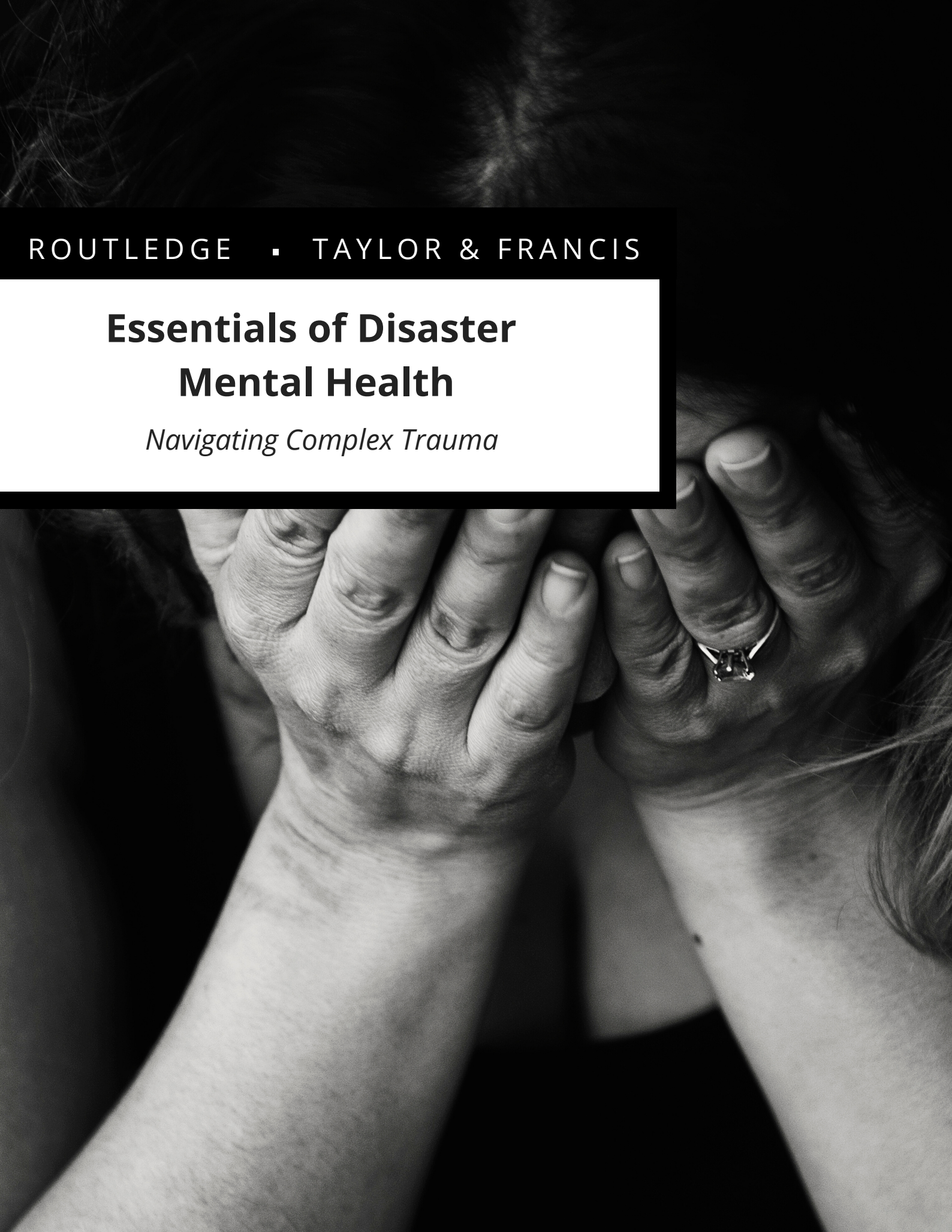

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Essentials of Disaster Mental Health

Navigating Complex Trauma

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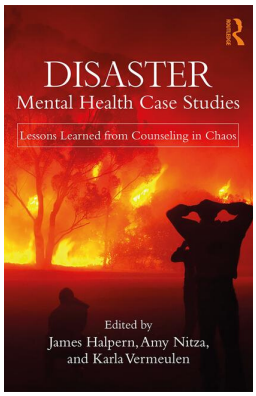

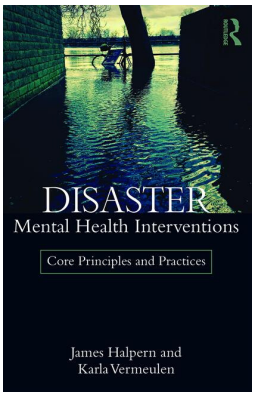

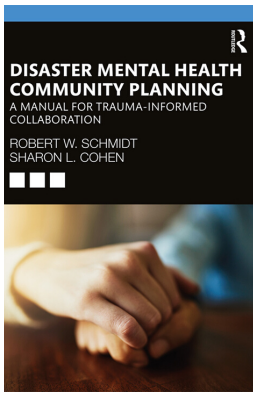

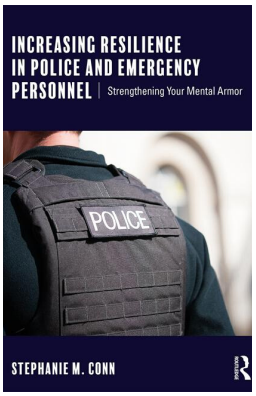

Description

This collection provides expert advice on the key principles of disaster mental health and how to deliver effective, trauma-specific treatment in both the short and long-term. It also includes a case study on the 2014 Ebola outbreak in Guinea.

2014 Ebola Outbreak in Guinea

Reine Lebel

I grew up in a house we shared with an emergency medical clinic in Quebec, where my father was a physician. I was trained in humanistic psychology and was inspired by the work of Médecins sans Frontières or Doctors without Borders (MSF) in providing humanitarian aid to people affected by war, epidemics, and natural disasters. I was drawn by their rebellious nature and by the freedom they claim; as described in their Charter, they provide health care to all, without discrimination based on race, religion, or political beliefs. I was also touched by their use of *témoignage* (testimony), their observations from the field that give voice to the most vulnerable people on this planet. I embraced the dream of joining their team and integrating a psychosocial component to medical emergency response.

Since 1999 I have deployed as a mental health officer (MHO) with MSF and other non-governmental organizations (NGOs) in contexts of war, natural catastrophes, and other critical incidents. Two experiences were turning points in my life as a humanitarian: volunteering during Hurricane Andrew in 1992 in Florida and participating with my daughter, a physiotherapist, in mobile clinics treating people suffering from polio in Malawi. My first Ebola deployment in Democratic Republic of Congo (DRC) prepared me to join the team during the outbreak in Guinea in Western Africa.

The Pre-Disaster Community

Prior to the Ebola outbreak, Guinea was a little-known country to most of the world. It is a land of surprising natural beauty, with its tiny villages and delightful population. The Gueckedou Prefecture is situated in the southernmost region and shares borders with Liberia, Sierra Leone, and Côte d'Ivoire. The area has three main ethnic groups, Guerzé, Toma, and Kissi, each with its own language. The country is approximately 85 percent Muslim, with the rest practicing Christianity or indigenous African religions. Around the turn of the last century, the region became a refuge

for those who fled the civil wars in Liberia and Sierra Leone; the population of the city of Gueckédou grew from 80,000 people in 1994 to 221,700 people less than a decade later.

Because of the density of the rainforest, political and social affiliations function on a small scale. Many people still live in small villages of around 100 to 200 people in mud huts open to a communal space where people gather; food is often shared from large communal bowls. The family compound accommodates large extended families and polygamous marriages.

Gold, diamonds, bauxite, and iron are valuable resources, yet the population lives in intense poverty. The fragile economy, poverty, weak infrastructure, and limited educational resources have exacerbated ethnic tensions around the influx of refugees who have fled the civil wars. The rainforest grows precious woods, and with increasing demand came deforestation. With these ecological problems, bats fed closer to villages, making it easier for people to kill and eat them. When Ebola struck for the first time in Guinea's history, the country was totally unprepared for the epidemic that followed.

The Disaster

In December 2013, a mysterious killer disease began spreading from the small village of Miliandou in the Guinea forest; it was not identified as the Ebola virus until March, 2014. As this was the first outbreak of Ebola in Guinea, the Ministry of Health did not have the specialized training and equipment to mount an effective response. According to the World Health Organization, 221 people were infected and 146 had died by the end of April, 2014. By mid-October that number had risen to 3,803 people infected and 2,535 dead. The *Lancet* reported in February, 2015 that the epidemic had left more than 2,000 orphans under 15 years of age in the country.

It is believed that the Russet fruit bat transmits the Ebola virus to other mammals; people become infected by eating these animals, and the disease is then transmitted to other people by direct contact with body fluids. It's a severely contagious disease that can rapidly lead to death. In Guinea, people traditionally live close together, share the same plate, and sleep in the same bed, which impacted the spread of the virus. Women and girls were at increased risk because they usually took care of the sick and cleaned the bodies of the dead as part of funerary rituals, when the viral charge was at its highest.

Ebola had important psychosocial and economic consequences. The mystery surrounding the disease, the lack of knowledge about it, and the lack of a specific treatment created intense fear and distress, and even paranoia, which led to aggressive acts against MSF. Many members of a

family can be infected, and the rapid contamination created stigmatization and rejection of those infected. This led some people with symptoms to run away from home; many fled into the bush and died there. This was particularly tragic because a patient admitted quickly to a *Centre de Traitement Ébola* (CTE; Ebola Treatment Centre) had a better chance of survival.

My Thoughts Pre-Response

At the beginning, when MSF invited me to join the team in Guinea, I experienced shortness of breath and questioned my motivation. I remembered my reaction of horror and fear when I first learned about this horrible disease, yet I also remembered that when I was deployed in DRC in 2012, I worked with an experienced team, which was comforting. I learned from them best practices in caring for my own life and the lives of my colleagues and our patients. I appreciated the synchronicity, the synergy, and the solidarity of the team.

I felt privileged to have participated in the eradication of Ebola in DRC. I remembered the humorous Canadian scientist, in charge of the laboratory, whose visionary work on Ebola led to the development of a vaccine. I remembered how the learning process was active within MSF: our opinions were respected, our fears and questions were given attention, and support was provided.

I felt ready, courageous enough to join the team in Guinea, and I was rapidly deployed. I trusted my life was safe, yet I made sure to officialize my will, and took time to talk to my children, friends, and some family members about the challenges, and how we would keep in touch.

My Response Experience

When I arrived in Guinea in early April, 2014, my first mandate was to set up the psychosocial program in Macenta, a village in the forest. However, there had been a recent stoning attack on an MSF car there, a result of rumors which had been circulating that MSF – the strangers, the white people – were responsible for bringing the disease to the region. It was also said that MSF was removing and selling body parts and blood, and that we kept people as prisoners in the CTEs, depriving them of water and food, and poisoning them with medication. Because of this attack, the team was evacuated to the city of Gueckedou, where my mission started.

At the end of my first long and exhausting day, I attended the funeral of an 18-month-old girl who had died that afternoon. She was wrapped in a miniature white body bag. The population was crying in a deluge. I was stunned and wordless. I sobbed as we walked toward the small, freshly dug grave. The expression of grief through songs, cries, and screams was such a

strong reminder of the funeral of my African son-in-law six years earlier that for a moment I questioned whether I would be able to carry on this mission. However, after sharing my sadness, being with my new team, caring for myself with soft music, meditative readings, and a good night's sleep, I was prepared to continue on.

One of my first steps was to build a national mental health team. I started with one person, and our team grew to 16 mental health workers. We hired local staff fluent in the culture and the language of the patients. We provided ongoing training to the new staff on topics including typical reactions to stress, PTSD and other mental illnesses, Psychological First Aid, counseling skills and processes in the CTE context, solution-focused therapy, compassion fatigue, and self-care planning. At the same time, these national personnel were a precious source of information on the culture, and on the perception of MSF and the activities being held in the CTE and in the community.

Our goal as the mental health team was to help diminish suffering by promoting coping and wellbeing. We offered Psychological First Aid (PFA) and basic counseling. We listened to each patient's needs and tried to attend to them, putting in place strategies to provide care for them while ensuring everyone's safety. We worked to reduce fear and panic, and to promote a sense of calm, in order to help patients adhere to their medical treatment protocol and increase their chances for recovery. These interventions were also aimed at helping to prevent PTSD and other disorders.

Inside the CTE

Support started during the admission of patients to the CTE, which was a distressing experience for them; many were confused and feared they had just come to die. It had a significant psychological impact. We provided PFA, and attempted to establish trusting relationships with them. We met with them without the personal protective equipment (PPE), behind an orange, garden-type fence which established a safe distance. One day a young woman arrived at the CTE, screaming in anger and fear. She was getting weak fast, but she refused food and water. She wanted to run away. When she finally agreed to talk to us, we told her that the CTE was not a prison and if she wanted to leave she could. We offered her the choice of some specialty foods, including beef feet bouillon cooked in town by someone she knew. Trust happened through that recipe. We would put the soup in a plastic bag and bring it to her; she started to eat and eventually recovered. To us, the ability to offer these specialty foods promoted connections and healing. However, one day the finance department told us that these meals were costing too much and that we had to cut them. We had to explain the importance of these meals to the mental health of our

patients. They then agreed to maintain them, but after my deployment I learned that they had later been cut. My team members and I were upset about this decision because we had lost an efficient and effective way to connect with patients.

We provided support for patients during all the phases of the hospitalization. Test results typically came out in early afternoons – an anxious time for everyone. If the patient's results were negative (indicating that they were not infected or had been cured), we assisted them with reintegration back into the community. It was a joyful occasion as they walked out of the high-risk area, dressed in brand new clothes provided by MSF (the clothes they were wearing when they arrived at the CTE often had to be destroyed due to contamination). Yet it was not easy for patients to leave the supportive environment of the CTE and face a community that was reluctant to welcome them home due to the fear of contagion and suspicions that these patients were actually being used as a part of a plot to spread the virus. When possible, a few members of the mental health team along with a member of the health promotions team accompanied the person back home to reconnect the individual with their community: the village chief, elders, traditional healers, neighbors, and the family. To establish trust, we listened to their fears and concerns, and answered their questions. We invited representatives of the community to visit the CTE as a way to counter the rumors and diminish fear. This work was always tricky; sometimes it felt like a slow, edgy dance.

We offered support to the majority of patients (those who were capable of walking around) without the use of PPE. These meetings happened over the orange fence, in a small space made with plastic sheeting and a sun protection net. In these cases the counselor was in a low-risk zone while the patient remained in the high-risk zone. However, if patients were bedridden, very ill, or dying, we would dress in PPE to visit them in the high-risk zone. This meant being covered from head to toe, not leaving even a millimetre of skin exposed; the head covered by a hood, the eyes under wide ski goggles. I could not last for more than 50 minutes at a time in this suit. We always entered two or three people at a time, usually with a hygienist or a member of the medical team so that we could observe each other's reactions and care for each other. It reminded me of the scuba diving protocol. The first time I walked in the high-risk zone, I had some fear of coughing, or worse, of choking, when my throat felt dry and when I walked towards the exit, to get "ungeared." This process had to be done perfectly with the assistance of hygienists to prevent contamination. It was important to manage stress, breathe, and walk slowly and to be mindful about our reactions.

We prepared carefully for these visits in the high-risk zone by reminding ourselves about our vulnerability, the overwhelming emotions we would feel, and the limited time we could spend in our gear. We gave ourselves

permission to end a visit when we needed to. We identified which patients needed special attention and planned our visits according to where they were located in the tents. We prepared some specific topics or questions to get to the point efficiently but without pressure.

During these visits we sat on our heels at bed level to catch the eyes of the patient, trying to have some conversation. Mostly using simple signs, we tried to ask about how they were and what they needed; this was PFA in the Ebola context. We visited children, many unaccompanied, and brought them gifts. It felt unbearable not to be able to cuddle the crying children, but when other patients were recovering and safely able to do so, they would start to take care of the children. This kindness was an immense source of strength for the children.

For patients who were too ill to recover, we provided palliative care. For example, when a nurse from our team was dying, we made sure to be present for her as much as we could and listened to her needs in order to improve her comfort and attend to her last wishes. It was very difficult to provide this care while also trying to stay safe and deal with our own emotions.

We also provided support to families. We helped organize sanitary funerals while being attentive to cultural traditions and rituals. We educated people about the high risk of contamination at the moment of death, including the importance of not allowing anyone to touch the body and the necessity of using a body bag. We invited a few family members to attend the washing of the body done by hygienists in PPE. We helped families plan and prepare for the viewing of the body. We offered to take pictures and videos of the ceremony. After a funeral, we visited communities to demonstrate our care and commitment.

Caring for people while also keeping ourselves safe was an ongoing preoccupation and a difficult task. Prevention of infection, fear of contamination, and dealing with contamination of staff members were ongoing concerns. Among the most difficult times was when a member of our mental health team became infected. Our visits to the villages were put on pause as we struggled to accept this situation. We also struggled with what seemed to us to be a paranoia contaminating the world: We were being stigmatized by the international community. In addition to the emotional stress this caused us, it had practical consequences as well. For example, some employees from Air France refused to serve Guinea for some time, resulting in delays into and out of the country. We feared being cut off from France. To cope, we held frequent group discussions with the staff on ongoing questions related to Ebola, on self-care, stigmatization, and other issues. Individual counseling sessions were available for staff to discuss private issues.

Some patients became advocates and allies in the fight against the disease. One of these, the first male survivor (as he proudly reminds everyone) was

an easy patient – full of humor, and a positive force in the CTE. He was very grateful to be alive and has since spent his life giving testimonies to the media and in the community about his experience. He became part of the health promotion team; his commitment was to diminish the rumors and to promote rapid treatment. He also worked with the psychosocial team to help survivors reintegrate into their communities and took charge of a center for orphans right on the CTE grounds. He created the *Association pour les Patients Guéris d'Ebola*, an association for the survivors of Ebola.

The End of the Epidemic in the Gueckedou Prefecture

The last Ebola patient was treated at the end of December, 2014 but a period of surveillance lasted until the area was declared Ebola-free in March 2015. During that waiting period, the psychosocial team visited survivors in their communities and learned more about the biopsychosocial consequences of this disease. We worked with the association for Ebola survivors and helped set up a peer support network. I also took this opportunity to provide additional training to the mental health team on PTSD, vicarious trauma, compassion fatigue, resilience, and art therapy.

The national staff working in the CTE, including the medical team, the hygienists, the outreach team, and counselors had been confronted daily with patients' suffering, accompanying them to the end, and caring for colleagues, family members, and loved ones. Some had had to act outside of their traditional values, such as a young man providing hygiene care to an elder. They were victims of stigmatization by neighbors and shunned by their villages. To me they were the heroes, the ones keeping the CTE working while the expatriates were coming in and going out. The mental health team took the initiative to organize talking groups for these 307 national workers. We used these groups to provide them with support, and to help address the challenges they would face in returning home and reintegrating into the same reluctant communities as the patients themselves. We also assisted them with job skills training, including translating their valuable experience in the CTE into a resume.

Several ceremonies were held to honor and provide closure to the experience. One was held within the CTE, to honor the Ebola fighters, those who died, and the survivors. Another was organized for the community in the centre of Gueckedou with the participation of elders and community leaders to honor the MSF staff and the partners who contributed to the fight. This ceremony also served to invite the communities to unite against stigmatization and to greet their children back in the villages.

Finally, the CTE site was empty and a small group of us gathered around a major fire built to consume all the structures of the CTE. We held hands, wept, and hummed a kind of a universal lullaby. We hugged each other tightly, no words spoken. MSF refers to "the politics of fear" in

a book written in 2017 on lessons learned post-Ebola. To me the Ebola fighters within MSF with whom I worked fought not only to eradicate Ebola, but to promote human rights.

My Post-Response Adjustment

Canada, my home country, decided to quarantine humanitarians coming back from West Africa. Thus, after debriefing with MSF for a few days in Brussels, I decided to remain in Europe during the 21-day surveillance period. During that same time in the United States, one of my colleagues who was infected and fighting for his life was being heavily criticized in the media. When I finally returned home, my name was called out publicly on the plane and I was escorted off by two unwelcoming Immigration Officers. The negativity of the press, the ignorance of governments, and the way we were treated made me upset and very angry. It was a lonely time.

I know that having the blues is part of coming back home, and I have developed a personal self-care ritual to help with reintegration. I usually go scuba diving after a deployment, but that was not possible this time. I participated in informal debriefings offered by MSF and had access to the psychological services and peer support network they made available.

I stayed home incognito for three days to sleep and rest before seeing anyone or going grocery shopping, which I always dread; going from the tightly controlled, life-or-death environment of the CTE to the openness and countless choices available in a grocery store was particularly overwhelming. When I started to be calmer, the emotions of grief resurfaced and my body was in pain. Long-term massage and physiotherapy took care of the tensions stored in my muscles. It was good to see my family, have fun with my grandchildren, and party with my friends. I have dear friends whom I can count on, who have listened to my stories since I started this work. I love to forest bathe, listen to music, read, meditate, find new travel adventures, and to sit quietly in my house by the river and admire the normality of life. I am sensitive to humanitarian issues on this planet, but I make sure to not dwell on the news. Sharing my experience in conferences and in the media also helps; it gives a voice to those struggling.

Lessons Learned

- Develop an integrated response team that involves relevant professionals and community members. Include mental health and health promotion professionals as first responders, and recruit a national team and start training them immediately. Involve them in gaining the trust of the community. Develop relationships with local authorities, the village chief, elders, traditional healers, and religious leaders. Invite them to visit your facility.

- Messaging and communications about a disease and its prevention and treatment are essential. It is important to take time to educate patiently without patronizing and to listen with respect to questions asked. Start early community visits where patients are found and develop strategies for the media. The psychosocial component must be recognized as an essential aspect of the intervention as more people were touched by fear and stigmatization than those who died from Ebola.
- Learn to manage the fear associated with a disease outbreak so it does not become irrational. Confident humanitarians are needed. Prepare by learning about the best practices to protect everyone and be open to developing new ones. The messages should be transmitted positively and with hope about participating in such a mission versus putting only emphasis on the dangers.
- Supporting staff needs is paramount in an intensely stressful situation like a disease outbreak:
  - Encourage all staff to develop self-compassion to prevent burnout, and put in place a self-care plan.
  - A full day a week of break should be compulsory for all.
  - Offer confidential psychological support to international staff by video from a person independent from the programs and the logistics. The mental health officer should not be the counselor of colleagues with whom they live, socialize, and discuss patients, except in a case of a critical incident when immediate action must be taken.
  - Care for the national staff from the beginning of the mission. Offer psychoeducation about self-care, regular emotional support on many issues, and debriefing following an incident. When closing the mission, organize emotional debriefing and offer trainings for national staff according to their needs. Hold ceremonies to honor their efforts.
  - Hold ceremonies in the community to honor all those who collaborated in the fight and encourage activities to reduce stigmatization.

Disaster's Impact: Extreme Reactions

On September 11, 2001, when the first plane slammed into the World Trade Center, people were shocked but not sure what to make of it. For many, it was only when the second plane hit that they began to realize the country was under attack. No matter the cause or the extent, this was a big story, and journalists flocked to the site. Gillian had been working for a local TV affiliate of a major network for six years. Her good looks and personality helped her to be well thought of in on-camera interviews and stories in the Big Apple. Before coming to New York she had done crime reporting in Detroit, so she knew how to follow sirens and response vehicles. She and her small crew made their way downtown and arrived shortly after the second plane hit. They were setting up only blocks away when the first tower fell. Gil and her crew were not just reporting; now they were also victims. They dropped their equipment and ran for their lives, which was not easy for Gil, as she had to pull off her high heels as she ran. What she remembered quite clearly as the dust and debris engulfed her was that for a few seconds she could not breathe, and she thought: "I am going to die." She remembered feeling almost numb until she was pulled out of the rubble by two New York City firefighters, who saved her life. Her crew was also okay, though the equipment was destroyed. They went back to the studio, cleaned up, and quickly went back to cover the story. For Gil and her crew it was the story of a lifetime. That night, when she got home, her mother called and begged her to return home. "If you're lucky enough not to get mugged in New York you'll get blown up in a subway," her mother said. Her husband's reaction was more troubling. He said she was "out for the glory." He complained that he had tried to reach her all day and didn't think she made him enough of a priority. Although Gil was disappointed in the reactions from her mother and husband, she continued to cover the story. She was on camera with residents who could

not return home and worried about their pets, and with firefighters who lost their brothers. She interviewed New Yorkers who lived far enough away from Ground Zero to take in strangers who could not get home. These citizen neighbors provided showers, towels, meals, beds, and comfort to their fellow New Yorkers. Gil's stories had consistent themes of tragedy and resilience. Two months after the attack she was walking down the street when an ambulance passed, with sirens wailing. She startled, began to cry, and couldn't stop shaking. Then she couldn't sleep, didn't want to go downtown, and eventually was reluctant to leave her apartment. She thought that sleeping pills mixed with alcohol might help, but when that recipe failed she saw a psychotherapist, who diagnosed and treated her successfully for Delayed-Onset Posttraumatic Stress Disorder—PTSD.

As we've discussed in earlier chapters, even when acute stress reactions resulting from disaster experiences are severe, they typically dissipate over time. However, a portion of disaster survivors do not recover. Some, in fact, can develop symptoms that last for decades (Holgersen, Klöckner, Boe, Weisaeth, & Holen, 2011), severely impairing their ability to work, sustain relationships, feel safe, and generally function in life. There is an important distinction between *disaster distress* and *psychiatric illness*, and we must be sure that we identify those with more extreme problems and provide them with evidence-based best treatments to try to cure these often debilitating reactions. In this chapter we'll examine key elements of these extreme reactions.

This chapter requires a bit of a shift in focus from our earlier emphasis on posttrauma reactions being unpleasant but understandable and typically transient responses to disasters. That is indeed the norm, but not the rule. Some percentage of disaster survivors won't recover but will go on to develop a clinically diagnosable mental illness. However, because disasters leave so many more distressed than disordered, the field of disaster mental health tends to overlook those who develop a diagnosable illness. For example, the federally funded Crisis Counseling Assistance and Training Program mostly provides assistance for survivor distress but offers little assistance for those with a psychiatric diagnosis. Yet these are the people who are in fact suffering well after the disaster has passed—and, given the collective nature of disasters, there are a lot of them. Take, for example, a hurricane that impacts 50,000 people. Even if only 5 percent of the survivors go on to develop PTSD or another disorder, this means that 2,500 people will develop serious and lasting reactions that require professional mental health care. Most of the literature and research in the field is appropriately devoted to assisting the majority of survivors with disaster distress, but we must be certain that those with psychiatric illness are identified, referred for, and receive evidence-based long-term treatment (North & Pfefferbaum, 2013).

RISK FACTORS FOR PTSD AND OTHER ILLNESSES

Norris, Friedman, and Watson (2002) did a great service when they summarized the results from 160 studies on 102 different events, which included "floods, hurricanes, earthquakes, wildfires, nuclear and industrial accidents, an array of transportation accidents on the ground, in the air, and at sea, terrifying sniper attacks, and bombings that caused unthinkable destruction." Some of the over 60,000 survivors studied experienced some stress and distress while others developed significant impairment. A large majority of disaster survivors were shown to be quite impacted by disaster, with only 11 percent minimally impaired, 50 percent moderately impaired, 21 percent severely impaired, and 18 percent very severely impaired. These findings make it clear that disasters cause considerable psychological harm, and there is a critical need for thoughtful planning to deliver mental health support, not only in the acute phase of the recovery but over time as distress evolves into illness for some.

Severity of the outcome and the need for mental health services have a lot to do with the disaster itself. A heavy rain leading to basement flooding throughout a community is less likely to cause a psychiatric illness than sniper attacks that result in severe injuries, threat to life, or loss of loved ones. Norris and colleagues' summary (2002) found that, when a disaster has at least two of the following four characteristics, there will be acute and long-lasting impairment in a substantial proportion of the population:

1. The disaster was large in scope, causing extensive damage to property.
2. The disaster created significant and ongoing financial hardship for the community.
3. The disaster was caused by human intent.
4. The disaster resulted in significant trauma: injuries, life threat, death.

If you consider these four characteristics of disaster, it is no surprise that an event such as the attack on the World Trade Center resulted in a high rate of mental disorder in the impacted population. In a study of survivors of the World Trade Center attacks, 35 percent of those directly exposed to the danger met the criteria for PTSD (North et al., 2011a). Keep in mind that New Yorkers who were out of town or lived far from the site were not impacted in the same way as someone was who worked in the area, lost a job, was injured, or lost a loved one. Yes, people outside New York City were upset after the attacks (Silver, Holman, McIntosh, Poulin, & Gil-Rivas, 2002), and those who spent a lot of time watching television coverage showed more symptoms, but they did not meet the official diagnostic criteria for PTSD (Schlenger et al., 2002). As we all know, the attack on the World Trade Center was not an act of nature or an accident. It was caused

by human intent, and, as such, contributed to the increased trauma and impairment among those directly affected.

In addition to the nature of the event and disaster characteristics, Norris et al. (2002) identify four categories of risk factors for distress and illness following disaster: stress and trauma, survivor characteristics, family characteristics, and resources. Some findings seem obvious while others are more surprising. Although more recent studies help to explain these patterns of risk factors, more research is still needed to help us understand what makes some survivors more susceptible to extreme reactions.

Stress and Trauma

Norris and colleagues found that those who are **directly exposed** to the event are more at risk. New Yorkers who were sleeping at home when the buildings collapsed were at less risk than those who fled the World Trade Center, or who witnessed bodies falling from the buildings. But keep in mind that exposure to the disaster also includes being emotionally close to those who were severely impacted. Months after the Virginia Tech shooting, the highest posttraumatic stress symptoms (suggesting probable PTSD, though this was not formally diagnosed) were found for students who were unable to confirm the safety of friends or who experienced the death of a friend (Hughes et al., 2011). Those who live in a **neighborhood that is disrupted** or traumatized are more at risk, so survivors living in neighborhoods that are chaotic and undergoing repairs for months and even years are more likely to have lasting reactions. **High secondary stress** also predicts greater impairment. If a survivor's family member gets sick, loses a job, or has a dysfunctional marriage, he or she is more at risk. And, reinforcing the points we made in Chapter 3 about proximity and the dose–response relationship, people at the **epicenter** of the disaster may receive more aid, supportive services, and attention, but their exposure predicts the most serious psychological consequences. The higher the dose and the greater the exposure, the more likely not only that a survivor will have strong initial reactions, but that he or she will also develop psychiatric illness.

Survivor Characteristics

Norris and colleagues' (2002) second risk category involves the personal traits of those impacted. **Children** are the most vulnerable; we'll review why and how to assist them in more detail in Chapter 8. Within the adult population, **females** are more vulnerable than males, and **middle-aged adults** are more vulnerable than either young or older adults. This finding is

somewhat surprising, since we often think of the elderly as vulnerable and more at risk, and this can be true for those with physical or cognitive problems. However, older adults who are healthy and mobile, who have survived many challenges over their lifetimes, and who are less responsible for the well-being of small children might be better thought of as a resource after a disaster than as a group needing special assistance. Survivors of any age or gender are more at risk for long-term problems if they have **little experience coping with disaster**, so it hits them out of the blue; if they belong to an **ethnic minority** or a **lower socioeconomic class**; or if they had a **pre-disaster psychiatric history**. Earlier traumas are also a risk factor for developing post-disaster mental illness. College women exposed to the Virginia Tech shooting were more likely to report depression and PTSD two months and one year after the event if they had a history of sexual abuse or sexual trauma (Littleton, Grills-Taquechel, Axsom, Bye, & Buck, 2012). There seems to be a cumulative impact of multiple trauma experiences. There are also general **personality factors** associated with risk and resilience. Some of the personality characteristics that have been linked to distress and symptoms after a disaster include emotional instability, negative affect, lower sense of self-control or self-efficacy, being prone to rumination, lack of ability to engage in self-serving biases, lack of hardiness, and lack of adaptive flexibility (Bonanno, Brewin, Kaniasty, & La Greca, 2010).

Family Characteristics

Norris and colleagues also found patterns of vulnerability related to the survivor's family. A poor post-disaster mental health outcome is more likely for an adult if **children are present** in the home, if the adult is **female**, and if **a husband is present**. A child is most at risk when there is **parental distress,** and everyone, child and adult alike, is at risk if a **family member is present who is significantly distressed** or if there is **interpersonal conflict or lack of supportive atmosphere** in the home. These findings remind us of the importance of family systems. For example, in one study of very young children (five years or younger) in New York City after the attacks of 9/11, children who were directly exposed and whose parents were more in conflict and parented less well had more trauma symptoms (DeVoe, Klein, Bannon, & Miranda-Julian, 2011), reflecting the ripple effect of trauma through families. Although children might receive post-disaster attention and support at school, it's probably more important that their parents receive the attention and support they need to function effectively as caregivers. Mothers may experience the most stress and pressure, feeling responsible for the well-being of the entire family, and therefore are most at risk for developing symptoms. It might be surprising to readers to see that the presence of

a husband is a risk factor for women, but perhaps, when there is a crisis, he becomes another person for a wife to worry about. A family systems perspective also reminds us that one very distressed survivor or conflict in the home can have a significant impact on everyone else. These findings suggest that referrals for couple or family therapy should be a treatment option, even if only one member of the family has symptoms.

Resources

The final risk factor Norris et al. (2002) identify concerns resources, both material and social. When a disaster is imminent, those with more resources are better off. They can buy supplies to protect their property. They can evacuate and stay with friends, relatives, or at a hotel. If work is disrupted they can withstand interruptions in pay and they're more likely to have home insurance. In contrast, people with fewer economic resources are more likely to live in disaster-prone areas and in less sturdy housing. This was apparent in the aftermath of the 2010 Haitian earthquake, which killed hundreds of thousands as buildings collapsed on residents, in part due to low construction standards and no building codes.

All disaster mental health interventions are intended to replace resources as rapidly as possible. When disaster strikes and survivors lose possessions or the temporary or permanent use of their homes, it's more difficult to count on neighbors, friends, and relatives, who may also have been hit hard and have little to offer. If survivors begin to **lose belief in their ability to cope** and control outcomes, they're at risk for poor mental health outcomes. If they feel that they have **few or deteriorating social supports**, they're also at risk. This is why it's important for helpers to arrive on the scene quickly and provide reassurance before survivors lose hope. Survivors are also more resilient if they draw on their own strengths, resume normal activities as soon as possible, understand that they're in a community of people struggling with similar issues and problems, and share experiences, challenges, and solutions with their friends and neighbors. As outsiders and professional helpers, much in the same way that we can help individuals who are suffering by working with the family system, we should do what we can to support community members assisting one another.

TRAJECTORIES FOLLOWING TRAUMATIC EVENTS

People react to trauma and disaster in very different ways. Bonanno (2004) identifies four distinct patterns of disruption in functioning after traumatic events. There is one subset of trauma survivors who show symptoms at

the outset and continue to struggle over months and years (the "chronic" group). Another group of survivors are stable at the outset and remain psychologically healthy ("resilience"). The other two groups change over time. There are those who "bounce back" over time ("recovery") and those who initially function well but whose condition worsens over time ("delayed").

In one study of individuals who were highly exposed to the 9/11 attacks, researchers (Bonanno, Rennike, & Dekel, 2005) found 29 percent with symptoms that stayed elevated over time ("chronic"); 35 percent who showed little impairment throughout ("resilience"); 23 percent whose symptoms declined ("recovery"); and 13 percent whose symptoms got worse over time ("delayed"). These self-reported findings were confirmed by ratings from close friends and family members who evaluated participants on adjustment both before and after 9/11. We get some clues as to what can account for these differences from a study of trajectories of scores for PTSD among more than 16,000 rescue and recovery World Trade Center workers (Maslow et al., 2015). PTSD in this responder population was studied over eight to nine years. Members of the higher-risk groups were associated with:

- exposure, including the duration of their World Trade Center work
- witnessing of horrific events
- being injured or perceiving threat to life or safety
- bereavement
- job loss.

High PTSD within each group was associated with lower social support, divorce, separation, widowhood, and unemployment. Another study of trajectories of PTSD among 17,000 lower Manhattan residents and workers following the World Trade Center attacks demonstrated the impact of severe exposure, lack of financial resources, and treatment barriers (Welch et al., 2016).

Overall, there is considerable variability about how people fare immediately and in the long term. They can be minimally, moderately, or highly symptomatic at the outset and recover a short time later, or symptom-free initially with delayed onset months later, as in the case study at the beginning of this chapter. These findings demonstrate that there is a need to screen disaster survivors immediately after the event and then at regular intervals to ensure that we don't miss individuals whose reactions take some time to develop.

POSTTRAUMATIC STRESS DISORDER IN ADULTS

The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS-5). Later we present

the PCL-5 20-item questionnaire, which corresponds to the DSM-5 symptom criteria for PTSD and can be used for screening. First we'll review and summarize the criteria for a PTSD diagnosis according to the current edition of the *Diagnostic and Statistical Manual*, DSM-5 (APA, 2013).

Clients, the general public, and even professionals can overuse or extend the concept of trauma in a manner that risks minimizing its true impact. If you spill coffee on your computer or hear that your office may be beginning a series of job layoffs, you have a problem or stressor and you might be troubled or anxious, but you have not been traumatized. Still, the type of trauma that does qualify for a PTSD diagnosis is, unfortunately, all too common. Such an event occurs when the survivor feels his or her life or physical integrity is threatened or witnesses the serious injury or death of another. Over nine in ten Americans experience this kind of traumatic event in their lifetime (Curtois & Gold, 2009) due to disaster or another kind of distressing experience, and most research on the effects of disaster agree that PTSD is the disorder most often associated with exposure to disaster trauma.

Although trauma involves a threat to physical integrity or the perception of threat to one's life, it could also be said that trauma is a threat to cognitive or psychological integrity. The sight of a fragment of human tissue on one's sleeve hours after an explosion could be so grotesque, or imagining what a loved one suffered while confronting an active shooter so horrifying, that it presents a severe challenge to a survivor's understanding of the world and his or her place in it. Traumatic events, by definition, overwhelm our ability to cope. They shake and sometimes even shatter basic assumptions. We're forced to reconsider how benevolent, predictable, and controllable the world is. Derived from the Greek word for "wounded," trauma impacts our sense of vulnerability and self-esteem and leads to a cognitive reassessment (Calhoun & Tedeschi, 2013). Another way of looking at traumatic reactions is that they create a turning point in the life narrative, the watershed event that divides life into "before and after" (Janoff-Bulman, 2010). For some people, the "after" stage remains fixed on the loss or traumatic memory.

Summary of Criteria for a Diagnosis of PTSD

To qualify for an official PTSD diagnosis according to DSM-5, clients must meet a number of criteria regarding their experience and symptoms.

Criterion A necessitates **exposure to trauma**. This means exposure to actual or threatened death, serious injury, or sexual violence through one of the following:

- direct exposure
- witnessing the trauma to others in person

- learning of direct trauma exposure of a close family member or close friend
- repeated or extreme exposure to aversive details of trauma, such as handling dead bodies or body parts, or child protective workers being repeatedly exposed to details of child abuse.

Note that exposure via media does not count as a qualifying experience, except under certain professional conditions (for example, a law enforcement professional who must view images of child pornography in the course of investigations).

Criterion B describes **intrusive symptoms** that must include one of the following, beginning after the traumatic event:

- recurrent involuntary and intrusive memories of the traumatic event
- recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic events
- dissociative reactions, such as flashbacks, in which the individual feels or acts as if the traumatic event were recurring
- psychological distress at exposure to reminders of the trauma
- physiological reactions to reminders of the trauma.

Criterion C involves **persistent avoidance of stimuli** associated with the traumatic events, beginning after the traumatic event and is evidenced by at least one of the following:

- avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely related to the traumatic event
- avoidance of or efforts to avoid people, places, conversations, activities, objects, situations that arouse distressing memories, thoughts, or feelings about the trauma.

Criterion D involves at least two of the following **negative cognitions and moods** associated with the trauma:

- inability to remember an important aspect of the traumatic event(s)
- persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
- persistent distorted cognitions about the cause or consequence of the trauma that lead to self-blame or blaming others
- persistent adverse emotional state, such as fear, horror, anger, guilt, or shame
- diminished interest or participation in significant activities
- feelings of detachment or estrangement from others
- persistent inability to experience positive emotions.

Criterion E involves **alterations in arousal and reactivity** beginning or worsening after the trauma with at least two of the following symptoms:

- irritable behavior and angry outbursts
- reckless or self-destructive behavior
- hypervigilance
- exaggerated startle response
- problems with concentration
- sleep disturbance.

Duration of the disturbance must be for more than one month and cause significant distress or impairment in social, occupational, or other area of important functioning and must not be attributable to substance use or a medical condition.

It's difficult to convey how debilitating PTSD can become for some people as the symptoms strengthen and reinforce each other in a true vicious circle. Not only are the intrusive memories and dreams unpleasant, but they trigger the autonomic stress reaction—the fight or flight response—as if the threat is still present. To shield oneself from this pain, the patient learns to avoid reminders of the traumatic experience. At first this is a very effective way of reducing distress. The problem is that it tends to become increasingly generalized. Initially people may avoid, say, going to the building where they survived an attack. Then they start to avoid the entire neighborhood, because there might be reminders present. Then they start to avoid leaving their home at all, or watching television that might include news about the event. At the same time they feel hypervigilant and are always on guard for the threat to return. They begin to view the world as unsafe, and become consumed by blaming themselves or others for what happened. They don't sleep. Ultimately they withdraw from social and family relationships. Over time it can become more and more difficult to treat PTSD as the symptoms become entrenched. This is why early diagnosis and treatment need to be a focus of our DMH response.

Screening and the PTSD Checklist

A diagnosis of PTSD can't be made until one month after the traumatic event and requires a full clinical assessment. This means that rates of PTSD following a disaster can be underestimated, as survivors don't utilize mental health treatment (if it's available) and it's not practical or realistic to provide all survivors with full clinical evaluations. However, brief and uncomplicated screening tools can be very useful to ensure that survivors who need the most help get it. Screening locations could include work, school, community, and primary care settings. If survivors show a positive screen result they should be guided to full clinical assessment and treatment (North & Pfefferbaum, 2013). This approach was used quite successfully

after the London subway and bus bombings in 2005 (Brewin et al., 2008), as we mentioned in Chapter 5.

One of the most commonly used screening tools, the PTSD Checklist for DSM-5 (PCL-5), is a 20-item self-report measure that assesses the symptoms of PTSD:

1. repeated, disturbing, and unwanted memories of the stressful experience
2. repeated, disturbing dreams of the stressful experience
3. suddenly feeling or acting as if the stressful experience were actually happening again (as if you are actually back there reliving it)
4. feeling very upset when something reminds you of the stressful experience
5. having strong physical reactions when something reminds you of the stressful experience (for example, heart pounding, trouble breathing, sweating)
6. avoiding memories, thoughts, or feelings related to the stressful experience
7. avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)
8. trouble remembering important parts of the stressful experience
9. having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as "I am bad," "There is something seriously wrong with me," "No one can be trusted," "The world is completely dangerous")
10. blaming yourself or someone else for the stressful experience or what happened after it
11. having strong negative feelings, such as fear, horror, anger, guilt, or shame
12. loss of interest in activities that you used to enjoy
13. feeling distant or cut off from other people
14. trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)
15. irritable behavior, angry outbursts, or acting aggressively
16. taking too many risks or doing things that could cause you harm
17. being "superalert," or watchful, or on guard
18. feeling jumpy or easily startled
19. having difficulty concentrating
20. trouble falling or staying asleep.

Each symptom is followed by a self-report rating scale of 0–4, with a rating of "not at all," "a little bit," moderately," "quite a bit," and "extremely." Patients can complete the PCL-5 in approximately five to ten minutes (see www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp). A

provisional PTSD diagnosis can be made by treating each item rated as 2 ("moderately") or higher as a symptom endorsed, then following the DSM-5 diagnostic rule that requires at least one criterion B item (questions 1–5), one criterion C item (questions 6–7), two criterion D items (questions 8–14), and two criterion E items (questions 15–20) (see www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp for details on scoring).

For screening to be effective, the exposed population needs to be contacted in order to be sure that all people at risk are evaluated. This is not always a simple or easy task. After some disasters, survivors evacuate temporarily, while others leave the area for long periods of time or do not make themselves easily available for mental health screening. Also, some survivors may be symptom-free at one month after the event but could screen positively months or even years later. A systematic and thorough screening of exposed populations should take all of these considerations into account in order to maximize the chances of getting care to people who most need it.

MAJOR DEPRESSIVE DISORDER

Although PTSD is more common and a more frequently researched extreme reaction, disasters also consistently produce higher rates of Major Depressive Disorder (MDD). It's also more likely that a survivor might have a pre-disaster history of MDD than of PTSD, putting him or her at somewhat higher risk of relapse.

According to the DSM-5, qualifying for a diagnosis of MDD requires five or more of the following symptoms to be present during a two-week period, and they must include either (1) depressed mood or (2) loss of interest or pleasure:

1. depressed mood most of the day, nearly every day
2. diminished interest or pleasure in all or almost all activities
3. significant weight loss (more than 5 percent of body weight in a month) or increase or decrease in appetite
4. insomnia or hypersomnia
5. psychomotor agitation or retardation
6. fatigue or loss of energy
7. feelings of worthlessness or guilt
8. diminished ability to think or concentrate, or indecisiveness
9. recurrent thoughts of death or suicide.

For a diagnosis of MDD, these symptoms should not be attributable to substance use or another medical condition, or to the recent (within two months) loss of a loved one, and they must create significant disturbance in social, occupational, or other areas of important functioning.

When experienced after a disaster, MDD symptoms may prevent survivors from engaging in necessary recovery activities, prolonging their suffering. Depression could also be induced not by the disaster experience itself but by its ripple effects: Disasters are not only life-threatening but they can create horribly depressing conditions, including economic and job loss. Consider the Deep Water Horizon oil spill in the Gulf of Mexico in 2010. Although there was some loss of life, it was also an ecological and economic catastrophe. It had a devastating effect on marine life in the Gulf; cleanup crews and fishermen got sick; there were significant economic losses in the fishing, tourism, and energy industries; and adults and children living miles from the coast reported physical and mental health symptoms (Buttke et al., 2012). Oil gushed for months and leaked for years, and the cleanup continues today, as do legal consequences. Among people with spill-related income loss, more than 83 percent experienced clinically significant depression one year after the disaster (Morris, Grattan, Mayer, & Blackburn, 2013; D'Andrea & Reddy, 2014).

In spite of the increased rates of depression following disaster, there is little evidence for increased rates of suicide. However, there is evidence that people already struggling with depression and suicidal ideation are at greater post-disaster risk (Bonanno et al., 2010). Losses from disaster, such as the economic losses that can lead to depression, can take months or years to develop, which again points to the need to monitor and screen communities long after disaster strikes. There are a number of screening tools available for major depression, including the Beck Depression Inventory II and the Center for Epidemiological Studies Depression Scale (see North & Pfefferbaum, 2013). Antidepressant medications can also provide relief from symptoms for many people with MDD, though many medications take days to weeks to begin to have an impact. If you're working with someone who reveals a history of MDD be sure to ask if they have access to needed medications and try to connect them with a healthcare provider to restore a prescription if necessary.

COMPLICATED/TRAUMATIC/PROLONGED GRIEF

Grief is an unavoidable and painful but normal reaction to loss, as we described in the previous chapter. After the death of a loved one, bereaved people often feel sorrow, anger, guilt, anxiety, and anguish. They may ruminate about the deceased person and reflect on the events that led up to the death. They can have physical reactions to their loss, such as sleeping too much or too little, and they can develop behavioral symptoms. They might not want to see friends or family or go to work. For most people, the painful feelings and thoughts gradually diminish. But, for some, the grief reaction

remains and can become increasingly incapacitating. Although not listed as a disorder in DSM-5, some experts refer to this as Complicated Grief, Traumatic Grief, or Prolonged Grief (PG). People who have suddenly or violently lost loved ones in a disaster may experience Complicated Grief (Bonanno et al., 2007).

Research by Holly Prigerson and colleagues (2009) suggests that those with PG can:

- yearn for or be preoccupied with the deceased
- experience life as empty and meaningless without the deceased
- feel stunned, dazed
- feel shocked about the death
- have trouble accepting the death
- feel that a part of them died along with the deceased
- have difficulty moving on with life without the deceased
- experience a sense of numbness since the death
- find it hard to trust others since the death
- avoid reminders of the deceased
- experience survivor guilt
- feel bitterness or anger related to the death
- be on edge or jumpy since the death.

Survivors with PG sometimes want to die themselves, as there is significant emotional suffering and a desperate desire to be reunited with the deceased. Fortunately, long-term therapies for PG have been shown to be effective (Boelen, de Keijser, van den Hout, & van den Bout, 2007; Shear, Frank, Houck, & Reynolds, 2005).

OTHER HEALTH AND MENTAL HEALTH PROBLEMS

Although disaster-caused PTSD and Major Depressive Disorder receive the most attention when we consider extreme mental health reactions, there are additional serious problems that may cause suffering among individuals, families, and communities.

Disasters kill people and cause acute injuries, including permanently life-altering ones such as limb amputations and traumatic brain injuries. Even when disasters don't cause immediate physical injury they can create chronic stress that leads to physical illness over time. While 2,753 people died at the World Trade Center on 9/11, more than 9,000 were determined to be eligible for medical claims. Some were injured during the attacks, but many more were first responders or recovery workers who developed health problems only after months or years had passed. They continue to show higher rates of respiratory illness, heart disease, gastrointestinal

disease, type 2 diabetes, and cancer (Centers for Disease Control and Prevention, 2014; Miller-Archie et al., 2014; Solan et al., 2013). These illnesses cause considerable stress to individuals and their families. The wear and tear on the body that grows over time as a result of exposure to repeated or chronic stress results in compromised immunity, atherosclerosis, obesity, bone decay, and atrophy of brain cells (Bonanno et al., 2010).

Clinicians and public health workers are often concerned that disasters will lead to a spike in substance abuse as survivors self-medicate their symptoms with drugs or alcohol. The good news on substance abuse is that one analysis (North, Ringwalt, Downs, Derzon, & Galvin, 2011b) of almost 700 survivors of ten disasters found that only 0.3 percent of the sample developed an acute new onset of alcohol use disorder. This is consistent with previous research that found it's rare for survivors to turn to drugs or alcohol at a problematic level for the first time post-disaster, though use of substances for occasional stress release was not uncommon. The bad news is that 83 percent of participants who had been in recovery at the time of the disaster acknowledged consuming alcohol after the event. Alcohol abuse not only harms the user's body and mind but is linked with domestic violence, sexual assault, physical and verbal abuse, and violent crime. North et al. conclude that continuing or recurring substance use disorders made up the vast majority of problematic cases, so post-disaster support should target survivors with a history of drug or alcohol use rather than focusing on assessing for new onset of substance use disorders. This underscores the importance of getting a sense of substance use patterns among those you're helping after a disaster and providing information on positive coping that steers those at risk away from relapse, such as posting information about local 12-step meetings in shelters, or encouraging those in recovery to be sure to continue whatever sobriety practices helped them in the past.

REFERRALS FOR LONG-TERM CARE

In general, helpers should be sensitive to the fact that those needing long-term treatment following exposure to disaster could be feeling reluctant, ashamed, and embarrassed about needing help, as well as fearful of the painful feelings and memories connected with the traumatic event. Keep in mind that there's a stigma to seeking any kind of mental health treatment among many groups. Making matters worse, avoidance of reminders of the traumatic event is a core symptom of PTSD, making engaging in therapy that involves talking about the experience harrowing for PTSD sufferers to even consider. Therefore, data on disaster survivors who actively pursue

treatment for PTSD don't accurately reflect the number of survivors suffering from PTSD who are in need of help but resist seeking it.

Even when we're able to do screening and outreach to disaster survivors, there's a problematic gap between identifying those showing signs of psychiatric illness and getting them high-quality care. This is unfortunate, as there's substantial literature demonstrating the effectiveness of psychotherapy in the treatment of PTSD and MDD. Clients should be reassured and supported for acknowledging their problem and seeking treatment. Clinicians using evidence-based best practices are more likely to obtain positive results, so you should make referrals to clinicians you know have these practices in their toolkits. Thorough description of these treatments is beyond the scope of this book, but it is important for DMH helpers to know what forms of referrals should be made for trauma survivors. The National Center for PTSD recommends the practices listed below as the most effective current treatments (see www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp). For more detailed information, see the second edition of *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies* (Foa, Keane, Friedman, & Cohen, 2009).

Recommended Evidence-Based Long-Term Care Approaches for PTSD:

- Prolonged Exposure therapy
- Cognitive Processing Therapy
- Stress Inoculation Training
- other forms of cognitive therapy
- Eye Movement Desensitization and Reprocessing
- medication.

As this list suggests, various forms of cognitive behavioral psychotherapy are considered the treatments of choice, though there are no disaster-specific PTSD modalities, as treatments were generally developed to address PTSD in survivors of sexual assault, motor vehicle accidents, or other traumatic experiences. The efficacious, evidenced-based cognitive behavioral treatments that exist for this disorder are short-term and highly structured. Present-day state-of-the-art treatments for PTSD include Prolonged Exposure (PE) therapy (Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (CPT), among others. These treatments embrace the perspective that PTSD is treatable, and their overall philosophy is to remove "blocks" to recovery. Each treatment has a different emphasis, with PE emphasizing exposure and emotional processing. The exposure-based therapies introduce clients to

reminders and memories of the traumatic material. This exposure enables clients to overcome their avoidance behaviors and to modify their emotional reactions. In CPT (Resick, Monson, & Chard, 2008), there is less exposure and increased cognitive processing—hence it is a more "frontal lobe" approach that may be appealing to those who are resistant to the idea of intense exposure to memories of the traumatic experience. CPT helps clients to learn to identify and correct distorted and unhelpful negative thoughts and maladaptive behaviors, particularly those related to the traumatic event. These are treatments of hope, with therapists serving as coaches who expect the active engagement of their clients. PTSD patients who become more hopeful during treatment are more likely to recover from depression and PTSD (Gilman, Schumm, & Chard, 2012). CPT and PE achieve a higher level of evidence for treatment effectiveness for PTSD than any other therapies.

There is a recognized undertreatment of disaster survivors with serious psychological problems (North & Pfefferbaum, 2013), and this is perhaps more true for children. Four years after Hurricane Katrina, even after living conditions had stabilized, 29 percent of pediatric patients had significant mental health problems that could have been recognized and treated earlier. As we'll discuss in the next chapter, although they are resilient, children are a large and vulnerable population. Teachers and parents can overlook children's symptoms and chastise them for being moody or acting disruptively when they are in fact suffering from a trauma-related illness. School-based screening followed by Trauma-Focused Cognitive Behavioral Therapy could help with difficulty concentrating, sleep disturbance, and academic and social adjustments. Group therapy at school and individual treatment at mental health clinics have both been shown to be successful in treating PTSD symptoms in children 15 months after Hurricane Katrina (Jaycox et al., 2010). Pediatricians and school officials can be better trained to ensure that children are evaluated and receive the post-disaster services they need (Olteanu et al., 2011).

Overall, we hope this chapter has convinced you of the need to be attentive to disaster survivors who may not fit our expected patterns of recovery and resilience, but who appear to be at risk for extreme reactions that require professional mental health support. Their suffering can be intense, but it is treatable, and even curable.

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Four Principles of Disaster Mental Health

Chapter Preview
A. Collaboration of Community Partners
B. Communication and Relationship Building
C. Vulnerability of Community Populations
D. Understanding Trauma

Sometimes it pays to throw all plans out the window and assume a haphazard approach to life's events in order to enhance creativity and enjoy new and fresh outcomes. In such cases, much can be learned. Many people follow this live-and-let-live approach when they go on a vacation. They let the outcome of one experience move them toward another. Such results can bring much enjoyment and different ways of perceiving the norm.

This cavalier approach is inexcusable when lack of planning can actually scar people's lives forever. Such is the case with disaster mental health planning. Not following a specific strategy to prepare for and respond to a horrendous disaster can lead to much suffering by hundreds if not thousands of people. Lack of planning can actually be worse in such circumstances because many of the individuals who are doing their best to help others may also be traumatized. First responders are often impacted the most, for example, because they are at the center of the event. These people need to follow a strict, practiced routine.

Disaster mental health planning is a method allowing those concerned about the psychological wellbeing of their community members to identify their residents' needs and the resources required to determine the optimum solution in a disastrous situation. Successful planning:

1. Equally engages all participants in the decision-making process;
2. Supports collaboration and a dialogue between the planning members as well as community residents;
3. Gives collaboration members the information they need to make effective decisions;
4. Encourages the entire community to weigh in on and learn from decisions made;
5. Enables the sharing of resources and filling in needed gaps in service;
6. Discourages expensive redundancies and encourages spending on items most needed;
7. Provides a means for assessing and caring for those at greatest risk;
8. Offers an approach specifically focused on the local conditions and priorities;
9. Encourages give-and-take among people with different interests, life goals, and knowledge;
10. Educates citizens in how to prepare for potential adversity;
11. Builds resilience and personal strength to better cope with the next disaster; and
12. Establishes a way to make continuous improvements over time.

This manual stresses four principles required for successful community planning: Collaboration, constructive and unbiased communication, assessment of the most vulnerable populations, and trauma-informed treatment.

A. Collaboration of Community Partners

In the strictest definition, words such as "collaboration," "teamwork," "coalition," "partnership," and "network" have individual meanings based on who is participating and how long the members meet to reach their goals and objectives. As in this manual, these terms are often used interchangeably, particularly by communities working together for joint purposes. In general, collaboration means just that—more than two groups and/or individuals working together for a shared goal.

Collaborating divides a larger goal into more easily doable tasks. As problems become more complex and comprehensive, and solutions are required for

larger numbers of people, collaboration acts as a powerful tool for mobilizing individuals. By working together and integrating personal abilities, experience, knowledge, and services in your disaster mental health collaboration, you can tap excellent resources and refrain from duplicating efforts.

Humans have been collaborating since prehistoric times when they joined forces to drive bison off a cliff. Now decisions are much more complex, and people recognize increasing the value of meeting and sharing with one another to reach an intended goal. This does not make collaboration an effortless process. Given the complexity of the goals as well as the varying personalities and agendas of those collaborating, it is anything but easy. The old joke goes, "What do you get when you put ten economists (or any other occupation) in a room? Eleven different opinions."

Collaborations may be loose associations in which members work for a short time to achieve a specific goal and then disband. They may also become organizations in themselves, with governing bodies, particular community responsibilities, funding, and permanence. Regardless of their size and structure, they exist to create and/or support efforts to reach a particular set of goals based on their vision and mission. The collaboration's goals are as varied as the structures themselves, but often contain elements of one or more of the following:

1. Influencing or developing public policy, usually around a specific issue;
2. Changing people's behavior, such as reducing smoking or drug use;
3. Building a healthier community;
4. Addressing an urgent situation;
5. Empowering certain elements of the municipality, or the community as a whole, to take control of its future, such as addressing the needs of senior citizens or determining how youth may be used as community resources;
6. Obtaining or offering services, such as funding for a needed intervention;
7. Offering more effective and efficient programming, in which organizations enhance cohesiveness and coordinate responsibilities so more participants have access to a greater variety of services.
8. Pooling services and resources of several organizations to accomplish a task that cannot be done alone;
9. Increasing communication among groups in which there was previously little contact in order to break down barriers and stereotypes and create alliances that learn from each other, establish trust, and face common goals;
10. Invigorating the depleting energies of group members who are trying to accomplish too much alone by focusing efforts around an issue through heightened hope and renewed strength;

11. Planning and launching large communitywide initiatives on a variety of issues for long-term campaigns in areas that were previously considered impossible or very difficult to achieve;
12. Combining the collaborative influence of once separate groups to advocate more change; and
13. Accelerating positive community change by combining the strengths of several groups to jointly solve problems and make decisions on important issues fulfilling community needs.

To effectively respond to mental health needs when a disaster occurs, it takes the diversity of know-how, ideas, experience, and interests of a collaboration. The hard work is well worth the end result: With each disaster, it becomes more apparent that joining forces is required to best help those in need.

B. Communication and Relationship Building

No one can say enough about the importance of constructive communication in the collaborative process. This includes ethical and objective give-and-take between the sender and receiver. One person closely listens to what is being said by the other, accepts this message, and acknowledges it is heard with or without additional information required. Communication is a critical component in all aspects of planning and implementation.

Trust is critical to relationship building. Collaboration members have a wide variety of backgrounds, experiences, and opinions, and it can be difficult to bring these people together without effective communication that allows them to better understand one another. If individuals want to make the most productive use of their knowledge, they need to trust and be trusted. They must know people are carefully listening to what they have to say, without bias or suspicion. A strong correlation exists between the amount of trust people have for one another and their ability to make worthwhile decisions.

Misinformation breaks down communication and leads to faulty or lack of positive actions. When people carefully listen to one another, misinterpretations and misunderstandings are greatly reduced. Further information and clarification can be conveyed by asking questions and confirming that a message has been effectively sent and received.

Situations are continually changing in these complex times. Effective communication also allows your collaboration to readily share updated information needed to alter future actions. Similarly, in today's environment, every minute is important. Positive communication encourages fewer disagreements and faster decision-making. Likewise, collaboration requires motivated members.

Why would anyone want to spend valuable time on a process when this input does not matter? If their ideas count, people will become more involved in planning. They will also go out of their way to volunteer additional time to future responsibilities.

Having effective communication greatly relies on the facilitator or person(s) leading the planning process. However, that person also needs to remind all members they must take responsibility for their own personal interactions. Everyone at the collaborative table assumes an equal role in the outcome.

C. Vulnerability of Community Populations

According to the World Health Organization (WHO, www.who.int), vulnerability is the degree to which a population, individual, or organization is unable to anticipate, cope with, resist, and recover from the impacts of disasters. The populations at greatest risk before a disaster, including the mentally ill, are the ones most shunned or ignored when the event actually occurs. Later in this manual, you will read more about those at most risk when catastrophes hit and how your planning group can define its own disenfranchised population through assessment.

The increasing frequency and severity of disasters is having more of an impact on these vulnerable populations. When normalcy is shattered in a mass shooting or structures are destroyed in natural catastrophes, it becomes very difficult to support those who previously had difficulty acting on their own. Response takes longer, and more risks arise for these individuals.

When arriving at a disaster site, state and national first responders may not prioritize those at greatest risk. This is not due to lack of caring, but rather because they are not familiar with the specific community and who requires the most support. Your collaboration, through assessment of local residents' needs, can direct responders to high-risk facilities or neighborhoods. You can also work closely with the medical teams, since vulnerable populations often require more supportive physical care.

Persons with mild to moderate mental health disorders often suffer from additional emotional problems in calamitous situations. It is not unusual to see displaced individuals wandering alone by their damaged homes or terrified and emotionally distraught in shelters. Mental illness also goes hand in hand with other types of vulnerabilities, such as aging, physical disabilities, and impoverishment. These individuals may have been coping relatively well before the disastrous event but now feel additionally burdened by changing circumstances. Those with more severe mental disorders may not search for help at all, being constrained by such barriers as isolation, stigma, fear of rejection,

lack of knowledge, and limited or nonexistent access to services. In many cases, they may have been abandoned by their families or displaced from their homes. If your community does not have a plan to help the mentally ill, these vulnerable individuals could become even more cut off from support services and quickly deteriorate.

D. Understanding Trauma

Immediately after a disaster, the people most emotionally affected should be offered a form of care through the Crisis Counseling and Training Program (CCP) or Psychological First Aid (PFA) because many will experience anxiety or mild depression. Depending on how close they were to the epicenter of the disaster and what they saw and experienced, from 6% to 33% of the people exposed to a disaster will develop Acute Stress Disorder (ASD). In general, survivors of acts of violence such as mass shootings have shown higher rates of ASD than people who survived natural disasters (U.S. Department of Veterans Affairs, 2019).

ASD can occur during the first month after a disaster, and the symptoms are very similar to PTSD. The diagnosis of ASD is applicable from three days up to

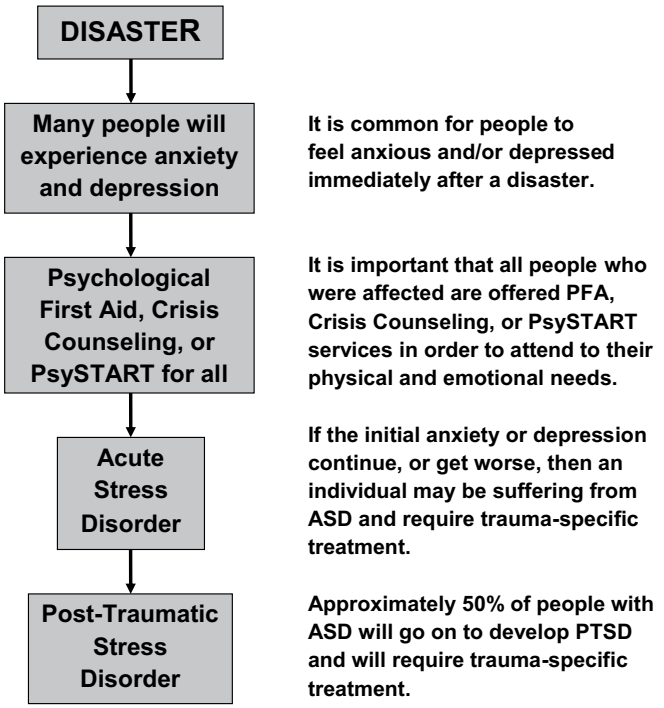

FIGURE 2.1 From a disaster to PTSD

a month following the initial trauma. If symptoms continue after a month, then it is diagnosed as PTSD. Approximately half of all people with ASD will go on to develop PTSD (*Psychology Today*, 2019). Individuals who are still experiencing stress and anxiety but do not have a diagnosis of ASD or PTSD can still benefit from wellness activities to deal with the stress of their experiences. (See Chapter 7 for examples.)

Trauma Symptoms

If people are showing several of the following symptoms, they may be suffering from some level of trauma and not realize it (Timberline Knolls Residential Treatment Center, 2019). This can happen to anyone after a disaster, even the therapist treating the victims.

Physical Signs of Trauma:

Unexplained sensations including pain;
Sleep and eating disturbances;
Low energy; and
Increased arousal (hyper-arousal).

Emotional Symptoms:

Depression and fear;
Anxiety and panic;
Numbness, irritability, and anger;
Feeling out of control; and
Avoidance.

Cognitive Changes:

Distraction;
Decrease in concentration;
Memory lapse; and
Difficulty with decisions.

Behavioral Signs and Effects:

Compulsion;
Substance abuse;
Eating disorders;
Impulsive, self-destructive behavior;
Dissociation/changes in interpersonal relationships;
Isolation, avoidance, and social withdrawal;
Sexual disruption; and
Feeling threatened, hostile, and argumentative.

Re-experiencing the Trauma:

Flashbacks;
Nightmares;
Intrusive thoughts; and
Sudden emotional and/or physical flooding of co-occurring disorders.

In the best-case scenario, anyone who struggles with some abnormal symptoms after a disaster should be encouraged to get treatment and not worry about any stigma attached to seeking help from a mental health professional. Also, many people do not have visible signs of physical injury after a tragedy but are nonetheless experiencing great emotional turmoil. In addition to offering immediate psychological support such as CCP and/or PFA, part of your collaboration's plan should be to ensure trauma-informed therapists are also available and readily accessible at post-disaster sites to encourage further help if necessary. Remember, the longer the trauma symptoms remain, particularly after a month, the greater chance PTSD is present, and the symptoms will not go away on their own—and will perhaps even become worse.

Trauma's Impact on the Brain

This manual also stresses the importance of recent changes in trauma treatment that are an outgrowth of better understanding of the brain. When people experience a horrific event or live through a highly stressful and life-threatening situation, they can become traumatized. As a result, they may become highly anxious and depressed, sleep poorly with nightmares, and lose weight from

loss of appetite. Over the past decade, neuroscientists have learned considerably more about changes occurring in these individuals' brains that lead to trauma symptoms, although these researchers have much further to go.

Brain scans literally shed a lot of light on what happens when someone has PTSD. A traumatized brain does not function efficiently or effectively. The lower part of the brain contains the amygdala, a small almond-shaped organ. When sensing danger, the amygdala tells the body to fight back or run away. This is known as the "fight-or-flight response." Sometimes people cannot run or fight, so they just freeze and keep all these powerful emotions inside (Huey, 2018).

PTSD sufferers display hyperactivity in the amygdala when responding to stimuli that in some way resemble the original traumatic event or events. The amygdala tries to protect the individual by being on constant alert and ready to react. This condition is called "hypervigilance." If the amygdala senses danger, it overpowers the frontal lobe, or the cognitive part of the brain, where reasoning and logic occur and makes the person react as if the threat is real and present.

For example, when some combat soldiers return home and hear a car backfire, they dive for cover. They are "triggered" by the sound because it resembles gunfire. People without PTSD react differently when hearing this same loud sound. They can immediately evaluate the situation and determine that nothing is threatening their safety because the amygdala is not overpowering the frontal lobe. Similarly, PTSD sufferers who have lost their homes or family members in a horrendous hurricane may react to strong winds and rain by shaking, sweating, or trying to seek shelter. Sleeping also becomes difficult because the brain is never completely resting; it is in an ever-vigilant protection mode. Prolonged lack of sleep only worsens the trauma symptoms.

Memories Formed Under Stress

The brain of someone with PTSD also handles memories differently. According to neuro-researchers, memories formed under the influence of intense emotion, such as a traumatic event, are difficult to forget, unlike those from a routine day. Memories are stored in the part of the brain called the hippocampus. When perceiving an event is a serious threat, the amygdala tells the hippocampus to "flag this because it is important." The hippocampus may not recall some aspects of the event but can hyper focus on strong details of the incident such as sounds and smells (Huey, 2018). The amygdala, the hippocampus, and the hypothalamus lie very close to each other. The hypothalamus works with the pituitary gland, which sends hormones to the body so it is safe from a perceived danger (Johnson, 2018).

When people have PTSD from a traumatic event, such as those who were very close to the disaster's epicenter, their negative memories will not go away

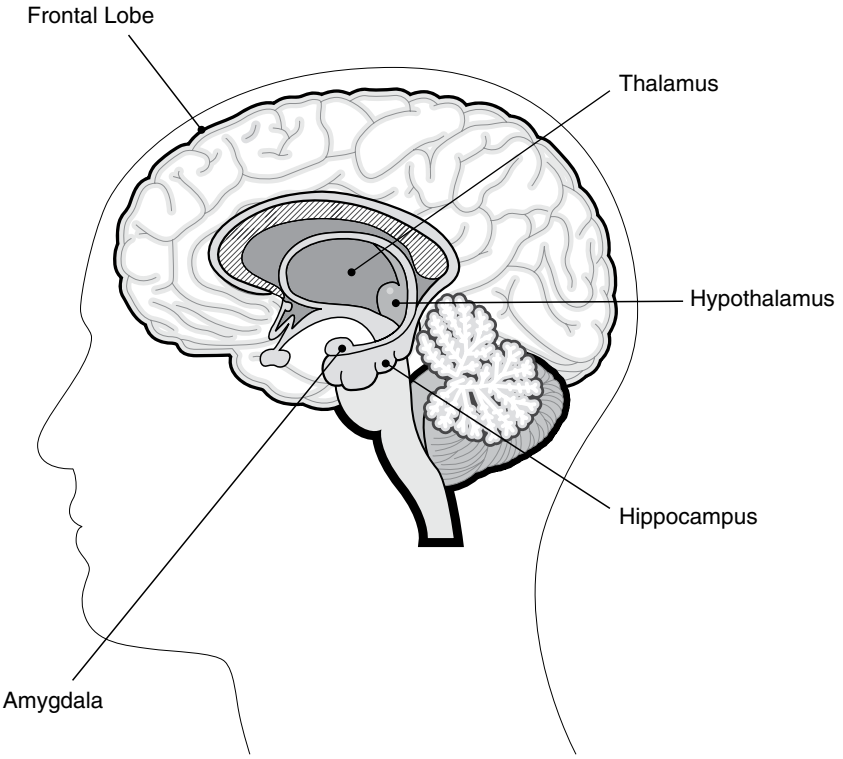

FIGURE 2.2 Parts of the brain affected by trauma

Source: Illustration by Leon Kamerman Schmidt

on their own. As a result, these individuals constantly feel as if the traumatic incident just happened. It is thus critical that these persons get treatment as soon as possible. Unfortunately, many first responders to a disaster mistakenly think their training will keep them from being severely affected by a traumatic event. They ignore any ongoing symptoms and do not seek help. Many of them will try to self-medicate with alcohol or drugs, which only worsens the problem. Police officers, firefighters, medical professionals, and clergy members, who are usually the first on the scene, should be encouraged by their employers and community leaders to seek a mental health evaluation to determine if they have PTSD. Suffering from trauma is not a sign of weakness; it is a normal reaction to a very abnormal event.

Changes in PTSD Treatment

Cognitive approaches such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which focus on the top of the brain, or the frontal lobe, have been the accepted treatment for PTSD. However, recent studies now suggest another

approach using techniques that work to calm the brain and release traumatic memories. For example, several studies with veterans have shown a substantial reduction in PTSD symptoms in just six hours of treatment with Emotional Freedom Techniques (EFT), a somatic approach that uses the body's acupressure points (Church, Geronilla, & Dinter, 2009; Geronilla, 2016).

Psychiatrist and noted trauma specialist Bruce D. Perry, MD, PhD, prefers to help PTSD patients "from the bottom up" rather than "from the top down" (Lyons, 2017). Instead of working with the cognitive functions of logic and reasoning found in the frontal lobe at the top of the brain, Perry focuses lower down on the amygdala and hippocampus. This bottom-up approach is necessary because the amygdala can easily be triggered in a traumatized person. It is unable to reason and designed for protection and will overpower the frontal lobe and take action. When treating people with PTSD, it is important to calm their amygdala and reassure them there is no present threat. This is the only way to release the traumatic memories imbedded in the lower brain and once again allow the self-regulation of emotions. As Perry (2014) puts it, "Regulate, relate, reason." Bottom-up treatments include Eye Movement Desensitization and Reprocessing (EMDR), EFT or tapping, and Brainspotting. These mind/body techniques calm the amygdala, allow access to the traumatic memories, and gently release those that are "stuck." (See Chapter 7 for more information on these trauma therapies.)

TO DO

1. Think about the business and personal groups of which you have been a member. How did the communication and collaboration between and among members strengthen or hinder the group's progress? As your community forms a disaster mental health collaboration, what will help the group form stronger bonds and get more accomplished? What may stand in the way of furthering communication and progress? For example, if many of the members are from similar types of organizations, they may be fearful of sharing data with one another.
2. Whom do you consider the most vulnerable populations in your community? How would/did these individuals fare in a disaster? Are they presently receiving the support needed to prepare them for major impact and change?
3. How familiar are you with PTSD through your employment or personal life? Do you think mental illness is increasing in the U.S., or has it historically been of major concern but now more recognized?

4. This chapter suggests that collaboration, communication, recognizing vulnerable populations, and trauma-informed care are the four principles to best help your disaster mental health intervention process. Do you have any other suggestions on how to more effectively respond to mental health needs following a community disaster?

Resources

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Reader's Notes

Secondary Traumatic Stress
Uncomplicated Strategies for Complex Trauma

> *You are not supposed to be happy all the time. Life hurts and it's hard. Not because you're doing it wrong, but because it hurts for everybody. Don't avoid the pain. You need it. It's meant for you. Be still with it, let it come, let it go, let it leave you with the fuel you'll burn to get your work done on this earth.*
>
> (Glennon Doyle Melton, *Love Warrior: A Memoir*, 2016)

You have likely heard of post-traumatic stress disorder (PTSD) but, chances are, many of you haven't heard of secondary traumatic stress (STS). I would like to draw awareness to STS since police officers who repeatedly respond to trauma victims are at risk of developing STS, if not PTSD (Hafeez, 2003; Marshall, 2003; Salston & Figley, 2003). I also want to distinguish STS from burnout, because these conditions are oftentimes discussed as if they are the same condition. They come from different sources and call for different responses to deal with them.

PTSD and operational stress injuries are typically associated with what is referred to as a "primary" trauma, where the event involves a threat to the safety of the police member. This distinct event is easier to identify as the source of traumatic reactions. It's called a "Big T," in that it is considered a "Big Trauma." For example, on this day, the police responded to a shots-fired call. Officers were shot at and returned fire, killing the suspect. This is the material of Chapter 2. In addition to the explicit acknowledgment of the event, there is usually a formal provision of support such as a debriefing, contact with a peer support

or critical incident stress management team member, or at least a verbal acknowledgment that it was a "helluva" call.

On the other hand, STS refers to a set of psychological symptoms that mimic PTSD but, unlike the singular critical incident that tends to accompany PTSD, STS occurs when a police officer is continuously exposed to the suffering and traumatization of others. These are referred to as "Small T's" or "Small Traumas," even though they certainly don't feel small, especially over time. The impact of this ongoing exposure to suffering is insidious. The officer cannot point to a single event as the culprit. Initially, this made it difficult to file claims with the workers' compensation board. Fortunately, a few compensation boards have recently recognized the cumulative effects of ongoing exposure to trauma (STS) on police officers. Some provinces in Canada now offer presumptive coverage, where the stress injury is assumed to be from the work and the burden of proof that it's NOT work-related is on the board. In my opinion, this is better than the police having to prove it's related to their work.

THE IMPACT OF CHRONIC EXPOSURE TO STRESS

So, what does STS look and feel like to the person that has it? As with PTSD, the effects of STS are psychological, physiological, behavioral, and spiritual. Psychological symptoms include depression, anxiety, distressing emotions, intrusive imagery, numbing or avoidance, and, sometimes, dissociation. It also affects your perception of situations. It may result in chronic suspicion of others, a heightened sense of vulnerability, feelings of powerlessness, and a lack of control. Physiological symptoms include headaches, gastrointestinal distress, heart palpitations, hypertension, heart disease, kidney diseases, hyperglycemia, hypoglycemia, fatigue, and premature aging. Behavioral symptoms include addictive or compulsive behaviors such as substance abuse, physiological arousal, relationship difficulties, absenteeism, excessive force, and sleep disturbances. Police work also changes the "soul" of police officers as they repeatedly face human suffering, deception, and violence.

In a study of cumulative career traumatic stress, an alternative name for STS, police officers reported high levels of disturbance from their exposure to trauma on the job (Marshall, 2003):

- 74 percent of participants reported experiencing recurring memories of an incident;
- 62 percent experienced recurring thoughts or images;
- 54 percent avoided reminders of an incident;
- 47 percent experienced flashbacks of an incident;
- 96 percent of participants reported that their opinions of others had changed;

- 92 percent reported they no longer trusted others;
- 82 percent believed the world was an unsafe place;
- 88 percent experienced prejudices they did not hold prior to being on the job;
- 11 percent experienced suicidal ideation as a result of the occupation.

These statistics are alarming; especially the 11percent of officers who had considered suicide due to their job. I can't help but wonder about underreporting in this category due to a fear of negative consequences.

In Chapter 2, we talked about critical incidents and their underlying physiological processes and effects. So, it makes sense to look at what happens to the body when it's exposed to chronic stressors such as secondary traumatic stress. When you're first presented with a stressor, your body tries to adjust to meet the demands of the situation. These adjustments occur through secretion of hormones from the hypothalamo–pituitary–adrenal axis, catecholamines, and cytokines. It's your body's way of trying to meet the demands of life, to eventually maintain a state of equilibrium (McEwen, 2000, 2005). However, over time, the repeated occurrence of stressful life events or worrying about them results in imbalances, also known as an *allostatic state*, a state of adaptation to the stressors (McEwen, 2005). If not corrected, you will reach a tipping point where allostasis, which was originally adaptive, becomes *allostatic load* or *overload*.

> "Allostatic load" refers to the price the body pays for being forced to adapt to adverse psychosocial or physical situations, and it represents either the presence of too much stress or the inefficient operation of the stress hormone response system, which must be turned on and then turned off again after the stressful situation is over.
>
> (McEwen, 2000, p. 110)

The strain of allostatic load becomes unbearable on individuals, breaking down adaptive coping, further impairing their functioning. Allostatic load makes you more vulnerable to stress-related illnesses such as heart disease, cancer, ulcers, and migraine/headaches. When cortisol levels remain high over extended periods of time the brain becomes damaged. Literally the structure and function of the brain change. For instance, chronic elevation of cortisol is associated with major depression (Sheline, 2003). Stress-related illnesses also include psychological injuries such as PTSD, anxiety, and chronic difficulties with memory.

Research shows that prolonged stress affects the immune system which, in turn, contributes to chronic anxiety and cognitive difficulties (McKim, Niraula, Tarr, Wohleb, Sheridan, & Godbout, 2016; McKim, Patterson, et al., 2016). Inflammatory immune cells in the spleen

send messages to the brain, contributing to individuals also having exaggerated behavioral responses to stress. Chronic stress also contributes to difficulties with short-term memory. Based on these findings, researchers believe that targeting the immune system may help treat mental health conditions (McKim, Niraula, et al., 2016; McKim, Patterson, et al., 2016).

Exposure to stress in police work has been referred to as "death by a thousand cuts" (Kirschman, Kamena, & Fay, 2014). It's a daily occurrence that goes unnoticed by others because they're doing their own thing. Even worse, if you attended these calls with others, which is usually the case, others may question how you developed a stress reaction to these calls while others didn't. You may even question this yourself. It becomes a blame game where people blame the person who admits to having a reaction to the call for being "weak," "off-duty mad," or accusing them of claiming work-related trauma for symptoms actually due to personal problems.

There are several problems with this rationale. The most glaring problem is that there is an assumption that others are not affected because they haven't said anything yet. The likelihood of them saying anything after hearing that another is being judged is greatly reduced, inadvertently reinforcing the false assumption that the person was the only one affected by the calls. Even if the first person isn't blamed by others, others who are affected by these calls may still not speak up for any number of reasons—fear of losing desirable assignments, promotion, pride, and so forth.

The second problem in blaming the person who reported being affected by the calls is that no two officers have attended the exact same calls in their career. Even if two officers attended the exact same calls in their career, which is highly unlikely, there are other factors that affect how traumatizing a call is. An accident scene may remind one officer of a previous one where he had prolonged exposure to a victim. Worse yet, the victim may have resembled a significant person in the officer's life, increasing the psychological strain of the call. Further complicating matters, if this officer is having problems in other areas of his life—family, health, financial—then he is more vulnerable to being affected by a difficult call. In short, the factors of the call (how long you're in contact with the victim, intensity of contact with the victim, relatability to the victim(s), history of calls of this nature) interact with the personal factors of the officer (personal and professional trauma history, health, presence/absence of personal issues and support) to determine the effect of the call on the officer. So, no two officers will have the same reaction to the same call.

Continuous exposure to the suffering of others, an integral part of policing, can slowly take a toll on your wellbeing. Like poison, small, continuous doses of others' suffering can make you sick. You won't

know why you're sick and you may even feel that your symptoms are "normal" because they have appeared so gradually. Symptoms such as difficulty sleeping or sleeping too much, changes in your belief system relating to your self-concept, others, and the world in general, and a desire to "tune out" by drinking alcohol, shopping, staying busy, or remaining glued to the television, may start to appear. You may find yourself thinking about difficult calls, crime victims, and the horrors of accident scenes when you are "tuned in" to your mind. You might notice tension in your body when you pay attention to it. This is why many people find ways to tune out. The problem is you can't stay tuned out indefinitely. There are negative consequences to this. Small ailments become bigger, chronic conditions that are harder to resolve.

DELAYED-ONSET PTSD

There is considerable research to support delayed-onset PTSD (McEwen, 2003; Smid, Mooren, van der Mast, Gersons, & Kleber, 2009; Solomon & Mikulincer, 2006). Chronic exposure to trauma throughout a police career can certainly contribute to delayed-onset PTSD. Individuals who develop PTSD at a later time typically have "partial PTSD," also called "subsyndromal" or "prodromal PTSD," following the event(s). These individuals might experience many of the symptoms of PTSD but don't meet all of the criteria for a diagnosis. The avoidance symptoms of PTSD are typically the criteria that are missing for full diagnosis (Andrews, Slade, & Peters, 1999). In police work, you may not be able to avoid situations and places because of the demands of the job. Furthermore, you may not have functional impairment immediately following your exposure to traumatic events. Despite this, subsyndromal PTSD is similar to PTSD as far as disability is concerned (Gillock et al., 2005). Ongoing exposure to traumatic events or even difficult life events continuously increases your risk for full PTSD.

Delays in addressing the accumulation of trauma exposure for police may make matters worse, as studies have shown that the longer the delay in following up with military personnel exposed to trauma, the higher the incidence levels of delayed-onset PTSD. Additionally, soldiers had fewer exposures to military trauma but a greater proportion of delayed-onset PTSD (Smid et al., 2009). It's possible that, if there had been more incidences, full PTSD criteria would have been met sooner. I share this because there are several parallels between policing and the military and because several members of the military eventually go into policing. The key takeaway is that delaying getting help is not advised. Accumulated unresolved traumas don't simply evaporate. They may pop up after you have retired and are no longer busy with the demands of the job.

McFarlane (2012) suggests two mechanisms by which delayed-onset PTSD occurs: *kindling* and *sensitization*. With kindling, life events have the strongest impact when they first happen. Then this event is impacted by how you process the information that follows. In other words, the initial event starts the "fire." Then negative thoughts about the event act as kindling branches laid on top of this fire. They keep the fire going, spreading the fire until it becomes full-blown PTSD. The sensitization process relates more to continuous trauma exposures and your reactions to them. To continue with the fire metaphor, it's as if one keeps lighting fires next to each other. The fires will come together into one large conflagration and consume the forest of the police officer's mind. Sensitization is dose-dependent, in that the more exposures, the more symptoms experienced (Copeland, Keeler, Angold, & Costello, 2007).

Delayed-Onset PTSD and the Aging Process

The delay of PTSD may also be attributable to the aging process (Aarts & Op den Velde, 2007). Aging is hard enough without this added risk factor! Initially, researchers thought that the age-related onset of PTSD was due to cognitive and physical decline that broke down individuals' coping mechanisms. More recently, research has challenged this "deficiency model," suggesting instead that, after decades of adaptive coping, other triggering events in late adulthood put individuals at higher risk for PTSD.

For instance, as we get older, we experience more losses—loss of spouse, siblings, and friends through death—which may trigger old losses that have not been resolved (Aarts & Op den Velde, 2007). If you've not allowed yourself to grieve these losses, you've just pressed on, doing your job, it can catch up to you. These parts of your past fuel the angst of your current loss. Trauma and loss can have an exponential effect when not dealt with. As the losses pile up, they can remind you of your own vulnerability.

Also during old age, individuals begin to reminisce, contemplating their lives, considering their selves prior to and since the traumatic events, in an attempt to make meaning at the end of their lives. This reminiscing can lead individuals to unearth unresolved traumas, feelings of guilt, sadness, and questions relating to their identity (Aarts & Op den Velde, 2007). Events such as hospitalizations or exposure to mass media depictions of war or racism can also "retraumatize" individuals, sparking the onset of PTSD (Aarts & Op den Velde). According to this research, delayed-onset PTSD could occur after decades of being relatively symptom-free. This can be confusing for the person experiencing these symptoms as well as the clinician treating them. It might

even lead to misdiagnosis of depression or dementia in older people, since being hospitalized or watching media depictions of war would be considered normal events. The activation of PTSD would be misunderstood since there's no obvious trauma in recent history to explain these symptoms.

Changes in life, such as retirement, were also believed to make it where individuals could no longer be distracted by work (Krystal, 1981). However, later research indicated that retirement was not as detrimental to individuals' health as once believed (Palmore, Fillenbaum, & George, 1984). On the other hand, *early* retirement was detrimental but it was likely the case that there were already problems in functioning that led to early retirement, not early retirement leading to problems (Aarts, Op den Velde, Falger, Hovens, De Groen, & Van Duijin, 1996). So, the longer you're on the job, the higher the likelihood that you can develop PTSD from the sheer volume of traumatic exposures, as well as the impact of other life factors such as loss of loved ones and retrospective reflections that re-activate distant unresolved concerns.

Delayed-Onset PTSD and the Police Organization

Providing organizational support for subsyndromal PTSD is complicated by the reactive nature of most organizational initiatives. Subsyndromal PTSD is also challenging for organizations that attempt to categorize their employees in a black or white manner: well/not well, fit/not fit for duty. The gray area created by subsyndromal PTSD can be confusing, leading to skepticism. The employer's skepticism may lead to misattributing the cause to poor work performance, marital problems, poor health, financial difficulties, or drinking problems. Simply put, the *effects* of delayed-onset PTSD over time are mistakenly viewed as the *cause* of it.

On the other hand, police organizations may mistakenly conclude that police are hardened individuals, resistant to harm (Adamou & Halem, 2003). McFarlane (2012) suggests it is important for employers to identify the accumulation of workplace traumatic exposures. This is the rationale behind annual check-ups or rotations for specific overly hazardous assignments. He also recommends that alternative duties be presented to the employee, but this may not always be an option for those in first responder work. Police may feel stigmatized by the assignment change and co-workers might be resentful, claiming special treatment for one leading to more work for them.

The kindling and sensitization process of PTSD also occurs with depression. Making matters worse, the depression can reach a level where it sustains itself without any outside influence (Patten, 2008).

You don't need to experience additional traumatic exposures or difficult life events to be trapped by negative thoughts and reactive to triggers. The pain and fatigue, which tend to accompany PTSD, are also maintained.

Police Suicide

The ongoing suffering from PTSD, depression, or anxiety, can be enough for police to think that taking their lives is the only viable option. Even the problem solver can feel trapped and unable to find a solution for what they're facing. As I was writing this section of the book, I received a call from a police lieutenant who was concerned about one of his officers. He told me that he directly asked the officer, a friend of his, if he was considering suicide. Even though he knew what answer to expect, it really scared him to have his suspicions confirmed. The officer said he was at the end of his rope. He felt that all he could do was let go. The lieutenant wisely, and honestly, empathized with his plight and urged him to climb back up the rope. He knew that he could do it, as the lieutenant had been there himself. He shared this, as this is the kind of guy he is; a straight shooter who wasn't afraid to show his human side.

There are several signs that people are considering suicide. Some well-known signs include saying goodbyes, getting one's business in order, withdrawing socially, talking about suicide either directly or indirectly such as expressing a lack of hope such as "What's the point?", "It never ends," "I can't wait until it's all over," or making comments about being helpless such as "I can't do anything right" and "I have no control over anything." Increased substance use, deteriorating hygiene, and emotional volatility also suggest possible suicide risk. Persons facing unsolvable problems or problems that at least appear to be unsolvable are also at heightened risk for suicide.

Some of the less-common signs for suicide are taking excessive risks at work in hopes of being accidentally killed or an abrupt improvement in mood. This improvement comes because the person is no longer struggling with the indecision about suicide. He or she has made the decision and is experiencing a brief sense of peace as he/she knows that the suffering is "almost over." This sign tends to shock family and friends after the completed suicide, as they will report that the person seemed to be doing better.

Dealing with Suicidal Thoughts

If you find yourself thinking suicide is the only option, you're not alone. Many people have moments when suicide seems to be the only source of relief for them. It is a desperate time, and when things get this bad, it seems like the pain will NEVER end. Yet, nothing, other than death, is permanent—not pain, not happiness, not sunshine, nor rain. You

may think it's hopeless and that you are helpless to change your circumstances but neither is true. I encourage you to reach out and ask for the support you need and deserve. I have had people show up at my counseling office unannounced (not my clients at the time) as a last-ditch effort to get help before they made the irreversible decision to end their lives. I asked them what I am now asking of you—give therapy a try. Talk to *someone*. What do you have to lose? More importantly, what do you have to gain?

If you think someone you know is contemplating suicide, I encourage you to directly, kindly ask them if they are considering taking their life. Tell them they're not alone. Tell them you are concerned for them and that you would like to help in some way. Ask them what they need. You may not be able to give it to them but you can help them find it. Don't pretend that you fully understand. In fact, say that you don't understand but you want to. Ask them if it's okay if you check with them again later in the week and then follow through. Get support from someone else to help you help this person—a peer support team member, mental health professional, family member, trusted friend, and/or pastor. There are hotlines for police struggling with mental health and/or suicidal thoughts. There are several options listed in the resource section at the conclusion of Chapter 5.

Going Home

You may find yourself depleted at the end of your shift. Yet, you may not have the option to go home and simply go straight to bed. You may be met at the door with demands for your time and attention for personal life roles such as spouse and/or parent. You have to find ways to make the transition from work to home a little smoother. Perhaps the transition will require a mental shift of your roles, reorienting yourself to your personal life. Other times it might be a matter of energy. Let's talk about what you can do for each challenge.

Police work is emotionally and physically demanding. At the end of any given shift, you may have been exposed to a variety of tragedies, insults and abuses, and adrenaline-filled situations. You may be physically and emotionally depleted as you make your way home to their family. Yet, your family life will call for you to have physical and emotional energy to interact with them, and perform your partner and/or parent role when you get there. This mismatch in needs can be problematic for you and your family. You want peace and quiet. Your spouse wants to tell you about their day. Your kids want you to play with them. Your patience may have been depleted long ago, leading you to be irritable, maybe even outright angry. I've had officers tell me that they feel terrible about their behavior when they get home but they're at a loss as to what to do about it. Their spouses aren't happy either. They can't understand why their spouse isn't happy to see their

family. The funny thing is that people are prone to treating total strangers with more respect and patience than their own family members. This is because many don't fear negative consequences from family members because they know they are emotionally attached to them. I'd say this line of thinking is quite backwards! It might help to ask for a small amount of time for you to get reoriented to your home life. You might need to take the long way home, listening to your favorite music, or maybe listening to the absence of noise in your car, in order to get your head cleared of the chaos that you've been in for the last 8–12 hours. One officer told me of deliberately asking his fiancé to give him 20 minutes to himself when he got home. He took this time to be intentional about exiting the police role and entering his home role. It's a small sacrifice of time to improve the quality of interactions that follow.

On the other hand, you might be hopped up on adrenaline after a busy shift and notice that your family is operating at a much slower pace. I've heard it described as trying to plug in a 220-volt appliance into a 110-volt outlet. Things just might blow up, leaving you in the dark as to what just happened. You may find that spending time with your family is boring, compared to the excitement at work. You might try to chase this excitement by returning to work, hanging out with co-workers and talking shop, or watching TV shows that relate to your work. Some might try to recapture the high with risk-taking behaviors like driving fast, gambling, using substances, shopping, or extramarital sexual affairs. Unless you hit a jackpot when gambling, not much good will come from these behaviors. In fact, these are the kinds of things that get police into trouble, under investigation, and divorced. It's a good idea to make plans for your transition. Go for a run, hit the gym, go for a bike ride, and then go home. If your shift doesn't allow for any of these (people would call in on you for running the neighborhood at 2 a.m.), you may find it helpful to take even 20 minutes to do something to take the voltage down before you walk through the door. Take a brisk walk around the block (five times, if needed). Maybe even take the dog with you to get Fido some exercise as well. Dogs can be very calming too, or, at least, comforting most days.

One odd but effective recommendation that I give clients is to look at their feet. If you're wearing your work boots, you're in work mode. If you're wearing running shoes, you're personal you, maybe it's athlete-you, maybe it's puttering-around-the-house-you. If you can't tell from the footwear, look an inch beyond at the floor. Where are you? If you're at home, you're not police. You're a spouse, parent, child, sibling, roommate, anything other than police. I know. I know. They say police is a 24/7 job and I get it. But, if you don't put in the time in the other roles when you're not at work, you won't have anything to go home to.

POLICE ADMINISTRATORS

Police administrators are certainly not immune from secondary traumatic stress. In fact, they may be more likely due to having more years of service. Not only do they have their own work history, filled with trauma exposure, but they can also be exposed to the suffering of their officers. Police administrators also have risk factors such as longer hours, sedentary work, and less camaraderie than line officers. In smaller agencies, administrators still respond to calls for service or, at a minimum, respond to the larger, more public (and more heinous) calls to oversee the handling of the call. Most police administrators will also be older and may have worked the streets at a time when talking about reactions to the calls would never have been acceptable and when education and training relating to STS would not have been available. Adding insult to injury, if they're much older, they may also be dealing with the stressors that are common to older adults such as health declines and loss.

In addition to having the added risk of STS, administrators are in the position to take actions to minimize officers' suffering from it. Police have repeatedly named their work environment as their biggest stressor (Abdollahi, 2001; Bell, Kulkarni, & Dalton, 2003; Burke & Paton, 2006; Hart, Wearing, & Headey, 1995; Liberman, Best, Metzler, Fagan, Weiss, & Marmar, 2002; Marshall, 2003). Police have repeatedly cited supervisory support, or the lack of, as a key factor for their ability to cope with STS. They make decisions about workers' compensation claims that affect officers' rights to treatment for work-related injuries. As, I said at the beginning of this chapter, oftentimes, there's no one call that the officer can point to as the reason for their occupational stress injury. It is the accumulation of traumatic calls that led to PTSD, anxiety, or depression.

Administrators, particularly field supervisors, make decisions about how long officers stay on the scene, exposed to the suffering of others. Continuous exposure to the traumatization of others can tax an officer's ability to cope with his/her exposure to trauma. Officers reported feeling physically and emotionally exhausted when they got stuck on a call involving trauma to another. Some officers, especially those that work in remote areas, are oftentimes stuck on calls by themselves for ungodly amounts of time. Chronic physiological arousal can result in the officer's inability to use his/her emotions as signals (van der Kolk, 1996). Emotions are supposed to provide us with information about events but it gets lost if you're emotionally exhausted from continuous exposure to STS. After being on the call for a while, your adrenaline levels will drop off, leaving you even more vulnerable to the effects of STS. Administrators should make every effort to get their officers relieved from their duties, even if just briefly. Relieve them yourself, if

you can, so they can run to the station (even the gas station) to use the bathroom or change out of a wet or contaminated uniform. If that's not possible, bring them something to the scene that'll help them hang in there; coffee, a bottled water, a snack, etc. It's the little things that can make a big difference.

Another very important role administrators play in the mental health of their officers is that they're the holders of information: what's happening in the department, how complaint investigations are unfolding, and where and how to get mental health support. Some departments are better at making information about mental health resources available to officers than others by placing these resources on an employee-only website. This prevents employees having to ask around, broadcasting their need for support. Many officers I've spoken with reported that it was difficult to get the information they needed to access mental health services. Some even had to go through their supervisors to find out what was available to them. As you can imagine, this can certainly be a barrier for getting support due to the stigma of being weak by asking for help. Sadly, many of the officers I've talked with relayed that police managers "scoff at the idea" of seeing a psychologist or counselor.

In an ideal world, police agencies wouldn't have staffing shortages and financial constraints. Police could take time off, as needed, to bounce back from the barrage of calls. Officers who have been battered by one shitty call after another would benefit from having time off. We don't live in an ideal world though. So, administrators might have to be creative in rotating assignments to more evenly distribute the call load. Just make sure it's understood that the rotation isn't punitive, or because you feel that someone isn't managing their calls, district, or workload. In some police positions, usually outside of patrol, there might be an option to even let officers flex their hours for non-work activities. When it's an option, it has been shown to be very helpful in restoring or maintaining work–life balance and, consequently, job satisfaction. I know that I appreciated getting to change my hours when I was a detective. I was able to take Spanish classes at the university in the morning and work my cases in the afternoons and evenings. I felt like it was a win–win for me and the department, and I appreciated my sergeant's support in my goal to learn Spanish.

Even if none of these options are available, and many times they're not, honest verbal support of line officers and their work can go a long way. Officers have told me that they knew their work was appreciated by their sergeants and they were happy to do it. Those that felt their admin was pushing them without concern for their wellbeing or felt that their accolades were hollow, did not fare as well. They don't get much satisfaction pleasing an admin that doesn't care about them. Police can also detect bullshit when it's being given to them from

citizens AND administrators. The *perception* of support has a stronger impact than the *actual* support given (Kaniasty, 2005).

CIVILIAN EMPLOYEES

Just like officers, civilian police employees can be affected by continuous exposure to traumatic events. As mentioned in Chapter 2 on critical incidents, dispatchers, call-takers, and other civilian employees tend to have additional risk factors for being affected by their work that are not usually accounted for. They don't receive the same amount of support as sworn police members do. They're at the bottom of the organizational hierarchy, they feel an added sense of responsibility for officers and the other first responders they dispatch for, and they usually lack proper training to do their jobs (Burke, 1991). Beyond this, although their work environment may shield them from the dangers of the street, it has its own dangers: confinement to a dark, noisy, hectic, and uncomfortable room. This environment contributes to additional stress (Burke, 2005).

Beyond the horror that might be heard on the phone line or radio, dispatchers and call-takers have the added stress of having to rely on other people to provide them the information they need to do their job. They make decisions based on partial and incorrect information from others, which can be intentionally or unintentionally withheld. They don't have the benefit of getting information from the caller/radio other than by what they hear. Unlike sworn members, there's no visual information for them to assess. Dispatch/call-taker work has been referred to as "a gunfight with blinders on" (Patterson, 2005, p. 21). So, until people start "Facetiming" 911, they only have what they're told and what they can hear in the background, to make sense of what is happening. This can leave them feeling quite powerless over and over again.

Adding insult to injury, sworn members may dump on dispatchers and call-takers for gaps in information because they felt ill-informed to safely or adequately respond to the call. Callers routinely don't know where they are, or fail to relay self-incriminating details relating to weapons on scene, and so forth. Having been a dispatcher before I was an officer, I tried to stay aware of the challenges call-takers faced in trying to extract information from panicked, intoxicated, and uncooperative callers. I hate to admit it, but there were times when I *still* got mad at them if I felt I was endangered based on a lack of good information. Officers may also be dismissive of the stress dispatchers and call-takers have, since they're not in physical danger in the field. The denial of their difficulty heaps more stress on them.

Dispatchers and call-takers are stretched thin throughout their shift. While officers divide the call load and take breaks (even if to write

a report), many times dispatchers and call-takers don't really get any downtime. The sheer volume of calls and radio traffic subject dispatchers and call-takers to ridiculous amounts of trauma. Studies of dispatchers have shown chronic elevation of cortisol, the stress hormone, throughout lengthy shifts (Bedini, Braun, Weibel, Aussedat, Pereira, & Dutheil, 2017; Weibel, Gabrion, Aussedat, & Kreutz, 2003). Because they're forced to be sedentary while doing their job, they aren't able to burn off any stress, as police in the field are sometimes able to do. Being sedentary also contributes to health issues, which, in turn, worsen the chances of recovering from STS.

POLICE FAMILY MEMBERS

Research indicates that if a police officer is suffering from STS, his or her partner is also at risk for STS (Dwyer, 2005). The partner is exposed to the trauma when the officer retells the events of the day. Even if details are left out, the partner may fill in the details and create a disturbing mental image to accompany the story. Family members also wrestle with the same questions about these events that police members do (Figley, 1998). Family member symptoms will mimic the symptoms of the police member, which can be very confusing. The more details are shared with them, the more symptoms they will experience.

Making matters worse, sometimes, in their efforts to support their loved ones, police and family members ruminate together about their fears and worries. This makes symptoms of anxiety and depression worse, not better. This is referred to as the "pressure cooker" effect, as the angst rises with the mounting pressure of these talks (Hobfoll & London, 1986). The more loved ones offer support, listening to their crisis, the worse things can get. I would add that this happens in the home, as well as in the workplace. Everybody gets riled up when you're all ruminating. Worrying excessively with your loved one can have the opposite effect of what you're hoping for. It's better to talk about worries and reactions but to not dwell on them, with them dominating all of your conversations.

Other times, it can be very tiring managing your family when the police member is struggling with STS. You might find your patience wearing thin. You may even come to believe that your police member is using their job as an excuse to explain bad behavior. Maybe they are. Sometimes, police, like everybody else, do things that make their situation worse. You may be tempted to take out your frustrations on your police member. No good can come from this. You'll just be batting your frustrations back and forth at each other, in a downward spiral. Instead, talk with them about it. Hear them out. If they say their job is making them drink (spend, yell, sleep all the time), try to mentally

separate the frustrating consequences of their bad behavior from their underlying intentions; which is usually to shield him-/herself from the stress or pain. Every day I hear stories of wounded people trying to do their best in the world, but still making poor decisions to get by. I'm not suggesting that you be okay with the bad behavior. But if you villainize the doer for the deed, it will likely only add to their own beliefs that they're a bad person that's ruining their life and the lives of their family. Instead, appeal to the person you know and love, who is buried under a blanket of pain. You might find that it *does* relate to their work or that it relates to any number of other demons they're struggling with. You're not likely trained to be their therapist (nor would that be a good idea to be the treating clinician, if you were), but you can help them to feel understood and gain some insight into the destructive consequences of their behavior. This might open the door to them getting professional help or, at a minimum, motivate them to make change on their own.

Family members experiencing STS from supporting their police member can feel very isolated from others (Galovski & Lyons, 2004). Others may not understand their symptoms, or know what to say or do; leaving police family members to feel even more isolated. Family members don't get the same levels of support their police members do. If police members work for responsive supervisors, they're likely to get a referral for support. Most wouldn't think to include support services for family members who are also affected. Some of the information for family members might be geared more toward how to support the police member, not for the family, per se. You're not alone though. I have listed several organizations in the Suggested Resources section at the end of this book.

PREVENTING STS FROM BECOMING STSD

When asked about what hindered his ability to cope, one officer relayed an incident where an infant had been sexually abused, stating

> I mean you often hear that line, you know, 'I've seen it all'. I didn't see that one coming. It's just, wow, I can't believe there are people who actually do that, so it . . . it's hard to process something that you don't understand.

Instead, acknowledge that you are having a normal reaction to traumatic events and that your body is telling you that you need to deal with it. Talking with a professional can help. You can unload the burden you have been carrying and find ways to manage your reactions to previous and ongoing experiences of trauma. Secondary traumatic stress does not have to evolve to the status of "disorder" before you get

support. You wouldn't wait until you got a cavity to brush your teeth. Your mental health warrants the same level of preventative care.

What can you do to insulate yourself from the effects of STS? My study on how police cope with their exposure to secondary traumatic stress resulted in 14 key factors that influenced their coping:

1. self-care—taking care of physical, emotional, and spiritual health;
2. support from family and significant others;
3. talking to co-workers—informally debriefing and supporting each other;
4. emotionally disengaging from emotionally draining calls;
5. having a supportive work environment;
6. access to mental health resources;
7. personality—being positive, not taking self too seriously, etc.;
8. ability to help the victim (might mean adjustment of your definition of this);
9. relatability to the victim (hindered when this happened, so emotional detachment helped);
10. scene reminders (made it harder when having to return to scene/area often);
11. continuous exposure to call or mentally dwelling on it;
12. exposure to human nature (hindered when only exposed to the negative/dark side);
13. vulnerability of the victim (especially children);
14. presence of additional stressors—health, financial, relationship.

Officers felt they had control of some of these issues (self-care, emotional disengagement, and connecting with supportive others) but some situations relied on organizational or situational factors to make it easier or harder on them (nature of the work environment, continuous exposure, scene reminders, ability to relate to the victim). Whether or not you control things influences what is most adaptive for you to do in the situation. When you can control it, it's best to act on it, approach the issue. When you don't control it, it's best to avoid trying to change it and, instead, change your response to it.

> *Man is capable of changing the world for the better if possible, and of changing himself for the better if necessary.*
>
> (Frankl, 2006, p. 131)

According to Anshel (2000), avoidance coping, the cognitive and behavioral process of creating distance from a stressful situation, is recommended for circumstances where you don't have the ability to

change the circumstances. Some officers use avoidance coping by making a point not to learn personal details about victims or using dark humor to lighten the intensity of the situation. I know I did this when going to a tough call. I made it a point to NOT look at the pictures on the fireplace mantle when I went to someone's house to do a death notification. It didn't help me in that moment to see that this was once a (seemingly) happy family. What is particularly difficult is when the person who worked the death scene, is the same one doing the death notification. Ideally, these would be different people. Dark humor can also go a long way in lightening up something that you have no control over. I've heard (and made) sick jokes about going to lunch during an autopsy. It sounds like you're deranged to talk in such a way, but the reality is that you can't bring back the dead. You're not causing harm to the person's family if you are discrete about it and kind when interacting with them. It doesn't mean that you don't care; that you're calloused.

Avoidance strategies should be healthy ones like exercise or focusing on the aspects of the job that you do control. Maladaptive avoidance coping includes using alcohol or drugs or overeating and these mechanisms have a well-documented history in policing (Cross & Ashley, 2004; Gershon, 2000; Kohan & O'Connor, 2002).

There are many ways you can take care of yourself—exercise, participating in hobbies outside of work, maintaining supportive relationships, talking with co-workers, and talking with a professional. Officers have reported that it helped them to periodically unload their troubles on a person not involved in their personal life, such as a mental health professional. It's a good place to let it all out without fear of judgment or traumatizing the listener. Officers cited talking to co-workers as a helping factor even before being asked what helped them cope with STS. In the course of describing what it was like being a police officer, several spoke of camaraderie and teamwork as key reasons for enjoying their work. For some, talking with co-workers took place mostly at work following critical incidents. For others, it extended to off-duty activities such as playing sports and just "hanging out." Speaking a common language of police jargon makes it easier to feel supported and understood by co-workers. Talking about other things besides "shop talk" with co-workers can also be helpful. Oddly, officers are reluctant to talk about their reaction to traumatic events even though they recognize that they feel better after they do (Evans, Pistrang, & Billings, 2013). Research has found that a cohesive social network reduces the effects of traumatic stress (Ozbay, Johnson, Dimoulas, Morgan, Charney, & Southwick, 2007). Palm, Polusny, and Follette (2004) suggested that those who cannot talk to their co-workers may experience more isolation, creating difficulty for managing their exposure to STS.

CONFRONTING UNFIXABLE SUFFERING

Police who go from call to call, problem to problem, may find their worldview changing for the worst. Entering policing, you may have believed that the world was a benevolent, predictable place. After some time on the job, these beliefs can be shattered and replaced with beliefs that people, including you and your family, are vulnerable to harm. This change in worldviews is believed to result in anxiety, depression, or PTSD, as you become acutely aware of your mortality (Janoff-Bullman, 1992).

If you find yourself struggling with feeling that you are facing unfixable suffering, you may also wish to change your view of how you define success in your work. You will never eliminate crime. You must look for the smaller victories—the small changes that you can make in the lives of others. You may not be able to prevent the burglary, or even get their stuff back, but you can give people suggestions for making their home more secure. One officer relayed:

> This person had his house broken into and had a bunch of jewelry stolen. One of the pieces of jewelry was a ring that his deceased father had given him and his brother. It had some sort of inscription on it that was important to this particular person. He didn't care what happened to everything else. He just wanted that ring back and he was visibly distraught. He and his father had a very close relationship. So, you can't imagine what that person is going through, now that that one connection has been taken. I told him just call the pawn shops, let them know and if this particular jewelry shows up, have them call us. Well sure enough the next day two guys are in a pawn shop trying to sell it with a bunch of other jewelry. We end up getting the guys. I called him up and I said "Sir, thank you very much for your call" and he was like "Really? So, what did you get?" I'm like, "Well, I told you I'd get your ring back" and when I gave it to him, his face just lit up and he was just absolutely happy. That's why I do my job! It's never these big dramatic things.

For this officer, he had to adjust his definition of what success looked like in his work. Earlier in his career, he had a bigger picture idea of what his job was. It had been about preventing or reducing crime, which just isn't realistic.

You can define success as being able to comfort accident victims during one of their most difficult times. Working with crime and accident victims, I oftentimes hear of the difference it made to have

an empathetic police presence. In fact, some police officers got into policing because they had a positive interaction with police during their darkest hour. They decided they wanted to be that source of comfort and protection for others.

When I switched from short-term response support as a police officer to a longer-term support as a therapist, I got to hear these stories. I learned that most people heal from traumatic events. I'm not saying they're unscathed. I'm just saying that life goes on and people can heal from even the most horrific of circumstances. However, police don't usually get to hear how the story ends, so to speak. They just see the person at their darkest hour and then go on to see the next person at their darkest hour, and so on. When I studied how officers coped with secondary traumatic stress, officers told me that it bothered them that they never really knew how it all turned out for the crime victim. They rarely got to see that the victim moves on and goes back to their daily lives. Their "victimhood" is the first and last impression of them. Occasionally, you might get some kind of closure. It's more likely with firefighters and paramedics who save peoples' lives in medical emergencies. The victims (patients) drop by the fire hall or write a letter to thank them for their help. This happens in policing too, but to a lesser extent. Without the ability to follow up with crime victims, you're stuck with having to fill in the blanks for yourself as to how they're doing. It helps to recognize that tragedy is as much a part of life as success is. It isn't the exception. It's always been that way. Throughout history, people have faced and moved past tragedies. They will continue to do so after you leave the call. You have to learn to live with believing in this without witnessing it. One officer told me of her prior experience of trauma as giving her this wisdom as she faced the tragedies of others in police work.

> I feel like I understand the grief that the people are going to go through. So, I don't take on as much of it. I know that I got through this. Now I know that these people will be able to. It was turning that dread of realizing that I know what the near future might be like and then thinking they're going to get through it the same as I did.

It's also important to recognize and accept your limitations as a human. You cannot fix problems that took months or years to develop. As I said in Chapter 2, there is a difference between responsibility and accountability. You share the responsibility with multiple others, including large systems, to address the problems that police are called to handle. You have to focus on the small part for which you could be held accountable. This means taking measures to keep others and yourself safe, taking good notes from victims and witnesses, doing your

best in interrogating suspects, writing good reports, and leave the rest of the situation to all the other people you share responsibility with: the victims, witnesses, assisting officers, crime scene technicians, district attorney, and jury, to name a few.

LET GO OF THE OUTCOME

I remember my first week in field training as a mixture of excitement, pride, and nervousness about my ability to be a police officer. I was dispatched to meet a domestic abuse victim who had managed to escape her home to call for help. As I took her statement, I noticed the scars on her face and body, likely the remnants of previous beatings. I remember the fear and desperation in her voice as she pleaded for help with her situation. When we arrested the abuser that night I remember thinking that this is what it was all about –righting the wrongs, protecting the vulnerable, and bringing a sense of order to the world. A week later my idealistic views were dashed when I learned that the abuse victim had been beaten to death. I immediately began reviewing what I had done, not done, could've done, and should've done that might have created a different outcome.

Unfortunately, this was not an isolated event. There were many like it where my desire to make the world a better place just wasn't happening. Was I a bad cop? Should I have chocked it up to my inexperience as an officer? Or was there more to it? This was happening to every cop, regardless of their level of experience. So, clearly, it wasn't a matter of being a "good" or "bad" cop. I learned that it was the limited influence that cops actually have in the circumstances they face every day. So how do you do a job where you feel that your influence is limited in the big picture? You have to change your view of what success means.

If I had determined in week one that I was not effective in my work, there are countless instances that I would not have been able to prevent crimes, console victims, and catch bad guys and gals. You have to look at those instances when you evaluate your effectiveness. Unfortunately, human nature directs you to pay more attention to what went wrong than what went right. In this way, you (mistakenly) feel that you can have more control the next time you're facing a similar situation. This is not to say that you can't learn from experiences and get better at handling events in the future. It is to say that there is a limit to how much you control circumstances despite your best preparation, training, and wisdom. You are human beings, after all, faced with so many variables outside of your control. Even if you do make a "mistake" in a situation, the outcome is usually greatly influenced by so many other factors than your mistake. Take my personal example—I can reason that if I had not arrested him, he would not

have been so mad as to beat her to death. This is tricky because you can't prove it either way, which makes this logic torturous. But *I* didn't beat her to death. I never even touched her. *I* didn't put them together as a couple and *I* didn't teach him that he should demonstrate his dominance by beating others to submission. In fact, what I did was what was expected of me as a police officer. What if I hadn't arrested him and he killed her that night? Am I responsible for that too? It can feel like a no-win situation when all of the options could have negative consequences. The problem is that we assume a better outcome if a different course of action were taken. We also discount how many times taking a certain course of action *did* turn out well. I arrested lots of abusers after that without this outcome. Sometimes we also learn other information *after* the event has concluded and hold ourselves to a standard as if we knew it at the time of the event. It is important to separate what we knew at the time from what we later learned to avoid punishing ourselves for crimes we did not commit. These are some of the trauma-related guilt-thinking errors I talked about in Chapter 2.

What I am trying to convey here through my personal story is that we can sometimes be our own worst enemy when it comes to evaluating our decisions and performance. Attaching the outcome of an event to your input is dangerous and based upon faulty logic that rarely gets questioned. You need to question this logic—Did your singular input create the outcome? Did you have all the information you needed at the time? Could it have turned out poorly if you had taken a different course of action? Could a different action have made the situation even worse than it turned out? Have you taken this action before without these outcomes, maybe even positive ones? These are important questions that can not only save you a lot of grief, but can help you see the big picture.

When chronically exposed to the suffering of others, it also helps to bear in mind that you are only exposed to a small slice of the population. Think about it. Nobody calls the police to come observe that little Johnny is doing well in school. You are only called upon when something bad happens. This is why it is so critical for you to maintain relationships outside of policing and participate in non-police activities—to expose you to the rest of the population, to keep a balanced view of humanity. I know this is hard to do with shiftwork but it's doable, with effort.

I have presented some pretty scary symptoms and staggering statistics regarding the effects of STS. I hope what you takeaway from this is that you have the power to take a proactive approach to counter these effects. If you are already experiencing these effects, I hope you find comfort in knowing you are not alone and that help is available. The effects of this can be worsened by many of the organizational stressors that come with police work. These are discussed in the next chapter.

TOOLS FOR YOUR DUTY BAG

- STS mimics symptoms of PTSD but comes from chronic exposure to the suffering of others.
- No two officers will have the same reaction to the same call because they haven't had the same accumulation of calls.
- The longer on the job, the higher the accumulation of traumas, and the higher the risk of PTSD from STS.
- Accumulation of STS can lead to thoughts of suicide. Suicide is a permanent solution to a temporary issue.
- Coming home following exposure to STS can either deplete you or key you up. Take measures to transition to your home environment: exercise, listen to music, read, make time for quiet (even if only 10–20 minutes).
- Supervisor support is one of the strongest protective factors against STS. Perceived support is more important than received support.
- Emergency communicators also have a higher risk for STS than expected due to sedentary work, confinement to an uncomfortable work environment, and a lack of support combined with having an added sense of responsibility.
- Family members demonstrate PTSD symptoms from exposure to police members. Family should take care of themselves and mentally separate the doer from the deed when the police member is coping in destructive ways.
- Take action early to counter STS: exercise, get support from family, talk to co-workers.
- Adjust your definition of success. Remember, you didn't create these situations and you can't "fix" them either.

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