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MENTAL HEALTH RESPONSE TO MASS VIOLENCE AND TERRORISM



A T R A I N I N G M A N U A L

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

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CHAPTER I

BACKGROUND AND OVERVIEW

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

Purpose of The Manual

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

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

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

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

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

Overview of The Manual

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

Chapter II: Human Responses to Mass Violence and Terrorism

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

Chapter III: Mental Health Intervention

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

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

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

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

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

Chapter V: Stress Prevention, Management, And Intervention

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

Chapter VI: Setting Up Training

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

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

Chapter VII: Comprehensive Training Course Outline

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

Chapter VIII: Additional Training Needs and Options

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

Overview of Resources

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

Glossary of Acronyms

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



CHAPTER 11

HUMAN RESPONSES TO MASS VIOLENCE AND TERRORISM

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

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

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

T A B L E 1 : COMPARISON OF MASS VIOLENT VICTIMIZATION AND NATURAL DISASTERS		
DIMENSION	Mass Violent Victimization	Natural Disasters
Examples	<ul style="list-style-type: none"> • Mass riots • Terrorist bomb • Bioterrorism • Hostage taking • Mass shooting • Aircraft hijacking • Arson 	<ul style="list-style-type: none"> • Hurricane • Flood • Drought • Earthquake • Volcanic eruption • Tornado • Wildfire
Causation	<ul style="list-style-type: none"> • Include evil human intent, deliberate sociopolitical act, human cruelty, revenge, hate or bias against a group, mental illness. 	<ul style="list-style-type: none"> • Is an act of nature; severity of impact may result from interaction between natural forces and human error or actions.
Appraisal of Event	<ul style="list-style-type: none"> • Event seems incomprehensible, senseless. • Some view as uncontrollable and unpredictable, others view as preventable. • Social order has been violated. 	<ul style="list-style-type: none"> • Expectations defined by disaster type. • Awe expressed about power and destruction of nature. • Disasters with warnings increase sense of predictability and controllability. • Recurring disasters pose ongoing threat.
Psychological Impact	<ul style="list-style-type: none"> • Life threat, mass casualties, exposure to trauma, and prolonged recovery effort result in significant physical and emotional effects. • There are higher rates of Post-Traumatic Stress Disorder (PTSD), depression, anxiety and traumatic bereavement that can last for a longer period of time. 	<ul style="list-style-type: none"> • Property loss and damage are primary impacts, so reactions relate to losses, relocation, financial stress, and daily hassles. • Disaster traumatic stress typically resolves over 18 months, with lower rates of diagnosable disorders unless high number of fatalities and serious injuries.
Subjective Experience	<ul style="list-style-type: none"> • Victims are suddenly caught unaware in a dangerous, life-threatening situation. May experience terror, fear, horror, helplessness, and sense of betrayal and violation. • Resulting distrust, fear of people, or being “out in the world” may cause withdrawal and isolation. • Outrage, blaming the individual or group responsible, desire for revenge, and demand for justice are common. 	<ul style="list-style-type: none"> • Separation from family members, evacuation, lack of warning, life threat, trauma, and loss of irreplaceable property and homes contribute to disaster stress reactions. • Anger and blame expressed toward agencies and individuals responsible for prevention, mitigation, and disaster relief.
World View/ Basic Assumptions	<ul style="list-style-type: none"> • Assumptions about humanity are shattered; individuals no longer feel that the world is secure, just, and orderly. • Survivors confronted with the reality that evil things can happen to good people. • People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time. 	<ul style="list-style-type: none"> • Spiritual beliefs may be shaken (e.g., “How could God cause this destruction?”). • Loss of security in “terra firma” that the earth is “solid” and dependable. • People lose their illusion of invulnerability; anyone can be in the wrong place at the wrong time.

Continued on next page

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

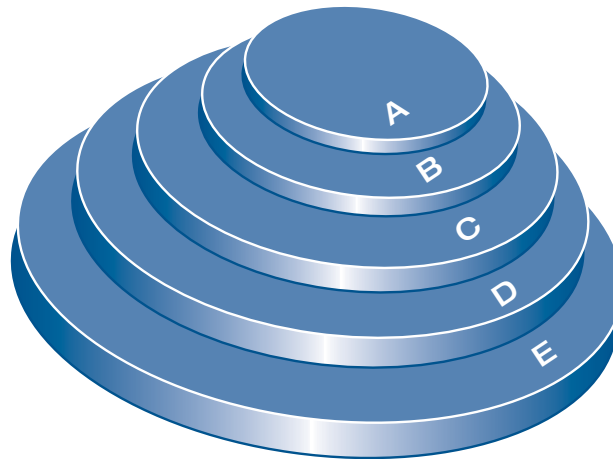
DIMENSION	Mass Violent Victimization	Natural Disasters
Stigmatization of Victims	<ul style="list-style-type: none"> • Some victims may come to feel humiliation, responsibility for others' deaths, survivor guilt, self-blame, and unworthy of assistance, thus assigning stigma to themselves. • The larger community, associates, friends, and even family may distance themselves to avoid confronting the idea that crime victimization can happen to anyone. • Well-meaning loved ones may urge victims and bereaved to "move on," causing them to feel rejected and wrong for continuing to suffer. • Hate crimes reinforce the discrimination and stigma that targeted groups already experience. 	<ul style="list-style-type: none"> • Disasters tend to have greater impact on people with fewer economic resources due to living in lower-cost, structurally vulnerable residences in higher-risk areas. • Survivors from cultural, racial, and ethnic groups; single parent families; people with disabilities; and the elderly on fixed incomes experience greater barriers to recovery causing double jeopardy and potential stigma.
Phases of Response and Reconstruction	<ul style="list-style-type: none"> • Impact • Outcry • Disbelief, shock, and denial • Interaction with criminal justice system • Working-through process • Coming to terms with realities and losses • Reconstruction 	<ul style="list-style-type: none"> • Warning, threat • Impact • Rescue and heroism • Honeymoon • Interaction with disaster relief and recovery • Disillusionment • Coming to terms with realities and losses • Reconstruction
Media	<ul style="list-style-type: none"> • The media shows more interest in events of greater horror and psychological impact. • Excessive and repeated media exposure puts people at risk for secondary traumatization. • Risk of violations of privacy. 	<ul style="list-style-type: none"> • Short-term media interest fosters sense in community that "the rest of the world has moved on." • Media coverage can result in violations of privacy; there is a need to protect children, victims, and families from traumatizing exposure.
Secondary Injury	<ul style="list-style-type: none"> • Victims' needs may conflict with necessary steps in the criminal justice process. • Steps required to obtain crime victim compensation and benefits can seem confusing, frustrating, bureaucratic, and dehumanizing and trigger feelings of helplessness. • Bias-crime victims may suffer prejudice and blame. • Victims may feel that the remedy or punishment is inadequate in comparison to the crime and their losses. 	<ul style="list-style-type: none"> • Disaster relief and assistance agencies and bureaucratic procedures can be seen as inefficient, fraught with hassles, impersonal. • Disillusionment can set in when the gap between losses, needs, and available resources is realized. • Victims rarely feel that they have been "made whole" through relief efforts.

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

Population Exposure Model

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

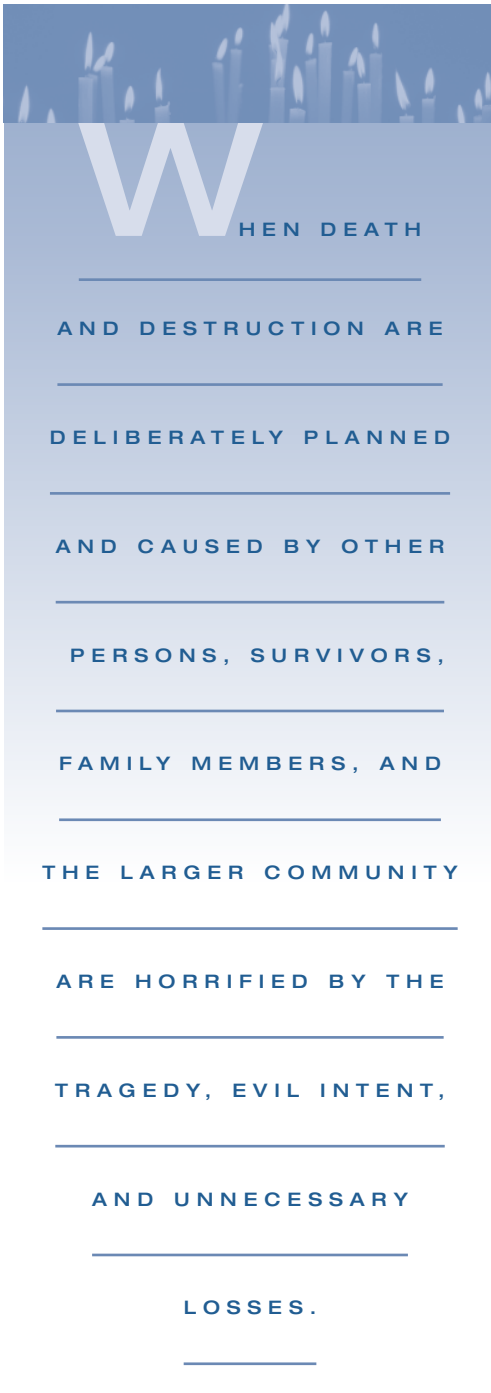
FIGURE 1: POPULATION EXPOSURE MODEL



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

Population Exposure Checklist

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



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

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

Traumatic Event And Stressor Characteristics

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

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

(Green, 1993)

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

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

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

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

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

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

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

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

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

Survivor Characteristics

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

In the immediate aftermath of a large-scale, severely

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

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

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

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

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

TABLE 2 : SURVIVOR CHARACTERISTICS

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

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

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

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

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

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

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

Immediate Adult Reactions to Trauma, Victimization, And Sudden Bereavement

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

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

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

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

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

Physical Reactions

Physical reactions can include:

- Faintness, dizziness
- Hot or cold sensations in body
- Tightness in throat, stomach, or chest
- Agitation, nervousness, hyper-arousal
- Fatigue and exhaustion
- Gastrointestinal distress and nausea
- Appetite decrease or increase
- Headaches
- Exacerbation of pre-existing health conditions

Behavioral Reactions

Behavioral reactions can include:

- Sleep disturbances and nightmares
- Jumpiness, easily startled
- Hyper-vigilance, scanning for danger
- Crying and tearfulness for no apparent reason
- Conflicts with family and coworkers
- Avoidance of reminders of trauma
- Inability to express feelings
- Isolation or withdrawal from others
- Increased use of alcohol or drugs

Emotional Reactions

Emotional reactions can include:

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

Cognitive Reactions

Cognitive reactions can include:

- Confusion and disorientation
- Poor concentration and memory problems
- Impaired thinking and decision making
- Complete or partial amnesia

- Repeated flashbacks, intrusive thoughts and images
- Obsessive self-criticism and self-doubts
- Preoccupation with protecting loved ones
- Questioning of spiritual or religious beliefs

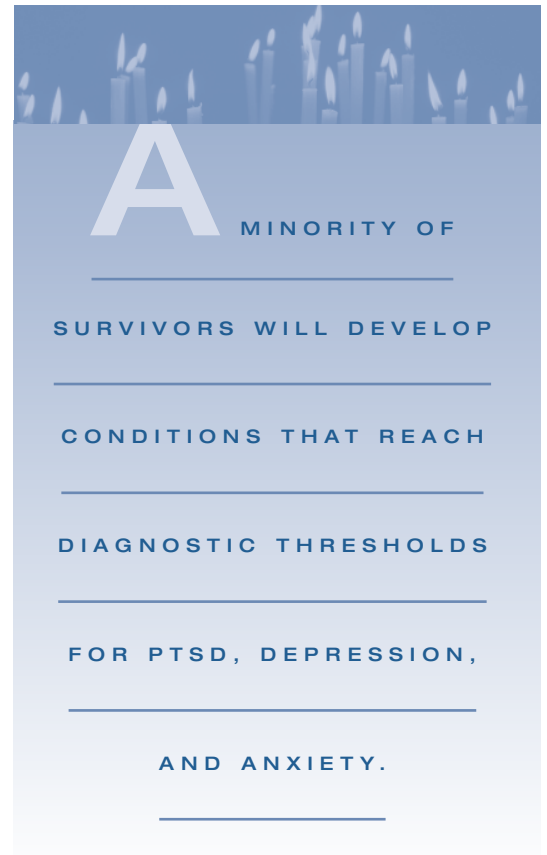
Long-Term Responses Of Adults

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

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

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

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



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

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

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

Traumatic Bereavement

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

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

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

Screening and Assessment Checklist

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

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

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

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

Model of Human Responses to Trauma and Bereavement

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

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

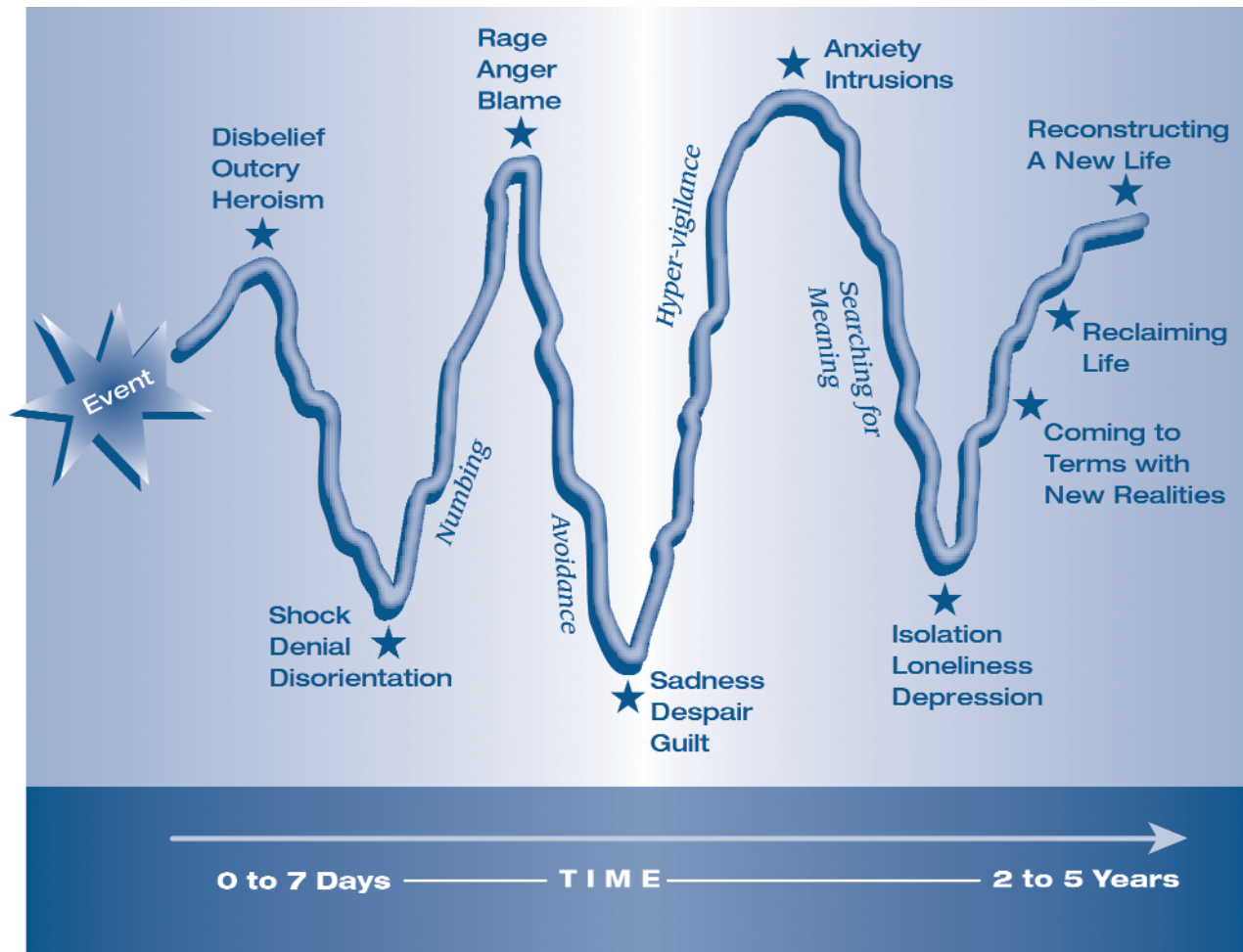
mechanism is a gradual and graceful way to deal with the murder of a loved one, allowing families the time that they need to make the transition from shock and denial into the grieving process.

(Cummock, 1996)

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

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

FIGURE 2: MODEL OF RESPONSES TO TRAUMA AND BEREAVEMENT



(Note. Adapted from CMHS, 1994)

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

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

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

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

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

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

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

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

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

Children and Adolescents: Priority Considerations And Reactions

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

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

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

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

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

shared traumatic experience.

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

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

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

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

Traumatic Event and Stressor Characteristics

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

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

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

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

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

Post-Trauma and Grief Reactions

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

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

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

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

Young Children (1–5 years):

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

School-Aged Children (6–11 years):

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

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

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

Screening and Assessment Checklist

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

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

Older Adults: Priority Considerations And Reactions

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

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

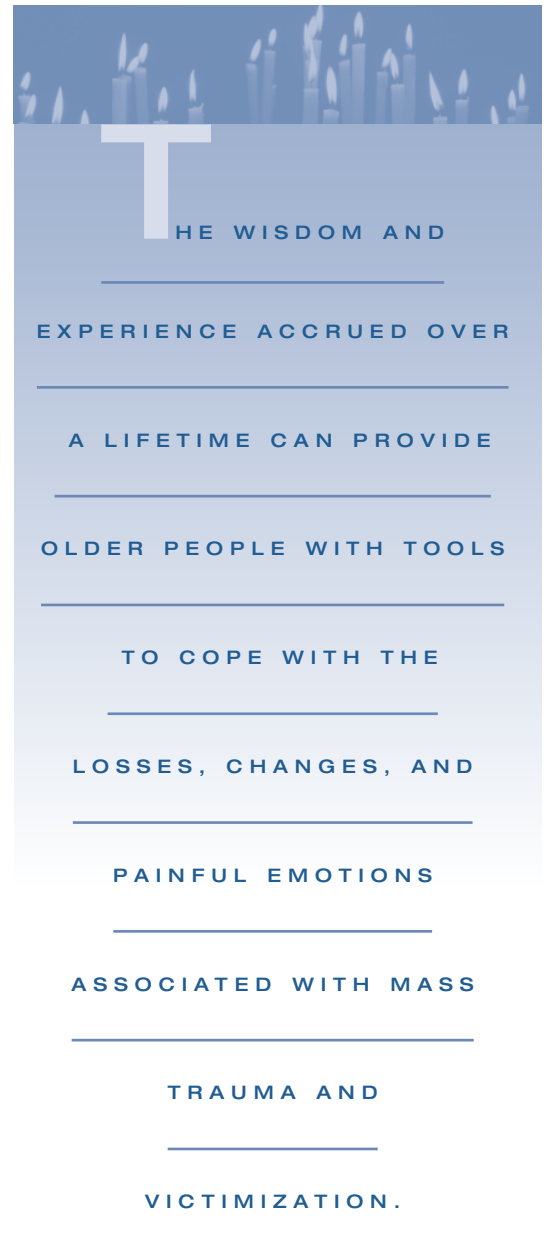
When older adults have entered the "elderly" stage in the aging process and have health problems or have become physically frail, their experience of the tragedy often is influenced by their physical needs. A sudden, threatening, traumatic event evokes fear, helplessness, and a vulnerability in many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

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

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

Screening and Assessment Checklist

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



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

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

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

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

Cultural and Ethnic Groups: Priority Considerations And Reactions

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

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

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

Cultural Response Checklist

- ✓ Meanings associated with current disaster and emergency response
- ✓ Beliefs and practices regarding death, burial, mourning, trauma, and healing
- ✓ Trauma and violence in country of origin and within the United States
- ✓ Signs and symptoms of post-traumatic stress, grief, depression, and anxiety
- ✓ Views about mental health and providers
- ✓ Professional courtesy (e.g., greetings, who to talk to first, who is “family”)

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

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

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

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

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

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

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

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

Recommended Reading

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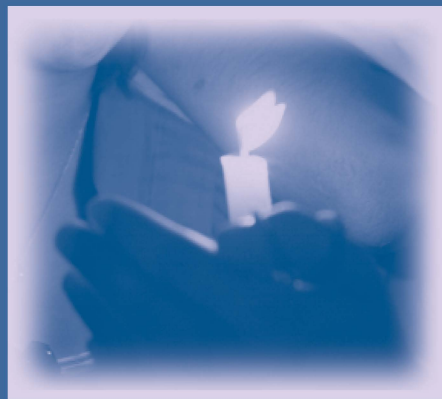
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This concludes Study Guide 1 of this 6.5 credit hour course. This material has been FREE TO READ. However, if you wish to obtain a certificate for this course, you must be enrolled in the course (i.e., you must pay to take the quiz -- unless you have purchased an Annual Subscription, in which case you pay nothing to take quizzes and obtain certificates for one year from date of purchase).

When you are ready, you may go to the Study Guides and Quizzes Page for Course 6A, to take the quiz for this Study Guide 1 (which is the first section of Course 6A). You may access Study Guide 2 whenever you are ready. When you have passed the quizzes for Study Guides 1 and 2 - and submit the Feedback Form - you may instantly download your certificate for 6.5 credit hours.

As always, it is recommended that you print a copy of the quizzes before you begin to read the materials, to mark answers as you find them in the materials. You may then transfer your answers to the online quiz.