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“When Disaster Hits a Community”

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(What follows is an expanded version of my comments during the teleconference.)

There has been much emphasis over the past several years placed upon acute interventions after a specific and circumscribed disaster affects a community. But it is my opinion that there needs to be an increasing emphasis placed also on deepening our appreciation for the nature of a disaster, the nature of the affected community, and what the community response to a disaster comprehensively entails. In other words, the process--how a disaster response team conducts stress debriefings within hours or days following an incident --has sometimes supplanted the content--tailoring the intervention over hours, days, weeks, months, and even years to meet the real needs of the members of the community. Networking allows many of us involved in this field to find resources on post-disaster community response in the form of books, government publications, health department publications, and after-action reports. My goal in today's teleconference is to network with you regarding my thoughts and opinions and experiences in this specific area of disaster medicine and to guide you to helpful resources for knowledge and for training. I wish to present a conceptual framework for looking at this area and not to provide you with information you likely already know, e.g., psychiatric nosology and treatment of stress disorders.

My views can be expressed in two analogies. First, consider the contrast between the purely biological psychiatrist who prescribes medication as the sole means to resolve the disaster of a patient's crumbling mental health, and the psychodynamically-trained psychiatrist who has a solid knowledge of what forces shape the patient's mental health and coping, what internal or external events have overwhelmed coping mechanisms, and how medication and talk therapy (of whatever kinds appropriate) can be successfully used in resolving the mental health crisis. The former psychiatrist stands out, the latter one stands out after blending in by "entering" the patient's internal mental life. Another analogy can be drawn with the television network news anchor who reports on a faraway disaster but has little or no concept of how the disaster has truly affected the members of a community. He can be contrasted with the beat reporter for the local newspaper or television station who reports the disaster first-hand by virtue of her intimately knowing the community--and vice versa--and effectively stands out on the screen or in print because she has first blended in.

Standing out and blending in are the two components to success which I have used in a variety of military and civilian disaster situations over my 10 years of disaster mental health work in the Navy as a member of our SPRINT (Special Psychiatric Rapid Intervention) Teams (1). My approach is to work within established procedures of being a disaster mental health consultant and resource for the leadership of the affected community. However, at the same time, I function as a behind-the-scenes observer of sociological, historical, cultural, and mythological data and processes as well as an organizational psychologist. This sharpens my focus on the community's reaction and the community's needs after a disaster.

Over the years, my work has been informed by four guiding concepts.

First, those who work in the disaster mental health field have traditionally used the term “disaster” to refer to a specific accident, or incident, or event--whatever the cause--which then leads to persons experiencing it as a traumatic event (hence, the condition post-“traumatic” stress disorder). In other words, a disaster is necessary to the definition of clinically-defined trauma. **[I have my own working definition of a disaster: an unexpected event that occurs in one’s own life--as both outwardly lived and inwardly experienced--of such significance as to irretrievably alter both of those aspects of one’s own life and, as well, to leave one with both haunting and emotionally charged memories and with some extra degree of wariness about the future.]** However, the sociologist Kai Erikson (2,3) very clearly articulates a more comprehensive and accurate definition, I believe: any event or condition which brings about a traumatic condition could be considered to have been (be) a disaster. Traditionally speaking, the acute disasters are well-described in the annals of mental health and sociology literature. But for many individuals, chronic conditions such as poverty, medical illness, divorce, death of a spouse or a child, torture, or living in areas with industrially polluted earth and ground or drinking waters--and occupations with known “burnout” such as emergency medical care personnel--can be considered disasters, as well. It is not only the nature of a disaster which defines our work but more importantly, it is the fact that individuals experience trauma in very private, idiosyncratic, and possibly cumulative ways. I believe that exposure to combat can be considered a disaster, depending upon the views, experiences, and personality of that individual soldier, sailor, airman, or marine; it is also shaped by the experiences of the unit, platoon, squadron, etc. as well as by the leadership during and after combat.

A second principle is to look beyond the meaning of the word community when describing the effects of a disaster. Community can be looked upon as a collection of houses and buildings and organizations and businesses and roads and land, and cars and trucks and other means of transportation, and people who own, use, or inhabit these structures or things. Kai Erikson (2) provides a very valuable and illuminating discussion of how community differs from communality (the nature of the network of human interrelationships--the interpersonal underpinnings of a neighborhood, a region, a farm district or business district, a county, etc.). Reliance upon and responsibility for persons in a collective sense--of present, past, and future; of physical proximity and closeness; of shared cultural and ethnic strengths--is the communality that is especially strained and disrupted from an acute disaster. But a poverty-stricken farming community, a small group of combat-exposed veterans returning to the US with most of their unit killed or wounded or returned separately, a cluster of violent deaths among members of a high school, the primary industry in a small town suddenly closed by the national parent chain, or a multidisciplinary AIDS Clinic in a medically-underserved area closed because of lack of funding can all represent disasters with a rupture of communality. I believe that our biggest challenge in disaster response work is restoring communality.

From the moment I hear of an incident--a disaster--I do think of both the physical community and the human communality that could be effected. The only difference between a major motor vehicle accident with much loss of life that occurs in a town and a jet airliner crash with complete loss of lives that occurs outside a major city is the size of a net that is cast over the community and communality. In the former, it is a relatively circumscribed net. In the latter (especially if it was an international flight), the net of communality affected reaches into families and friends and businesses and institutions worldwide, as well as into the airlines company itself as “the cause,” and even into the international collective consciousness of grief, anger, and moral retribution if a terrorist cause is suspected. It is not that the emotional brushfires are that much greater in a larger disaster than smaller disaster; the intensity remains the same but they can burn worldwide.

The psychological, sociological, and mythological ramifications of a disaster which befalls or strikes a community can be very longlasting, subtle, and destructive; to use one analogy, it can be like termite damage to a house which goes unchecked, destroys the basic foundation of the house, and at a future time, results in a sudden collapse or a need to

completely destroy the house and begin rebuilding. This can come as a complete surprise, as the owners of the house may have kept it well painted and secure from the effects of weather. Unfortunately, the house looked nice to all observers and gave the appearance of a solid, enduring house and home. I have recently learned how a community struck by a devastating flood gave all outward appearances of recovering well, as chronicled and heralded in a series of newspaper articles. The outside world of counselors and government did not delve much, because all looked well. It has only been months later that the extent of a disintegrated communality has become evident in very painful and hopefully not insurmountable ways. The disaster-response-trained mental health care provider who by training and practice and personality always looks beyond the individual to see the family and the group would be in an excellent position to monitor such a community closely after a disaster and to ensure the sense of communality is truly restored.

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Jane Schnare is a psychotherapist who lives in the Bayswater area of Blandford, Nova Scotia, Canada. She recently provided me with valuable insight into understanding the bridge between the nature of a disaster and the nature of a community affected by that disaster as well as by other traumas in the months before and after that disaster. In September 1998, SwissAir Flight 111 crashed offshore only a handful of miles from her home and those of others in her small community. [I was sent there to be on-scene as the Navy SPRINT psychiatrist (with additional expertise and credibility as a former diving medical officer) to provide as-needed advice for the senior persons in charge because of the hazardous nature of the diving and the stressful situations of recovering human remains and personal effects that the Navy divers faced. I also worked with Canadian force medical personnel in assisting them by being their eyes and ears for monitoring the emotional climate in the recovery efforts of Canadian military personnel along the shore, local townspeople and fishermen, and among the military remains handlers at the temporary morgue. I did not meet Mrs. Schnare then but read about her in later newspaper articles and subsequently talked with her by telephone many times.]

Her community experienced the loss of children and adults either months before the crash or within several months after the crash, many of them due to violence not typically occurring in the community. The airliner crash was another type of violent disaster, which cumulatively added to a sense of denial (almost a disassociation from, as she described) of the possibility that these actually occurred, as well as a sense of numbness that was closely harbored and not usually spoken about within the community. Community support groups were made available, but there was minimal demand and participation. This was most likely because there were no casualties in the community from the crash, e.g., wreckage from the plane striking houses or community members traveling on the ill-fated plane. Had this happened, then the nature of the disaster would have been directly brought home to the community, the grief and numbness would have been more palpable, and community members would have tended to need followup support groups, therapy, etc.

This is not to say that the community and the communality were not affected to a significant degree. Many of the community members heard the plane pass over their houses that night at a low altitude, definitely in distress; jet airliners pass over this part of Canada only at very high cruising altitudes. The explosion just a few miles offshore was heard and felt by many. Word quickly spread. Fishermen boated out to the scene and, for the next many hours, retrieved body parts and personal effects from the water while they worked nonstop. Body parts and remains washed ashore around the community and continued to do so for months afterward, albeit sporadically. The shock at the mass destruction of life only miles away, the visible proof that washed up on shore, the sudden invasion of the coastline and communities by military personnel and helicopters, the conversations with gruesome details held in town and in homes and at schools heightened fears among schoolchildren and worry among parents. The almost immediate invasion of the media as well, from around the world, spurred an almost carnival-like atmosphere which collided with community needs to respect the dead, the families of the dead, and the overall

community disdain for publicity and exposure to the world. This was coastal rural Canada, where communities lived in strong communality in tough environmental conditions, a degree of isolation from the big cities and fastpaced stressful life styles, and a willingness to accept death by accident as a condition of fishing or living by the sea. This was the culture that Ms. Schnare lives in, works in, and well understands.

Acute interventional debriefings were not really demanded by those in the community. When they were provided by the Red Cross, there was relatively little participation. In contrast, Mrs. Schnare's approach was to stand by and tailor whatever approach was needed to help whoever asked, over time, whether in the form of school meetings with children and teachers, meeting with parents, providing educational meetings on disaster psychology and common sense ways to reduce stress from the overall situation. Later, she provided information on the significance of a locally-erected monument and other crash anniversary events.

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A third guiding principle I use is that it is exceedingly important to have a conceptual grasp for distinguishing the nature of the acute incident. I categorize them as: natural disaster: accidental (technological, transportation, etc.) disaster: disasters caused by intent to harm others, with a corollary of chemical/biological/radiation attacks; business or industry workplace disasters; and disasters which directly or indirectly traumatize children and adolescents. The nature of the disaster has significant psychological implications for individuals, for the communality affected, and for interventions now and later. These types can be distinguished as follows.

The natural disaster such as a tornado or hurricane devastating a community brings up issues of loss and fate and luck. There can be an inward-turning and soul searching for why it happened. Because it is a natural disaster, some will implicate nature's whims, others will say it is bad luck, and others will say ruefully that such disasters of weather have happened in the past in the same area but were never thought to occur again. Family members endure the disaster together, and there is an expectation that all victims' remains will be recovered for burial. There is a sense of an enduring future, based upon rebuilding or relocating. Memorial sites can be erected as healing ritual which can later be visited by many. As a corollary, intense blame may be fixed on an individual or a group such as a meteorology service or a town's civil defense warning system if these do not protect the community for whatever reason.

In an accidental disaster, there can be a sudden and devastating loss of life and property. Survivor guilt and blame for forcing a spouse, for instance, to take a subsequently doomed airplane flight can be intense among family members. An effort to affix blame as to the cause of the accident is expectable, intense, and litigious. Any suspicions of terrorism or intent to cause harm can fuel outrage at company and governmental officials in charge. Suspicions of error in judgment, negligence, or design defect likewise are combustible sources of rage. A large number of victims--their remains and personal effects--may not be recoverable if the incident occurred at sea or was totally obliterating. Remains and personal effects when recovered may be kept for long periods of time, angering relatives, until identification can be made and their use in a possible criminal investigation is over. Especially in a transportation accident, there may not be a communality sense of loss from which surviving members or next-of-kin can gain support, as victims may have been brought together by chance from many parts of the world. An erected memorial near the disaster site can have great importance for victims' relatives and others who visit from faraway places.

In a disaster caused by intent by one or more persons to harm others, this violence casts a shadow of incomprehension, rage, insecurity, and distrust across the fabric of a community that can best be likened to a permanent stain in clothing. Individuals and the community as a whole will have their sense of trust and safety in day to day society shaken. There is a fear this could recur again. A strident demand for justice is common. If the perpetrator(s) is never caught, then for many survivors, there is an even greater sense of

unremitting distrust, loss, and anger that never goes away. If the perpetrator is caught and justice unfurls, the rage of some survivors or rescue workers remains focused on the defendants. Once the trials are over and sentences meted out, that rage in some individuals has nowhere to go but inward; self-destructive behaviors and even suicide can result, further adding to the numbing and painful sense of loss within the community.

A corollary to the disaster caused by intent to harm is that of the use of biological, chemical, or radiation weapons in terrorism or war (4-6). These disasters are unique. They are a form of psychological warfare or threat of the highest degree: it is based on extreme fear of an unknown agent(s) that have no sensory cues; the morbidity and mortality come from within (body systems may be affected without external injury); social restraints are imposed because of a fear of contact and spread through social interactions; the diseases or injuries caused can be longlasting and recurrent within the individual or the community, as significant psychiatric morbidity can occur even without injury or contact exposure; psychiatric morbidity can be a major source of casualties out of fear and (mis-)interpretation of somatic symptoms, with the high possibility of epidemics of hysteria and somatization; and the nature of the weapon (agents) goes against the grain of basic warfare where the enemy is seen or heard and proximally near, whether in the air or the sea, or on the ground

In a business or industry (workplace) disaster, issues of causation and liability may remain indeterminate for long periods of time because of the need for investigations and the conflicting demands placed upon the corporation from families of victims, coworkers, senior management and executives (who are inferred to have the workers best interests at heart), shareholders, governmental regulating agencies, and the public/consumers. Recounting of specific events, catharsis of strong emotional reactions, survivor guilt, redress and justice against the perpetrators or those responsible in the organization are common themes in interventional debriefings, but participating individuals may fear their job security and pensions, or possible future claims for disability, would be jeopardized by their openness.

Finally, there are two kinds of disasters in which children and adolescents in a school or a community may become traumatized: the first is one where there are survivors from an incident which directly killed or injured classmates, friends, and peers; and the second is when there is an incident which caused death or injury to family members of a large number of children or adolescents. The extent of grieving and suffering among community members is likely higher in the former type. But in either type, the aftereffects are felt in the community for a very long time. Such deaths in either situation cut to the real and existential heart of a family, communality, and a community, because the hopes for successful propagation of all of these over time and generations is based upon the children.

My fourth guiding principle emphasizes EMPATHY and UNDERSTANDING. To be effective, it is so important to have a conceptual grasp and good fund of working knowledge about individual psychological responses to both acute and chronic disaster conditions I described above and a personal and professional ability to truly listen to others and to communicate both empathy and/or sympathy, when appropriate

My colleague Lieutenant Commander Ed Simmer (a Navy psychiatrist and head of our SPRINT Team at Naval Medical Center, Portsmouth, VA) and I have described with much detail the types of group interventions that can be done in a community beset by a disaster. This is contained in our book chapter "**When trauma affects a community: group interventions and support after a disaster,**" being published this spring in The Healing Circle: Group Psychotherapy for Psychological Trauma, edited by Robert Klein and Victor Schermer, by Guilford Press. We discuss the important role for Critical Incident Stress Management (CISM), as well-described by Jeffrey Mitchell and George Everly in their many publications (e.g., 7), and for the Community Crisis Response Team (CCRT) process, well-described by the National Organization for Victim Assistance (8), after an acute disaster. What we also spend considerable effort in emphasizing is the role of various types of groups that can be done in the community over a short or longterm basis, after an acute disaster. These include the standard Support Groups (which provide psychological education with emotional support as the primary function over weeks or months), the

periodic Topic Groups (which provide recovery topic advice such as completion of paperwork for insurance claims and loans, how to pick a building contractor, etc.), and the Event Groups (which bring large groups of disaster survivors together on an as-needed basis to address an entire community's needs, e.g., anniversary commemorative event) (9). The approach to planning for these types of groups and tailoring them to the community requires a knowledge of the past, present, and future aspects--strengths and weaknesses--of that community and communality.

It is important to understand that neither CISM, CCRT, or any of the community groups we describe above are forms of standard group therapy. The focus is not on changing the individual, but rather supporting and preserving the existing communality as it struggles to regain the sense of community it once embraced. The persons who lead these groups are usually not mental health care providers nor are they required to be. Rather, they come from a wide cross-section of trades and professions with a common denominator of being trained to be part of disaster response teams.

The individual mental health provider who wishes to play a helping role when a disaster affects a community, should obtain the requisite training in CISM/CCRT as a minimum and keep in mind--educate oneself and be educated--in the principles I set forth above. In the chapter Ed Simmer and I wrote, as well as in the invaluable resource provided by my colleague Diane Myers (10), an emphasis is also placed on the mental health care provider's need to consider his or her own physical and mental health, family situation, presence of other life stressors, and the nature of the practice and patients that he or she cares for, as real factors which modify the availability and participation of that provider on a disaster response team in the community. That said, providers also need to consider what specific role(s) they are interested in playing: 1) member of a disaster response team that can deploy immediately out into the community or elsewhere to work either with (debrief) other disaster response personnel or with survivors; 2) member of a hospital-based stress debriefing team that can respond to tragedies in the hospital; 3) member of a mental health response emergency team, part of the hospital emergency services department, which can assist and take care of large numbers of mentally ill persons in the community, medically injured or not, who virtually flood the hospital emergency room or mental health clinics after a major disaster; 4) member of a mental health resource team that conducts longterm support groups for hospital personnel or for members of the general community, after a disaster; or 5) member of community agencies or government (local, state, or federal) agencies tasked with disaster response planning and training and coordination with other agencies.

Telephone numbers for further basic information on training done around the country are: International Critical Incident Stress Foundation, Ellicott City, Maryland, (410) 750-9600; and National Organization for Victim Assistance, Washington, DC, (202) 232-6682. Local and state disaster response or emergency services agencies may provide opportunities for training leading to certification in critical incident stress debriefing, as well.

There are some excellent additional published resources on this field that include theory, training, management, and practice (10-13). The National Mental Health Services Knowledge Exchange Network (PO Box 42490, Washington, DC 20015; 1-800-789-CMHS [1-800-789-2647]; ken@mentalhealth.org), sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, provides numerous, free-of-cost, and excellent DHHS publications (e.g., 10) and videotape programs on many aspects of disaster mental health services and programs; the Network will send a catalog from which orders can be made. But FIRST, I advise anyone interested to read Kai Erikson's books (2,3) for necessary perspectives which serve as a basis for everything else written or taught, cited below.

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