for Public Officials

U.S. Department of Health and Human Services (SAMHSA), Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Room 17C-26, Rockville, MD 20857, 2002.

<http://www.riskcommunication.samhsa.gov/index.htm>

Crisis & Emergency Risk Communication: By Leaders for Leaders, Course Book and Participants Manual

U.S. Department of Health and Human Services (HHS) in partnership with the Centers for Disease Control and Prevention (CDC) Public Health Practice Program Office and the CDC Office of Communication (OC), Office of the Director (OD).

<http://www.cdc.gov/communication/emergency/leaders.pdf>

http://www.cdc.gov/communication/emergency/part_man.pdf

Effective Media Communication during Public Health Emergencies, WHO Handbook, Field Guide, and Wall Chart

Published by the World Health Organization, 2005.

<http://www.who.int/csr/resources/publication>

Terrorism and Other Public Health Emergencies: A Reference Guide for Media

Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, Washington, D.C. September 2005.

<http://www.hhs.gov/emergency/mediaguide/PDF/HHSMedisReferenceGuideFinal.pdf>

WHO Outbreak Combination Guidelines

Published by the World Health Organization, 2005.

<http://www.who.int/infectious-disease-news/IDdocs/whocds200528/whocds200528en.pdf>

WHO Outbreak Communication, WHO Handbook for Journalists: Influenza Pandemic

Published by the World Health Organization, 2005.

http://www.who.int/csr/don/Handbook_influenza_pandemic_dec05.pdf

Disaster Relief Organizations, Agencies and Programs

American Association of Marriage and Family Therapy (AAMFT)

<http://www.aamft.org>

American Mental Health Counselors Association

<http://www.amhca.org>

American Nurses Association

<http://www.nursingworld.org/news/disaster>

American Psychiatric Association

<http://www.psych.org>

American Psychological Association (APA)

<http://www.apa.org>

American Red Cross Disaster Services (ARC)

<http://www.redcross.org/services/disaster>

Center for Mental Health Services (CMHS)

<http://www.mentalhealth.samhsa.gov/cmhs>

Department of Health and Human Services (DHHS)

<http://www.dhhs.gov>

Department of Homeland Security (DHS)

<http://www.dhs.gov>

Department of Veterans Affairs (VA)

http://www.va.gov/about_va/history

Disaster Psychiatry Outreach (DPO)

<http://www.disasterpsych.org>

Federal Emergency Management Agency (FEMA)

<http://www.fema.gov>

International Society for Traumatic Stress Studies (ISTSS)

<http://www.istss.org>

National Association of Social Workers

<http://www.naswdc.org>

National Center for Post-Traumatic Stress Disorder (NCPTSD)

<http://www.ncptsd.org>

National Child Traumatic Stress Network (NCTSN)

<http://www.nctsn.org>

National Disaster Medical System (NDMS)

<http://www.ndms.dhhs.gov>

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National Organization for Victims Assistance (NOVA)

<http://www.dhs.gov>

National Voluntary Organizations Active in Disaster (VOAD)

<http://www.nvoad.org>

New York Disaster Interfaith Services (NYDIS)

<http://www.nydis.org>

New York State Emergency Management Office (SEMO)

<http://www.nysemo.state.ny.us>

Office of Victims of Crime (OVC)

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

Project Liberty

<http://www.projectliberty.state.ny.us>

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov>

Intervention Resources

Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized

Figley, C (editor). New York: Brunner/Mazel, Inc., 1995.

Early Intervention for Trauma in Adults: A Framework for First Aid and Secondary Prevention

Litz, B.T. & Gray, M.J. In *Early Intervention for Trauma and Traumatic Loss*. Edited by Brett T. Litz. New York: The Guilford Press, 2004. Pp 87-111.

Grief Counseling Resource Guide

Published by the New York State Office of Mental Health (OMH), 2004.

<http://www.omh.state.ny.us/omhweb/grief/>

The Immediate Response to Disaster: Guidelines for Adult Psychological First Aid

Young, B.H. In *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice*. Edited by Elspeth Cameron Ritchie, Patricia J. Watson, and Matthew J. Friedman. New York: Guilford Publications, 2006.

Mental Health Intervention for Disaster

National Center for Post-Traumatic Stress Disorders (NCPTSD)

http://www.ncptsd.org/facts/disasters/fs_treatment_disaster.html

Issues and Populations of Special Consideration

An ADA Guide for Local Governments: Making Community Emergency Preparedness and Response Programs Accessible to People with Disabilities (2005)

U.S. Department of Justice, Civil Rights Division, Disability Rights Section

<http://www.usdoj.gov/crt/ada/emergencyprep.htm>

Helping Children after a Disaster

American Academy of Child & Adolescent Psychiatry, No. 36. Updated July 2004.

www.aacap.org/publications/factsfam/disaster.htm

Crisis Counseling Guide to Children and Families in Disasters

New York State Office of Mental Health in collaboration with the Task Force on Mental Health Response to Disasters, September 26, 2000.

<http://www.omh.state.ny.us/omhweb/crisis/crisiscounselingguide.pdf>

Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations

U.S. Department of Health and Human Services. Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations. DHHS Pub. No. SMA 3828. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

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U.S. Department of Veterans Affairs, National Center for Post Traumatic Stress Disorder (NCPTSD)

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