

“People are always changed by disasters  
and other traumatic life events,  
but they need not be damaged by them”

Weaver 2007, *Mental Health Section Connection*; Washington, DC: NASW

97

## CASE VIGNETTE

98

**Winston** is a 55-year-old married auto mechanic who was working 3 blocks from the World Trade Center on 9/11. He witnessed both towers falling and then he went home to his family in Brooklyn.

Six weeks later, he complains of flashbacks of both towers falling, nightmares of being crushed under the towers, lying awake in bed for hours at a time, spells of sweating and trembling daily when he crosses the Brooklyn Bridge into Manhattan, inability to concentrate on his work, and dropping his tools when car engines backfire. He is very interested in his family and the news, he continues to attend his darts club, and he goes to Ground Zero every weekend to deliver sandwiches to the recovery workers.

99

## TIMING OF DISASTER PTSD

### How early?

- ▶ PTSD starts quickly after traumatic events
  - No delayed PTSD

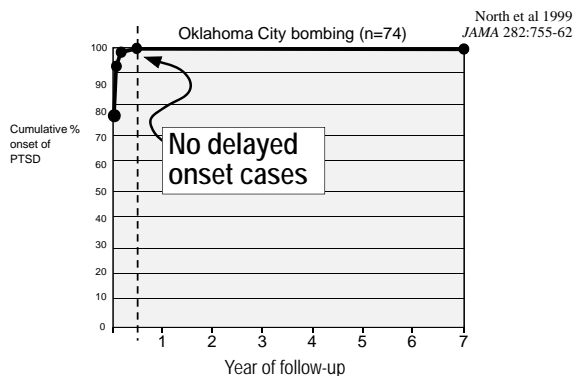
### ...And how long?

- ▶ PTSD tends to be chronic

**EVIDENCE?.....**

100

## TIMING OF PTSD ONSET



101

## WHAT ABOUT THE FIRST MONTH? (BEFORE YOU CAN DIAGNOSE PTSD)

### Acute stress disorder

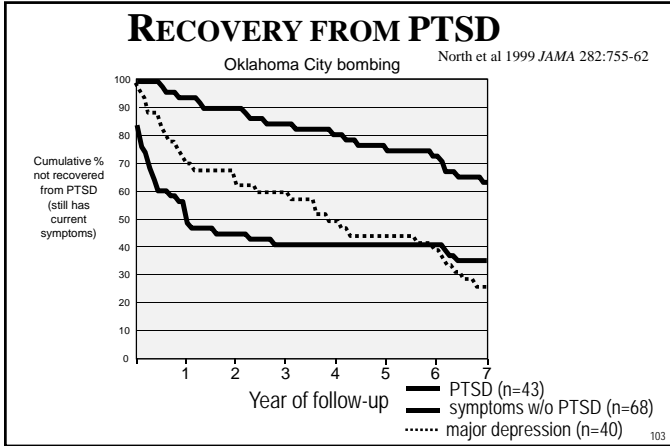
- Brief (2 days to 4 weeks): 3 dissociative symptoms plus symptoms of groups B, C, & D
- Short term label - questionable validity (what does it mean? - may not be pathological)
- Clinical utility: diagnostic code to document services

### Group C symptoms

- Avoidance & numbing
- Marker / identifier for PTSD

**Pre-existing psychopathology** – esp. major depression

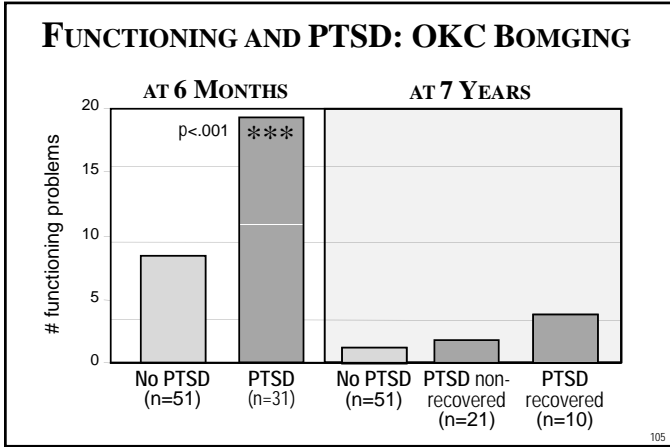
102



### TIMING OF DISASTER PTSD

- There's no "early" PTSD
- There's no "delayed" PTSD
- ...There's just PTSD...

And some come to treatment late



### EMPLOYMENT

Of 86 working (71 full time) at time of bombing:

Employment status at 7 years:

- working full time 71%
- working part time 8%
- looking for work 3%
- housewife 3%
- retired 8%
- disabled 6%

All 5 seriously injured:  
 loss of eyes (n=3)  
 head injuries (n=2)  
 20+ surgeries (n=2)

### Any Questions

### LUNCH TIME

## Any Questions



109

## SECTION 2: INTERVENTION

110

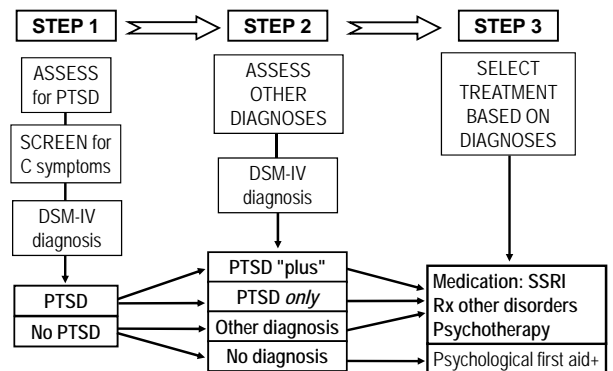
### ORIENTATION TO DISASTER INTERVENTION

This next section takes you through the disaster mental health intervention process from early phases to long-term recovery

- First opportunity to assist = early post-disaster, at site or nearby recovery center – lots of people want to help then
  - but need for intervention usually lasts a long time - often neglected
- Your mental health professional training and experience provide most of the skills you need...
  - with additional disaster-specific focus and direction for early post-disaster settings (different from later interventions)

111

### FLOW CHART FOR POST-TRAUMA ASSESSMENT & INTERVENTION



112

### STEP 3: SELECT INTERVENTIONS

*Choose the intervention that fits...diagnostically based*

- **Psychiatric disorders:**
  - Specialized therapy programs
  - Medication
  - Counseling
  - Be vigilant for urgent triage indicators
- **Subdiagnostic distress:**
  - Psychological first aid, education, reassurance, social support, symptom management, observe

*For intervention, one size does NOT fit all*

113

### TIMING OF DISASTER INTERVENTION

- ✓ Interventions need to start early
- ✓ We need to be there for people over the long haul as their need continues
- ✓ Do not automatically label all PTSD presenting to treatment late as delayed PTSD (rather, it's delayed *treatment*)

114

## DISASTER DO'S AND DON'TS

### Do:

- Think twice before you rush off to the site to help  
→ Is help really needed? – prepare/connect in advance
- Focus on immediate needs - the comfort of physical help (eg, securing warm clothes or dry socks, searching for loved ones) is a powerful form of psychological assistance
- Respect people's need to talk or be quiet
  - Your presence in itself can be very reassuring
  - Know when to back off and not pressure the person
- Anticipate a diversity of perceptions, values, & responses

115

## DISASTER DO'S AND DON'TS

### Don't...

- ...expect things to be organized
- ...plan to do conduct psychotherapy or prescribe medications at the acute scene  
(Main initial tasks are providing comfort and acute stabilization)
- ...expect people to feel better immediately or try to fix them
- ...forget to take care of yourself

116

## RATIONALE FOR INTERVENTION

### PRACTICAL, LOGICAL, SIMPLE, INTUITIVE

- Basic support and restoration - solve immediate problem
- Not focused on psychopathology (but need to identify it)
- Builds on resilience
- Goals: 1) respond to distress  
2) re-establish predisaster functioning

### "DRIVING ON THE WRONG SIDE OF THE ROAD"

- NOT conventional counseling
- Contains elements both common to and divergent from established counseling practices
- More directive, active, and immediate

117

## PSYCHOLOGICAL FIRST AID (PFA)

### A form of mental health assistance provided in the immediate aftermath of disaster, to address acute distress and promote coping and functioning

- ▶ Provided by mental health and other disaster response workers
- ▶ Flexible for use in a variety of settings, populations, and cultures
- ▶ Developed through expert consensus  
(PFA is intuitive and is consistent with available scientific evidence, but research to demonstrate efficacy is needed)

*See: Psychological First Aid Field Operations Guide, National Child Traumatic Stress Network and National Center for PTSD*

118

## PSYCHOLOGICAL FIRST AID (PFA)

### 10 elements of PFA:

- 1) Being there – physical support, engagement
- 2) Safety and acute stabilization
- 3) Supportive listening & information gathering
- 4) Education & reassurance
- 5) Coping & stress management
- 6) Problem solving
- 7) Connect with support
- 8) Symptom management
- 9) Know when more help is needed
- 10) Caring for the caregivers

119

## 1) BEING THERE

### Be unobtrusive, helpful, and compassionate

- Approach the setting first as a caring helper, not as a mental health professional ("shrink")
- Be an anchor: your focused, calming presence will influence others

### Address immediate physical needs, comfort, and concerns

- This is a powerful mental health function!
- Your presence in itself can be comforting ("ministry of presence")
- Ask: "Is there anything you need?" "Is there something I can do to help you be more comfortable?"
- Your care for people's needs is also a means to an end....preparatory activity to intentional mental health work (helps connect you)

120

## BEING THERE....

- People needing your assistance may be:
  - Those who seek out your help
  - Those who clearly need help and will tell you if you inquire
  - Those who do not obviously need help but will tell you if you inquire
  - Those who reject your help (later they may possibly be more receptive)
- Respect interpersonal styles (sometimes cultural):
  - Touch – some people find it comforting, others find it invasive
  - Physical distance – too close is invasive (varies by individual)
  - Eye contact – in some cultures, prolonged eye contact is inappropriate
  - Privacy and trust – some people will be slow/hesitant to open up

*Be sensitive to interpersonal cues about touch, distance, and privacy*

121

## 2) SAFETY AND STABILIZATION

### Redirect people from further harm

- Attention to physical safety is actually a mental health intervention:  
*If you can help keep people safe from physical harm they are less likely to suffer psychological trauma from that harm*
- This pertains to protection from ongoing disaster-related and post-disaster hazards (such as unsafe building structures, broken glass, sharp objects, and dangerous spilled substances)
- It also pertains to protection from other harm such as:
  - Exposure to traumatic images (eg, witnessing horrific scenes in the disaster aftermath)
  - Reminders (eg, through extensive media viewing)
  - Loss of privacy (eg, to media personnel, onlookers, attorneys)

122

## ACUTE STABILIZATION AND DE-ESCALATION....

- May be needed for individuals who are so acutely distressed that they:
  - cannot function
  - are disruptive to others
  - present a direct threat to their own or others' safety
- Strong and overwhelming emotions are often brief in duration
  - Give the person a few minutes of privacy to process cognitive overload and calm down—may allow episode to blow over
  - Tend to some nearby business, telling the person you will be available and will check back shortly to offer help

123

## ACUTE STABILIZATION AND DE-ESCALATION....

- If possible, separate disruptive individuals to a quieter place
- Enlist calm family/friends to comfort distressed individuals
- Main interventions for acute situations:
  - Offer support
  - Focus on manageable and immediate concerns
  - Offer distracting and grounding techniques
- For very agitated individuals:
  - Approach calmly; invite calm discussion
  - Establish orientation (is the person confused/disoriented?)
  - Offer specific choices (behave calmly/seek higher level of assistance)

124

## 3) SKILLED LISTENING

- Listen to the stories with concerned interest
  - a mental health function
- Invite thoughts - gently probe for detail
  - don't extract unnecessary painful trauma details (follow the person's lead; take cues from the person)
  - don't force feelings; let them emerge spontaneously (and prepare for intense emotions)
- Gather appropriate information: exposures, injuries, medical history, medications, psychiatric history

125

## 4) EDUCATION & REASSURANCE

Varies by whether a psychiatric disorder is present or not:

If **NO** psychiatric disorder → *Normalize the experience:*

- Validate common emotional reactions
- Disturbing feelings don't equal mental illness ("Normal responses to abnormal events")
- Most people don't develop mental illness - symptoms subside with time

If psychiatric disorder is present → *Overcome stigma:*

- Biological basis of persistent emotional changes and medication mechanisms
- Many treatment options available: treatment is effective

126

## RISK COMMUNICATION....

### Purpose:

- ▶ Provides timely information to help keep people safe
- ▶ Offers appropriate reassurance in the disaster setting
- ▶ Informs people of what is being done for them and what is in their future

*People feel better if they know what is going on and if they have confidence in the reliability of the information they receive.*

### Elements:

- **Listen** to people's concerns – respond with timely & regular updates
- Model calmness, compassion, and confidence
- Be honest & forthcoming
- Admit not knowing something rather than guessing; avoid speculation
- Beware of anger, blame, and conflict

Covello et al 2001 *J Urb Health/Bull NY Acad Med* 78:382-91

127

## 5) COPING & STRESS MANAGEMENT

- Lend permission to cry, feel bad, be nonproductive, focus on self for a period of time
- Regain control of some aspect; restore routine
- Utilize social supports
- Positive self talk
- Appropriate use of humor
- Self care (easy to neglect in crisis)
  - sleep, meals, hygiene, exercise, habits, down time, relaxation, pleasurable activities – achieve a healthy balance (avoid excesses)
- Active coping is the healthiest

128

## ....FINDING MEANING & PERSPECTIVE

- Natural part of the healing process
  - Making meaning
  - Finding greater perspective in one's life
- Discover and respect personal values
  - What is important to the individual
  - Avoid judgment; avoid "blaming the victim"
- Personal roles: "victim," "survivor"
  - Listen to the person's language in self description
- Philosophy, spirituality, world view

129

## 6) PROBLEM SOLVING

- Make a list; prioritize
- Weigh advantages and disadvantages of potential choices
- Develop more than one approach
  - allows a backup if Plan A doesn't work
- Try new behaviors and develop new skills
- One step at a time - manageable units first
- Keep sight of larger perspective and progress

130

## 7) CONNECT WITH SUPPORT

Two main sources of support can help people in times of disaster:

- Family and friends
  - People who know the individual are best situated to comfort and support that person
- Support services (eg, social workers, medical providers, FEMA, welfare services)
  - Professionals have skills and resources that may help people get back on their feet
- ▶ Social supports and needed resources can go a long way toward helping people feel better
- ▶ People who lack social supports may be at increased risk for psychological adjustment problems

131

## 8) ACUTE SYMPTOM MANAGEMENT

In the early post-disaster period, the most bothersome post-traumatic symptoms are likely to be hyperarousal (group D) symptoms:

- ▶ Feeling jittery, jumpy, restless, irritable
- ▶ Nervousness, anxiety, worry, fear, panic
- ▶ Insomnia

Ways to manage these acute hyperarousal symptoms:

- Distraction – engage in absorbing or pleasurable activities (games, puzzles, reading, movies, social events); selective focus
- Relaxation techniques – deep breathing, muscle relaxation, pre-hypnotic induction
- Pharmacotherapy

132

## RELAXATION: DEEP BREATHING

- To help people calm down or relax - good in office settings (originally used to help pregnant women to relax) or in crises
- Ultimate goal is to use in critical or stressful conditions – but learn it in calm situations to develop mastery
- Use comfortable chair, plant feet on floor, close eyes, take deep breath and hold as long as possible, then slowly exhale with suggestion: "the more slowly you let out the air the more relaxed you will feel."
- Practice in sets (max. 5-6) with same instructions every time (max. 2-3 times a day). Compare heart rate before and after.

- For insomnia, jumpiness, hypervigilance, anger <sup>133</sup>

## MUSCLE RELAXATION

- Lie supine on flat surface – get comfortable, close eyes
- Tense one muscle group (eg, both eyes; one thigh) and hold for several seconds, then release and feel the muscles relax
- One at a time, systematically tense and release all muscle groups of the body (eg, head → toe)
- On completion, bask in the sensation of relaxed muscles
- Repeat as many times as desired

- For insomnia, jumpiness, hypervigilance, anger <sup>134</sup>

## RELAXATION: PRE-HYPNOTIC INDUCTION

Instruct individual to lie comfortably on floor, eyes closed. Read scenario in hypnotic, calm, quiet tone of voice.

**SCRIPT:** "Imagine yourself on a beach, contemplating the clear blue water, waves slowly lapping up along the shoreline. It's a perfect day—the air is warm and slightly breezy; the sun warms your skin. The salt air is refreshing and nostalgic. You walk to the edge of the water and scoop up some seashells. A gentle wave laps up over your hand and carries some of the smaller shells off into the ocean with it. The receding waves gently suck the sand from around your toes and you burrow them into the soft wetness again...." (and it goes on)

- For insomnia, jumpiness, hypervigilance, anger <sup>135</sup>

## SHORT-TERM RELIEF WITH MEDICATION

*Symptomatic* approach to crisis medication:

- Habit-forming drugs (addictive) for anxiety and sleep:
  - benzodiazepines
    - ▶ **CAUTION** if substance abuse or severe personality disorder
    - avoid abuse / chronic use (days to weeks, as needed only)
- Non-addictive sedative alternatives:
  - zolpidem, zaleplon, diphenhydramine, trazodone, mirtazepine

<sup>136</sup>

## 9) KNOW WHEN MORE HELP IS NEEDED

- Indications that more help may be needed:
  - Intolerable symptoms persist or escalate despite interventions
  - Pre-existing psychiatric disorder requiring ongoing psychiatric care
  - The person requests additional assistance
  - The person worries you
- Indications that **urgent** help may be needed:
  - The individual is too overwhelmed to be able to care for self and/or dependents (eg, stops eating/drinking; neglects child)
  - Indications of impending harm to self (suicidality) or others (homicidality/assaultiveness/extreme agitation)
  - The person cannot be oriented (eg, delirious)

<sup>137</sup>

## 10) CARING FOR THE CAREGIVERS

Disaster workers can themselves experience psychological distress or even become mental health casualties in difficult circumstances of disaster settings:

- Extended exposure to intense emotional distress
- Personal exposure to injury and infection
- Personal exposure of self and loved ones to the disaster; worry about safety of loved ones and personal property
- Difficult working conditions, chaos
- Long work hours, cumulative fatigue
- Separation from usual supports and familiar comforts
- Ethical dilemmas

<sup>138</sup>

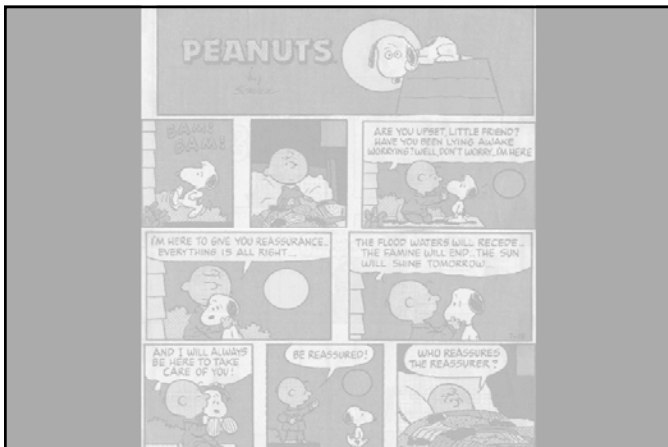


## ...THE CAREGIVERS...

Stressors experienced by disaster workers:

- Exhaustion, inefficiency, loss of enthusiasm or interest for the work
- Diminished ability to focus and concentrate
- Preoccupation, inability to put thoughts and images aside, dreams of the post-disaster setting and people
- Guilt feelings, worry, despondency, irritability, anger
- Frustration (over inability to do enough; with response of leadership and authorities; with circumstances)
- Burnout, "compassion fatigue"
- Interpersonal conflict and damage to relationships

140



## ADVICE FOR CAREGIVER SELF-CARE

- First, follow the same basic advice recommended for those you are caring for (rest, nutrition, hygiene, exercise, relaxation, healthy balance)
- Care for your colleagues
  - Give them a break
  - Offer positive support and encouraging words
  - Keep an eye on their fatigue level and help them accept needed rest, nutrition, and time off
- Spend restorative time together (eg, breaking bread together; follow-up meetings to review the operation and work out the kinks for next time)

142

## ADVICE FOR CARING FOR THE CAREGIVERS

Supervisors can help disaster personnel by:

- distributing work loads equitably
- monitoring workers for signs of distress and fatigue
- communicating with workers to keep them informed and learn about problems/needs that arise
- providing encouragement
- facilitating opportunities for peer support
- providing psychological support through formal group or individual therapy

143

## Any Questions



144

# CASE VIGNETTE

145

**Roger** is a 36-year-old therapist working at a distance from the World Trade Center. Since September 11, he has been dealing with a stream of traumatized clients, day in and day out, and it is wearing him down. He has been noticing with alarm that he is starting to "tune out" during sessions. His dreams have been invaded by the stories of his clients. He is becoming bothered by the lack of empathy that he has seemed to develop for his clients.

In recent weeks, Roger has been irritable with his wife and children with little or no provocation. Noise bothers him, and he becomes infuriated at them if they do not turn off the television immediately during news reports of the terrorist attacks. He says, "I am angry at the world and at the people who have changed me into this."

(continued....)

146

...Roger does not talk about his feelings with his family because he feels he needs to shield them from his experience and his feelings or with his colleagues because he is ashamed of his feelings. He has been able to talk with his priest, who has been somewhat supportive. (But now his priest is suffering from burnout and spent the rest of the session telling Roger about it.)

Roger's moods and his persistent irritability make it more difficult for him to enjoy his job and to be as effective as he was before 9/11, but he still feels he is functioning reasonably well at home and at work, and that his personal relationships have not changed appreciably.

(continued....)

147

## BEYOND PSYCHOLOGICAL FIRST AID

- There is more to disaster intervention than psychological first aid and treatment of specific psychiatric disorders
- The next section will provide symptom tools and other interventions beyond PFA, transcend issues confined to diagnosis, and discuss issues of later disaster phases

148

## SYMPTOM TOOLS

- Symptom management tools are responsive to specific presenting problems
- Management of intrusion (Group B) and hyperarousal (Group D) symptoms requires somewhat different tools than does management of avoidance and numbing (Group C) symptoms
- Includes long term applications for chronic symptoms (especially Group C symptoms)
- Walk the individual through the steps using the person's own personal examples to allow person see results for self ("Wow, you're right!")

149

## BASIC TOOLS FOR B & D SYMPTOMS

- Relaxation therapy
- Guided imagery
- Systematic desensitization
- Thought-stopping
- Cognitive reframing
- Assertiveness training
- Sleep hygiene
- Lucid dreaming

150

## STRATEGIC UTILIZATION OF B & D SYMPTOM MANAGEMENT TOOLS

- Responsive to the individual's presenting problems
- Don't apply all at once
- Practice leads to mastery
  - practice together if person "can't do" it
- Suggestion: most people benefit with practice
- Only specific application to trauma presented here (refer to standard texts for general use of these tools)

151

## SYMPTOM MANAGEMENT TOOLS

B & D SYMPTOMS	MANAGEMENT TOOL
Intrusive memories	Cognitive reframing, guided imagery, thought-stopping, systematic desensitization
Flashbacks	Cognitive reframing
Nightmares	Lucid dreaming
Insomnia	Sleep hygiene, relaxation, guided imagery
Irritability / anger	Assertiveness training, relaxation
Hypervigilance	Relaxation, cognitive reframing
Jumpy, easily startled	Relaxation, guided imagery, systematic desensitization

152

## GUIDED IMAGERY (1)

- A mental technique to master frightening or unpleasant events (Note: the individual must have some ability to recall pleasant past events and be able to image scenes mentally)
- Actively pursue memories of the most pleasant times related to the context of the painful recollections

### Examples:

- 1) A witness to a recent subway station catastrophe cannot return there because of the vivid mental images it triggers
- 2) "Whenever I hear or see an airplane I'm terrified it's going to crash into my building."

- For intrusive memories, jumpiness, insomnia

153

## GUIDED IMAGERY (2)

Task: learn to alter the negative image

### Procedure:

- 1) Visualize the location at a pleasant time (past or future): imagine meeting friends for lunch at the site, or going home from there on a Friday afternoon for a happy 3-day weekend
- 2) "Visualize an airplane flying nearby. It's carrying your grandmother from California to visit you. You will soon see her smiling face. Recall many pleasant memories of greeting family and friends in airports and watching airplanes land and take off."

- For intrusive memories, jumpiness, insomnia

154

## SYSTEMATIC DESENSITIZATION (1)

- Helps confront fearful and anxious situations (a coach is helpful)
- Construct hierarchy of ~10 scenarios, from easiest to most difficult
- Use simple relaxation or calming procedures (eg, muscle relaxation, deep slow breathing, or imaginal relaxation)
- Relax, close eyes, imagine self in first scene → fearful thoughts and feelings emerge → when images become unbearable, signal (lift finger) and switch to relaxation mode
- Follow hierarchy until able to confront anxious and fearful scenarios without having to switch to relaxation
- End sessions with previously mastered scenario from hierarchy
  - leaving an unsuccessful last exercise can be demoralizing

- For intrusive memories, jumpiness

155

## SYSTEMATIC DESENSITIZATION (2)

Example: A witness to a mass murder episode in a restaurant could not bring himself to even enter another restaurant

- First, he learned relaxation techniques & practiced until proficient
- While in relaxed states he imagined walking through a restaurant, increasing the imagined exposures until he was comfortable imagining himself eating a small meal at the restaurant
- Then he actually went to a restaurant and walked through, and with mastery of that, he sat down for a minute, and continued to increase his time in the restaurant and order things to eat
- Within a few months he was again dining regularly at restaurants

- For intrusive memories, jumpiness

156

## THOUGHT-STOPPING

**Premise:** Startle technique interrupts flow of unwanted, feared, or annoying thoughts that lead to frightening and uncontrollable emotions and behaviors

**Procedure:**

- 1) Instruct individual to relax (use muscle deep breathing, relaxation, etc.)
- 2) Have individual focus on troublesome thought for a few minutes
- 3) Unannounced, make loud noise or shout, "STOP!" (Ask if it worked.)
- 4) Repeat process: again, individual focuses on troublesome thought → say "STOP." Decrease volume of "STOP" command with each trial down to a whisper. Desired outcome = person can interrupt own intrusive thoughts by whispering "stop" to self
- 5) Last step: substitute positive, adaptive thoughts

- For intrusive memories

157

## COGNITIVE REFRAMING (1) (RESTRUCTURING)

- Premise: people can mentally self-defeat with dysfunctional, negative (and often factually untrue) cognitions
- Task: identify, change, and restructure negative cognitions
- Essential element: expectation one can change own behavior
- Ask enabling and probing questions → how would new cognitions change things?
- Need practice to identify and change cognitions

- For intrusive memories, flashbacks, hypervigilance

158

## COGNITIVE REFRAMING (2) (RESTRUCTURING)

**Example:** rescue worker feels "like a total failure" after failing to save his coworker

- Question: "In your career, how many people have you saved?"
- Response: "Hundreds."
- The individual is directed to practice throughout the day, repeating, "I have saved hundreds of people, but I could not save this particular person."
- Tips: practice in calm moments; cue from frequent routines (eg, when washing hands, brushing teeth, bedtime)

- For intrusive memories, flashbacks, hypervigilance

159

## ASSERTIVENESS TRAINING

- **Assumptions:**
  - 1) people disagree but are entitled to state their positions
  - 2) no one should tell adults how to feel, act, & behave
- **Essential elements:**
  - 1) Identify confrontive/anger-provoking situation - someone pressuring you
  - 2) Listen, clarify the other's position, acknowledge differences - refrain from arguing; be aware of your own feelings
  - 3) Decide your preferred response - consider compromise - is there a win-win scenario?
- **Ideally:** role play real-life situations with a coach

- For irritability / anger

160

## SLEEP HYGIENE (1)

### Develop good sleep habits:

- 1) Regular sleep-wake routine, bedtime habits (eg, bathe; brush teeth)
  - Arise at regular time in morning - even if little or no sleep obtained (you'll be tired and sleep better the next night)
  - No daytime naps - no matter how tired you feel
  - Don't worry about sleep - worry only delays sleep (and you may have even slept more than you realize). Feeling tired doesn't have to ruin your day - people can function on small amounts of sleep if needed (though not optimal)
- 2) Make bedroom comfortable: dark, quiet, pleasant temperature, comfortable bed; relieve physical needs (hunger, thirst, bladder, pain)

- For insomnia

161

## SLEEP HYGIENE (2)

- 3) Use bed only for sleep (or sex) - train brain to associate bed with sleep
  - No TV, hobbies, balancing check book in bed
  - Wait till sleepy or tired to go to bed → if not asleep by 30-60 minutes, leave bedroom
  - Return to bed when relaxed or drowsy
  - Repeat as needed till asleep
- 4) Prepare body's metabolism for sleep 2-3 hours before bedtime:
  - No caffeine, excess fluids, alcohol (interferes with sleep architecture), or hard exercise (do that earlier—aids sleep)
  - Relax in a warm bath, enjoy a warm drink (hot tea, warm milk & honey), or read (though nothing too exciting)

- For insomnia

162

## LUCID DREAMING

Technique to gain awareness of dreaming during sleep - to awaken at will or change dream content from nightmares to pleasant dreams. Steps:

- 1) Review dreams immediately on waking, memorizing details before memory fades. Return to dream - remind self it is a dream. Log dreams in journal.
- 2) At sleep time, consciously instruct self to recognize dreams and to have lucid dreams. Count: "One, I'm dreaming; Two, I'm dreaming..." (to maintain dreaming awareness during transition from wakefulness to sleep)
- 3) Develop waking habits supporting conscious dream lucidity - repeat (to self) throughout daytime: "Am I dreaming or not?" - answer, "Yes, I am dreaming."

**Example:** Recurrent nightmare of plane crashing into a building; after weeks of practice, the person turned the plane into a beautiful bird that flew into the clouds

- For nightmares

163

## Any Questions



164

# BREAK TIME

165

## PTSD=CHRONIC GROUP C SYMPTOMS

People with only groups B & D symptoms recover early, leaving in chronic treatment mostly people with prominent C symptom profile (also usually accompanied by troublesome B & D symptoms):

- Emotionally overwhelmed, cannot cope
- "Checked out" emotionally - numb and distant, "frozen" state
- Not ready to re-encounter traumatic experience

Therapies requiring people with PTSD to face their traumatic event before they are ready *may re-traumatize them*

166

## APPROACH TO THE C SYMPTOM PROFILE

Traumatic events challenge 3 basic life assumptions:

1. personal invulnerability
2. perception of the world as meaningful
3. view of the self as positive

Group C symptoms reflect inability to cope with shifts from these vital assumptions

167

## APPROACH TO SYMPTOM MANAGEMENT - GROUP C

- For PTSD, *first consider antidepressant Rx*
  - Reduces disabling C symptoms, permitting other interventions
  - Exposure therapies have documented efficacy (and cognitive-behavioral therapies are also used)
- *Do not focus on negative parts of traumatic experience*
  - May re-traumatize
- Re-establish pre-disaster mental pathways to pleasant and positive memories by retrieving positive experiences in same content area

168

## SYMPTOM MANAGEMENT TOOLS - GROUP C

C SYMPTOM	MANAGEMENT TOOL
Avoids thoughts	Actively recall the most positive memories of pleasant times related to the context of the painful memories
Avoids reminders	Seek out cues that evoke memories of good times and good feelings - focus on remembering minute details of these
Event amnesia	Recall positive, pleasant events that can be remembered
Loss of interest	Resume specific past favorite activities for specified durations
Detachment/estrangement	Reconnect with an important person in your life (preferably outside of the disaster zone)
Restricted range of affect	Get in touch with feelings of happiness and sadness not related to the event
Sense of foreshortened future	Imagine or anticipate a happy or pleasant event beyond the time of the imagined end

169

## AVOIDANCE SYMPTOMS (1)

**Premise:** A more tolerable set of associations can be established by revising and replacing the traumatic context with pleasant pre-event associations

**Task:** Actively recall the most positive memories of pleasant times related to the context without invoking the painful memories

**Example:** A manager of an Italian restaurant could not bear reminders of anything related to the place where an explosion killed his employees and many customers

- Use guided imagery to help him re-establish positive pre-event associations: quiet work days, payday, comforts of the shop – remembered in minute detail

170

## AVOIDANCE SYMPTOMS (2)

**Procedure:** Remind him that despite his current negative memories associated with the restaurant, previous memories were positive

- Ask him to describe pleasant images and memories from the store before the event: "Tell me about the first day you worked there, the sights, sounds, and smells in the place"—get all the details
- Ask about other specific memories there such as favorite items on the menu, what did he like about being there (eg, wonderful smells of spices and bread baking, nice customers, good employees)
- This is the same concept as building monuments on sites of catastrophic events...people remember positive experiences of the people who were lost, not the negative event itself

171

## EVENT AMNESIA (1)

**Premise:** Inability to remember details of the event does not by itself signify memory problems (and the therapeutic benefit of remembering traumatic details is not established empirically)

**Task:** It is more important to reassure the person that memory functions are intact for significant past events → help the person recall positive, pleasant experiences prior to the event

**Example:** A woman says, "I remember virtually nothing about evacuating our worksite—but my coworkers told me all about things I did. Am I losing my mind?"

172

## EVENT AMNESIA (2)

**Procedure:**

- Ask her to describe a recent memorable event (eg, a vacation)—get graphic details (eg, sitting in a beach chair on a white sand beach sipping an umbrella drink, feeling the smooth texture of the drink going down, the warmth of the sun on her hair, the cool sea breeze on her face, sand between her toes)
- Point out that ability to recall this level of detail indicates her cognitive abilities are not lost and that her lack of traumatic recollection seems to be an isolated phenomenon
- Inform her that at some time in the future, details of the event may come into conscious focus—but it is OK even if they don't

173

## LOSS OF INTEREST (1)

**Premise:** When people lose interest in former activities after a traumatic event, they may need a boost to get back into their routines

**Task:** Encourage the person to resume one specific past favorite activity for a brief period

- This may provide the momentum to get the individual back in full swing
- It allows the person to back out (and perhaps try again later) if it doesn't feel right at that time

174

## LOSS OF INTEREST (2)

**Example:** "I've lost interest in everything, even piano. I used to get such satisfaction from playing, but I don't anymore. I might as well just sell the piano because I don't think I'll ever play again."

**Procedure:** Prescribe procedures to help the individual recapture positive emotions of previously enjoyed activities → attend a piano concert, listen to a compact disk of a favorite piano piece, or just sit at the piano bench remembering how it used to feel to play

- Gains with one specific activity can be followed by efforts to stimulate other interests
- Just the realization that one has abandoned pleasant activities may be enough to stimulate re-engagement

175

## DETACHMENT/ESTRANGEMENT (1)

**Premise:** When social contacts are disrupted after a traumatic event, specific attention may be needed to re-establish them

**Task:** Encourage the person to reconnect with one or two important people in his or her life (preferably outside the traumatic environment)

- Encourage the person to make one phone call, send a note, or arrange a lunch date
- One single social event may allow a number of opportunities to reconnect or back off and resume social activities at a measured pace

176

## DETACHMENT/ESTRANGEMENT (2)

**Example:** "I don't feel like I'm even a part of my friends or my family anymore. After work I just go home, eat leftovers by myself in front of the TV, and hardly even pay attention to it. I haven't wanted to join family events or go out with friends since it happened."

**Procedure:** Instruct the individual go out with someone he or she knows on a superficial social outing, such as a movie or an art museum (nothing more intense until practice increases interpersonal comfort level), or rekindle an old friendship from happier times in the past – go through the motions until the feelings can catch up

177

## EMOTIONAL NUMBING

**Premise:** After traumatic events, a person's range of affect may be restricted to negative emotions or no emotion at all

**Task:** Encourage the person to get back in touch with previous feelings of happiness and sadness not related to the event

**Example:** "I feel empty since 9/11. I can't laugh and I don't even cry anymore. I don't think I can ever feel happy again."

**Procedure:**

- Rekindle the rich array of feelings from the person's past by having the person recall the saddest and happiest moments of life prior to the negative event
- Happy and sad music or movies from the past help stimulate feelings

178

## FORESHORTENED FUTURE

**Premise:** Acting with a future orientation makes the future seem more real

**Example:** "Why worry about rebuilding, since before we could even get it done, something else is probably going to happen to destroy us?"

**Task:** Imagine/plan a pleasant event beyond the time of the imagined end

**Procedure:**

- Find out when the individual thinks the end will be
- Point out that doomsday predictions are generally wrong  
→ "You'll need contingency plans in case the world is not destroyed"
- Ask the individual to make plans for the month after the projected end of the world (eg, a New Year's party, a vacation to the Caribbean)

179

## Any Questions



180

## MEDICATIONS FOR POST-DISASTER DISORDERS

Diagnostic approach (not for isolated symptoms):

- For PTSD (ie, prominent group C Sxs)
- Also for other anxiety and depressive disorders
- SSRIs, TCAs, MAOIs
- Longer term; need follow-up
- Other promising Rx's – adjunctive use  
(eg,  $\beta$ -blockers,  $\alpha$ -2 agonists,  $\alpha$ -1 blockers, anticonvulsants)

Schoenfeld et al 2004 *Psychiatr Serv* 55:519-31  
Braun et al 1990 *J Clin Psychiatry* 51:236-8; Marshall et al 2001 *AJP* 158:1982-8  
Tucker et al 2001 *J Clin Psychiatry* 62:860-8; Davidson et al 2001 *AGP* 58:485-92  
Davidson 2006 *J Clin Psychiatry* 67(suppl2):34-9; Cooper et al 2005 *Aust NZ J Psychiatry* 39:674-82

181

## RX OF POST-DISASTER DISORDERS

- FDA-approved for PTSD: sertraline, paroxetine
- If no improvement, try nefazodone or venlafaxine  
- also, other antidepressant medications (esp. SSRIs, TCAs, MAOIs)
- PTSD effectiveness is independent of antidepressant effects
- Treatment response unrelated to trauma type, time from event, or severity
- Benzodiazepines not effective as primary Rx for PTSD

Schoenfeld et al 2004 *Psychiatr Serv* 55:519-31  
Braun et al 1990 *J Clin Psychiatry* 51:236-8; Marshall et al 2001 *AJP* 158:1982-8  
Tucker et al 2001 *J Clin Psychiatry* 62:860-8; Davidson et al 2001 *AGP* 58:485-92  
Davidson 2006 *J Clin Psychiatry* 67(suppl2):34-9; Cooper et al 2005 *Aust NZ J Psychiatry* 39:674-82

182

## PHARMACOTHERAPY FOR PTSD

Antidepressants for PTSD:

- PTSD Rx is similar to major depression Rx
- Not addictive or habit-forming
- Consistent use of medication required
- Effective for group B, C, & D symptoms
- Women possibly respond better than men
- Relapse significantly reduced compared to placebo

183

## SOME SPECIALIZED TRAUMA THERAPIES

- Cognitive Behavioral Therapy (CBT) - Beck, others
- Stress Inoculation Training (SIT) - Michenbaum
- Prolonged Exposure Therapy (PET) - Foa
- Critical Incident Stress Management (CISM) - Mitchell
- Eye Movement Desensitization/Reprocessing (EMDR) - Shapiro
- Traumatic Grief Therapy - Shear
- Psychodynamic psychotherapy for trauma
- Group therapies for trauma
- Family therapies for trauma

These are NOT **FRONTLINE**

184

## STRESS DEBRIEFING

A BRIEF REVIEW

185

**QUESTION:**

**WHAT IS DEBRIEFING?**

**Like pornography...hard to define,  
but you know it when you see it:**

186

## STRESS DEBRIEFING

- Group intervention originally designed to process first responders' traumatic experiences & emotions
- Inconsistent definition and application in actual practice
- Research shows single-session debriefing does not prevent PTSD
  - but it was never designed to prevent PTSD

Rose et al 2003 *Psychother Psychosom* 72:176-84

187

## HYPOTHESIS

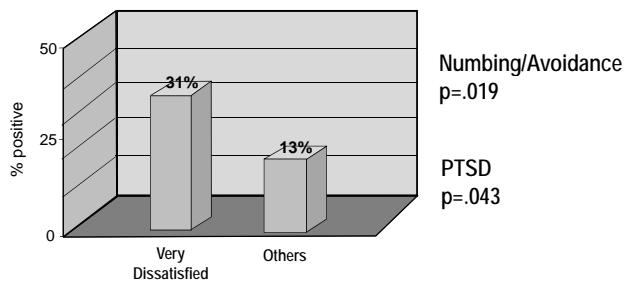
Debriefing might be problematic for those with prominent Group C (avoidance & numbing) profiles, ie, those with PTSD

...retraumatizing those who are unable to face exposure to the memories...?

188

## DISSATISFACTION WITH DEBRIEFINGS: PTSD AVOIDANCE/NUMBING

Oklahoma City Bombing - 181 Firefighters



189

## LET'S GET REAL

### WHAT DOES DEBRIEFING OFFER?

- Information/education/reassurance
- Ventilation/sharing
- Cognitive processing
- Coping skills
- Social support

### WHAT DEBRIEFING *DOES NOT* DO:

- ⊗ Prevent PTSD (or any psychiatric disorder)
- ⊗ Treat PTSD (or any psychiatric disorder)

190

## CAUTION WITH DEBRIEFING

- No evidence for effectiveness - no support for assumption that discussing the traumatic experience is therapeutic
- Debriefing may "medicalize" normal distress by increasing awareness of psychological distress & expectancy of psychopathology
- May lead to erroneous conclusions that enough has been done to prevent further problems; inadequate substitute for other elements (social support; professional help)
- Different people have different needs and vulnerabilities (varying potential for harm; varying need for more than debriefing)

191

## DEBRIEFING RECOMMENDATIONS

- Oklahoma City firefighters with prominent avoidance & numbing (ie, PTSD) were dissatisfied with debriefing
  - could re-traumatize those not ready to confront this material
- Debriefing may provide opportunities for support, education, and informal assessment (it does not prevent or treat PTSD)
- Debriefing should not be mandatory
- Carefully select participants (exclude highly distressed)

192

## Any Questions

---



193

## CONCLUSIONS

194

### **POLICY AND PRACTICE SHOULD BE EMPIRICALLY DRIVEN**

---

Interventions should be tailored to needs of those being served, not those serving

- **Psychiatric illness:**
  - ▶ recognize and treat
- **Distress:**
  - ▶ intervene without pathologizing

195

### **LOCAL DISASTER MENTAL HEALTH RESPONSE**

---

- Disaster mental health skills - NOT same as PTSD in practice settings
- Organization and planning to avoid chaos post disaster
- Federal disaster agencies - crisis oriented, psychological first aid (not for psychiatrically ill)
- State departments of mental health poorly equipped (eg, postdisaster problems ≠ schizophrenia, bipolar)
- Consider different exposure groups separately

196

### **ORGANIZING POST-DISASTER MENTAL HEALTH INTERVENTIONS**

---

- Predisaster planning and networking
- Establish leadership & roles for responders
- Train professionals - psychological first aid, *P-FLASH*
- Credential professionals
- Coordinate agencies and disciplines - federal, state
- Risk communication - authorities, media
- Assess interventions applied - evaluation, research

197

### **POST-DISASTER MENTAL HEALTH TASKS**

---

- **Behavioral management:** keep the calm
  - intervene with upset or disruptive individuals
  - support first responders in recounting and advising
- **Psychiatric**
  - manage practical problems (eg, Rx replacement)
  - assess, triage, & manage psychiatric problems (eg, psychosis vs. delirium vs. panic)
- **Mass mental health**
  - risk communication (what people should do / not do)
  - prevent mass panic

198

## MENTAL HEALTH TASKS IN HOSPITAL SETTINGS

- **Behavioral management:** keep the calm
  - Emergency Department staff
  - hospital wide employees
- **Psychiatric**
  - triage & manage patients with psychiatric issues
- **Mass mental health**
  - risk communication (medical safety information)
  - advise staff what safety precautions to take

199

## MENTAL HEALTH TASKS IN COMMUNITY SETTINGS

- **Behavioral management:** keep the calm
  - practical crowd direction
  - special procedures for directly involved victims
  - organized disaster worker plan
- **Psychiatric**
  - practical support & reassurance
  - rapidly assess & triage critical emergent cases
- **Mass mental health**
  - risk communication
  - accomplished via media & community leadership

200

## Any Questions



201

## REVIEW OF PURPOSE AND GOALS

This presentation provided a mental health tool kit for practical, front-line post-disaster mental health interventions:

- Differentiated normative and pathological responses
- Provided flow charts with algorithms for evaluation, identification, triage, and management
- Imparted front-line disaster-related mental health skills geared for different phases and populations

202

## PAPER WORK

203



204

**QUESTIONS**

**QUESTIONS & ANSWERS**  
**QUESTIONS & ANSWERS**

**QUESTIONS & ANSWERS**  
**QUESTIONS & ANSWERS**

**ANSWERS**

205

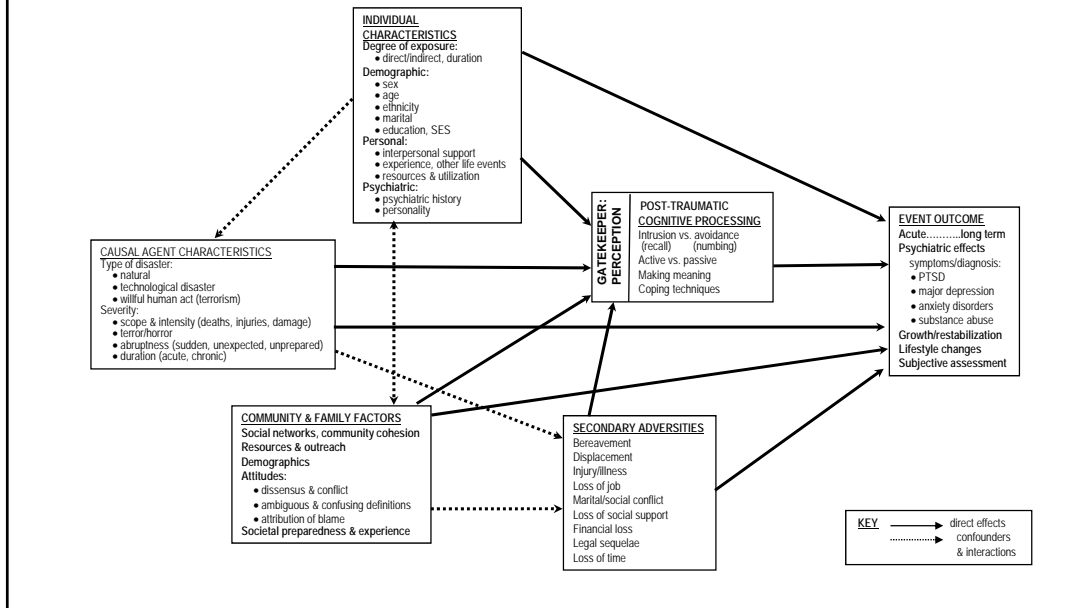
**The End.**

---

206

# COMPREHENSIVE MODEL OF DISASTER TRAUMA RESPONSE

North 2004, in Gorman, *Fear and Anxiety: The Benefits of Translational Research*, American Psychiatric Publishing



# FLOW CHART FOR DISASTER MENTAL HEALTH ASSESSMENT & TRIAGE

