# New York DMH **Responder**

Office of **Emergency Preparedness and Response**          Office of **Health Emergency Preparedness**

## Welcome

Welcome to the Fall 2012 issue of the New York DMH Responder, our quarterly newsletter for the Disaster Mental Health Community. This issue focuses on Mass Casualty Incidents (MCI) and assisting survivors with traumatic loss. Anyone who experiences the death of someone they were closely attached to know that the impact is not solely emotional; it also involves major and often painful adjustments to roles and routines as they reshape their life around the absent loved one. Regardless of your professional role in the response to an MCI you may be able to provide a degree of comfort to the newly bereaved, compensating at least partially for their inability to turn to natural support systems in the disrupted post-disaster environment.

The Research Brief describes a "Dual Process Model of Coping with Bereavement" which may be helpful to consider as you address people who have recently experienced a death in a mass casualty incident or other crises.

As always, your feedback and suggestions for topics to cover in future issues are welcome. Please email any comments to Judith LeComb at prepedap@health.state.ny.us or Steven Moskowitz at Steven.Moskowitz@omh.ny.gov.

## Mass Casualty Incident Overview

Mass casualty incidents (MCIs) – events that cause more injuries, illness, and/or fatalities than local resources can address – present very specific response needs, both logistically and emotionally. The following is a brief overview of the characteristics of MCIs that may influence mental health needs among both survivors and responders; additional detail as well as guidance on assisting those impacted will be presented in the Department of Health training and webcast on November 30, 2012, described on page 6.

### MCI Characteristics

This category of disaster includes (but certainly isn't limited to) mass casualty transportation accidents, major fires, structural collapses, terrorist attacks, hazmat and industrial incidents with injuries or fatalities, and biomedical events like disease outbreaks. As this list indicates, MCIs can be natural or human-caused; accidental or intentional. What all have in common is that by definition they involve human pain and suffering, so the traumatic impact on survivors is likely to be intense, as are the stressors on those who try to help.

Beyond the specific type of event, certain characteristics are likely to influence mental health reactions, including the following:

**Size**
Event scope, intensity, and duration are all generally large during MCIs, which are also likely to cause multiple types of damage including injuries and deaths, economic losses of property and jobs, and disruption of

## Mass Casualty Incident Overview, *continued*

schools and businesses. This means that survivors' recovery environment is severely disrupted, depriving them of sources of normalcy and support they might rely on after more individual traumatic experiences. This kind of psychosocial resource loss is an identified risk factor for negative psychological reactions.

### Timing

Often MCIs have a sudden onset with little advance warning, which means survivors had no opportunity to prepare and may be stunned or overwhelmed by their sudden experience, and responders may need to scramble to organize the response. Other MCIs may expand over time, like pandemic flu outbreaks, causing ongoing fear and anxiety as people wonder if they or their loved ones are going to be affected. It may be difficult to recognize when an event is truly over, and it's very hard for people to begin to recover until they feel safe again.

> *Just as there is no loss of basic energy in the universe, so no thought or action is without its effects, present or ultimate, seen or unseen, felt or unfelt.*
>
> – *Norman Cousins*
> *(American author, 1915-1990)*

### Biomedical Impact

The nature of illness or injury the MCI causes is associated with psychological distress as well as physical suffering. In a major earthquake, terrorist attack, or other violent event there may be an overwhelming number of people who need treatment for crush injuries, thermal or chemical burns, or other wounds, followed by a need for amputations, risk of infection, and other secondary problems. Severe pain may go untreated. If people are ill, their experience will depend on the disease's communicability and lethality, and whether needed medical care is available. And if victims have died, the condition of the body may be a source of great distress for their loved ones, both because it may suggest the deceased suffered terribly, and because having remains that are missing, destroyed, or fragmented can prevent survivors from carrying out comforting rituals (see the article on page 3 for more on this topic).

As this brief summary suggests, after MCIs there are likely to be high levels of shock, grief, and other emotions, as well as a spiritual impact on families, workers, and community – in other words, on everyone involved. In many cases lives and communities are irreversibly changed. For example, the small towns of Lockerbie, Scotland, and Clarence Center, NY, were permanently altered by the planes that crashed into homes there in 1988 and 2009, as were the loved ones of those who died on the planes, and the responders who came to help.

Compounding the expectable reactions of distress, sadness, anger, and the like that are common after any kind of traumatic experience, survivors of MCIs may still be coping with serious physical pain or illness, and/or with traumatic bereavement if a loved one was killed. And whether they were directly impacted or not, community members and responders also may experience significant fear and anxiety if long-term health effects are unclear, as well as the emotional trauma resulting from the gruesome sights and sounds they encountered during the event. Survival guilt may also be present for those who wonder why they lived while others didn't. Given their high profile, MCIs usually generate significant media interest and presence. While some survivors welcome the public acknowledgment of their suffering, this attention can be experienced as intrusive or sensation-seeking, and therefore distasteful and distressing.

MCIs' impact on responders is also likely to be more intense than routine emergencies or disasters without extensive casualties. Initially, MCIs are chaotic and confusing, with multiple response groups working in different capacities as they attempt to rescue survivors and recover remains. This presence of multiple stakeholders (some of whom may be competing with others) creates role ambiguity at the same time that it creates a need for teamwork and multi-agency coordination, and it heightens the need for security and law enforcement. Exposure to death may also be disturbing for responders, even if they have no personal connection to the deceased. In particular, it may be distressing for workers who are involved in body handling and/or who witness gruesome or bizarre scenes that may include dismemberment, decomposition, or other troubling images.

Helping people cope with these emotional reactions is every bit as important as addressing their physical needs, especially immediately after the event when the intense physiological stress response may lead people to take risky actions like failing to evacuate or entering unsafe areas to search for survivors. We hope you will participate in the full training on Nov. 30 to learn how you can best help others after mass casualty incidents.

# Talking to Survivors after Traumatic Loss

Since the defining characteristic of mass casualty incidents (MCIs) is the presence of multiple fatalities or injuries, responders to these events are likely to find themselves talking to people in the raw state of early bereavement. This state is usually intensely painful for survivors, even following expected deaths after serious illness or those of elderly people whose passing is seen as following the natural course of life. Not surprisingly, these emotions are heightened when the loss is due to an MCI or other unexpected event.

MCIs make it hard for everyone to distance themselves from thoughts about mortality due to the presence of mass casualties – and MCI deaths are traumatic by definition. These fatalities are perceived as untimely and unfair, and often intensify feelings of disbelief, shock, and anger. The risk of complicated grief and bereavement are increased. The need for funerals and memorials is magnified, but holding them may not be possible due to the physical state of remains or the general conditions in the community. The inability to follow traditional mourning rituals adds another level of despair for survivors who may feel distressed at not being able to provide this final service for the deceased, and who are deprived of the social support these rituals normally provide.

Regardless of your professional role in the response to an MCI, you may be able to provide a degree of comfort to the newly bereaved, compensating at least partially for their inability to turn to natural support systems in the disrupted post-disaster environment. Many people will simply want someone to talk to about the deceased person, so being a willing listener can provide a more valuable service than you might imagine. However, the act of listening to highly distressed people who are just beginning to confront their loss can be disturbing and may place you at risk for burnout or vicarious traumatization. It's important to prepare yourself to take on this role, and to pay attention to your own functioning and take a break or seek out someone to talk to yourself when needed.

Some points to keep in mind when talking with loved ones about a death in the family:

- Depending on when you speak with family members you'll see very different kinds of emotions. Although there are no clearly marked emotional phases in the aftermath of an MCI, early on you're more likely to see shock and disbelief, followed later by sadness and grief. The emotional phases in an MCI may be very different from other disasters: Don't expect to see a "honeymoon phase."

- Although feelings change over time, everyone copes and grieves differently. There are enormous cultural as well as gender differences, particularly in terms of expressiveness. Some responders react to extreme emotionality with fear and can wrongly assume that the individual is more disturbed than he or she is. Others believe that people must experience and express intense emotionality or they're not processing the death properly. Don't judge survivors if they show significantly more or less emotionality than you think is appropriate.

- The notion of "grief work," meaning that people need to go through a series of stages of mourning in order to successfully adjust to loss, doesn't fit all cultures. (See the Research Brief on page 4 for an alternative model of bereavement.)

The following are some questions concerning culture and ritual that you might consider asking when speaking with survivors. The nature of these questions will change depending on how long after the death you meet with family members, and the attitudes and culture of the survivors:

- According to your culture/religion, what happens after death?

- What are your religious or cultural beliefs about how to best mourn a death? Have you been able to fulfill these expectations?

- Are family members in agreement about handling the funeral or mourning rituals?

- Are there funeral or memorial rituals you'd like to perform but have not been able to accomplish?

Answers to these questions may point to tasks you can assist with or resources you can connect the survivor with, and talking through them can also help survivors structure their thoughts and begin to take planning into their own hands.

Finally, the following are some statements people often default to when they don't know what else to say after a death. Though well-meant, these platitudes provide little real comfort and should be avoided:

- "You'll be alright."
- "You must be strong for your children/parent."
- "This too shall pass."
- "I know how you feel."
- "It could have been worse."

# Research: Dual Process Model of Coping with Bereavement

(Stroebe et al., 1999)

If you've experienced the death of someone you were closely attached to, you know that the impact is not solely emotional; it also involves major and often painful adjustments to roles and routines as you reshape your life around the absent loved one. Stroebe and Schut (2010) describe these distinct adjustment tasks as a "Dual Process Model of Coping with Bereavement" which may be helpful to consider as you address people who have recently experienced a death in a mass casualty incident or other crises.

The model suggests that following the death of a loved one, survivors experience both a "loss-orientation" and a "restoration-orientation." Survivors are coping with grief and loss when they're focused on the tie or bond with the dead person, thinking or ruminating about life as it had been, looking at old photos, or yearning for or crying about the deceased. These are very painful feelings. If survivors are in this mode, it may be best to meet them where they are with a compassionate presence.

On the restoration side, survivors also have to cope with the reality of needing to deal with a large number of new changes and stressors. Some will have to take on much more responsibility for finances or childcare. Some will have to substantially reorganize and rearrange their lives, such as selling a house (or simultaneously dealing with the loss of a home if it was also destroyed in the disaster). Therefore, they may not only be intensely sad, they may also be worried and stressed about how their lives will change.

And the two processes often interact: When people are aware of and worried about anticipated changes they'll have to make in terms of roles, identities, and relationships on the restoration side, they may experience denial or avoidance on the loss-oriented side that limits coping and slows adjustment. For example, the distress of knowing one must adapt to a new identity as a widow(er) instead of a spouse may

cause the person to avoid the necessary letting go of the deceased rather than accepting the new role. This model captures the complexity of bereavement, acknowledging the major stress of life changes that occur while the client is experiencing the distress and pain of grieving.

**Source**
Stroebe, M., & Schut, H. (2010). The Dual Process Model of Coping with Bereavement: A decade on. *Omega: Journal of Death and Dying.* 61(4), 273-289.

## Talking to Survivors after Traumatic Loss, *continued*

Also avoid religious statements like "It was God's will" or "S/he is in Heaven/in a better place/with God now" unless you know for sure that they're in keeping with the person's values or beliefs. Instead, consider offering these statements of condolence and support:

"I'm so sorry for your loss."

"I can't imagine what you're feeling right now, but I will be here to help you however I can."

Further information on working with people after a traumatic loss will be included in the Mental Health Response to a Mass Casualty Incident training and webcast November 30, 2012 (see Training Update).

# American Red Cross DMH Response to a Small Plane Crash in Shirley, New York

(Suffolk County: Long Island Red Cross Chapter)

> *Note:*
> *Even when a disaster doesn't cause extensive casualties the impact on those who respond can be intense and can necessitate mental health support, as this case study demonstrates.*

A neighborhood in Shirley, NY, a small community close to the Atlantic coast on Long Island experienced a horrific event on a Sunday afternoon in August 2012. The working class neighborhood was familiar with the sound of small planes taking off and landing since they live within a mile of a local airport. This day was different as they heard a plane flying closer than usual and at a very low altitude. Several people watched as the small plane with a pilot and two passengers struggled to stay aloft. Unfortunately, serious malfunctions crippled the plane; it just missed the roof of a home and crashed into a large tree in the front yard and immediately burst into flames.

People in the neighborhood ran to the crash site, pulled garden hoses over to try to extinguish the fire, and attempted in vain to pull the pilot from the plane. The two passengers were ejected upon impact and were also in flames. Police arrived and urged the rescuers to stand back but they desperately continued their rescue efforts. Others helped to remove burned clothing from the two passengers who were conscious and awaiting ambulances. The pilot died at the crash scene and one of the passengers died at the hospital. The other passenger survived with serious burn injuries.

Red Cross received notification of the event the following day and deployed four Disaster Mental Health workers across two shifts that day. Having experienced the onslaught of the media on the day of the crash the neighborhood was reticent when they first saw us walking from door to door to connect with them. Within an hour, when word had obviously circulated that we were there to help, people starting waiting at the end of their driveway to take their turn speaking with us. Those people who were active in the rescue effort were quite traumatized: tearful, dazed, recurrent thoughts and visual images of the burning plane and passengers, difficulty sleeping, startled and fearful when planes came overhead and guilty about not having been more successful in the rescue.

The DMH response focused on making an empathic connection, active listening, trauma/resilience education (including expectations for gradual reduction in the acute stress reaction) and referrals to local mental health clinics. One of our Hispanic DMH volunteers spoke to several of the Spanish-speaking neighbors; an option welcomed by them when English was more of a struggle with the high level of distress. Toward the evening as other neighbors returned home from work a group formed with the DMH volunteers close to the crash site.

While much of the neighborhood was seen by DMH that day and they were very grateful the DMH team was concerned about their recovery. As a result a Red Cross Emergency Response Vehicle with water and snacks was sent with a DMH worker and Disaster Chaplain four days later in the evening. Again, the neighborhood gathered and DMH work continued. Informational brochures were distributed about recovery from psychological injury along with a disaster hotline number. Mental health referrals were more readily accepted as people recognized the persistence of their stress responses.

All disasters are disturbing for survivors and for responders. Some are worse than others. The extent of direct involvement of the neighborhood rescuers and the horrific events that they witnessed created an intensity of experience that resulted in very serious psychological injury. From the perspective of the very experienced DMH responders it was also a striking experience – both good and bad. The contribution of the DMH response to the recovery of the neighborhood was so clear. Yet, the narratives were difficult to hear and to forget and the level of anguish and distress of the rescuers was haunting. Secondary traumatization was no longer just a theoretical concept for the Red Cross DMH responders. However, the Red Cross routinely implements peer support after difficult DMH responses and this was very helpful after this one.

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# Disaster Mental Health Training

The upcoming DOH Disaster Mental Health is entitled "Mental Health Response to a Mass Casualty Incident" and is scheduled for November 30, 2012, 1-4pm. The goal of the training is to prepare DMH responders for the particular challenges and stressors, both personal and professional, involved in responding to Mass Casualty Incidents involving multiple deaths or injuries. Topics will include an overview of mass casualty incidents (event types and characteristics; likely response settings); early interventions for MCIs (Psychological First Aid, crisis intervention, talking with survivors about loss); longer term issues (memorials, anniversary reactions); and the need for self-care. This training will be provided in-person at SUNY New Paltz, Lecture Center, Room 100. For those individuals who are unable to attend in-person training a simultaneous webcast will be provided at the following locations:

Canton-Potsdam Hospital
Potsdam, NY*

Catskill Regional Medical Center
Harris, NY*

Corning Hospital
East Corning, NY*

Erie County Medical Center
Buffalo, NY

FF Thompson Hospital
Canandaigua, NY*

HANYS, Rensselaer, NY

Iroquois Healthcare Association
East Syracuse, NY*

Nassau Suffolk Hospital Council
Hauppauge, NY*

NorMet Hospital Association
Newburgh, NY*

Olean General Hospital
Olean, NY*

Rochester Regional Healthcare Association
Rochester, NY*

St. Elizabeth Medical Center
Utica, NY*

Samaritan Medical Center
Watertown, NY*

UHS Binghamton General Hospital
Binghamton, NY*

Westchester Medical Center
Valhalla, NY

*Limited space available

If you are interested in attending please register by clicking https://www.nylearnsph.com. Course name is OHEP-DMH-03 Mental Health Response to Mass Casualty Incident. If you have difficulty registering on the NYSDOH Learning Management System (LMS) please send an email to edlearn@health.state.ny.us or call 518 474-2893.