CHAPTER III

MENTAL HEALTH

INTERVENTION

Mental health support, psychological first-aid, and crisis intervention have become expected and valued components of disaster response, particularly following mass casualty incidents. A range of mental health services are provided for victims, bereaved family members, first responders, disaster workers, and the community-at-large. Mental health workers assist with hotlines responding to queries about missing persons, on death notification teams, at respite centers for rescue and recovery workers, at the site of the disaster to support grieving loved ones, and as consultants to government officials. Mental health services are practical, accessible, empowering, and compassionate.

This chapter presents the key overarching principles for mental health intervention following mass violent victimization. Only credentialed mental health professionals should provide some of these interventions; others are appropriate for all human service and crime victim assistance workers serving survivors. The mental health response manager usually determines the appropriate scope of practice for providers with varying backgrounds. This chapter provides general guidelines.

Immediate and long-term interventions with adults, followed by similar information related to children and adolescents, are presented. The "immediate" time frame generally refers to the first several weeks post-incident; "long-term" refers to months, sometimes years, after the event. Since many long-term interventions require specialized in-service training, this chapter provides only an orienting overview. Chapter VIII includes topics for in-service training. Many of the immediate interventions are appropriate throughout the recovery period, especially in first contacts with survivors, family members, and the community-at-large.

Special considerations for mental health intervention with older adults are included throughout the chapter. Developing cultural competence and effectively serving all groups in the community is important. Suggestions for cultural sensitivity are included throughout the chapter and addressed in a specific section toward the end of this chapter.

Because these tragic events occur in a larger community and recovery context, the next section describes predictable events with mental health implications, such as death notifications and stages in the criminal justice process. The mental health support role is discussed in relation to each event. Then, the importance of community support through memorials, rituals, and maintenance of local traditions is discussed. A practical table providing a list of reactions to trauma and intervention options for different age groups appears at the end of the chapter.

Key Principles For Mental Health Intervention

Violence, destruction, and death that is deliberately and malevolently caused by another human is horrific and tragic. Victims, responders, the community, and sometimes the entire country experience the impact of mass criminal victimization, along with varying degrees of outrage, sadness, and feelings of vulnerability. The following 10 key principles guide mental health providers, as well as other responders and human service workers assisting survivors:
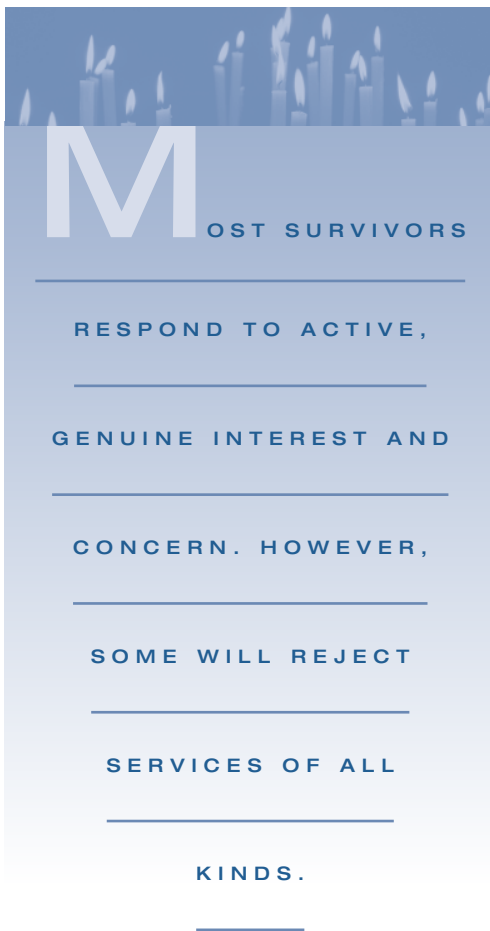
1. **No one who witnesses the consequences of mass criminal violence is unaffected by it.** Many groups may be emotionally affected, including emergency responders, government officials, media personnel, disaster workers, the community, those who view extensive media coverage, and mental health providers. A range of psychological support and educational interventions are important components of the overall response;

2. **Mass crimes, involving trauma and loss, affect both the individual and the community.** Psychological and physical damage to community structures that normally provide social support can compound an individual survivor's trauma and grief effects. This community harm impedes the recovery process. Blaming and scapegoating of particular groups, which may occur during the aftermath of mass victimization, can undermine the community's integrity and its capacity to care for its members. Intervention on both the individual and the community levels is necessary;

3. **Most people pull together and function following a mass tragedy, but their effectiveness is diminished**

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and they may have brief periods of being emotionally overwhelmed. Because of the magnitude and severity of psychological impacts inherent in mass violent criminal victimization, a wide range of intense emotional, physical, and behavioral responses are expected. However, human resilience and kindness predominate;

4. *While most traumatic stress and grief reactions are normal responses to extraordinary circumstances, a significant minority of survivors experience serious long-term psychological difficulties.* Survivors personally involved in the traumatic incident who experienced a threat to their lives, the death of a child, spouse, or significant other, are more likely to suffer long-term mental health consequences (North et al., 1999). In addition, survivors with prior histories of traumatization, psychiatric problems, or substance abuse are at greater risk;

5. *Mental health, crime victim assistance, and other human services must be tailored to the communities they serve.* Cultural competence is essential. Communities vary according to demographic characteristics, regional differences, religious affiliations, and cultural, ethnic, and racial groups represented. Each variable must be considered when developing an effective mental health response;

6. *Most survivors respond to active, genuine interest and concern. However, some will reject services of all kinds.* Respectful human kindness is the basis for intervention. This includes supporting survivors' choices to not receive outside assistance, and understanding that, for some, choices may change over time;

7. *Mental health assistance is practical, flexible, and empowering. It reflects survivors' needs to pace their exposure to harsh realities resulting from the event. First and foremost, providers must do no harm when intervening.* Mental health providers sensitively must determine each survivor's needs and coping style, quickly establish rapport and connection, and offer support and assistance appropriate for that

individual. Some survivors manage their intense reactions through protective denial and distancing, so that they may gradually come to realize the magnitude of the tragedy and their losses;

8. **Law enforcement procedures, medical examiner's protocols, disaster relief requirements, and criminal justice proceedings often confuse and distress survivors.** Mental health efforts that include effective coordination with key response agencies can mitigate survivors' frustration, anger, and feelings of helplessness. Providing clear information and support, and facilitating access to resources can help survivors and family members feel more in control and less alone;

9. **Provision of mental health services is an element of a multidisciplinary emergency response and supports the efforts of the primary responding agencies.** Law enforcement, emergency medical services, and rescue and recovery personnel have primary responsibilities and roles. Importantly, each contact with a survivor has the potential for easing the pain of the tragedy, whether by a mental health worker, a crime victim assistance provider, an emergency responder, or a disaster worker; and

10. **Support from family, friends, and the community helps survivors cope with the trauma and their losses.** Social support from loved ones and social networks comforts survivors, reduces their alienation and isolation, fosters hope, and promotes healing. Effective intervention involves connecting survivors with their primary supports and facilitating support systems coming together.

Mental Health Assistance Coordination

Mental health support may be provided by mental health professionals, crime victim services counselors, mental health volunteers from the American Red Cross and other responding voluntary organizations, and faith-based counselors. Effective coordination between responder groups providing mental health support is necessary to reduce conflicts and potentially intrusive duplications of effort, and to ensure appropriate services for survivors. Each group has a significant role in the overall response effort, so teamwork and cooperation are essential. Preplanning and preparedness involve defining the roles, responsibilities, and procedures for coordination between the various mental health responder groups and participating in drills before the event occurs.

Mental Health Service Provider Groups

In reality, all first responders, government officials, law enforcement personnel, crime victim assistance providers, and employers, as well as those more formally charged with "mental health services" have the potential to positively affect the mental health of survivors and family members. While the material presented here is oriented toward "counseling and support services," all who come in contact with survivors may find useful suggestions. The terms "mental health responder," "mental health worker," and "mental health provider" are used interchangeably to refer to individuals whose response efforts involve alleviating the pain and distress of affected groups and individuals.

Crime victim assistance providers assist crime victims and family members to access crime victim benefits and services and to provide

information regarding the criminal justice process. They also use many of the mental health interventions described in this chapter. While "crime victim assistance providers" are mentioned specifically when warranted by the context, they are intended to be included in the various mental health worker designations.

The term "mental health professional" refers to social workers, psychologists, psychiatrists, and other credentialed or licensed mental health providers. In general, psychological support, comfort, and practical assistance may be provided by other appropriately trained and supervised responders. Assessments and interventions with people showing higher levels of distress or with prior psychiatric problems, facilitation of group interventions, and mental health consultation with organizations and officials should be provided by mental health professionals. The designation "mental health response manager" refers to individuals responsible for determining needs, service targets, the mental health response plan, and the scope of practice for mental health responder groups, and for screening, training, assigning, and supervising mental health responders.

Immediate Mental Health Intervention

Goals and Priorities

During and immediately following a mass violent incident, those most impacted may experience shock, confusion, fear, numbness, panic, anxiety, distancing and "shutting down." Witnessing or suspecting the deaths of friends or family members can be emotionally overwhelming. Survivors who are not physically injured may be taken to separate sites to be interviewed as witnesses and to be connected with loved ones. Those with injuries are taken quickly to area hospitals. When the perpetrators have not been apprehended or the event is considered to be terrorism, all experience a sense of continued danger and threat. Mental health responders have four initial, immediate intervention goals: (1) identify those in need of immediate medical attention for stress reactions; (2) provide supportive assistance and protection from further harm; (3) facilitate connecting survivors with family and friends; and (4) provide information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts.

During this phase of the response, emotional stabilization is the primary objective. Because an overriding response of many crime victims is to feel vulnerable and fearful, interventions emphasize protection, safety, and promotion of a sense of security.

Acute response shock and confusion gradually give way to increasing awareness and understanding of what has occurred and the related personal consequences. Those most affected and their loved ones may be in hospitals, gathered at sites awaiting critical information, searching for missing loved ones, or in their homes. If homes and buildings were destroyed, those displaced may be in shelters, at alternate care facilities, staying in hotels, or in the homes of friends and family.

Mental health response managers quickly must determine those groups most affected and the best ways to reach them. Assuming that the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, intervention goals follow:

- Alleviate distress through supportive listening,

providing comfort, and empathy;

◆ Facilitate effective problem-solving of immediate concerns;

◆ Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor; and

◆ Provide psycho-educational information regarding post-trauma reactions and coping strategies.

## Immediate Mental Health Interventions With Adults

The following section describes eight interventions commonly used during the immediate aftermath of an incident involving mass violent victimization:

1. Psychological first-aid;

2. Crisis intervention;

3. Informational briefings;

4. Crime victim assistance;

5. Community outreach;

6. Psychological debriefing;

7. Psycho-education; and

8. Mental health consul-tation.

These interventions may be used with adults, older adolescents, and elderly individuals with adequate cognitive abilities. Descriptions of the interventions include guidance on when they are most appropriate, who should provide them, and how they can be implemented most effectively.

1. Psychological First-Aid

Rapid assessment determines those survivors in most acute distress and in need of medical attention. Initial triage decisions are based on observable and apparent data. Survivors experiencing obvious physiological stress reactions including shaking, screaming, or complete disorientation may need emergency medical attention. Those survivors who appear profoundly shut down, numb, dissociated, and discon-nected may also require medical attention. Medical assessment and assistance are necessary for elderly survivors who are vulnerable because of health conditions and physical or cognitive limitations. When survivors do not speak English, effective assessment and triage involves ready access to bilingual mental health responders and interpreters. Survivors who appear at risk for life-endangering behavior need to be evaluated by a mental health or other

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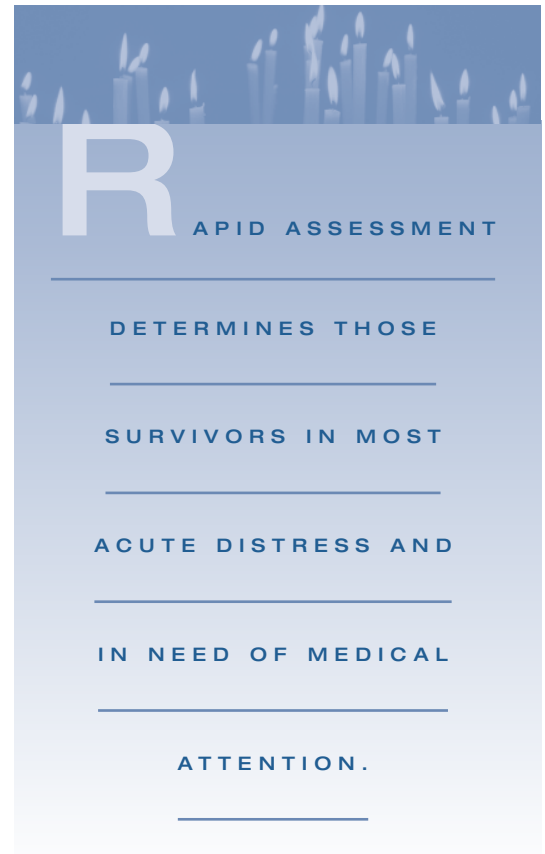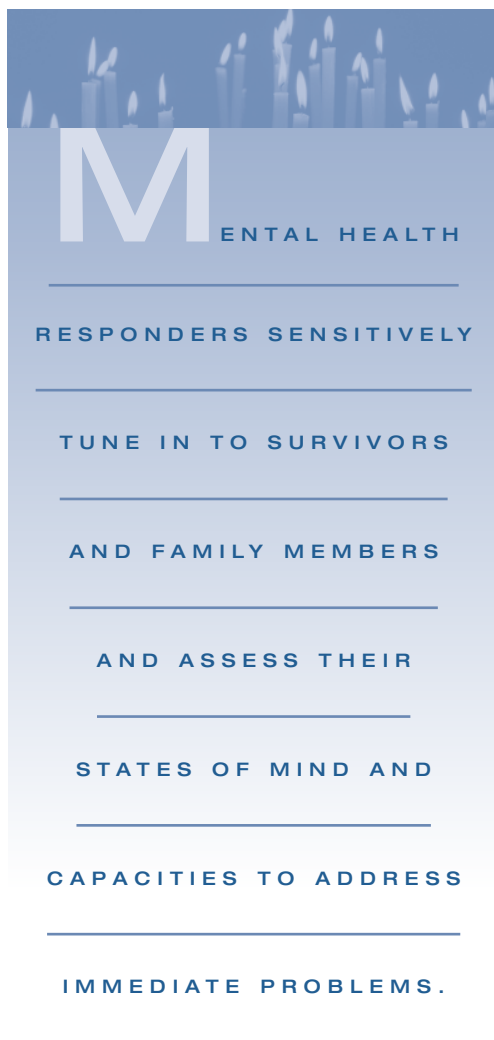
appropriate professional and receive necessary protective action.

Emergency intervention involves three basic concepts: protect, direct, and connect (Myers and Wee, 2003). Survivors need to be protected from viewing traumatic stimuli, from onlookers, and from the media. When disoriented or in shock, survivors should be directed away from the trauma scene and danger, and toward a safe and protected environment. A brief human connection with the mental health responder can help to orient and calm survivors. Also, responders help survivors connect with loved ones and needed resources.

Psychological support involves:

◆ Comforting the distressed survivor;

◆ Addressing immediate physical necessities (e.g., dry clothing, fluids, food, shelter);

◆ Supporting reality-based, practical tasks;

◆ Providing concrete information about what will happen next to increase a sense of control;

◆ Listening to and validating feelings;

◆ Linking the survivor to systems of support;

◆ Normalizing stress reactions to trauma and sudden loss; and

◆ Reinforcing positive coping strengths.

(Centre for Mental Health Services and NSW Psychiatric Institute, 2000; Osterman and Chemtob, 1999; Young, 1998; Raphael et al., 1996; Myers, Zunin and Zunin, 1990)

Mental health responders sensitively tune in to survivors and family members and assess their states of mind and capacities to address immediate problems. Intervening involves taking the survivor's lead in terms of pacing the interaction and not probing areas that are obviously painful. A number of experts have argued that when survivors or family members are using denial, wishful thinking, forgetting, or distancing to regulate their intense reactions, immediate interventions should not attempt to penetrate these coping defenses (Raphael and Dobson, 2002; Sitterle and Gurwitch, 1999; Lord, 1996).

2. Crisis Intervention

The goals of crisis intervention involve helping survivors regain some sense of control

over their immediate situations and re-establish rational problem-solving abilities. Crisis intervention typically involves four components: (1) promote safety and security; (2) identify current priority needs, problems, and possible solutions; (3) assess functioning and coping; and (4) provide reassurance, normalization, psycho-education, and practical assistance.

1. Promote safety and security:

"May I get you something to drink?"

"Are you feeling comfortable/safe here?"

Survivors need to feel protected from threat and danger. When given simple choices, many come to feel less powerless as they exercise some control over their situations—which is critical for engaging initial coping.

2. Identify current priority needs and problems and possible solutions:

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

"Who might help you?"

Selecting and successfully addressing one solvable problem as most immediate can help bring back a sense of control and capability. Existing

sources of assistance among friends, family, health care providers, or community resources may be helpful. Assist with accessing resources when necessary.

3. Assess functioning and coping:

"How are you doing? How do you feel you are coping with this?"

"How have you coped with stressful life events in the past?"

Through observation, asking questions, and reviewing the magnitude of the survivor's problems and losses, the worker develops an impression of the survivor's capacity to address current challenges. Based on this assessment, the worker may make referrals, point out coping strengths, and facilitate the survivor's engagement with social supports. The worker also may seek consultation from a medical or mental health professional.

Discussion of individual disaster experiences must be carefully tailored to the person's situation and coping style. For example, for those who are highly distressed, talking in much detail about their disaster experience and expressing related emotions might promote further destabilization. With these

individuals, provide reassurance and comfort and move on with problem-solving, if the person is able. For other survivors, detailed verbalization of their traumatic experience can facilitate some reality-based acceptance that, in turn, can contribute to appropriate problem-solving.

4. Provide reassurance, normalization, psycho-education, and practical assistance:

Support, reassurance, and acknowledgment and normalization of feelings and reactions occur throughout the intervention. It is important that the survivor feel the response provided by the worker is both personal and individual. Mental health workers must pay close attention to the individual's experience and style and not offer "pat" or "canned" responses. Psycho-education should address the particular reactions mentioned by the survivor, and provide additional information through a brochure or individualized information. Practical assistance may involve helping to arrange childcare, making a phone call, or obtaining critical information.

Mental health responders are challenged to determine how to assist each individual survivor and not to apply the same approaches to all. The

importance of flexibility and sensitivity is underscored as responders intervene with survivors from different cultural groups. The basic operating principle of "first, do no harm" dictates that responders approach each person and family with respect and sensitivity, and be vigilant to cues that might suggest their services are not wanted or their approach needs to be altered.

3. Informational Briefings

In large-scale crises, rumors and misinformation are common. Survivors and loved ones need accurate, reliable information delivered often, clearly, humanely, and in the appropriate languages. They seek information regarding the location and well-being of loved ones, progress of rescue and recovery efforts, the disaster's impact and resulting loss of life, current levels of threat and danger, and what might happen next. Receiving procedural information and updates regarding criminal investigations and the rescue operation can promote a sense of control when survivors feel powerless. Informational briefings may be provided by a government official, a law enforcement representative, or a spokesperson from a medical examiner's office. Official personnel should be available to provide current and

accurate information in response to the questions of loved ones and family members (Sitterle and Gurwitch, 1999).

Mental health responders typically do not provide informational briefings directly, however, they may consult with those responsible for them. Mental health providers may convey information to officials about the value of frequent briefings for survivors and family members. When cultural and ethnic groups are affected, mental health consultants may promote equivalent access to information and government officials, and facilitate liaisons with cultural group leaders. Mental health professionals also may offer suggestions regarding appropriate wording or terminology, the level of detail for sensitive information, approaches for addressing intense emotional reactions from survivors, and language to convey messages of compassion and condolence.

4. Crime Victim Assistance

Crime victim services are a central element of effective response. Interventions linked to the criminal justice process include:

- ◆ Protecting and advocating for the rights of crime victims;

- ◆ Providing information about the criminal justice process and the roles of the various participants in that process, provided in the primary, spoken languages;

- ◆ Facilitating access to State crime victim and other appropriate compensation programs for payment of crime-related expenses as well as other community resources; and

- ◆ Streamlining procedures for accessing services and benefits and responding to unique needs.

While no one can undo the losses and trauma of the event, sensitive and responsive recognition of victims' rights and needs throughout the criminal justice process can mitigate some of the most painful effects. When a large number of survivors have a "need to know" following a mass criminal event, an effective, centralized, and accessible system of information dissemination is appropriate. An active, working partnership between mental health responders and crime victim assistance providers ensures that the broad range of survivor and family needs will be addressed. Cross-referral, cross-training,

and cross-consultation is recommended (Office for Victims of Crime, 2000).

5. Community Outreach

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism. Many survivors will not seek mental health services actively, especially during the first several weeks. They often are not aware of the crime victim benefits available to them. When mental health providers sensitively initiate contact with survivors, their access to mental health services, crime victim services, practical assistance, and information about criminal justice proceedings can be established. When cultural, economic, language, transportation, disability, or age-related barriers exist, outreach is a valuable tool for reaching special populations and at-risk survivors. Community outreach involves:

◆ Initiating supportive and helpful contact at sites where survivors are gathered;

◆ Reaching out to survivors through the media, the Internet, and 24-hour telephone hotlines with responders who speak different languages;

◆ Participating in or conducting meetings for natural pre-existing groups through religious organizations, schools, employers, community centers, and other organizations; and

◆ Providing psycho-educational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers.

Mental health outreach workers form alliances with existing, trusted community entities and leaders to gain credibility and acceptance. Skilled outreach workers take the approach that they must earn the right to serve. While simple in concept, community outreach requires a range of skills. Outreach mental health workers must be comfortable initiating conversations with survivors who have not requested their services. Good interpersonal skills and the ability to quickly establish rapport, trust, and credibility are necessary. Workers must be able to think on their feet and be diplomatic. While it is ideal for outreach workers to be from the cultural and ethnic groups they are serving, this is not always possible, especially in the first weeks after an event. Workers must be knowledgeable and respectful of the values and practices of the cultural groups impacted by the event.

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6. Psychological Debriefing

A variety of organizations currently provide "psychological debriefing" in the aftermath of traumatic events. While most debriefing approaches are generally well-received by participants and perceived as helpful, it is important for community leaders to be well-informed about the specific intervention techniques being used in order to assure that any services provided are truly helpful and appropriate.

In recent years, many mental health experts have expressed concerns about the indiscriminate use of the term "debriefing" to apply to a wide array of individual and group approaches for various populations. In 2001, a panel of international experts convened to examine early intervention techniques stated the following:

> Use of the term "debriefing" for a variety of mental health interventions is misleading. Workshop participants recommended that this stand-alone term no longer be used to describe early mental health interventions following mass violence and disasters. For clarity, "debriefing" should be used only to describe operational debriefing,* and should not be used to describe psycho-logical debriefing, Critical Incident Stress Debriefing (CISD), and so on.
>
> *National Institute of Mental Health, 2002*

*Note: As used in this context, the term "operational debriefing" refers to routine information sharing without the psychological or emotional processing components.

Behind the concerns expressed regarding the indiscriminate use of the term debriefing is a concern regarding the varying quality and appropriateness of group interventions in the immediate aftermath of crisis events. While there are different views among experts on specific debriefing techniques, there is growing consensus regarding the need for more precision in tailoring intervention techniques for specific populations (Watson, 2004). It is generally agreed that there is no "one size fits all" approach that works for all populations and types of disasters.

The most commonly used debriefing technique is the Critical Incident Stress Debriefing (CISD) model, which was developed originally for emergency responders, who are occupationally exposed to repeat trauma and at risk for accumulated stress effects

(Mitchell, 1983; Mitchell and Everly, 1993). The CISD model, which is intended to be implemented as a part of a larger Critical Incident Stress Management (CISM) approach, has often been modified for particular groups with needs different from emergency responders.

A variety of group and individual psychological debriefing approaches have been used with a wide range of groups including emergency responders, employee groups, highly exposed survivors, community bystanders, and groups from the larger affected community. Some approaches may be referred to inaccurately as CISD, and sometimes simply referred to as "debriefing." Therefore, in all situations, it is important to carefully assess the actual techniques being implemented.

Careful attention must be paid to individual exposure levels and response to a traumatic event when considering the timing and goals of any group intervention techniques. For example, intervention techniques that strongly encourage "emotional processing" in the immediate aftermath of a trauma may not be appropriate for many individuals who are still in a state of shock or agitation (Watson, 2004).

In addition, mental health providers should be careful not to "promise" more than an intervention can actually deliver. While group techniques may provide an early method of survivor contact and may be useful for social support, preliminary screening and psycho-education, there is no evidence that existing early debriefing techniques alone can "prevent" later mental health needs. In addition, many experts have expressed concerns that mandatory participation in debriefings that require emotional processing in the immediate aftermath of a trauma can actually increase stress levels (Watson, 2004).

Facilitating group approaches requires extraordinary skill and care and should not be performed without specific training. Simply knowing and following the steps of a specified debriefing model is not enough. A skilled group facilitator will carefully assess the needs of a group and will take care to assure that activities do not disrupt the normal human processes of remembering, forgetting, meeting challenges, and incorporating losses (Raphael and Wilson, 2000).

When working with disaster victims at a time of great vulnerability, it is important to assure that any psychological interventions do no harm. When in doubt about the appropriateness of a group intervention technique, community leaders may be well advised to seek "a second opinion." Consultation with a variety of experts with careful attention to the goals, required training, and demonstrated evidence base for specific populations can help assure that early intervention sets a foundation for emotional recovery for all individuals exposed to trauma.

7. Psycho-Education

Psycho-education is a core component of mental health response for survivors and their families, health care providers, social service workers, and providers of other community services. Information is provided about post-trauma reactions, grief and bereavement, effective coping strategies, and when to seek professional consultation. Brochures or simple handouts that describe common physical, emotional, cognitive, and behavioral trauma reactions for children and adults are widely distributed in appropriate languages. Material should be oriented specifically to the actual event and locale and adapted to each survivor group or audience to ensure age-appropriate, role-specific, and

culturally relevant materials. All forms of media are used to disseminate information, so that the messages reach the largest number of people.

Validation and reassurance through psycho-educational information mitigate survivors' fear that they are "going crazy." When survivors learn their reactions are "normal" and expected following similar events, many can understand, accept, and cope with their reactions and situations. However, some survivors experience this normalization of their pain as minimizing or dismissive. Psycho-education is more successful when mental health responders adapt their educational comments and materials to each survivor's concerns and style.

Parents and caretakers typically ask mental health providers questions about how best to help children following traumatizing mass victim-ization. Educational presen-tations for parents may be offered through schools, religious organizations, and other community organi-zations. Psycho-education regarding children's needs addresses common questions and provides practical guidance.

Samples of brochures and public information materials are readily available in print (American Red Cross, 2001, 1997; Office for Victims of Crime, 2001; Center for Mental Health Services, 2000a, 1995; American Academy of Child and Adolescent Psychiatry, 1998; American Psychological Association, 1996; Grollman, 1995; Lord, McNeil and Frogge, 1991) and on the Internet (see Internet Sites at the end of this publication).

8. Mental Health Consultation

Emergency services and law enforcement administrators make many decisions that have mental health implications for survivors. Government officials also make critical decisions, provide information, and make statements directly to survivors and their families and through the media. Mental health professionals can be brought into decision-making and planning teams to advise leaders regarding mental health issues. Leaders may seek mental health consul-tation on issues such as optimal scheduling, mental health support, and leave time for rescue and recovery workers; sensitive procedures for obtaining personal information and DNA samples from families for body identifi-cation; whether children should accompany families to the disaster site; rituals and memorials for honoring the dead; integrating acknowl-edgment of the tragedy into traditionally celebratory or recreational events; and management roles and support as affected employees return to work. When mental health consultation is sought, inadvertent retraumatization or unnecessary stress may be avoided (Pynoos and Nader, 1988). To function effectively in this consulting role, mental health professionals must be well-versed in emergency and criminal response protocols, as well as experienced in reactions to disaster, trauma, and bereavement.

Survivors with serious psycho-logical reactions to the traumatic event also may be members of religious groups, students at local schools, recipients of services at senior centers, community mental health center consumers, or members of culturally identified organizations. Service providers, clergy, principals, and teachers can be supported and educated through mental health consul-tation regarding the effects of trauma and how best to assist their constituents. In addition, impacted businesses, organi-zations, or government offices may seek to develop systematic mental health support and recovery assistance for their employees and managers (Young et al., 1998).

Long-Term Mental Health Interventions With Adults

Goals and Priorities

Mental health response managers must set realistic goals, priorities, and expectations for long-term mental health services. This is a time when need probably will exceed available resources. Managers must be vigilant to prevent programs and staff from overextending and suffering stress overload.

The immediate interventions of psychological first-aid and crisis intervention may be adapted for initial contact with survivors seeking psycho-logical support and mental health services during the recovery period. Survivors and family members may have delayed reactions or have traumatic symptoms triggered by reminders, community events, or criminal justice proceedings. They may need to wait for physical injuries to heal before seeking psycho-logical assistance. Many seek more intensive counseling and psychotherapy following immediate intervention. Specialized services are provided by mental health professionals with training in treating PTSD, depression,
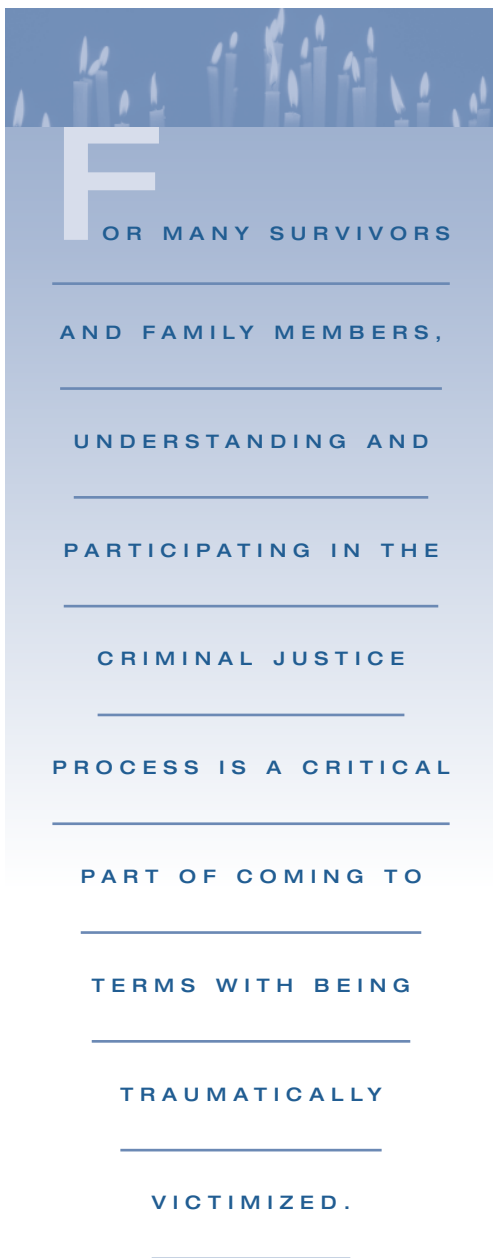
anxiety, and traumatic bereavement.

Crime victim assistance, community outreach, psycho-education, and community-building interventions are ongoing. Mental health providers should design their intervention services to be appropriate to the particular group receiving those services and relevant to their stage in the recovery process.

Activities for long-term mental health intervention include:

◆ Identifying individuals and groups in need of mental health and crime victim assistance services;

◆ Using systematic screening approaches to prioritize the delivery of more intensive mental health services;

◆ Providing different levels and types of mental health services: outreach, consultation, crisis intervention, and individual and group counseling;

◆ Supporting the provision of a range of crime victim services: accessible crime victim benefits, available criminal justice procedural information, practical assistance, and trouble-shooting;

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◆ Providing mental health support and consultation for community rituals, memorials, and other community events; and

◆ Providing appropriate psycho-educational information to all affected survivor and responder groups and health care and social service providers in the community.

In this section, crime victim services, brief counseling interventions, and support groups are briefly discussed. These overviews orient the reader to possibilities and highlight directions for further study and training. Recommended readings are provided at the end of the chapter.

Crime Victim Services

Crime victims are eligible to receive compensation for certain crime-related expenses. Eligibility and benefits vary from State to State. These benefits may include payment for medical and mental health treatment expenses, funeral and burial expenses, and compensation for lost wages and loss of support. Assistance, including crisis intervention, emergency transportation and shelter, counseling and criminal justice advocacy, also is available. Through close coordination and communication with crime victim assistance providers, mental health workers can be informed about helpful resources.

For many survivors and family members, understanding and participating in the criminal justice process is a critical part of coming to terms with being traumatically victimized. Crime victim assistance seeks to safeguard victims' rights by ensuring access to information on all criminal justice proceedings. Survivors and family members may observe trial proceedings and provide victim impact statements. They are entitled to explanations of the trial process, updates on current developments, and emotional support. Mental health providers should be trained specifically to provide mental health services during trial proceedings because they need to be knowledgeable about criminal justice proceedings and their mental health implications.

The following descriptive overview of criminal justice procedures is intended as an orientation for mental health workers who may be unfamiliar with the steps in the judicial process. Following an act of mass violence or terrorism, when the investigation has identified suspect(s) and sufficient evidence, the alleged perpetrator(s) are

arrested. If the alleged perpetrator is charged as a juvenile, his or her identity may not be disclosed. Upon completion of an initial investigation, the investigating law enforcement agency makes recommendations for criminal offense charges to the prosecutor's office. The case is then transferred to the prosecutor's office. When no suspects are identified or no arrests are possible, family members' and victims' reactions are related to the absence of criminal justice proceedings and, ultimately, to the absence of possible justice for the wrongs they have suffered.

Some of the evidence collected at the crime scene will be essential to the prosecution of the case and will not be released until after the trial. Other items, not required as evidence, such as personal effects or clothing, may by returned to families and loved ones. It may be difficult for loved ones to see the deceased's personal items for the first time when they are presented at trial. Prosecutors and crime victim assistance and mental health providers often prepare family members for seeing personal items to be presented at trial. For example, personal items held as evidence following the terrorist bombing of Pan Am Flight 103 in 1988 were returned to

families and loved ones after the trial was concluded 13 years later. Each item was cleaned, packaged, and personally delivered by detectives from Lockerbie, Scotland.

The prosecutor may conduct a preliminary hearing or grand jury to determine if sufficient evidence exists to charge an individual with a crime. Then, an arraignment hearing is held and the accused is informed formally of the charges pending. At this point, the accused becomes referred to as "the defendant." The defendant enters a plea of "guilty" or "not guilty." Each of these steps is likely to be psychologically distressing for survivors and loved ones. Their sense of control is enhanced by being informed, anticipating events and how they might react, and planning for social support.

A long delay may occur before the case goes to trial. The case may be postponed several times before the trial or sentencing is actually heard, making it difficult for family members to make arrangements or take time off from work. Delays and postponements also can increase victims' fear of testifying. If there has been considerable publicity surrounding the event, the location of the trial may be

moved to another part of the country, making it more difficult for survivors or loved ones to attend. They still need accurate information and updates regarding the discovery process, continuances, and plea or sentencing bargaining. The trial, sentencing, and appeals processes may continue for years after the event. Some survivors are likely to be involved in providing victim impact statements to the judge and jury.

Because of the long time span involved in these cases, mental health and crime victim services need to be available over an extended period. The "working through" and reconstruction processes from a traumatic loss often take years and occur in stages over time. Inevitably, key events in the criminal justice process trigger reactions and pain. However, these expressions may also lead to a gradual integration and acceptance of the tragedy.

"Responding to Terrorism Victims: Oklahoma City and Beyond" provides a detailed account of crime victim assistance services and underscores the considerable overlap and coordination between mental health and crime victim services (Office for Victims of Crime, 2000). Additional background

information is available in the Attorney General Guidelines for Victim and Witness Assistance (U.S. Department of Justice, 1999) and through the OVC Resource Center (www.ncjrs.org).

Brief Counseling

Survivors most immediately exposed to the event, and those who suffered the death of loved ones or serious injuries, may need intensive counseling (North et al., 1999; Green, 1993). In addition, survivors and community members with prior or pre-existing psychiatric conditions or substance abuse problems, and those with histories of prior traumatization are at greater risk for long-term difficulties (Halligan and Yehuda, 2000; North et al., 1999; Breslau et al., 1998). Some survivors will continue to experience high levels of psychological distress and may suffer disturbing and intrusive symptoms that interfere with their daily functioning. Survivors who are developing PTSD or who already have developed PTSD remain "stuck" on the trauma. They constantly relive it through their thoughts, feelings, or actions, and begin to organize their lives around avoiding triggers and reminders. They continually act out their overgeneralized sense that the world is unsafe (van der Kolk,

McFarlane, and van der Hart, 1996). The therapeutic goals of long-term interventions involve:

◆ Stabilizing emotions and regulating distress;

◆ Confronting and working with the realities associated with the event;

◆ Expressing related emotions during and since the event;

◆ Understanding and managing post-trauma symptoms and grief reactions;

◆ Developing a sense of meaning regarding the trauma;

◆ Coming to accept that the event and resulting losses are a part of one's life story; and

◆ Moving on and reconstructing one's life.

Most therapeutic approaches recognize the vulnerable survivor's capacity to confront painful realities and the intense emotions that develop gradually. The treatment process must move at a rate the survivor can tolerate. The therapeutic relationship is an essential part of this process. The survivor progresses to facing the trauma experience and losses, self doubts, fears, and pain when there is sufficient trust that the

therapist is genuinely engaged and can truly bear witness to the personal significance of the trauma. The therapist must be able to remain solidly and empathically engaged while hearing of the horror, tragedy, and intense emotions associated with the traumatic event (Raphael and Wilson, 1993; Herman, 1992). The normal "working through" process that allows traumatized survivors and bereaved family members to move on and reconstruct their lives can take years. Five years was common for survivors of the Oklahoma City bombing (Office for Victims of Crime, 2000).

Counseling may use a particular treatment approach or incorporate a combination of different approaches. Treatments commonly used for post-traumatic stress and traumatic bereavement include cognitive-behavioral therapy (Ehlers and Clark, 2000; Young et al., 1998; Foa, Rothbaum, and Molnar, 1995); phase-oriented treatment (van der Kolk et al., 1996; Herman, 1992); bereavement counseling (Raphael et al., 2001; Rando, 1993; Worden, 1982); eye movement desensitization and reprocessing (EMDR) (Shapiro, 1995); brief dynamic therapy (Marmar, Weiss, and Pynoos, 1995; Lindy, 1996; Horowitz, 1986); and psychopharma-cology (Friedman et al., 2000;

Davidson and van der Kolk, 1996). These modalities have varying levels of scientific evidence supporting their efficacy. Many practicing mental health professionals attempt to match the treatment approach to the recipient's perception of its acceptability and helpfulness. The various trauma and bereavement psychotherapy approaches have elements in common as well as differences. All approaches set stabilizing the survivor's post-trauma reactivity as a primary objective. Psychopharmaco-logical treatment can help reduce the severity of symptoms so the survivor can function better and engage in psychotherapy more effectively.
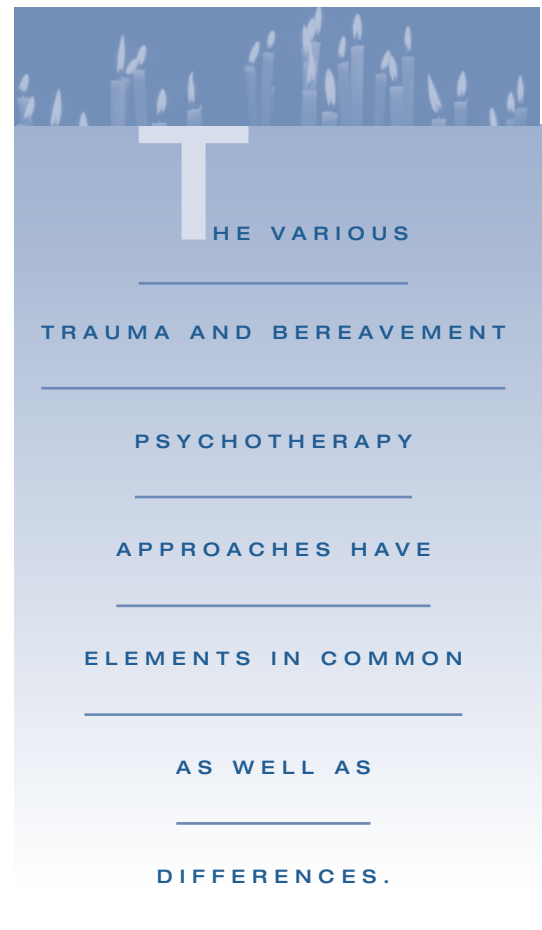
Cognitive-behavioral treatment focuses initially on teaching skills to manage anxiety, cope with stressors, and challenge irrational and maladaptive thoughts. Dynamically oriented approaches place greater initial emphasis on developing the therapeutic alliance, and then on the symptom reduction and relief that can occur by telling the "trauma story" in a safe environment. Cognitive-behavioral approaches incorporate repeated exposure to details of the trauma while actively managing the related distress facility. Dynamic approaches look for links between key

aspects of the trauma, the survivor's vulnerabilities, prior life experiences, and past coping behavior. Bereavement counseling often takes a more developmental or stage-related approach, viewing successful "working through" of a traumatic death as requiring completion of a series of tasks. Each approach considers the recovery process to occur in stages over an extended period of time. Thus, returns to treatment for "booster" sessions or for additional support and processing are expected as survivors confront environmental triggers and challenges in their psycho-logical recovery.

Mental health responders may employ intervention strategies used in these modalities to assist with crisis intervention. Having the necessary skills to conduct meaningful assessments and provide a course of treatment with at-risk survivors, however, requires specific training and supervision, as well as a mental health professional license or certification, depending on State regulations.

Support Groups

Group treatment is especially appropriate for survivors of mass victimization because groups provide social support through validation and normalization of thoughts,

THE VARIOUS

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emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others who understand can be powerful. In addition, group reinforcement for stress management and problem-solving techniques may bolster courage and creativity. Because some trauma survivors feel isolated in their struggles to cope, groups provide much needed social connection through support for shared experiences. Sharing helpful information about service and financial resources and other types of assistance is another important function of support groups.

Groups with homogenous memberships may be offered for parents, children, members of a particular neighborhood or commonly affected occupational group, and for survivors who suffered a particular trauma or loss (e.g., bereaved parents, people who lost their jobs as a result of the trauma, grandparents who are raising grandchildren). Group members may be connected by age, gender, or cultural group. Support group sessions often combine some structured sharing and discussion about trauma experiences and recovery issues and psycho-educational presentations.

Because of the potential for intense group dynamics and

members with complicated trauma and grief reactions, these groups should be facilitated by an experienced mental health professional, ideally with a co-facilitator. In most instances, groups should be time-limited with expectations defined at the outset. A cohesive, effective group often will want to continue meeting. Mental health response managers and facilitators must decide if continuing the group is the best use of limited program resources, given other community needs. Group members may elect to transition into a more self-help or social support model. Facilitators may assist with this transition, but end their formal role with the group.

Immediate Mental Health Interventions for Children and Adolescents

Goals and Priorities

Initial contacts with children, adolescents, and their families often take place at schools, hospitals, family notification and support sites, and shelters providing support services. These settings typically serve multiple functions, so the environment can be chaotic, noisy, and not be suited for

lengthy or private conversation. In the immediate aftermath of a horrific incident involving mass violent victimization, parents and caretakers attempt to respond to their children's needs as well as their own. They seek mental health consultation regarding their children's well-being. Parents and caretakers ask questions about their children's behavior, what to tell their children about the specifics of the incident, how to help them deal with a missing or deceased parent, if they should limit TV exposure to traumatic scene replays, and if their child should go to a funeral, stay with an out-of-town relative, or see them cry. Psycho-education for parents and caretakers is an essential component of early mental health response.

Through psycho-educational and other immediate mental health interventions, the mental health response assists traumatized and bereaved children to:

◆ Regain a sense of safety and security;

◆ Gain an understanding and acceptance of the events that have occurred;

◆ Appropriately identify and express reactions;

◆ Grieve and effectively cope with traumatic stress; and

◆ Resume age-appropriate roles and activities.

(Pynoos and Nader, 1993; Vernberg and Vogel, 1993)

The last two goals are not likely to be achieved during the short term, yet they do underlie mental health intervention throughout the recovery period. The following section highlights several interventions: psychological first-aid, play areas, participation in disaster relief, and school interventions. The table at the end of this chapter provides specific suggestions for intervening with children and adolescents.

Psychological First-Aid

Children and adolescents directly involved in the traumatic event, or witnesses to it, may need immediate mental health support. If they appear to be disoriented, in shock, or behaving strangely, one-to-one support with a protective adult and contact with a child mental health professional are necessary. Immediate interventions include physical comforting, rest, repeated concrete explanations of what happened and what is going to happen, repeated assurances that they are safe and secure, access to materials to draw or play, and opportunities to verbalize (Pynoos and Nader, 1993). In addition, traumatized children may be calmed with

snacks for nurturance, blankets for warmth and nesting, familiar structured play activities, and appropriate limit setting (James, 1989).

Play Areas

Play areas for children often are set up adjacent to or within family gathering settings. Opportunities for quiet play, structured activities, and more active play can be provided for children of different ages and interests. Certified pet therapy animals have been used successfully in play areas (American Psychological Association Task Force, 1997). Providing a setting and structure for play gives children an opportunity to release energy and be distracted from the trauma, and gives parents some respite. While play activities should not involve "focused therapy," child mental health professionals may offer individual nondirective and nonintrusive interventions regarding feelings, talking about experiences, or correcting misconceptions with children and their parents.

Participation in Disaster Relief

Some adolescents value playing an active role in the relief effort and helping others. They may feel enhanced self-efficacy and greater mastery of their situations when

contributing in meaningful and concrete ways. For example, they may assist with food and beverage distribution, moving supplies, child care, functioning as helpers at an operations center, etc. However, it is critically important that they not be asked to function in roles that expose them to additional trauma. Their role in assisting others should be viewed, in part, as a mental health intervention and should be monitored accordingly.

School Interventions

School is a central part of children's and adolescents' lives. The school environment provides an ideal locus for mental health contact because it is familiar, offers structures conducive to re-establishing routines and a group setting in which sharing of experiences and group support may occur. Schools constitute the most effective and efficient context for post-trauma mental health assistance for children and their families (Pynoos et al., 1998). Mental health support must be provided to principals, teachers, and other school personnel. Teachers and staff may experience their own trauma and grief reactions, as well as anxiety about returning to a seemingly unsafe school environment. They need support to address the incident's impact on themselves and their own families.

Multifaceted school interventions are recommended (Flynn and Nelson, 1998). Telephone hotlines for parents, staff, and students that provide up-to-date information and mental health support may be established. Schools often set up walk-in clinics or drop-in centers for students to self-refer or for referral by teachers or parents. Informational, psycho-educational, and supportive meetings may be provided for parents and caretakers. Special support groups may be provided for at-risk students who were directly exposed, whose parent was killed, or who are having severe reactions. Absenteeism outreach that is nonpunitive and responsive to students' and parents' concerns helps facilitate students' return to school.

Classroom Interventions

Classroom interventions are conducted as soon after the traumatic incident as possible. Teachers and child mental health professionals may cooperatively facilitate interventions. The objectives of these age-appropriate classroom sessions are to: (1) foster cognitive understanding of the facts surrounding the trauma and to clarify misconceptions; (2) provide an opportunity to discuss and express thoughts and feelings; (3) identify at-risk students and staff; and (4) plan for a gradual return to normal routines (Gillis, 1993; Klingman, 1993). Intervention methods are drawn from an array of options including group discussion, free or focused drawing, sentence-completion, and story-telling (Young, 1998; Vernberg and Vogel, 1993; Federal Emergency Management Agency, 1991b).

Classroom intervention addresses the level of exposure and trauma experienced by the class and minimizes the potential for restimulating fears and anxieties. Mental health professionals must take care to avoid exposing children who were not directly involved in the trauma to material that could become a basis for subsequent post-traumatic stress reactions. The overarching principle, "first, do no harm," again has relevance.

Long-Term Mental Health Interventions for Children and Adolescents

Goals and Priorities

Children and adolescents who have witnessed and closely experienced an incident

involving mass violence or who have suffered the traumatic death of a loved one can face significant psychological effects and an extended recovery. Pre-existing adjustment or learning difficulties often are exacerbated. The sense of innocence and security associated with childhood may be lost. The normal developmental stages associated with growing up bring predictable challenges, yet the traumatized child's ability to negotiate these challenges is compromised. Family, school, and other networks in the child's world all have important roles in the recovery process. Mental health intervention and treatment address the following five areas:

1. Understanding the child's unique experience of the trauma;

2. Assisting the child in developing strategies to cope with traumatic reminders;

3. Addressing grief and the interplay of traumatization and bereavement;

4. Intervening with post-trauma adversities such as a decline in school performance; and

5. Identifying and redressing missed developmental opportunities and

trauma-based self-attributions and worldview.

(Pynoos et al., 1998)

These various areas and tasks may be addressed in school, group, family, and individual interventions, and through different therapeutic modalities. The following discussion explores both brief counseling and support groups. A multifaceted approach includes thoughtful construction of a "safety net" for the child's welfare. Both the Recommended Readings at the end of the chapter and the Reference List at the end of the manual provide additional resources for mental health professionals. Clearly, specialized training is necessary.

Brief Counseling

The safety, rapport, and trust developed in one-to-one counseling may be necessary for the traumatized and/or bereaved child or adolescent to explore underlying fears, fantasies, distorted perceptions, guilt, shame, and self-blame. Over time, the child may approach the terror, horror, and helplessness that they experienced during the event. As the child develops the ability to identify, understand, and manage feelings, he or she is more able to deal with difficult, painful

THE SCHOOL ENVIRONMENT PROVIDES AN IDEAL LOCUS FOR MENTAL HEALTH CONTACT BECAUSE IT IS FAMILIAR, OFFERS STRUCTURES CONDUCIVE TO RE-ESTABLISHING ROUTINES AND A GROUP SETTING IN WHICH SHARING OF EXPERIENCES AND GROUP SUPPORT MAY OCCUR.

memories. The child therapist uses a range of supportive, nonthreatening approaches including art and play therapy, therapeutic games, and psychodrama.

Support Groups

Many children and adolescents benefit from group activities and support. School classes, religious groups, day camps, youth groups, day care centers, and 4-H clubs are often suitable for mental health intervention. These interventions may involve a memorial or commemorative activity, or education about some related aspect of the event, followed by a discussion of reactions, feelings, and coping skills. Through these group interventions, at-risk children may be identified and contact may be made with their families. In addition, ongoing support groups may be offered for highly exposed and traumatized children and adolescents. These groups for at-risk children are more therapeutic in nature and may follow a structured format over 6 to 10 weeks. Groups may be helpful, especially for traumatized adolescents, to allow working through distur-bances in peer relationships (Pynoos and Nader, 1993).

Considerations For Immediate And Long-Term Mental Health Intervention with Cultural and Ethnic Groups

The increasing population diversity of the United States and the constant flow of visitors from other parts of the world ensure that survivors of acts of mass violence and terrorism are likely to be culturally, racially, and ethnically diverse. Similarly, survivor's experiences are shaped, in part, by their cultural, ethnic, and racial backgrounds. Different levels of acculturation within a cultural group may result in younger survivors having a more bicultural or dominant culture perspective; older survivors may adhere more to the ways of their countries of origin (Paniagua, 1998). Also, cultural differences between rural and urban survivors, among the various regions of the United States, across differences in educational and socioeconomic levels, among different age groups, and among different religious and nonreligious groups, color how people view the event, mental health intervention, healing, and recovery. Consequently, mental health services,

criminal justice procedures, emergency medical services, and medical examiner's office protocols require culturally sensitive explanation, adaptation, and liaison.

Mental health responders may conduct triage and immediate interventions with survivors who do not speak English, who attribute very different meanings and expectations to traumatization, who express emotions and symptoms in culture-specific ways, and who have divergent notions regarding "mental health," "recovery," and appropriate psychological intervention.

Groups with different cultural customs define "family" in different ways and have different traditions and rituals surrounding death and burial. Mental health providers quickly must become culturally competent with each affected survivor group. Cultural experts, community leaders of the affected cultural groups, elders, and indigenous social service providers can provide valuable insights, training, and consultation for mental health workers. Cultural competence is the responsibility of each mental health responder, program administrator, manager, and supervisor. Competencies include:

◆ Valuing diversity, respecting differences,

and seeking to develop and adapt service delivery models to fit cultural groups;

◆ Recognizing differences in communication styles, social etiquette, and problem-solving methods;

◆ Providing services and information in appropriate languages;

◆ Understanding of and respect for different cultural definitions of personal well-being and recovery from traumatic events;

◆ Knowing which "accepted" crisis intervention practices fit and which do not;

◆ Incorporating the sophisticated and varied cultural pathways to mental health including healing rituals;

◆ Using strength-based and empowerment approaches to cultural group survivorship and healing; and

◆ Providing extensive and ongoing cultural competence training and supervision of mental health responders.

(U.S. Department of Justice, 2000; Nader et al., 1999; Hernandez and Isaacs, 1998).

Tips for Working with Interpreters

✔ Avoid using relatives, children, and friends as interpreters

✔ Use certified, qualified interpreters with mental health and trauma training

✔ Allow opportunity for interpreter to build rapport with survivor

✔ Allow at least twice as much time. Use sequential mode of interpretation (survivor speaks, interpreter interprets what has been said into English, mental health provider speaks, interpreter speaks again

✔ Be aware of the interpreter's discomfort, avoidance, and biases

✔ Interpreters should also receive cultural competence training, if possible

✔ Debrief interpreter's reactions

(Paniagua, 1998; Westermeyer, 1995)

Basic Cultural Sensitivity Checklist

✔ Convey respect, good will, nonjudgment, courtesy

✔ Ask permission to speak with the person or family

✔ Explain role of mental health worker in culturally relevant terms

✔ Acknowledge differences in behavior due to culture

✔ Respond to concrete needs

(Paniagua, 1998; Young, 1998)

The following description of interventions used after the 1989 mass shooting of school children and staff in Stockton, CA, illustrates cultural competence and a blending of approaches:

With an awareness of cultural beliefs and practices including religious and medical practices, the school principal invited local clergy including Cambodian and Vietnamese Buddhist monks, a Vietnamese Catholic priest, and Protestant ministers to perform a blessing ceremony upon the school and school grounds. This included the exorcism of

MENTAL HEALTH PROFESSIONALS MAY HAVE AN IMMEDIATE SUPPORT ROLE WITH BEREAVED FAMILIES AND LOVED ONES DURING AND AFTER FORMAL DEATH NOTIFICATION.

spirits including the bad spirit of the man who killed the children and himself and the spirits of dead children who might grab other children and take them into the next world. Children were given chants to use when frightened; children and adults were given factual information to dispel rumors and unfounded fears.

(Dubrow and Nader, 1999)

Loss of hope, meaning, and perceived control are universal aspects of trauma. The rebuilding of hopes, reconstructing of meaning, and finding a sense of empowerment to regain control are necessary for recovery from trauma and loss (Herman, 1992). Experts propose that there are meaning-making and self-organizing parts within everyone that are particularly active following catastrophic traumatic events. These parts can help survivors construct meaning around horrific events or may lead them to the repetitive rigidity associated with post-traumatic stress disorder (Gusman et al., 1996).

Community-building and empowerment are essential for regaining control and fostering community survivorship. On the individual level, human contact, kindness, listening,

and respect can transcend cultural differences and provide an avenue for survivors to be heard and witnessed regarding their traumatic experiences and losses.

Key Events with Mental Health Implications

Survivors' and family members' psychological responses to mass criminal victimization occur within a context of a number of predictable events, each with inherent mental health implications. These events may be tied to relief, rescue, and recovery efforts; criminal justice proceedings; and cultural and religious rituals for honoring those who were killed. While individuals vary in their reactions to these events, mental health responders can be more effective when they anticipate and prepare for their potential psychological impact. The following discussion focuses on seven key events, potential psychological reactions to them, and possible mental health interventions. Events included in this section are: (1) death notification; (2) ending rescue and recovery operations; (3) applying for death certificates when no identified remains have been found; (4) events involved in

criminal justice proceedings; (5) returning to the crime scene and disaster impacted areas; (6) memorials and funerals; and (7) determination of formulas and methods for distributing Federal, State, employer and charity funds to victims and families. Each occurrence of mass violence or terrorism has unique elements and circumstances with significant mental health consequences. An important component of the mental health response is identifying events with potential mental health implications during the aftermath, determining potential mental health needs, and flexibly and creatively implementing a system for mental health support and intervention.

Death Notification

Mental health professionals may have an immediate support role with bereaved families and loved ones during and after formal death notification. Mental health professionals typically do not deliver information regarding deaths, but may participate on teams with the person(s) responsible for this notification. These teams may include a representative from the medical examiner's office, a funeral director, a health care professional, a chaplain, and a mental health professional (Jordan, 1999). Mental health

professionals provide support to the family receiving the news, mental health consultation, and conducting the notifications when requested.

Including a mental health professional with child specialization on the notification team is advised when families have questions about their children's needs (Sitterle and Gurwitch, 1999). Notifiers can more sensitively provide death notification for families from different cultural and ethnic backgrounds when they are informed about the group's customs regarding the expression of grief and anguish and rituals surrounding death and burial.

The most traumatic moment for many people is notification of a sudden death and can become a focal point for later PTSD (Young, 1998; Lord, 1996). Properly conducted, the notification process can help begin healing. The following guidelines are included in the Mothers Against Drunk Drivers comprehensive curriculum on death notification (Lord, 1996):

◆ Obtain critical information before notification. It is important to be able to provide information about how, when, and where the person died, how the identification was made, and where the body is. If possible, learn

about the person(s) to be notified, any medical conditions, and who is included in their support system;

◆ Notify the family member of the deceased simply, directly, and in-person. After the persons responsible for notification have identified themselves and are seated, clarify the family members' relationship to the deceased. Using the victim's name, state clearly and without euphemisms that he or she has died. Use warmth and compassion and say, "I'm sorry." Do not take the deceased's personal items to the notification;

◆ Expect intense emotional and physical reactions (flight, fight, and freeze). A member of the team should have CPR training and be able to treat shock reactions. Respond non-judgmentally and supportively to all reactions and questions. Avoid leaving the bereaved person alone, but do allow privacy for grief reactions;

◆ Provide practical assistance. The bereaved person may need assistance making arrangements to be transported to identify or

view the body. They may need help making phone calls to arrange for transportation, child care, or to contact relatives or their employer; and

◆ Help the family decide about viewing the body or photographs. Ensure that the bereaved person is informed and prepared regarding what they will see and the condition of the body. For many, it is very important to see the remains of their loved one. A lesson learned from the Oklahoma City bombing is that many families ended up regretting not viewing their loved one's remains. They had been discouraged from doing so because of the degree of mutilation (Office for Victims of Crime, 2000; Jordan, 1999). For others, viewing the body may be seen as inappropriate for cultural or religious reasons. Family members should be supported in making informed choices and encouraged to have accompaniment and support.

Mental health professionals may provide training for notifiers on how best to support those receiving the devastating information. Families may prefer to have privacy after receiving the notification or they may desire continued support from the mental health professional. The Mother's Against Drunk Drivers resource materials provide additional guidance regarding delivering sensitive death notification (Lord, 1996).

Ending Rescue and Recovery Operations

Waiting for official notification that a loved one was killed violently is excruciating. Family members must depend on rescue workers and passively wait, while the site of impact is typically secured by local law enforcement and, in some cases, military units. Families hold out hope that their loved one was spared and many protect themselves from the anguish associated with the reality of their loved one's death through denial. Often, it is not until the body is recovered and official death notification received, that the death is accepted and grieving may begin.

The psychological impact for affected families is profound and intense when a recovery operation ends before all bodies have been recovered. Some feel the physical body and person they loved is being abandoned. They are left in a state of limbo, unable to accept the reality of the death and to engage in rituals to acknowledge the ending of their loved one's life. For some cultural groups, failure to provide a proper burial has far-reaching meanings.

Officials responsible for deciding when to end body recovery operations may consult with mental health professionals regarding how to sensitively communicate this to families. It is critically important that families receive this information directly from the proper authorities and not through the media. Typically, families focus on several questions, "Is there a chance anyone is still alive?" "What is the condition of the bodies?" "How much did my loved one suffer?" and "Will all the bodies be recovered?" Officials should be truthful, straightforward, and precise. They should provide loved ones with the facts so that they may better understand why certain decisions are being made (Cummock, 1996).

Applying for Death Certificates When No Identified Remains Have Been Found

An official death certificate is required for beneficiaries to receive life insurance benefits, Social Security benefits, Federal and State victims compensation, death benefits from State and Federal Workers Compensation, and death benefits from the Public Safety Officers Benefit Program. Three weeks after

the September 11 attacks on the World Trade Center, families could begin the procedures for obtaining death certificates at the Family Assistance Center. Government officials recognized that remains, if they were ever found, would not be identified for months, which could threaten many families' financial stability because they would not be able to access death benefits.

Families with limited savings and resources needed to address their financial needs quickly. Families needed to complete legal procedures and provide documentation to obtain a death certificate so that they could receive funds and benefits payable upon death. Some experienced this step as abandoning hope and betraying their commitment to their loved one. Bereaved family members had to act more accepting of the death than they truly felt.
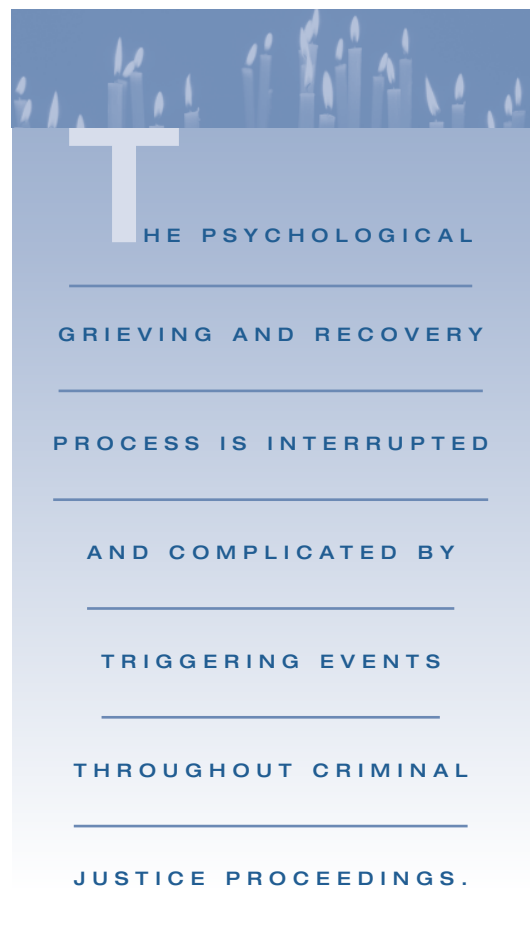
Mental health professionals can assist families as they struggle with the dilemmas posed by the decision to apply for a death certificate. Mental health workers can accompany families as they meet with attorneys, provide documen-tation, and complete forms. They can offer alternativ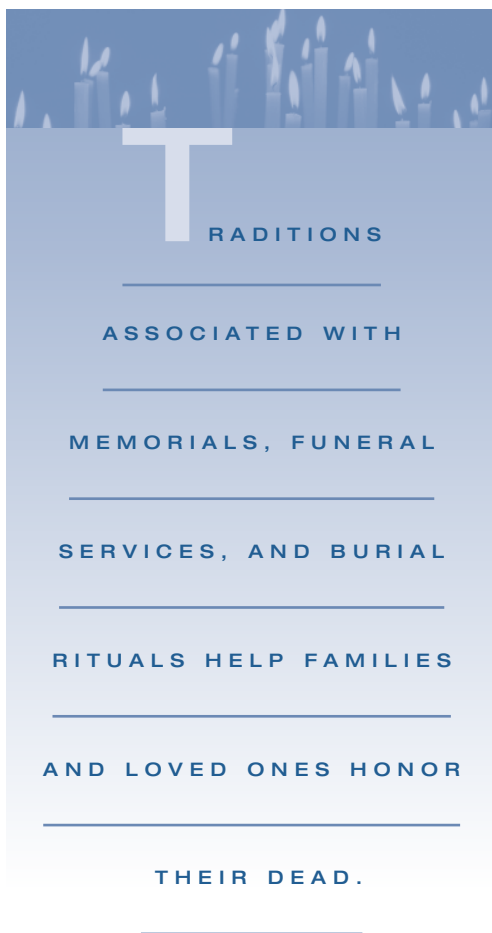e perspectives when families view obtaining the death certificate as a betrayal or acceptance of the death. In some cases, mental health professionals can explore other financial options with those who are unable to begin the process of obtaining a death certificate.

Events Involved in Criminal Justice Proceedings

The psychological grieving and recovery process is interrupted and complicated by triggering events throughout criminal justice proceedings. Survivors, loved ones, and the community demand that justice be served. Some sense of resolution is often linked to trial outcomes. However, for many, the devastating consequences of the evil acts of the perpetrators are never adequately or justly redressed through the criminal justice system. When the alleged perpetrator(s) are not identified or arrested, survivors and victims' families must live with the knowledge that the perpetrators are alive and at large.

Survivors are thrown into an unfamiliar and disorienting criminal justice system. Criminal justice procedures may not appear to make sense and can seem removed from the attainment of justice. Crime victim assistance providers, law enforcement personnel, prosecutors' offices,

THE PSYCHOLOGICAL GRIEVING AND RECOVERY PROCESS IS INTERRUPTED AND COMPLICATED BY TRIGGERING EVENTS THROUGHOUT CRIMINAL JUSTICE PROCEEDINGS.

TRADITIONS

ASSOCIATED WITH

MEMORIALS, FUNERAL

SERVICES, AND BURIAL

RITUALS HELP FAMILIES

AND LOVED ONES HONOR

THEIR DEAD.

and mental health providers work together to ensure that survivors have:

◆ Information about the investigation, the criminal justice system, and upcoming proceedings and status updates;

◆ Psychological support that anticipates and responds to the impact of key events in proceedings; and

◆ Opportunities to make informed decisions regarding participation in the criminal justice process.

Key events with mental health implications during the criminal justice process include the investigation, lack of arrests, prosecution, court delays, sentencing, and possible post-disposition events such as an appeal, parole hearing, escape from prison, a request for clemency or pardon, and an execution (U.S. Department of Justice, 2000).

Returning to the Crime Scene and Disaster-Impacted Areas

The first time survivors return to or view the scene of mass violence can be extremely upsetting, if not overwhelming. Many view the impact zone as sacred ground and expect the area to be treated with respect and reverence. Visiting the actual location of the event can trigger a range of intense reactions. When property destruction is widespread, witnesses can view the physical damage as visible evidence of their personal losses. When physical damage has been repaired and cleaned up quickly, those most closely affected may find that everything "looks the same," when nothing for them is the same.

Residents returning to homes or apartments where mass trauma took place may have lost their sense of home as a safe haven. Their neighborhood may sound and look like a "combat zone" with sirens, police-enforced checkpoints, and a massive rescue and recovery operation underway. Views out of windows may be permanently altered. When buildings are deemed to be sufficiently safe, residents may be allowed to return to their homes for 15 to 30 minutes to retrieve important items and check on pets who may have been trapped. Law enforcement typically controls this process and maintains security at the buildings. Mental health providers may talk with residents as they wait for entry, providing support for concerns about valued

possessions and pets or helping with housing issues.

Employees may be returning to their place of employment or students to a school where the mass violence or terrorist attack took place. Frequently, survivors experience previously unexpressed traumatic reactions, such as a profound upwelling of grief. They may feel unsafe, insecure, and unable to concentrate on their duties. Mental health professionals may provide consultation to employers and school adminis-trators on re-entry activities, mental health interventions, and reasonable expectations of job or school performance.

Mental health professionals may assist those returning to or viewing impact sites by describing what they will see, hear, and smell, and by informing families and victims about what they will be allowed to do at the site. Mental health professionals may help families and victims anticipate and prepare for their reactions. As family members were transported by ferry to Ground Zero, the site of the World Trade Center attacks, mental health and spiritual care providers offered gentle, nonintrusive support. Before boarding the ferry, a represen-tative from the Police Department briefed families. Mental health workers

provided note cards and pens for loved ones to write messages to leave at the site. As family members walked from the ferry to the site, recovery workers stopped working, took off their hard hats, and silently paid respect to the grieving families. Some family members were overcome by their physical and emotional reactions, and required emergency medical attention. Many families requested chaplains to assist with honoring their deceased loved ones. Mental health professionals solved the immediate concerns and needs of the families and maintained a nonintrusive, supportive presence.

Memorials and Funerals

A site for memorializing often spontaneously appears within hours of a mass tragedy. Community members bring flowers, photographs, mementos, and messages. The site, often close to the location where the violence occurred, becomes a place for remembering, honoring, grieving, and giving and receiving support. Following the September 11 terrorist attacks on the Word Trade Center, families and friends posted photographs of missing loved ones in the hope they would be found alive. Thousands of photographs of people on vacation, with their

families, at weddings, at work, graduating from college, or playing sports were posted on walls in public areas in New York City. Gradually these pictures, capturing so much life and vibrancy, became a memorial of tragic loss.

Mental health professionals may assist government officials or emergency managers to consider appropriate and protected locations for memorials. Logistical issues often need to be addressed following a large-scale, mass-casualty tragedy. At memorial sites, mental health professionals may be available for support. At the same time, mental health professionals should allow and support the natural human processes that take place and not intrude on mourners' private moments.

Traditions associated with memorials, funeral services, and burial rituals help families and loved ones honor their dead. When the family has not received physical remains, funeral directors, mental health professionals, and faith-based counselors may assist the family in defining meaningful rituals and symbolic gestures to both acknowledge the death and commemorate the life of the victim. Funerals are typically private. Mental health providers should attend only

as participants unless they have specifically been requested to serve a different function.

Determination of Formulas And Methods for Distributing Federal, State, Employer, and Charity Funds to Victims and Families

Mass violence and terrorist attacks against U.S. citizens can cause the desire to help those victimized. This desire translates into sizable donations of money, goods, and services that need to be managed and appropriately distributed. Charities, employers, and a number of Federal and State programs have funds for providing assistance and benefits to victims and families. Congress established the Federal Victims Compensation Fund following the September 11 terrorist attacks. Victims and families of those killed could apply for compensation for physical injuries, lost wages, lost future earnings, and pain and suffering resulting from the attacks.

Challenging issues surrounding eligibility criteria, definitions of "family" and "spouse," citizenship status, disability compensation, treatment of high vs. low-income individuals, deduction of other Federal benefits, differential benefits for emergency services or military personnel, and fairness and equity can result in divisive conflicts between victim groups, government officials, elected officials, and fund adminis-trators. In addition, those victimized by previous terrorist attacks both inside and outside of the United States may feel that their needs were ignored in the face of current, larger compensation levels. Similarly, subsequent victims may feel that prior victims were treated more generously.

Interventions With the Community

Violent acts that victimize a group of people harm not only individuals but also the community. Before the tragedy, the community may have thought that "this sort of thing doesn't happen here." The community's collective assumption pertaining to safety and the ability to protect its citizens from criminal attack are shattered. The reality that any community is vulnerable to random acts of mass violence and terrorism penetrates a sense of security, the fabric of the social order. In communities with high rates of violent crime and prior mass violence, the current incident involving mass victimization reinforces the perception that the community's systems for ensuring public safety are ineffective and, in some instances, that the community must be attracting violence. In each scenario, the community's perceived capacity to protect and care for its members has been damaged. Community-based healing activities and rituals may reinforce community strengths and promote community recovery.

Memorials, Rituals, and Commemorations

For many survivors, bereaved families, and affected community members, rituals and symbolic gestures provide a way to acknowledge the tragedy, experience emotions, reaffirm life, honor "goodness" in the community, grieve what has been lost, communicate messages of hope and remembrance, and join with others (Sitterle and Gurwitch, 1999; Flynn, 1995; Rando, 1993). Symbolic activities may connect people with each other and to the past and the future, as well as to a power or spirit beyond the human realm. Rituals may be personal such as privately reading a letter to a deceased loved one at a cemetery, or community-wide such as reading the names of those killed while lighting a candle for each person or honoring victims by installing a symbolic work of art or planting a tree at a public ceremony. Effective

community memorial and commemorative events transcend political, religious, class, and cultural differences and provide an opportunity for all to come together. When these differences have played a role in the event's impact or the community's recovery, such as with racially motivated or hate-based crimes, community leaders need to foster understanding, tolerance, and forgiveness across groups through public ceremonies.

Mental health professionals may function in a consulting role and should not be over-directive in planning these ceremonies. Survivor and community ownership of an event enhances the signif-icance for those the event is intended to help. Mental health consultants may suggest strategies to include children or other special survivor groups. They may alert planners to the potential for misunderstandings or alienation of survivors or groups through the use of particular language or symbolic activities. Mental health professionals may attend these community gatherings to provide psycho-logical support as needed and requested.

The six-month and one-year anniversaries of a traumatic event trigger many reactions in survivors. The anniversary can be a time of remembering and acknowledging losses and the people who were killed along with celebrating human resilience, kindness, and the courage to continue (Center for Mental Health Services, 1994). Community and religious leaders may provide messages of hope, tolerance, and healing. Commemorative plaques, trees, art projects, pins, or dedications may be incorporated. Group activities such as singing, participating in a period of silence, or sharing food together may contribute to community building.

Typically, criminal justice proceedings have not concluded when the one-year anniversary occurs. When investigations or criminal justice proceedings are ongoing, planners must clarify the purposes and focus for the one-year anniversary, as distinct from the determination of cause or the achieving of justice. Consultation with and participation of community members and representatives from all affected community groups ensure that commemo-rative events have meaning for all community survivors.

Usual Community Gatherings

Most communities have an annual schedule of events that may include holiday commem-

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orations, fairs, parades, and festivals. Similarly, schools have activities throughout the academic year such as homecoming weekend, plays, musical performances, and proms. Religious groups also mark the year with ceremonies and symbolic rituals. Each cultural group has gatherings with meanings tied to central beliefs and long-held traditions. Communities have found that a sense of continuity and strength can be provided through familiar events, especially when they are combined with an appropriate acknowledgment of the community tragedy.

Continuing familiar gatherings promotes hope and the sense that the community can overcome harm and eventually recover. Decisions to cancel or postpone these events must be made carefully, as they can provide valuable opportunities for social support and healing.

Mental health professionals may assist community leaders in deciding whether to hold a celebratory event in the wake of a tragedy, considering the potential for minimizing the enormity of people's losses. Mental health consultants may suggest ways to adapt the event so that it both honors the losses sustained by the community and provides a venue for members to come together. Community and religious leaders often play a significant role and may provide comfort, inspiration, and perspective to their constituents in attendance.

Symbolic Gestures

Symbols and rituals can have profound significance for people who wish to communicate gratitude and good will or who are searching to find meaning, courage, and hope. Even simple gestures can become powerful conveyors of compassion and condolence. In Oklahoma City, following the bombing of the Federal Building in 1995, a brown teddy bear linked rescue and recovery workers inside the perimeter and the community members standing vigil outside the chain-link fence surrounding the secured bombing site. Each day, the bear was hugged by community members outside and then carried inside and hugged by workers:

> The bear became a link between those inside who were involved in some of the most difficult work imaginable and those who stood vigil outside wanting so much to help. It was the *bearer* or their connection, their affection, their hope...such a simple, but moving, way to connect people necessarily separated by role, steel, and troops, yet connected by their common hopes and persistence.
>
> *(Flynn, 1995)*

Similarly, many families waiting for the recovery of their loved ones' bodies and formal notification of their deaths expressed appreciation of the recovery workers through gifts of yellow ribbons held by guardian angel pins:

> The purpose of the ribbons was to recognize workers' valor and courage, to provide guidance and support, and to symbolize care and concern for workers' safety and welfare during the dangerous search for bodies. The firefighters were grateful and, in fact, insisted on wearing the ribbons before entering the bombing site.
>
> *(Sitterle and Gurwitch, 1999)*

Mental health responders often are awed by the comforting and healing power of symbolism and rituals. Frequently, the best of the human spirit is communicated in the simplest manner. Mental health workers may assist affected groups in developing rituals or provide assistance with the logistics necessary to carry out their ideas. The power of the symbolic gestures come from survivors' hearts and minds. Mental health responders need to take care

TABLE 3: REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1-5	• Clinging to parents or familiar adults • Helplessness and passive behavior • Resumption of bed wetting or thumb sucking • Fears of the dark • Avoidance of sleeping alone • Increased crying	• Loss of appetite • Stomach aches • Nausea • Sleep problems, nightmares • Speech difficulties • Tics	• Anxiety • Generalized fear • Irritability • Angry outbursts • Sadness • Withdrawal	• Give verbal reassurance and physical comfort • Clarify misconceptions repeatedly • Provide comforting bedtime routines • Help with labels for emotions • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Demystify reminders • Encourage expression regarding losses (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

not to interfere in this important process.

Summary Table

Table 3 summarizes information provided in Chapters II and III. Trauma reactions are divided by age with intervention options applicable to each age group. These practical suggestions are appropriate for all human service workers, disaster relief workers, crime victim assistance providers, and mental health responders. All workers are advised to exercise caution when intervening in ways that might penetrate victims' self-protective coping. With immediate response interventions, being supportive and fostering safety and security are priorities.

TABLE 3: REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
6-11	• Decline in school performance • School avoidance • Aggressive behavior at home or school • Hyperactive or silly behavior • Whining, clinging, acting like a younger child • Increased competition with younger siblings for parents' attention • Traumatic play and reenactments	• Change in appetite • Headaches • Stomach aches • Sleep disturbances, nightmares • Somatic complaints	• Fear of feelings • Withdrawal from friends, familiar activities • Reminders triggering fears • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self blame • Guilt	• Give additional attention and consideration • Relax expectations of performance at home and at school temporarily • Set gentle but firm limits for acting out behavior • Provide structured but undemanding home chores and rehabilitation activities • Encourage verbal and play expression of thoughts and feelings • Listen to child's repeated retelling of traumatic event • Clarify child's distortions and misconceptions • Identify and assist with reminders • Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, identifying at-risk children
12-18	• Decline in academic performance • Rebellion at home or school • Decline in previous responsible behavior • Agitation or decrease in energy level, apathy • Delinquent behavior • Risk-taking behavior • Social withdrawal • Abrupt shift in relationships	• Appetite changes • Headaches • Gastrointestinal problems • Skin eruptions • Complaints of vague aches and pains • Sleep disorders	• Loss of interest in peer social activities, hobbies, recreation • Sadness or depression • Anxiety and fearfulness about safety • Resistance to authority • Feelings of inadequacy and helplessness • Guilt, self-blame, shame and self-consciousness • Desire for revenge	• Give additional attention and consideration • Relax expectations of performance at home and school temporarily • Encourage discussion of experience of trauma with peers, significant adults • Avoid insistence on discussion of feelings with parents • Address impulse to recklessness • Link behavior and feelings to event • Encourage physical activities • Encourage resumption of social activities, athletics, clubs, etc. • Encourage participation in community activities and school events • Develop school programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens

TABLE 3: REACTIONS TO TRAUMA AND SUGGESTIONS FOR INTERVENTION				
Ages	**Behavioral Symptoms**	**Physical Symptoms**	**Emotional Symptoms**	**Intervention Options**
Adults	• Sleep problems • Avoidance of reminders • Excessive activity level • Protectiveness toward loved ones • Crying easily • Angry outbursts • Increased conflicts with family • Hyper-vigilance • Isolation, withdrawal, shutting down	• Nausea • Headaches • Fatigue, exhaustion • Gastrointestinal distress • Appetite change • Somatic complaints • Worsening of chronic conditions	• Shock, disorientation, and numbness • Depression, sadness • Grief • Irritability, anger • Anxiety, fear • Despair, hopelessness • Guilt, self-doubt • Mood swings	• Protect, direct, and connect • Ensure access to emergency medical services • Provide supportive listening and opportunity to talk about experience and losses • Provide frequent rescue and recovery updates and resources for questions • Assist with prioritizing and problem-solving • Assist family to facilitate communication and effective functioning • Provide information on traumatic stress and coping, children's reactions, and tips for families • Provide information on criminal justice procedures, roles of primary responder groups • Provide crime victim services • Assess and refer when indicated • Provide information on referral resources
Older Adults	• Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems	• Worsening of chronic illnesses • Sleep disorders • Memory problems • Somatic symptoms • More susceptible to hypo and hyperthermia • Physical and sensory limitations (sight, hearing) interfere with recovery	• Depression • Despair about losses • Apathy • Confusion, disorientation • Suspicion • Agitation, anger • Fears of institutionalization • Anxiety with unfamiliar surroundings • Embarrassment about receiving "hand outs"	• Provide strong and persistent verbal reassurance • Provide orienting information • Ensure physical needs are addressed (water, food, warmth) • Use multiple assessment methods as problems may be underreported • Assist with reconnecting with family and support systems • Assist in obtaining medical and financial assistance • Encourage discussion of traumatic experience, losses, and expression of emotions • Provide crime victim assistance

Recommended Reading

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This is the end of Course 6A. You will need to complete Quizzes 1 and 2 <u>and</u> the Feedback Form in order to download your certificate for this course. To access the quizzes, return to your My Home Page and click the name of this course, which is an active link. This will take you to Quizzes 1 and 2.

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