



Supporting Materials

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Part 1

General Concepts

Ohio has been the scene of a number of natural disasters in recent years resulting in extensive loss of life and property. On several of these occasions, the Department of Mental Health, as well as other State Departments, has been called upon to assist local communities in their response and recovery to these disasters.

The State will not normally become involved in disaster related activities until it is requested to do so by the executive head of the local government affected. When requesting State assistance, the head of the local government must assure the Governor that all local resources have been expended and that State assistance is needed to address needs.

When this condition is met, the Governor may declare a “State of Emergency” to exist for identified region or county or counties impacted. This declaration authorizes all elements of State Government to actively provide assistance to reduce emergencies associated with the disaster. This assistance is not rendered unilaterally by each agency, but is centrally coordinated to insure maximum effectiveness. State assistance may be directed through the regular government structure or the Governor may activate the State Emergency Operations Center or EOC.

The EOC, operating under control of the Ohio Emergency Management Agency through the Ohio Department of Public Safety and in coordination with other state agencies and partners, coordinates Ohio’s emergency response and recovery activities when the Governor declares a “State of Emergency”. The Department of Mental Health Disaster Services Coordinator is liaison to the state Emergency Operations Center and may be assigned to work in the EOC when it is activated. The liaison is the central point of contact with Ohio’s local behavioral health boards and assist’s board leadership to identify emergency behavioral health service needs, existing or potential services gaps and provides technical assistance in coordination and support of community response and recovery activities.

Depending upon the extent of involvement state departments may also elect to establish a Disaster Control Center within their own organizations.



Behavioral Health Systems Response Operations

Governor's Proclamation of a State Emergency

The Governor's proclamation of a state emergency authorizes all elements of state government to actively render assistance to reduce emergencies associated with the disaster. This assistance is not rendered unilaterally by individual agencies, but is centrally coordinated to assure maximum effectiveness.

State assistance may be directed through the regular government structure or the governor may activate the State Emergency Operations Center located at the State Emergency Management Agency 2855 West Dublin Granville Road, Columbus, Ohio.

Ohio Department of Mental Health (ODMH)

In the event of a disaster or declared state emergency the ODMH under authority of the Director is responsible for coordinating the use, direction and allocation of the state's behavioral health resources. Behavioral Healthcare Organizations under the direction and control of ODMH may provide assistance as directed by the Director and in support of the Governor's emergency declarations. This role is further defined in the State of Ohio Emergency Operations Plan.



Community Behavioral Health Authorities/Boards

Also referred to as Alcohol Drug Addiction Mental Health Services Boards, Community Mental Health Services Boards, and Alcohol and Drug Addiction Services Boards

When a disaster/emergency impacts an area within a boards authority or jurisdiction, boards activate their local emergency response plans and through local systems of care provide direct behavioral healthcare services to impacted communities. The boards provide behavioral health responders and other representative(s) to the impacted communities, Disaster Assistance Centers and to local Emergency Management Agency command centers, to provide assistance, and appropriate behavioral health interventions to individuals affected by the disaster/emergency.

If this is not within the board's capability, it should request Department of Mental Health assistance.

Dependent on the impacted area several board areas may assist and coordinate provision of behavioral health services. Boards outside the affected area may also be asked by the department to assist in the recovery efforts. Boards maintain contact with ODMH and the department Disaster Services Coordinator to assure effective utilization of resources and collaborative planning that promotes recovery and community resiliency. Local authority boards are responsible for coordinating activities with the state, community partners and other agencies. These may include among others, provider agencies, schools, faith based community, Red Cross, health departments, local emergency management agencies, law enforcement, businesses and others.



Part 2

Early Psychological Responses to Crisis and Disasters

Responding to Danger



Human beings recognize and deal with dangerous situations. The human brain, body and mind have evolved to recognize and be aware of danger and to make responding to danger a natural survival priority or even an instinctive reaction. The routine daily events that are dangerous actually change over time due to both environmental and developmental considerations. Young children, even in a protective home, are in a potentially dangerous environment due to electrical outlets, back yard swimming pools, poisonous household chemicals and sharp objects. As children develop they expand their environment to include the world outside the home where bicycle riding, climbing trees, and walking to school expand the danger to the school age child. During the adolescent years driving automobiles, having access to guns, easy access to alcohol and/or drugs and increased amounts of time unsupervised by parents or other custodial adults can all be potentially dangerous situations. Ultimately, dangers vary over the life span due to changing roles, environmental conditions and choices that an individual makes.

What happens when an individual is in a dangerous situation is threefold. First, the individual assesses what the danger is and its level of severity. Strong emotional and physical responses occur secondly based upon their perceptions of the danger. And thirdly, the individual attempts to keep the danger from happening, or looks for strategies to limit the impact of the danger. How an individual feels about a danger depends on both how serious the individual thinks it is and also what they think can be done about it.

When Danger becomes “Trauma”

People live with potential danger everyday. Over the course of their lives people continually learn about the different types of dangers and also how to avoid or limit many of them. People are always looking for ways to make their lives safer in order to create a more joyful and fulfilling life experience. However, things happen and situations occur in which people have little to no control over an extreme event or its outcome. They are rendered helpless or at the very least are limited in their ability to “control” their environment or even their own self-involvement in the situation. These dangers become “traumatic” when they threaten the person with serious injury or death. If a person witnesses violence, serious injury or death it can be just as traumatizing.

A traumatic event is one in which the individual experiences immediate threat to themselves or to others and is followed by serious injury or harm. The feelings that result are terror, helplessness, and horror due to the extreme serious nature of the event. There are several examples of events that are routinely considered to be traumatic in nature such as: large scale or mass disasters that effect many communities including natural disasters; war; terrorism; large scale fires or explosions; and mass transit disasters such as plane crashes, bus accidents or railroad disasters. Some disasters are limited to a particular community or neighborhood such as crime, school violence or traffic accidents. There are also several individual disasters such as rape, child abuse, domestic violence or elder abuse; each being potentially traumatic experiences by their very nature. The level of traumatic response by survivors to any of these events is dependent upon many individual and social variables. Psychologist Jon Allen, in his book *Coping with Trauma: A guide to Self-Understanding* (1995), identifies two components to a traumatic experience: the subjective and the objective. He states, “It is the subjective experience of the objective events that constitutes the trauma... The more you believe you are endangered, the more traumatized you will be...Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects”.

“It is the subjective experience of the objective events that constitutes the trauma”
— Jon Allen

In the following few sections you will be provided with various considerations that determine individual trauma responses.

Note. Information for this section was obtained from The National Child Traumatic Stress Network (www.nctsnet.org), and The SIDRAN Institute (www.sidran.org).

Complex Anatomy of Traumatic Experiences and Human Responses to Those Experiences

To understand human trauma, consider ...

- ◆ **Nature of the crisis**
- ◆ **Factors in the system**
- ◆ **A news system to figure out**

Researchers indicate that human response to danger is a “complex” and “integrated” system of reactions that include body, mind and spirit. Many believe that, response to trauma, is a function of the characteristics of the traumatic event and characteristics of the individual. There seem to be many interactive components involved when attempting to assess crisis responses and an individual’s effort to establish some form of meaning to the event. One researcher/author, Nancy Webb, suggests that there are three interactive components that we must consider when attempting to understand human response to trauma; they are: Nature of the crisis; Factors in the support system; Individual factors.

How Do People Respond During Traumatic Exposure?

There are emotional, cognitive, physical, behavioral, and spiritual reactions that people experience during a traumatic event. These reactions are not necessarily unhealthy or maladaptive responses. Such reactions should be considered to be normal responses to abnormal events. However, if these reactions persist and are experienced weeks, months or years after the event, and they include recurrent nightmares or flashbacks or avoidant behaviors that interfere with occupational or social interactions, then help from a mental health professional may be indicated.

Emotional Responses

Shock, high anxiety, stunned, emotional numbing, appear to be “in a fog”, exhibit denial, dissociation, dazed, apathetic, feelings of unreality, panic, fear, intense feelings of aloneness, hopelessness, helplessness, horror, emptiness, terror, uncertainty, anger, hostility, irritability, depression, feelings

of guilt, loss of pleasure from familiar activities, difficulty experiencing loving feelings, blame, and grief.

Table 1: Factors that Affect Trauma Experiences

Nature of the Crisis	Individual Factors	Social Support Factors
<ul style="list-style-type: none"> • Single event vs. recurring • Solitary vs. shared experience • Presence of loss factor • Separation from family members • Death of family member • Level of exposure to the event • Loss of familiar environment • Loss of status or body function • Physical injury/pain • Presence of violence • Element of stigma • Presence of life threat 	<ul style="list-style-type: none"> • Age/developmental stage • Cognitive Level • Moral/Spiritual Beliefs • Pre-crisis adjustment • Past experience with crisis • Perception/Meaning of crisis event 	<ul style="list-style-type: none"> • Nuclear family • Extended family • School • Friends • Peers • Local community • Supportive others • Non-Supportive others

Cognitive Responses

Impaired concentration, suggestibility, vulnerability, self-blame, confusion, short attention span, blaming others, hyper-vigilance, nightmares, disorientation, difficulty in making decisions, memory impairment, disbelief, forgetfulness, lowered self-efficacy, decreased self-esteem, intrusive thoughts and memories, dream like or “spacey” feelings, thoughts of losing control and feeling guilty for surviving when others perished.

Behavioral Responses

Regressive behavior (especially in children), "spacing-out", erratic movements, pacing, impulsivity, withdrawal, non-communicative, changes in speech patterns, aimless walking, inability to sit still, increased relational conflict, reduced relational intimacy, alienation, impaired work or school performance, distrust, feeling abandoned/rejected, over-protectiveness, exaggerated startle response and antisocial behaviors.

Physical Responses

Muscle tension and pain, fatigue, fainting, chills, increased sweating, thirst, dizziness, insomnia, reduced immune response, decreased appetite, decreased libido, vulnerability to illness, rapid heart beat, elevated blood pressure, difficulty breathing, headaches, grinding of teeth, gastrointestinal upset, vertigo, chest pains and shock symptoms.

Spiritual Responses

Anger and a distancing from God, stops attending religious services, begins a sudden turn toward God, uncharacteristic involvement in religious activities, faith practices increase such as prayers, scripture reading, hymns, worship, communion but often with an empty or meaningless nature, belief that God is powerless or does not care, God has failed them, questioning of one's basic beliefs and there is often anger directed at clergy.

What Are the Common Responses Following Traumatic Exposure?

During a traumatic experience the survivor often becomes overwhelmed with emotional responses and fear reactions. The person may re-experience that trauma both mentally and physically any period of time following the traumatic event. Since these re-experiences can be uncomfortable and painful, the survivor generally will try to avoid any reminders of the trauma. The following are some of the symptoms that the survivor may re-experience over time.

Reoccurring Experiences

Mental, emotional, and physical experiences that occurred and are likely to re-occur include the following: thinking about the trauma, seeing images of the event, feeling agitated, physical sensations mimicking those that

occurred during the trauma, feeling as if they are still in danger, experiencing panic sensations, wanting to escape, getting angry, thinking about attacking or harming another, anxious and physically agitated, having trouble sleeping, having trouble concentrating all of which the survivor can not control.

Avoidance

Since thoughts about the trauma experiences continue to arise over time, the survivor often feels uncomfortable or becomes upset at the thoughts. The natural human response to these feelings is to try to avoid them. As a result, behaviors are motivated by this need to avoid reminders of the trauma. The following are some of the ways in which survivors avoid reminders. Actively avoiding trauma-related thoughts and memories, avoiding conversations and staying away from places, activities, or people who are reminders for the survivor, unable to remember important parts of what happened during the traumatic event, shutting down emotionally, feeling emotionally numb, unable to have loving feelings, experiencing strong emotions, feeling strange or that the environment seems strange or unreal, feeling disconnected from the outside world, avoiding situations that might invoke strong emotional reactions, feeling physically numb, no feeling of pain, and loss of interest in things that were once enjoyable.

Substance Abuse or Dependence

The question of whether there are increases in substance use, abuse or dependency following disasters is currently being studied. The following information is provided based on most recent research maintained at the National Center for Post Traumatic Stress Disorder. The empirical disaster research summarizes the issue of disasters and substance abuse or dependence. Rates of new onset of alcohol dependence disorders after a disaster, assessed according to DSM criteria, range from 0% - 2%. Virtually no cases of new onset drug abuse emerged in any of the studies. Although there are rarely new onsets, the total current prevalence of diagnosed alcohol dependence disorders is approximately 8%. Individuals in select groups who had significant problems with alcohol before a disaster are likely to have problems with alcohol use after a disaster. Rates of self-reported, problematic alcohol use are similar to the total prevalence (7%-9%). Using alcohol occasionally as a way of coping is more common, about 15% on average. These rates range from 6% - 40%. The high rates occur among



survivors with other psychological diagnosis. Unlike rates of most other diagnoses and problems, rates of alcohol abuse or dependence appear to be no higher in survivors of mass violence than in survivors of natural disasters.

Anger and Trauma

Anger is usually a predominant feature of a survivor's response to trauma primarily because it is a core component of the basic human survival response or instinct. Anger provides the increased energy that people need to cope with life's adversities. The presence of uncontrolled anger will often lead to a continued sense of being out of control of one's "self" leading to multiple personal and relationship problems. Anger can help a person survive a traumatizing event but anger can potentially become "stuck" as part of a more long-term psychological problem. As a result there is a possibility that this anger will manifest with other symptoms and develop into Post Traumatic Stress Disorder (PTSD) or other possible diagnoses.

Another area of research is finding that anger can also be a very normal response to betrayal and the loss of basic trust in others. One of the most prevalent areas where anger is viewed as a normal response to abnormal situations is when the survivor has experienced interpersonal exploitation or is the victim of violence and helplessness.

The trauma and shock of early childhood abuse has been shown to interfere with the survivor's ability to regulate their emotions. Violent and frequent episodes of extreme and out of control anger and even rage is a very typical emotional indicator of early childhood abuse.

Note. Information for this section was gathered from The American Academy of Experts in Traumatic Stress (www.traumatic-stress.org) & (www.ATSM.org) and from the National Center for PTSD (www.ncptsd.va.gov), National Child Traumatic Stress Network www.NCTSNet.org, American Academy of Child & Adolescent Psychiatry, American Psychological Association, Substance Abuse and Mental Health Services Administration and written by Roger P. Buck, Ph.D., Clinical Systems Manager, Alcohol Drug and Mental Health Services Board serving Athens, Hocking and Vinton Counties, Ohio.

Special Populations and At-Risk Groups

Population characteristics that may be at greater risk for psychological distress ...

- ◆ **Those highly exposed to the disaster**
- ◆ **Women**
- ◆ **Ethnic minorities**
- ◆ **Those of low socioeconomic status**
- ◆ **Those with prior psychiatric conditions**
- ◆ **Individuals with little experience dealing with trauma**
- ◆ **Those with affected spouses**
- ◆ **People living in traumatized communities**
- ◆ **Those experiencing additional or secondary stressors**

Source: National Center for PTSD (www.ncptsd.va.gov)

Following a traumatic event, there are several populations that have a greater chance of developing some type of psychological distress than others. In the last twenty years, there has been a fair amount of research conducted to identify groups that tend to have a more difficult time dealing with trauma.

Special Needs Populations

An important element of disaster preparedness and response is the consideration of persons with special needs. It is critical at all phases of a disaster; the pre-event planning, during the acute phase of the event and the post-event period, to understand the issues facing our most vulnerable citizens.

Individuals with Disabilities

Approximately one-fifth of the population, or 54 million Americans, have a physical, mental and/or emotional disability.

Of those disabled:

4 million require assistance with daily living

8 million have limited vision; 130,000 are blind

28 million have hearing loss; 500,000 are deaf

1.5 million are wheel chair users

7 million have mental disabilities

Many individuals have more than one disability. Individuals with disabilities are widely diverse with differing needs and circumstances. They are remarkably resourceful and can be a valuable asset in planning and preparing for disasters. In developing both individual and community wide response plans, issues such as those listed below must be considered.

Can the individual

- Hear warnings
- Safely & quickly evacuate home or workplace
- Move about the community after escaping
- Access needed equipment, medications or treatments
- Get to the distribution sites for water, food, and other needed supplies

Key Principles for disaster planning and response those highly exposed to the disaster

- ◆ **Accessible disaster facilities and services**
- ◆ **Accessible communications and assistance**
- ◆ **Accessible and reliable rescue communication**
- ◆ **Partnerships with media**
- ◆ **Partnerships with disability community**
- ◆ **Disaster preparation, education, training**

During emergencies, it is important to identify persons with special needs within in the affected community area. When evacuation is implemented, it can be expected that 5-7% of persons in the shelters will be disabled.

Individual reactions to disasters may include:

- Fear of loss of independence
- Resistance to leaving guide animals/pets, home, mementos
- Increased isolation and lack of awareness of resources
- Slower to admit full extent of their losses

Persons with disabilities tend to have increased anxiety and stress compared to the general population. However, studies have shown that the disabled have less incidence of post-traumatic stress disorder than the general population.

Disabled persons may function well in the community with the support of services such as public transportation, homemaking services, personal care aides and therapeutic treatments. These services may be unavailable during a disaster. Electricity-dependent equipment, medications and adaptive feeding devices may also be problematic. Individual and community planning is essential to prioritize the reconnection of essential services and prevent further injury or impairment to the individual.

Recent losses or cumulative unresolved traumas may leave the disabled person at-risk for difficulty coping with disaster after-math. On the other hand, successful adaptation to disabilities may increase their resiliency and strengthen their coping skills.



Older Adults

Persons 65 years and older currently represent 12.4% of the total US population. Ohio, ranked 17th in total geriatric population, has an older population of 13.3%. Not only are the numbers of older adults rapidly expanding but they are living longer as well.

- 6,000 Americans turn 65 everyday
- The fastest growing segment of the population is 85 years and older

Despite wide individual variations in aging, there are aging-related changes that may increase the vulnerability of older adults in times of crisis or stress.

They include:

- Decreased ability to maintain normal physiology under stress
- Increased susceptibility to illness due to alterations in the immune system
- Altered presentation of illness or disorders
 - Symptoms often present differently in older adults. For instance infection, malnutrition, dehydration, and other serious disorders may present as confusion, generalized weakness or loss of appetite.
 - Impaired thermoregulation
 - Older adults may have serious reactions to environmental changes in heat and cold.
 - The impact of illness may be more severe.
 - Due to other chronic illnesses or frailty, even a common virus can be life threatening.
 - Treatment may be less effective and may cause adverse effects.
 - Many older adults take multiple medications, prescription and over-the-counter, increasing the potential for adverse reactions.
 - Changes in vision and hearing can create difficulty in communication and adapting to environmental changes.

Approximately 42% of elders in the US have a disability.

28.6% have a physical disability

14.2 % have a sensory disability

10.8% have a cognitive/mental disability

Key geriatric principles in disaster response

- ◆ **Promote resilience and self-efficacy within the older person**
- ◆ **Perceive older persons as a valuable resource instead of a liability**
- ◆ **Provide access to health personnel and information as needed**
- ◆ **Be prevention-focused to help heal and protect elders from developing unhealthy behaviors**

Frailty is not a part of normal aging and is defined as health conditions that limit independence and increase dependency on others. Frail older adults use their functional reserve for basic survival and have no reserve to manage stress.

Basic intelligence and the ability to learn is preserved with aging. However, reaction times are slower, sleep patterns are more easily disrupted and the ability to focus or multitask is lessened. Cognitive abilities may be poorer in stressful and in emergency situations. Frail elders may become confused or disoriented due to stress, environmental changes and/or co-morbid conditions. Persons with dementia may exhibit difficult behaviors and become highly agitated due to the disruption in routines and environmental stressors.

Depression is a serious problem for many older adults. Studies show that as many as 30.5% of elders have minor depression and 6.0 – 14.4% have major depression. Older adults account for 21% of all suicides. With white males over the age of 70 years have the highest rate of suicide of all age groups. Illness, functional decline and prolonged bereavement can cause social isolation, further increasing the potential of depression. Substance abuse often goes unrecognized in older adults.

Cumulative losses and fear of losing their independence may leave older adults at-risk for difficulty in coping with disaster-aftermath. However, many older adults have developed good coping skills in the past giving them a reservoir of skills to cope with adaptability and resilience.

Note: Information developed by Barbara Palmisano, M.S., R.N. and Margaret Sanders, M.A., LSW of Western Reserve Geriatric Education Center, Northeast Ohio Universities College of Medicine. Funded by Health Resources and Services Administration (HRSA) curriculum development grant in Bio-terrorism and Emergency Preparedness and Aging.



Culture and Ethnicity

It is important to recognize that culture influences how individuals perceive and interpret traumatic events. And, culture influences how individuals, their families, and their communities respond. Some individuals of differing cultures experience cultural disaster stressors that may include: immigration status, language difficulties, lack of information, lack of health insurance, discrimination, difficulty accessing disaster services, and lack of financial resources. Cultural differences exist with regard to access to behavioral health services. A few examples may include: distrust of government programs, stigma toward mental health, cultural differences in response to loss. For mental health disaster responders, culturally competent conduct should include:

- Knowing the culture
- Self-educate about culturally-specific behaviors
- Rely on members of the community for information
- Understand the cultural expression of distress
- Respect the need for ritual and customs
- Encourage healthy coping
- Be alert to personal cultural biases
- Be respectful and well informed
- Willingness to admit personal limitations to understanding culture

It is essential that intervention efforts are sensitive to the cultural, religious and linguistic realities of the population served. Whenever possible, disaster mental health support services should be delivered by professionals that reflect the diverse characteristics shared by a community. Consideration should be given to language and ethnic barriers that may impede the acceptance and benefit of needed services. Other factors that should be considered are race, age, gender refugee/immigrant status, income, and size of the community.

If operating from a diversity deficit, the mental health professional needs to educate himself/herself to the relevant background of individuals, groups, or communities he/she is asked to serve. Culture and trauma experiences may

also contribute to the interpretation or definition of what is considered traumatic.

Note: Information related to Culture and Ethnicity was obtained by Debra M. Copeland, M.S, of the Ohio Department of Mental Health using the following resource: The National Association of School Psychologist Website www.nasponline.org; Raquel E. Cohen MD,MPH, http://www.crid.or.cr/crid/esp/Temas/Disaster_Mini_Course.pdf

Children



When considering interventions with children affected by a disaster it is important to recognize that families are extremely important systems and constitute the most important unit for post disaster treatment and intervention efforts. Interventions for children may be of limited effectiveness if the family is not considered as a whole. In fact, providing care and support to their overly stressed parents might be among the most effective ways to provide care and support to the children affected by disaster.

Children are very often very intuitive and aware and they can sense the anxiety and tension in the adults around them. Children experience the same feelings of helplessness and lack of control that adults feel in times of disaster. However, children lack the experience and knowledge of how to place the event in perspective or make sense of the crisis event. Since each child responds differently to disasters based on their maturity level, ability to understand and their personal support needs, it is easy to see why they might be more vulnerable to anxiety and other stress reactions. Being open about the consequences of a disaster and encouraging children to express their thoughts, feelings and fears is perhaps the most important thing that parents or guardians can do for the child in times of crisis/disaster. The following table is a brief summary of the reactions that you can expect to see in children as they respond to traumatic and other crisis events.

Table 2: Children’s responses to trauma

Impact on Young Children	Impact on School-Age Children	Impact on Middle and High School Students
<ul style="list-style-type: none"> • May have sleep difficulties, nightmares and bad dreams • Increase in regressive behaviors such as bedwetting or thumb-sucking • May lose recently acquired developmental milestones • Become clingy with parents and caretakers • Increased irritability and temper tantrums 	<ul style="list-style-type: none"> • Somatic complaints such as stomach aches, head aches and pains • Changes and/or inconsistencies in behaviors such as increase in irritability, aggression and anger • Impaired attention and concentration at school • May talk about event excessively or ask persistent questions • Feelings of shame or guilt for not having been able to do something helpful. May be frightened of their intense emotions and physical reactions in response to the traumatic event. 	<ul style="list-style-type: none"> • Feel self-conscious about their emotional response to the trauma • Feelings of shame and guilt • Revenge fantasies and focus on retribution • Radical shifts in their worldview • Changes in school performance, behaviors...may see self-destructive, reckless or accident prone behaviors emerge

The following tips may be especially helpful as you guide culturally diverse students through the recovery process following a disaster:

- Learn a child's "usual" behavior and cultural/ethnic responses to be able to identify "unusual" or problem behavior.
- Create a comfortable atmosphere for verbal expression in any language. Consider asking for a translator to help a child with limited English-language skills.



- Recognize that talking openly is not comfortable, appropriate, or even "polite" in some cultures.
- Be aware that terms that refer to race and ethnicity often have both overt and hidden meanings. Whenever possible, use the descriptive term that is preferred by the majority of persons in a specific group.
- Know that making eye contact is not accepted in some cultures. It is considered to be "defiant behavior" for some groups. In other cultures, particularly those with roots in Western Europe, lack of eye contact is seen as an indication that the person is being less than truthful.
- When using drawing activities to help children express themselves, keep in mind that colors and shapes have various meanings to children from different cultures, and to different children within each culture.
- Be aware that children from other cultures who have experienced loss, relocation, death, and war are at a particularly "high risk" of having serious problems after a disaster.
- Understand that some ethnic populations are more likely than others to have flashbacks to other catastrophes.

Note: Information for this section was obtained by Lisa Woznick and Debra M. Copeland, M.S, using the following resources: The National Child Traumatic Stress Network, Fran H. Norris, of the National Center for Post Traumatic Stress Disorder, and SAMHSA
<http://www.mentalhealth.samhsa.gov/cmhs/EmergencyServices/culture.asp> .

Coping Strategies

Recovery from traumatic or crisis events for the individual should include the awareness of the internal processes that occur as well as the external influences. The following chart is a pictorial representation of the process and the elements that impact the individual and their recovery process. (Developed by Roger P. Buck, Ph.D.)

Table 3: Four Central Dimensions of Recovery

Self Problem  Internal (The self does the action)	Others System  External (The self is acted upon)
Constructs of Self <ul style="list-style-type: none"> • Beliefs • Fears • Identity • Health • Attitude • Knowledge • Meaning 	Others <ul style="list-style-type: none"> • Family • Peers • Providers • Larger Society
Problem <ul style="list-style-type: none"> • The (what happened) or the thing that the person must recover • From the problem we derive <ul style="list-style-type: none"> • Cause • Effect • Possible Solutions 	System <ul style="list-style-type: none"> • Primarily the Mental Health System <ul style="list-style-type: none"> • Diagnosis • Medications • Facilities/Programs • Professionals • Disincentives • Other systems that affect recovery <ul style="list-style-type: none"> • Educational Legal/Penal • Human Services • Larger Society

The Importance of Active Coping

Keeping the above framework in mind and referring to it periodically may help to understand the effects that traumatic experiences have on an individual. When we refer to “active coping” processes we are talking about an individual’s active participation and taking some power and control steps toward their own recovery. When a person is actively coping with the effects of a traumatic event they are recognizing and accepting the impact that trauma has had on their life and taking direct coping actions to improve their life. Coping in an active manner consists of developing habits and an attitude of strength and control over various symptoms or effects of the trauma event.

Recovery is a daily process that is ongoing and gradual and the ultimate goal is not to become “cured”. People who continue to experience various physical and emotional reactions to a traumatic event are most often having normal human reactions to abnormal experiences. The healing process does not mean that the person forgets the traumatic events nor does it mean they no longer have emotional pain when they think about those experiences. What recovery does mean is that the person will (over time) have fewer symptoms, or symptoms that are less disturbing. The person will develop greater confidence in their ability to cope with their physical and emotional reactions and even feel more in control of those emotions.

The following is a listing of some of the more effective coping behaviors that a person can employ when troublesome symptoms occur.

Unwanted distressing memories, images, or thoughts

- Overwhelming reminders of trauma will most often lessen over time.
- Remind yourself that what you are experiencing are just memories nothing more.
- Remember that it is very natural and normal to have vivid memories of trauma events
- Talk about them with someone you trust.

Sudden feelings of anxiety or panic

- Physical reactions such as heart pounding and feeling lightheaded due to rapid breathing are not dangerous.
- The accompanying thoughts of fear of a heart attack or fear of loss of control are more upsetting than the actual physical reactions produce.
- Concentrate on slowing your breathing.
- These sensations will pass after a brief period of time.

Feeling as if the trauma is re-occurring (Flashbacks)

- True flashbacks are a rare occurrence but if they do occur you should keep your eyes open and notice your surroundings.
- You should talk to yourself and remind yourself of the time and place your body is currently in, and that the trauma event being relived was in the past and you are now in the present.
- Distract the memory by moving around and getting a drink of water or wash your face and hands.
- Talk with someone that you trust and explain what you are experiencing.
- Remind yourself that this is still only a reaction, though it is distressing, it is a common human response to extreme experiences.
- Tell your doctor and counselor about these flashbacks.

Trauma-related dreams and nightmares

- When you awaken from a nightmare or night-terror feeling or having thoughts of panic, remind yourself that you are reacting to a dream and that you are safe.
- Listen to soft calming music.
- Talk to someone if there is someone available.
- Watch a comedy show on television or other distracter.

- Get out of bed and orient yourself to your surroundings prior to returning to bed.
- Tell your doctor or counselor about your dreams and nightmares

Difficulty falling asleep and/or staying asleep

- Maintain a regular bedtime schedule.
- Do not do strenuous exercise just before going to bed.
- Use your sleeping area only for sleeping and/or sexual intimacies.
- Using alcohol, tobacco and caffeine interfere with sleep so you want to avoid their uses.
- If unable to sleep do not remain in bed worrying or thinking but get up and enjoy some soothing or pleasant activity.

Irritability, anger, and rage

- Take a time out to relax and think things over and/or walk away from the situation.
- Anger increases your stress and causes health problems.
- Talk to counselors and/or doctors about anger and learn anger management techniques.
- Talk about anger blow ups with those you have been angry with and resolve conflicts quickly.
- Exercise daily since exercise reduces body tension and helps release anger in a positive and more productive manner.

Difficulty concentrating

- Make “to do” lists and write things down that are important that you do not want to forget.
- Slow your self down and allow extra time to focus on what you need to do or learn.
- Break large tasks down into smaller units that are more manageable.
- Do not over extend yourself and schedule only those events or tasks that are manageable for each day.

- Recognize that you may be depressed since many people who are depressed have difficulty concentrating. Discuss this symptom with your counselor or doctor.

Difficulty feeling or expressing positive/loving emotions

- You are not being unexpressive on purpose. This is a common reaction to trauma.
- Do not feel guilty for an inability to express positive emotions.
- Participate in activities that you enjoy or used to enjoy since these activities might rekindle feelings of pleasure.
- Communicate your caring and love for others in new ways such as writing a card, leaving a person a small gift or just calling and communicating with another.

The whole purpose of this listing of behaviors is to suggest ways in which individuals that experience traumatic events can choose to respond. These are skills that a person can develop with practice over time and with the help of friends, family and professionals in their communities.

Early Grief and Mourning

There are several identifiable reactions that people who experience trauma will experience as they grieve and mourn the loss of a loved one or any other significant life altering loss. The following reactions are some of the more prominent ones.



Shock

The initial response to learning of the death of someone close to you is shock. When someone dies unexpectedly and suddenly or when a person takes their own life the shock is intensified. Shock will be potentially very acute as a result of these sudden and/or violent deaths. It is very common for shock to last days and weeks immediately following a death. Depending on many factors discussed previously, there are some who will experience shock more severely and for longer periods of time.

Early Grief and Mourning

- ◆ Shock
- ◆ Numbness
- ◆ Disbelief
- ◆ Searching
- ◆ Anguish and Pining
- ◆ Physical and emotional stress

Numbness

Human beings have an evolved defense mechanism where the mind will allow a person to feel loss slowly and part of that defense is manifest through the experience of numbness or unreal or dreamlike states. The thought emerges that “this can not be happening” and becomes the focus of attention for many people. Early bereavement may even include a feeling of distress and/or misunderstanding. An example of numbness may be best illustrated when a person is unable to cry at a close family members funeral. There is a protective nature to numbness that begins to gradually wear off and emotional pain begins.

Disbelief

It is very difficult for a person to believe that a close relative or friend has died especially if the death appears sudden or untimely. It is very possible to know cognitively that the person has died but on a deeper level it may seem impossible to accept it. Confusion, panic and fear are all common during the struggle between knowing a person has died and the disbelief of their passing.

Searching

Once individuals go through periods of shock, numbness and disbelief they may develop an overwhelming sense of loss. There is a period of emotional searching for the loved one, even though they know that person has died. A person might talk to a photograph, call out the person’s name, or even look for the deceased person as they walk down the street. The person who continues to use this form of denial will need some time in order to heal.

Anguish and Pining

Once a person really understands that a loved one has died tremendous misery and sadness sets in. There are powerful and even desperate longings for the deceased. The emotional intensity and pain is often frightening which often leaves the bereaved feeling totally devastated. When emotional pain is intense there is often an accompanying physical pain. The need to talk about the deceased is a natural part of the struggle to counteract their feelings of loss.

Physical and Emotional stress

Some of the physical and emotional symptoms that often occur after the death of a loved one are restlessness, sleeplessness and fatigue. Other symptoms might include: Bad dreams or nightmares; memory loss; inability to concentrate; dizziness, heart palpitations, physical shakes, choking, difficulty breathing, heaviness in the chest and throat, muscular tightness, headaches, neck and backaches. Other symptoms that may occur are loss of appetite, nausea and diarrhea. These physical effects of the shock of losing a loved one will pass with time.

Emotions that occur frequently during bereavement

The “self” or “ego” must adjust to the new information of the death of a loved one. Out of fear and emotional pain the ego will use several defense mechanisms to help the person adjust. Anger and even rage is perhaps one of the most common emotional reactions to the death. There is a general sense of helplessness at the unfairness of life, and anger may develop toward others who continue on with their life as if nothing has happened. Anger may become even more focused and intense feelings of blame may arise toward others who may have been involved or are perceived to have contributed to the death of the loved one. Anger toward the person who died is also very common. Anger is most intense at the time of death and then usually subsides over time.

Guilt and self-blame is another common emotion that occurs during the grief process. There is a sense of responsibility because the bereaved often feels they should have been able to prevent the death. When a sudden death occurs there is often intense guilt, because, since people don't usually live their life as if it were their last, there are ongoing arguments and disagreements that may have immediately superseded the death. This can cause the survivor to have intense feelings of responsibility and/or self blame which results in an increase in despair.

Note: Information for this section was gathered from The American Academy of Experts in Traumatic Stress (www.traumatic-stress.org) & (www.ATSM.org) and from the National Center for PTSD (www.ncptsd.va.gov), National Child Traumatic Stress Network www.NCTSNet.org, American Academy of Child & Adolescent Psychiatry, American Psychological Association, Substance Abuse and Mental Health Services Administration and written by Roger P. Buck, Ph.D., Clinical Systems Manager, Alcohol Drug and Mental Health Services Board serving Athens, Hocking and Vinton Counties, Ohio.

Grief and depression are emotions that the bereaved experience immediately following the death. These are natural responses to a terrible loss and should be expected to persist over a period of a few months up to several months, even years. Pathological grief will be discussed in a later section of this booklet.

Research shows that people who engage in meditative, colloquial or ritual prayer are more likely to respond in a healthy manner than those who do not.

Spirituality and Trauma

The Impact of Trauma

In order to address the impact of trauma upon a person and upon larger groups of people, it is imperative to understand the nature of the spiritual realm. The helping professional must understand and orient themselves with the victim's worldview. Awareness of a person's worldview is necessary because helping professionals will be confronted with such issues regardless of their level of preparation for such situations. "Understanding their nature is helpful to our level of preparation for intervention" (Robert Denton). This became apparent for those behavioral health responders who showed up at the various airplane crash sites on 9-11-01.

Traumatic events such as this have a tendency to challenge a victim's, as well as the professional helper's, presuppositions about the world. Trauma brings to mind thoughts about God or ultimate things, what are ultimate values and principles, as well as thoughts about death and the afterlife. In addition, ideas relating to justice and fairness come to light especially when considering how to live after such experiences. Victims often feel confused and disoriented after such situations because the perpetrator broke the rules and somehow the victim must reconcile their worldviews with the events that have taken place.

Trauma and Meaning Systems

Meaning systems are considered one's beliefs about the universe. It can also be described as the nature of reality and a person's relationship to it. Very often, such ideologies cause people to search for meanings within this system. Victimization can be seen as a direct attack upon a person's meaning system. Such systems are seen as being self-evident truths because they are assumed through philosophical or faith based statements. These patterns of beliefs or understandings provide worldviews by providing

explanations for various experiences. As people look at and consider these beliefs or understandings the discussion then leads to matters of spirituality and religion.

Trauma and Spirituality: Research

As the United States encompasses greater diversity inside its borders, workers should have the knowledge and skills to work with such multicultural influences. It can be understood that spirituality and religion have major functions for multicultural populations. In order to understand behavior the spiritual beliefs or aspects of human existence must be considered within the context of bio-psychosocial research and understandings.



Religion in times of trauma

Research also indicates that levels of spiritual connectiveness are strong predictors of the personal ability to handle deliberate injury. Spirituality has a psychological role and forgiveness is a therapeutic need. Religion is used most extensively for emotional support as a means of making sense of an event or act, which seems senseless.

Styles of problem solving underlying an individual's relationship with God, is another important spiritual component. There are three ways in which people solve problems. They either become self-directing, deferring or collaborative. Research indicates that the collaborative style of "Me and God" was the most functional problem solving technique used in times of traumatic stress.

Victims cope emotionally with death, injury or other crisis situations by using religion as an emotional support or problem-solving tool. Religion is the source of meaning and is a viable method for many for regaining a personal sense of control or empowerment through worship or prayer.

People are predisposed to religious and non-religious attribution; however the nature of the event influences which will be drawn upon. Abnormal events or those beyond the everyday coping system tend to trigger religious attributions. A possible buffer against stress could come from knowing that it is possible to seek help from a pastor, church or parish. The buffer process is facilitated by spiritual support from believing that God is there IF you need Him. There are positive outcomes associated with perceived support from God, as a partner in the coping process, which once again points out that the collaborative style is the most common form of religious coping.

Thoughts and Issues about Spirituality

The following is a list of questions that victims or survivors may ask as well as some questions that responders should consider:

- Why Me, God?
- Is tragedy directed toward people, or is it directed toward a community by God?
- Is God the cause of or solution to our suffering?
- If God is just, why is this so unfair?
- How does justice differ for victims, bystanders and offenders?
- Can there be real justice in the world?
- Was this tragic event an act of God's will?
- "God is all powerful, God is all-good, and bad things happen" –How can this statement be reconciled?
- Why does God allow children to be hurt?
- What type of sign does the survivor seek?
- Should God answer all prayers?
- Can you expect to understand God's answers?
- Why is there evil in the world?
- Who brings God to justice?

Critical Distinctions for Interveners about Spirituality and Religion

Spirituality is not the same as religion. It is non-denominational, inclusive, universally applicable and embracing of diverse expression while emphasizing interconnectedness of being. Interveners can deal with cherished beliefs without demanding doctrinal complicity.

Closing Thoughts

- "Never move the theological furniture when the house is on fire"
(Robert Denton).

- Be sure to self evaluate one's own beliefs as well as biases.
- Do not refute others' worldviews
- Respond, reassure, reinforce

Note. The information for this section (Spirituality) was originally written by Robert Denton Ph.D. and compiled by Nilu Ekanayake, Student, Ohio University, Athens, Ohio.

Terrorism and Bio-Terrorism

Terrorism and Bio-Terrorism are an increasing concern in our western society and around the world. The possibility of a terrorist incident involving chemical, biological, radiological, or nuclear weapons (CBRN) is a real threat in today's chaotic and dangerous world. Predicting how the public will respond to this kind of event is debated within current research literature. The literature does suggest that there will be significant differences between responses to CBRN terrorist activities and conventional terrorism, such as hijackings, bombings, sniper attacks and kidnappings.

The United States government is spending millions of dollars on preparations for the public health system's response to bioterrorism. This preparation has not included significant attention to the possible behavioral and emotional response of the public to such incidences. It is extremely important that the emotional and behavioral impact of a bioterrorism incident be considered due to the possible negative outcomes that public panic and other extreme reactions might generate. One of the major concerns of public health officials is that "worried well" individuals might flood the health care system with demands for health care due to their lack of understanding or through panic. This section of the supportive materials will highlight this and many other issues, concerns and possible emotional and behavioral responses that you might encounter if such an event is perpetrated upon the public. This information is provided in a "table" format to highlight what current research has discovered from recent crisis events. A significant amount of research has been represented in these tables and citations for that research can be obtained by going to the web site for The Milbank Quarterly, www.milbank.org/quarterly.html

The following tables were developed using information obtained from "The Milbank Quarterly", Volume 82, Number 3, dated 2004.

Table 4: Differences between Bioterrorism and Other Forms of Terrorism

Event Characteristics	Bioterrorism	Other Forms of Terrorism
Speed at which results are in effect	Delayed/prolonged	Immediate impact
Site of the attack	Unknown/ questionable	Specific and well understood
Boundaries, scope and knowledge of the attack	Unknown/ questionable	Usually well understood/obvious
Distribution of Affected victims	Geographically dispersed especially in human to human transmission of disease, or animal to human transmission of disease	Usually in a concentrated area
First responders	Physicians, nurses, Public health officials	Police, fire, EMS
Decontamination of victims and environment	Geographically dispersed	Confined environment
Isolation/quarantine	Required for transmittable diseases	Not usually necessary
Medical intervention	Antibiotics, vaccines	Trauma, first aid, antidotes

Psychological Consequences of Events Measured in the General Public

Bombing of Murrah Federal Building Oklahoma City, April 1995

Eight percent of Oklahoma City residents interviewed 6 months after the bombing who did not hear, see, or feel the explosion reported emotional symptoms consistent with Post-traumatic stress disorder (PTSD).

Terrorist attacks on World Trade Center (WTC) and Pentagon, September 2001

Forty-four percent of a national sample reported experiencing substantial emotional stress 3 to 5 days following the attacks. One to two months after the attacks, estimates of probable PTSD in areas close to the attack ranged from 3% (Washington D.C. metro area) to 11% (NYC area). Estimates of probable PTSD in the rest of the country was 4%.

One to two months following the attacks, 8% of Manhattan residents reported symptoms consistent with PTSD and 10% consistent with depression.

Among Manhattan residents in closest geographic proximity (south of Canal Street near the WTC), the prevalence was as high as 20%.

Seventeen percent of the U.S. population outside NYC had posttraumatic stress symptoms two months after the attack; 6% at six months. Prior depression or anxiety was associated with higher levels of posttraumatic stress symptoms.

Five to eight weeks after the attacks, increased use of cigarettes, alcohol, and marijuana was found among New York City residents living closest to the affected area and was associated with higher prevalence of current PTSD or current depression.

Three to six months after the attacks, 18% of 1,009 individuals interviewed in Manhattan had symptoms severe enough to put them at risk for PTSD. Only 27% of these individuals were receiving counseling or psychiatric treatment.

Anthrax letters mailed through U.S. Postal Service in New York, District of Columbia, New Jersey, and Florida, October 2001.

More than 30,000 people were offered prophylactic antibiotics despite the relatively narrow scope of the attack.

Two months following the first confirmed case, more than 75% of Americans surveyed believed they would survive if they contracted inhalational anthrax.

Less than 25% of Americans surveyed within two to four weeks of the anthrax attacks reported taking emergency precautions because of concerns of bioterrorism: there was no difference between areas with and without anthrax cases. Less than 10% of Americans reported avoiding public events due to concerns of bioterrorism.

There was no large-scale increase in the demand on the health care system following the anthrax attacks. Those surveyed felt their own doctor was most trustworthy source of reliable information in the event of bioterrorism in a community.

In the month following the first reported anthrax case there was a widespread increase of prescriptions for ciprofloxacin (40% increase) and doxycycline (30% increase) compared to the same time a year earlier.

SARS outbreak in Toronto, 2003

Ninety-seven percent of Toronto residents and 93% of Canadian residents surveyed during the SARS outbreak reported they would agree to be quarantined if exposed to SARS. Twenty-four percent of Toronto residents who were required to be quarantined or had a family member or friend quarantined due to SARS reported that it was a major problem while 51% said that being quarantined was a minor problem. Emotional difficulty from being quarantined was the most common major problem reported.

Psychological Consequences of Events Measured in First Responders

Bombing of Murrah Federal Building Oklahoma City, April 1995

Thirteen percent of 181 male firefighters and rescue workers who responded to the bombing met criteria for PTSD three years following the disaster. High rates of alcohol disorder (24% following disaster; 47% lifetime prevalence) were observed in male firefighters and rescue workers who responded to the bombing, but virtually no new cases occurred after the bombing.

Terrorist attacks on World Trade Center (WTC) and Pentagon, September 2001

In reports discussing the mental health response to the Pentagon attacks, authors cited anecdotal reports of the emotional consequences of recovering bodies, pulling victims from the scene, and going through the rubble and remains. The authors also noted that workers reported sleeping difficulty, stress, and anxiety during their mission as well as in the aftermath. Although these symptoms were not clinically assessed and empirically documented, they were widely cited in reports and articles.

In a mental health needs assessment for New York State conducted one month following the attacks, researchers estimated that approximately 24% of rescue workers would meet criteria for PTSD and require treatment.

SARS outbreak in Toronto, 2003

One month following the first SARS case, retrospective interviews indicated that the prominent reactions among hospital workers were fear, anxiety, anger, frustration, fatigue, insomnia, irritability, and decreased appetite. Anxiety worsened when isolation procedures changed, staff entered quarantine or personal treatment, staff developed fevers, or staff were admitted with unclear source of infection. Many staff were conflicted with their professional responsibility as health care providers and feeling fearful and guilty about potentially transmitting the SARS to their loved ones. Nurses on the SARS unit did not refuse assignments, but some professional and nonprofessional general medical floor staff refused to care for patients with SARS.

Twenty-nine percent of respondents in a hospital survey reported the SARS outbreak caused them to experience emotional distress which was more than double that of the general population. Nurses and allied health care professionals had significantly greater emotional distress than did doctors and staff not working with SARS patients directly.

Psychological Consequences Measured in Vulnerable Populations

Bombing of Murrah Federal Building Oklahoma City, April 1995

Almost 20% of sixth-grade students in a Town approximately 100 miles from Oklahoma City reported bomb related difficulty functioning two years after the attack.

Clinical needs assessment conducted with sixth-to-twelfth grade students seven weeks after the bombing found that posttraumatic stress symptoms were significantly higher in females, children who knew someone injured or killed and children who reported watching more bombing-related television news coverage.

Seven weeks following the attack, a majority of children in the Oklahoma City area reported fear that a friend or someone in their family would be hurt and reported being nervous or afraid; 40% felt helpless. Fear, arousal, and dissociation at the time of the bombing was the strongest predictor of posttraumatic stress symptoms, more important than physical exposure, relationship to direct victims, bomb-related television viewing, and continued safety concerns.

Terrorist attacks on World Trade Center (WTC) and Pentagon, September 2001.

Three to five days after the attack, almost one-third of children ages 5 to 18 in households in a national survey had emotional stress symptoms, and 42% discussed safety with their parents.

One to two months after the attacks, parents in 48% of households with children reported that at least one child in the household was upset by the attacks on Sept. 11.

Twenty percent of these children had trouble sleeping; 30% were irritable, grouchy, or easily upset; and 27% were described as fearing separation from their parents.

Twenty-two percent of parents living in lower Manhattan surveyed five to eight weeks after the attacks reported that their children had received some form of counseling related to their experiences after the WTC attack. More than half of the counseling was delivered in schools.

Within two months following the attacks, an increased demand for drug and alcohol treatment was found among individuals with preexisting psychological problems in 13 states and 4 major cities.

Significant increase was reported in children's visits to behavioral health clinics for acute and posttraumatic stress reactions and other anxiety disorders at military treatment facilities within 50 miles of Washington, D.C., for five months after September 11 compared with same period in the previous two years.

Survey of drug users conducted between one and four months following the attack found significant anxiety, anger and sadness; increase in drug use was as common as reductions in drug use.

SARS outbreak in Toronto, 2003

It is significant to note that there is no Research data or any information related to special populations and their psychological responses to the SARS outbreak. It might be assumed that information about disease outbreaks is being withheld from children or that there is little to no attention being placed on the behavioral health reactions of this population.

Summary

Terrorist attacks have both direct and/or primary victims but they also have secondary or indirect victims as well. It is essential that behavioral health professionals working to help primary victims and secondary victims recognize the myriad of emotional, cognitive, behavioral and physiological responses these various victim groups will experience. The unique aspects of terrorist activities and the reactions to those events are potentially too numerous to identify. As terrorist activities continue throughout the world researchers and responders are continuing to identify the psychological defenses that individuals use in order to adjust to and cope with the permanent changes that occur in an individual's life as a result of these events. As researchers continue to discover how and why people react as they do in a traumatic situation they have a better understanding of where, when and what to do in order to help victims change and adjust. Victims do not necessarily progress into psychological turmoil, confusion and personal adjustment failure. Professionals, first responders and other healthy supports can help alleviate and/or reduce emotional turmoil and help keep

individual victims from developing debilitating symptoms. The one important aspect that I suggest all professionals keep in mind as they work with victims or attempt to adjust as a result of their own exposure to crisis events is the following: “It is evident and clearly understood that everyone who is involved in a crisis and/or traumatic event will be permanently changed by the event however, that person does not have to necessarily be permanently damaged by that event”.

Note. Information for this section was gathered from the Milbank Quarterly (www.milbank.org/quarterly.html), and The Academy of Experts in Traumatic Stress (www.traumatic-stress.org) and written by Roger P. Buck, Ph.D., Clinical Systems Manager, Alcohol Drug and Mental Health Services Board serving Athens, Hocking and Vinton Counties, Ohio

Part 3

Long Term Psychological Response and Post Traumatic Stress Disorder

Trauma and the Development of PTSD

How do we define psychological trauma?

“An event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others,” according to the American Psychiatric Association. (DSM IV-TR, p. 424)

Experiences like war, terrorist attacks, rape, sexual abuse, accidents, domestic violence, manmade disasters and torture are some examples, which can lead to psychological trauma.

Trauma is much more common than once realized. Fifty to ninety percent of all adults and children are exposed to a psychologically traumatic event in their lifetime. (National Center for PTSD website)

Approximately sixty seven percent of trauma survivors will have some type of lasting psychosocial impairment as a result of their experience, including Post Traumatic Stress Disorder, depression, generalized anxiety disorder, panic, phobias or substance abuse. (National Center for PTSD website)

What is Post Traumatic Stress Disorder?

“During a trauma, survivors often become overwhelmed with fear. Soon after the traumatic experience, they may re-experience the trauma mentally and physically. Because this can be un-comfortable and sometimes painful, survivors tend to avoid reminders of the trauma. These symptoms create a problem that is called posttraumatic stress disorder, PTSD. PTSD is a specific set of problems resulting from a traumatic experience and is recognized by medical and mental health professionals.” (National Center for PTSD website)

PTSD is an anxiety disorder that can develop after exposure to a terrifying event or an ordeal in which grave physical harm occurred or was threatened.

Symptoms include a re-experiencing of the initial traumatic event in the form of flashbacks, intrusive thoughts, memories and nightmares. This is particularly evident when the person is exposed to triggers, reminders of the initial trauma, or on anniversary dates of the event.

Individuals with PTSD also experience emotional numbness and may attempt to avoid reminders of their ordeal. They may suffer from sleep

problems, depression, anxiety, intense guilt, irritability and anger outbursts. They may also be dually diagnosed with substance abuse disorders. Some trauma survivors attempt to mask their emotional pain and treat their PTSD symptoms by abusing alcohol and/or drugs in an attempt to self-medicate.

PTSD is only diagnosed if the symptoms have lasted for one month or longer. Prior to that, the trauma survivor may be diagnosed with Acute Stress Disorder, (ASD). Acute Stress Disorder parallels PTSD in terms of its initial symptoms. However, it is only used to diagnose individuals who are manifesting symptoms up to one month after the traumatic event. If symptoms continue after that time, the diagnosis must be switched to PTSD.

Re-experiencing symptoms of trauma in PTSD

Some of the ways in which trauma survivors commonly re-experience the traumatic event include the following:

- Having upsetting memories, images or thoughts about the event
- Feeling as if the trauma is happening to them again (Physiological experiences with flashbacks),
- Having bad dreams and nightmares
- Getting upset when reminded about the traumatic event (by something the person sees, hears, feels, smells or tastes)
- Feeling anxiety, fear or danger once more.
- Having feelings of anger or aggression and feeling the need to defend oneself
- Trouble controlling emotions because reminders lead to sudden anxiety, anger or upset
- Trouble concentrating, thinking clearly and having memory problems
- Trouble falling or staying asleep
- Feeling agitated and constantly on the lookout for danger
- Feeling shaky and sweaty

- Getting very startled by loud noises or by something or someone coming up on you from behind when you don't expect it (hyper-vigilance).
- Having your heart pound or having trouble breathing

Avoidance symptoms of PTSD

- Actively avoiding trauma-related thoughts and memories
- Avoiding conversations, places, activities or people that might remind you of the trauma
- Trouble remembering important parts of what happened during the trauma
- Shutting down emotionally or feeling emotionally numb
- Trouble having loving feelings or feeling any strong emotions
- Finding that things around you seem strange or unreal
- Feeling strange
- Feeling disconnected from the world around you and things that happen to you
- Avoiding situations that might make you have a strong emotional reaction
- Feeling weird physical sensations
- Feeling physically numb
- Not feeling pain or other sensations
- Losing interest in things you used to enjoy doing

Secondary and associated post-traumatic symptoms

Secondary and associated PTSD symptoms include the following:

- Depression can develop when a person has losses connected with the trauma or when a person avoids other people and becomes isolated.

- Despair and hopelessness can result when a person is afraid that he or she will never feel better again.
- Survivors may lose important beliefs when a traumatic event makes them lose faith that the world is a good and safe place.
- Aggressive behavior towards oneself or others resulting from the inability to control PTSD symptoms.
- Self blame, guilt and shame may arise when PTSD symptoms make it difficult to fulfill current responsibilities. Self blame causes a lot of distress and can prevent a person from reaching out for help. Sometimes society blames the victim of a trauma. Unfortunately, this may reinforce the survivor's hesitation to seek help.
- People who have experienced traumas may have problems in relationships. This is because they often have a hard time feeling close to or trusting people. This is especially likely when the trauma was caused or worsened by others.
- Trauma survivors may feel detached or disconnected from others because they have difficulty feeling or expressing positive feelings. After traumas, people can become overwhelmed by their problems, become numb and stop putting energy into relationships with friends and family.
- Survivors may get into arguments and fights with other people because of the angry or aggressive feelings that are common after a trauma. Also, a person's constant avoidance of social situations, such as family gatherings, may create hurt feelings or animosity in the survivor's relationships.
- Less interest or participation in things the person used to like to do may result from depression following a trauma. When a person spends less time doing fun things and being with people, he or she has fewer chances to feel good and have pleasant interactions.
- Social isolation can occur because of social withdrawal and a lack of trust in others. This often leads to the loss of support, friendships, and intimacy while increasing fears and worries.

- Survivors may have problems with identity when PTSD symptoms change important aspects of a person's life such as relationships or whether the person can do their work well.
- Feeling permanently damaged can result when trauma symptoms do not go away and a person does not believe they will get better.
- Survivors may develop problems with self-esteem because PTSD symptoms make it difficult for persons to feel good about themselves. Sometimes, because of how they behaved at the time of the trauma, survivors feel that they are bad, worthless, stupid, incompetent, evil, etc.
- Physical health symptoms and problems can happen because of long periods of physical agitation or arousal from anxiety.
- Survivors may turn to alcohol and drug abuse when they want to avoid the bad feelings that come with PTSD symptoms, but this actually leads to more problems.

What is Complex PTSD?

PTSD is an accurate diagnosis to depict what happens to an individual when faced with a short-lived trauma, such as a car accident, or natural disaster. However, research by Dr. Judith Herman of Harvard University has suggested that a new diagnosis, called Complex PTSD, needs to be added to the DSM-IV-TR to accurately describe the experiences of individuals who have undergone chronic trauma. Chronic traumas continue for months or years rather than one-time. Complex PTSD has also been referred to as the "Disorder of Extreme Stress."

Complex PTSD is often found in individuals who have been exposed to prolonged traumatic circumstances, such as childhood sexual abuse. (National Center for PTSD website)

"Clinicians and researchers have found the current PTSD diagnosis does not capture the severe psychological harm that occurs with such prolonged, repeated trauma. For example, ordinary, healthy people who experience chronic trauma can experience changes in their self-concept and the way they adapt to stressful events." (National Center for Post Traumatic Stress Disorder website)

Developmental research indicates that many brain and hormonal changes may occur as a result of early, prolonged trauma. These changes contribute to difficulties with memory, learning and regulating impulses and emotions. Combined with a disruptive, abusive home environment that does not foster healthy interactions, these brain and hormonal changes may contribute to severe behavioral difficulties such as aggression, eating disorders, self-mutilation and alcohol/drug abuse. It may also cause difficulties in emotional regulation such as intense depression, panic or rage and mental difficulties such as extremely scattered thoughts, dissociation and amnesia.

In cases of chronic trauma, the individual is generally held in a state of captivity under the control of the perpetrator and is unable to flee. Some examples of this include individuals held in concentration camps, prisoner of war camps, prostitution brothels, cults, child sexual abuse, organized child exploitation rings, ritualistic abuse, long term domestic violence and long term physical abuse.

In order for someone to be diagnosed with complex PTSD, they must have been under the total control of another person for a prolonged period, months to years.

The symptoms of Complex PTSD include the following:

Alterations in emotional regulation

This includes symptoms of persistent sadness, suicidal thoughts, explosive anger or inhibited anger.

Alterations in consciousness

Forgetting traumatic events, reliving traumatic events, or having episodes in which one feels detached from one's mental processes or body.

Alterations in self-perception

Including a sense of helplessness, shame, guilt, stigma and a sense of being completely different than other human beings.

Alterations in the perception of the perpetrator

Attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge.

Alterations in relations with others

Including isolation, distrust, or a repeated search for a rescuer.

Alterations in one's system of meanings

Loss of a sustaining faith or a sense of hopelessness and despair.

“Survivors of chronic trauma may use alcohol and substance abuse as a way to numb feelings. They may engage in self-mutilation or other forms of self-harm for the same reason. They may avoid thinking or talking about trauma-related topics because the feelings associated with the trauma overwhelm them.” (National Center for PTSD website)

There has been a tendency, even amongst some medical professionals, to blame victims of chronic trauma. They have been labeled by some as being “weak in character” because of their chronic victimization and often are misdiagnosed as borderline, dependent or masochistic personality disorder. However, these survivors are actually being unjustly blamed for merely experiencing the symptoms of chronic trauma. Researchers hope that the new diagnosis will prevent clinicians and others from blaming survivors for their symptoms.

Facts about PTSD

Approximately 3.6 percent of U.S. adults between the ages of 18 and 54, 5.2 million people, have PTSD in any given year. (National Institute of Mental Health, NIMH, website)

About 8 percent of individuals will be diagnosed with the condition in their lifetime. (National Center for PTSD website).

No one can completely protect him/herself from traumatic experiences. Traumas happen to many competent, healthy, strong, good people. It is not some sort of personal weakness or character flaw to be overcome with feelings of fear, helplessness or horror after a traumatic event.

Almost 30 percent of war veterans have PTSD. This is something we, as mental health professionals, need to seriously consider given the fact that our country is currently at war in Iraq. Many of these soldiers will return home with debilitating cases of PTSD.

But this is not to say these men are without hope and fatally flawed for life. A colleague of mine once said, “These men will come home permanently

changed, but not necessarily permanently damaged,” (Dr. Roger Buck, PhD, 317 Board of Athens, Hocking and Vinton Counties).

PTSD can develop at any age, including in childhood. Symptoms may begin immediately or usually within 3 months of the initial traumatic event, although in some cases they will not surface until years later. Once PTSD develops, the duration of the illness varies. It may last for six months or a lifetime. (National Institute of Mental Health, (NIMH), website)

PTSD is most likely to occur in individuals who have suffered abuse as children or those who have endured other prior traumatic events.

Being diagnosed with PTSD increases the likelihood that the individual may later struggle with alcohol or drug abuse problems.

More than 90 percent of individuals with severe mental illness have reported being exposed to at least one traumatic event in their lifetime.

Trauma survivors need to know first and foremost that they are not crazy. The common effects of trauma may lead them to believe so but these symptoms are actually an indication that the mind is coping effectively and appropriately. The symptoms of PTSD can be compared to the warning lights in the dashboard of your vehicle. They alert you to the fact that something is wrong that needs further examination.

PTSD in children and adolescents

Millions of children are exposed to traumatic events every year. More than 30 percent of them will go on to develop PTSD.

The types of trauma kids are exposed to include physical and sexual abuse, accidental or violent death of a loved one, violence in families and communities, natural disasters and terrorism, life threatening illnesses, injuries and distressing medical procedures, homelessness, refugee and war zone trauma. (The National Child Traumatic Stress Network, NCTSN)

Enduring traumatic stress in childhood impacts the normal development of the brain, interferes with children’s emotions and their ability to regulate them, upsets normal bodily functions, introduces a lifetime of insecurities about safety and protection. It also interferes with their basic educational skills, dramatically changes the child’s emerging personality, introduces problems with aggression and inhibition, leads to ongoing difficulties with

sleep, self-confidence, startle reactions and irritability and impairs the child's growing sense of trust and self-confidence. (NCTSN)

Some of the reactions to traumatic stress in adolescence include drops in academic performance and motivation for learning, abrupt changes in close relationships, withdrawing from normal healthy activities, reckless and high-risk sexual behaviors, difficulties in moral decision making, gang participation, self-mutilation, eating disorders and substance abuse. (NCTSN).

Therapeutic approaches commonly used in the treatment of PTSD

Cognitive-behavioral therapy—involves working with cognition to change emotions, thoughts and behaviors.

Exposure therapy—a form of CBT which uses carefully repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma.

Pharmacotherapy—medication to reduce symptoms of anxiety, depression and insomnia that often accompany the disorder.

Eye Movement Desensitization and Reprocessing, (EMDR)—a relatively new treatment that involves exposure therapy and cognitive-behavior therapy combined with techniques, eye movements, hand taps, sounds, that create an alternation of attention back and forth across the person's midline.

Group Treatment—allows trauma survivors to share their story with others who are able to offer understanding and support. It may help to foster a sense of trust again in trauma survivors.

Brief psychodynamic psychotherapy—focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. The survivor, by retelling their story in a safe, supportive environment, achieves a greater sense of self-esteem, develops effective ways of thinking and coping, and learns to deal more successfully with intense emotions.

What are some of the latest research developments regarding PTSD?

The National Institute for Mental Health and Veteran's Administration are presently investigating basic, clinical and genetic studies of PTSD.

"NIMH has access to a special funding source called RAPID grants, which allows researchers to immediately visit disaster sites such as plane crashes or hurricanes, to study the acute effects of the event and the effectiveness of early intervention." (NIMH website)

Other research studies in humans and animals are pinpointing specific areas of the brain and the circuits involved in anxiety and fear, which are integral to understanding PTSD and other anxiety disorders.

Fear causes an automatic, rapid, protective response in many systems of the body. This fear response has been found to originate in the brain's amygdala. (NIMH website)

Brain imaging studies have demonstrated that the hippocampus, a part of the brain critical to memory and emotion, appears to be different in individuals with PTSD. Scientists are investigating whether this is related to short-term memory problems associated with PTSD. Changes in the hippocampus are thought to be behind the intrusive memories and flashbacks that occur in PTSD clients. (NIMH website)

Individuals with PTSD have been found to have shortfalls of key hormones involved in the stress response including lowered levels of cortisol and higher levels of epinephrine and norepinephrine than normal.

Scientists have discovered that individuals with PTSD produce higher levels of the body's natural opiates. These opiates are released when the people are in danger and they temporarily mask pain. However, those with PTSD continue to release these increased levels of opiates even after the danger has passed, which may help to explain why trauma survivors struggle with blunted emotions.

Note: Information for this section was gathered from The American Academy of Experts in Traumatic Stress (www.traumatic-stress.org) & (www.ATSM.org) and from the National Center for PTSD (www.ncptsd.va.gov), National Child Traumatic Stress Network www.NCTSNet.org, American Academy of Child & Adolescent Psychiatry, American Psychological Association, Substance Abuse and Mental Health Services Administration and written by Lisa Woznick, Graduate Student, Ohio University, Athens, Ohio

Long Term Mourning and Grief:

Long-term grief and mourning

The transition time from short term grief and mourning to the long term is not specific. While the feelings of grief and mourning may only subside, there is a point where such emotions can cause interruptions in the activities of daily living. When individuals suffer from prolonged, delayed or unresolved emotions over a long period of time, they may suffer from abnormal grieving. According to the Northeast Medical Center, grief becomes abnormal when thoughts of suicide enter the picture or if psychotic symptoms exist such as losing touch with reality.

Symptoms of abnormal grieving include preoccupation with the deceased, pain in the same area of their body as the deceased had experienced, getting upset over memories, hearing the voice of the deceased, seeing the person who died or feeling stunned or dazed. Other symptoms include intense identification with the dead individual, belief that they too will die in the same manner as the deceased and a continual insistence that the deceased is still alive. Risk factors that may impact/cause prolonged grieving include lower socioeconomic status, individual characteristics, relationship quality, circumstances of death and other social context. Prolonged grieving makes individuals more susceptible to other disorders such as the onset or reoccurrence of Major Depressive Disorder, Panic disorders or other anxiety disorders, increased vulnerability to PTSD, drug and alcohol abuse, suicidal thoughts as well as the onset or worsening of health problems including cardiovascular disease and immunologic dysfunction. Treatment for this type of disorder can be found with grief support groups and grief counseling.

The information for this section (Long Term Mourning and Grief) was originally published through the North Memorial Medical Center, Robbinsdale, MN. and compiled by Nilu Ekanayake, Student, Ohio University, Athens, Ohio.

Part IV

Other Resources

Additional Web Based Resources

Organizational Structure and Response to Crisis and Disaster

Substance Abuse and Mental Health Services Administration

Mental Health Response to Mass Violence and Terrorism

www.mentalhealth.samhsa.gov/publications/allpubs/SMA-3959/default.asp

Disaster Epidemiology

www.cdc.gov/nceh/hsb/disaster/default.htm

Emergency Preparedness and Response

www.bt.cdc.gov

Facts about Anthrax

www.bt.cdc.gov/Agent/Anthrax/Anthrax.asp

U.S. National Library of Medicine

www.nlm.nih.gov/medlineplus.biodefenseandbioterrorism.html

U.S. Postal Service

www.usps.com/news/2001/press/serviceupdates.htm

American Psychological Association

www.apa.org/practice/drindex.html

American Red Cross Disaster Services

www.redcross.org/services/disaster

American Public Health Association

www.apha.org/public_health/state.htm

Links to state and local health departments

Food and Drug Administration
www.fda.gov/oca/sthealth.htm

Early Psychological Responses to Crisis and Disasters

Stress Reactions to Crisis and Disaster

National Center for Post Traumatic Stress Disorder

Phases of Traumatic Stress Reactions in a Disaster

www.ncptsd.va.gov/facts/disasters/fs_phases_disaster.html

Early Interventions for Trauma: Current Status and Future Directions

www.ncptsd.va.gov/facts/disasters/fs_earlyint_disaster.html

Critical Incident Stress Debriefing (CISD): Value and Limitations in Disaster Response

www.ncptsd.va.gov/publications/cq/v4/n2/hiley-yo.html

Treatment of Post-Traumatic Stress Disorder

www.ncptsd.va.gov/facts/treatment/fs_treatment.html

Mental Health Matters

www.mental-health-matters.com/disorders/print.php?disID=1

New York State Office of Mental Health

Disaster mental Health Training

www.omh.state.ny.us/omhweb/crisis/crisiscounseling10.html

Crisis Counseling Guide

www.omh.state.ny.us/omhweb/crisis/crisiscounseling9.html

Special Populations and At-risk Groups

Child Trauma Academy

www.childtrauma.org/ctamaterials/effects.asp

Natural Hazards Center

Study of children's response to exposure to traumatic events

www.colorado.edu/hazards/qr/qr103.html

Child Trauma Academy

www.childtrauma.org

The Barr-Harris Children's Grief Center

http://www.barrharris.org/Hurricane_Katrina.html

The National Child Traumatic Stress Network

http://www.ncatsnet.org/ncats/nav.do?pid=hom_main

The American Academy of Child & Adolescent Psychiatry Helping Children

<http://www.aacap.org/publications/DisasterResponse/>

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The Center for Traumatic Stress in Children and Adolescents

<http://www.pittsburghchildtrauma.com/>

National Association of School Psychologists

<http://www.nasponline.org/>

National Association for Education of Young Children

<http://www.naeyc.org/families/disaster.asp>

FEMA for Kids

<http://www.fema.gov/kids/>

National Center for Child Traumatic Stress: Terrorism and Disaster Branch

http://www.ncptsd.va.gov/pfa/Pre_School_Children.pdf

Coping Strategies

Crisis Counseling

Coping and Surviving Violent and Traumatic Events

www.crisiscounseling.org/TraumaLoss/CopingWithTrauma.htm

Media Awareness Network

Helping Kids Cope with Media Coverage of War and Traumatic Events

www.media-awareness.ca/english/resources/tip_sheets/helping_kids_cope.cfm

Centers for Disease Control

Information for Health Professionals: Coping with a Traumatic Event

www.bt.cdc.gov/masstrauma/copingpro.asp

Los Angeles County Department of Mental Health

Coping Strategies for Families

www.trauma-pages.com/famcope.htm

Searching for Coping Alternatives: A Challenge for Treatment

www.rohlof.nl/coping.htm

Terrorism and Bio-terrorism

When a Terrorist Act Occurs

www.sidran.org/sept11terror.html

National Crime Victims Research and Treatment Center

Psychological Trauma from Terrorist Attacks and Other Mass Casualty Incidents

www.musc.edu/cvc/MassDisasters.PDF

National Youth Violence Prevention Resource Center

Responding to Terrorism and War

www.safeyouth.org/scripts/terrorism/prosmental.asp

NOVA Online - - Bio-terror

Contains information on the eight lethal biological agents that may be used in biowarfare.

www.pbs.org/nova/bioterror/

Anthrax Information

www.bt.cdc.gov/

Draft for Comment, 4/17/2006

Handling Anxiety in the Face of the Anthrax Scare

<http://helping.apa.org/daily/anthrax.html>

Helping Students Heal: How Teachers can help

<http://www.msnbc.com/news/628001.asp#BODY>

Long Term Psychological Response and Post Traumatic Stress Disorder

New York Online Access to Health

www.noah-health.org/en/mental/disorders/ptsd/index.html

Psychiatric Times

Changes in the Concept of PTSD and Trauma

www.psychiatrictimes.com/p030435.html

American Psychological Association

The Effects of Trauma Do Not Have to Last a Lifetime

www.psychologymatters.org/ptsd.html

American Group Psychotherapy Association

Group Interventions for Treatment of Psychological Trauma

www.agpa.com

National Crime Victims Research and Treatment Center

Psychological Trauma from Terrorist Attacks and Other Mass Casualty Incidents

www.musc.edu/cvc/MassDisasters.PDF

The Child's Loss: Death, Grief, and Mourning

http://teacher.scholastic.com/professional/bruceperry/child_loss.htm

Estronaut

Women and Grief

www.estronaut.com/a/women_grief_mourning.htm

Rocky Mountain Region Disaster Mental Health Institute

Crisis Intervention Training for Disaster Workers

Draft for Comment, 4/17/2006

www.angelfire.com/biz/odochartaigh/crisis.html

Ohio Department of Mental Health-Office of Children's Services and Prevention

www.mh.state.oh.us/kids/kidsnewsletter/mayjune2005.pdf

National Technical Assistance Center for State Mental Health Planning (NTAC)

www.naspmhpd.org/NTAC_technical_assistance.cfm

National Association of State Mental Health Program Directors Under Contract with Centers for Mental Health Services (NASMHPD)

www.nasmhpd.org/index.cfm

Substance Abuse and Mental Health Service Administration (SAMHSA)

www.samhsa.gov/index.aspx

U.S. Department of Health and Human Services (DHHS)

www.hhs.gov

National Center for Post Traumatic Stress Disorder

Effects of Traumatic Stress in a Disaster Situation

www.ncptsd.va.gov/facts/disasters/fs_effects_disaster.html

PTSD and Physical Health

www.ncptsd.va.gov/facts/specific/fs_physical_health.html

Avoidance

www.ncptsd.va.gov/facts/problems/fs_avoidance.html

Anger and Trauma

www.ncptsd.va.gov/facts/specific/fs_anger.html

Nightmares

www.ncptsd.va.gov/facts/specific/fs_nightmares.html

Risk Factors for Adverse Outcomes in Natural and Human Caused
Disasters: A Review of the Empirical Literature

www.ncptsd.va.gov/facts/disasters/fs_riskfactors.html

Disasters and Substance Abuse or Dependence

www.ncptsd.va.gov/facts/disasters/fs_self_care_disaster.html

Effects of Traumatic Experiences

www.ncptsd.va.gov/facts/general/fs_effecs.html

Self-harm

www.ncptsd.va.gov/facts/problems/fs_self_harm.html

Coping with Traumatic Stress Reactions

www.ncptsd.org/war/fs_coping.html

Coping with PTSD and Recommended Lifestyle Changes for PTSD Patients

http://www.ncptsd.va.gov/facts/treatment/fs_coping.html

Crisis Counseling Guide-Defining Disaster

www.omh.state.ny.us/omhweb/crisis/crisiscounseling2.html

Sidran Institute

Helping a Child Manage Fears After a Traumatic Event

www.sidran.org/sept11fears.html

Re-traumatizing the Victim

www.sidran.org/anna.html

What is Psychological Trauma?

www.sidran.org/whatistrauma.html

National Child Traumatic Stress Network

Understanding Child Traumatic Stress

www.nctsnet.org/nccts/nav.do?pid=ctr_gnrl

Draft for Comment, 4/17/2006

Traumatic Stress Points-Winter 2004
Behavioral Health Following Mass Violence
www.istss.org/publications/TS/Winter04?behavioral.htm

The American Academy of Experts in Traumatic Stress, Inc.
National Mental Health Association
www.aaets.org

Coping with Loss
www.nmha.org/reassurance/coping.cfm

Understanding Grief and Loss in Times of War and Disaster
www.selfgrowth.com/articles.Maizler8.html

Focus Adolescent Services
Grief and Bereavement
www.focusas.com/Grief.html

For the Healthcare Professional: When Disaster Strikes
Understanding and Managing Normal Reactions of Traumatic Shock and Grief
www.dmhas.state.ct.us/trauma/strikes.pdf

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