Mental Health Response to Mass Violence and Terrorism

CHAPTER V: Stress Prevention, Management, and Intervention

When mental health professionals, crime victim assistance counselors, and other responder groups come forward to assist survivors following mass violence and terrorism, they experience the rewards associated with meaningful service and cope with a range of challenging stressors. The devastating losses, deaths and injuries, destruction of property, and emotional pain of survivors and bereaved loved ones can touch providers in powerful and personal ways. The emergency response working environment can involve physical hardship, unclear roles and responsibilities, limited resources, rapidly changing priorities, intrusive media attention, and long work hours. When an ongoing threat of future attacks or potential exposure to biohazards exist, workers cope with risks and threats to their own safety while helping others.

Despite the inevitable stresses and challenges associated with community crisis response, workers experience personal gratification by using their skills and training to assist fellow humans in need. Active engagement in the disaster response and "doing" for others can be an antidote for feelings of vulnerability, powerlessness, and outrage commonly experienced by nonimpacted community members. Witnessing the courage and resilience of the human spirit and the power of human kindness can have profound and lasting effects.

Mental health providers may work for several intense weeks as part of the immediate response and then return to their former jobs and lives. They may be local community members, or from other counties in the State providing mutual aid, or have flown in from other parts of the country as volunteers or paid consultants. Others may continue working for several years as mental health and crime victim services programs are developed, funded, and implemented. New staff may join the mental health response as formal intervention programs become funded and operational months after the disaster. Each scenario presents the worker with distinct stress-related challenges and may expose to the mental health response manager potential targets for stress management interventions.

This chapter discusses factors that contribute to worker stress and provides strategies for stress prevention and management. In counseling and assistance programs that continue for months, and even years, mental health providers counsel survivors and family members suffering significant psychological difficulties related to their trauma and losses. Mental health response managers must implement systems for clinical training, supervision, and case consultation to ensure high quality, appropriate mental health services and to mitigate the inevitable stress associated with this work. The end of the chapter includes a list of signs and symptoms of worker stress.

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Sources of Stress

Mental health worker stress results from the interaction of three factors: (1) the amount of exposure to trauma; (2) environmental factors such as working conditions and management practices; and (3) individual factors including the worker's perceptions, personal coping and stress reduction practices, personality, and applicable training and experience.

For example, high exposure assignments may involve participating in death notifications, accompanying and supporting families at morgues, supporting families as they provide DNA samples, viewing physical injuries and mutilation, counseling families who are planning funerals with no physical remains or formal death notification, supporting family members who are waiting for rescue and recovery information, and ongoing bereavement counseling following the traumatic death of a loved one. These assignments can be particularly challenging when prior professional roles have not included similar activities.

Inevitably, a criminal mass casualty event is experienced personally to some degree by all who reside in the targeted community. Mental health responders, who also are residents of the impacted community, may have been personally affected, may know victims, or may be touched through acquaintance networks. These individuals are at risk for stress reactions and should be assessed, monitored, and supported by their immediate supervisors.

Mental health providers and crime victim assistance counselors often are drawn to their professions from a desire to help people. This altruism and dedication to making a positive difference in people's lives, while valuable qualities, can contribute to unrealistic expectations or frustration with "interfering" policies. Altruism run amok may lead to taking on too many responsibilities, ignoring professional boundaries, and working beyond physical, psychological, and training limits. Responders, especially those who are inexperienced, face a particularly high risk of damaging over-involvement following mass violence and terrorism because of the powerful feelings evoked.

The terms "compassion fatigue" (Figley, 2001; 1995), "vicarious traumatization" (Pearlman and Saakvitne, 1995), and "empathic strain" (Wilson and Lindy, 1994) describe the gradual psychological and physical erosion that can occur when mental health providers become overloaded with traumatic material, and their usual professional management and personal coping strategies begin to falter. As mental health workers' relationships with survivors and bereaved families deepen, the possibility for over-identification and over-involvement increases. Over time, mental health providers are more likely to encounter their own unresolved losses or traumatic experiences which can interfere with therapeutic effectiveness and lead to added stress.

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Stress Prevention, Management, And Intervention

Effective mental health response managers and supervisors are well informed about the factors associated with worker stress and integrate a range of administrative controls and stress management strategies. Under the intense working conditions that are inevitable following criminal mass violence, supervisors and managers must assume shared responsibility for promoting a positive and healthy work environment, and not rely exclusively on workers' initiating their own self-care practices.

A proactive stress management plan focuses both on the environment and the individual. Providers feel valued and supported when stress prevention and management strategies are built into mental health operations and the organizational culture.

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Environmental Context

A clear organizational structure with defined roles and responsibilities for linestaff responders, leads, supervisors, and managers reduces the potential for staff stress (Quick et al., 1997). Research with first responders has shown that training and preparation helps reduce onthe- job stress (Ursano, et al., 1996). Consistent adherence to administrative controls, such as limiting shifts to no more than 12 hours and rotating between high, mid, and lowstress tasks promotes occupational health. Pre-event training in high-stress tasks contributes to a more prepared mental health work force. While guidelines may be difficult to put in place during the first week after a mass casualty incident when resources are likely to be overwhelmed, managers should aim for them as quickly as possible.

Team support also is a critical stress-reducer. The mental health response manager and supervisors are role models. If they do not observe the stress management practices that they recommend for staff, their efforts may lack credibility. Managers should address the following dimensions when designing a mental health response that prioritizes

environmental and organizational health:

- Effective management structure and leadership;
- Clear purpose, goals, and training;
- Functionally defined roles;
- Administrative controls;
- Team support; and
- Plan for stress management.

Table 4 provides strategies that address these six dimensions. Many suggestions for the immediate response time frame are applicable for the long-term response as well. Some approaches eliminate potential stressors, while others minimize the effects of unavoidable stressors. Mental health planners and managers must adapt the following to their own locale, resources, and disaster.

TABLE 4: ENVIRONMENTAL AND ORGANIZATIONAL APPROACHES FOR STRESS PREVENTION AND MANAGEMENT

Dimension	Immediate Response	Long-Term Response
Effective Management Structure and Leadership	• Clear chain of command and reporting relationships • Available and accessible leaders and clinical supervisors • Use of managers experienced in emergency response and community trauma	• Full-time disaster and crime victim assistance-trained supervisors and program manager with demonstrated management and supervisory skills • Clinical supervisors and consultants experienced in content areas and trained in MH response to community trauma • Clear and functional organizational structure • Program direction and accomplishments reviewed and modified as needed
Clear Purpose, Goals, and Training	• Clearly defined intervention goals and strategies appropriate to different assignment settings (e.g., crisis intervention, psychological debriefing) • Training and orientation provided for all MH workers	• Community needs, focus, and scope of program defined • Periodic assessment of service targets and strategies • In-service training on current recovery topics • Staff trained and supervised to define limits, make referrals • Feedback provided to staff on program accomplishments, numbers of contacts, etc.
Functionally Defined Roles	• Staff oriented and trained with written role descriptions for each assignment setting as part of preparedness plan • When setting is under the jurisdiction of another agency (e.g., Mayor's Office, Medical Examiner's Office, American Red Cross), staff informed of MH role, contact people, and mutual expectations	• Job descriptions and expectations for all positions • Participating crime victim services' and recovery agencies' roles defined and working relationships with key agency contacts maintained

Administrative Controls	• Shifts no longer than 12 hours, with 12 hours off • Rotation between high, mid, and low-stress tasks • Breaks and time away from the assignment encouraged and required when necessary • Necessary supplies available (e.g., paper, forms, pens, educational materials) • Communication tools available (e.g., cell phones, radios)	• Limits on working more than 40 hours/week • Two consecutive days off and vacation time required • Limits on and rotation from high-exposure duties (e.g., groups with bereaved parents, trauma counseling)
Team Support	• Buddy system for support and monitoring stress reactions • Positive atmosphere of support, mutual respect, and tolerance with "thank you" and "good job" said often •	• Team approach that avoids a program design with isolated workers from separate agencies • Informal and formal case consultation, problem-solving, and resource sharing • Regular, effective meetings with productive agendas, personal sharing, and creative program development • Clinical consultation and supervision processes built on trust, safety, and respect
Plan for Stress Management	• Attention to workers' functioning and stress management • Supervisors "float through" work areas to observe signs of stress • Education about signs and symptoms of worker stress and coping strategies • Individual and group support, defusing, and debriefing provided • Exit plan for workers leaving the operation: debriefing, re-entry information, opportunity to critique, and formal recognition for service	• Ongoing education and workshops regarding long-term stresses of disaster MH work and methods for self-monitoring and intervention • Comprehensive plan for environmental, organizational, and individual approaches and implementation timeline • Plan for regular stress interventions at work and meetings (see Table 5) • Confidential individual counseling available for work-related issues • Extensive program phase-down plan: timelines, debriefing, critique, formal recognition, celebration, and assistance with job searches

Many of these principles were applied at the Compassion Center (the family gathering site) in Oklahoma City following the Alfred P. Murrah building bombing, and at the Family Assistance Center in New York City following the World Trade Center terrorist attacks. At the Compassion Center, a stress management team focused exclusively on the needs of mental health workers and volunteers (Sitterle and Gurwitch, 1999). "Defusing" sessions, which consisted of 20.25 minute, structured conversations about distressing aspects of the assignment followed by psycho-education, were required for workers at the end of every shift. Mental health professionals participated in no more than two death notifications during a shift, four notifications in total, and attended defusing sessions after each notification. Stress management information was readily provided and available. Mental health professionals were available for consultation and support on an informal, individual basis and more formally when needed. The long-term response program, Project Heartland, contracted with an area psychologist to provide group debriefing and psychological support sessions with staff and confidential individual counseling for selfreferring staff members.

At the Family Assistance Center, mental health workers were divided into teams assigned to different areas and functions within the center. Another team supported families and victims on the buses as they were brought to the center. Each team leader oriented and monitored their mental health providers, ensured that they took breaks and had meals, and provided support and consultation as providers engaged in difficult and distressing situations.

Participation in high-stress assignments such as accompanying families to Ground Zero and intensive contacts with distraught, grieving families was limited, and workers rotated into lower-stress activities. Shifts were limited to 10 hours; taking a day off every seven days was required. Mental health professionals were designated to address mental health and other staff stress issues and to provide support, defusings, and debriefings.

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Individual Context

Entering a chaotic setting and providing mental health services to victims and family members immediately after a mass violent and highly traumatizing incident is likely to stimulate anxiety, adrenalized responses, and the intense desire to be helpful. While few would question that psychologically healthy and well-balanced individuals are best equipped to implement and maintain an effective mental health response, it can be challenging to function within a balanced range, especially during the initial stages of response. Mental health response planners and managers need to build in a range of supports and interventions that are appropriate to their workers' needs and personal styles. In addition, workers must assume personal responsibility for taking care of themselves, to remain effective and not impose burdens on others. Asking for help and support should be encouraged and validated.

As the community's mental health needs change over time, so, too will workers' stress management intervention needs. The individual component of a staff stress management program should address:

- Management of workload;
- Balanced lifestyle;
- Strategies for stress reduction; and
- Self awareness.

Table 5 provides practical suggestions. Immediate response suggestions apply to the long-term response as well. Involving staff in defining program norms and developing program-wide stress management practices encourages ownership and follow-through, and builds a basis for team support.

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Compassion Fatigue and Secondary Traumatization

National experts experienced in the mental health response to acts of mass violence and terrorism emphasize the need for systematic and comprehensive stress management with mental health staff (Center for Mental Health Services, 2001). The stressors associated with dealing with mass criminal victimization and mass casualties are intense and long lasting. Like other responder groups, mental health providers risk becoming secondary victims of the crime and its aftermath. Mental health response managers must evaluate how long mental health workers should remain in highexposure roles and whether certain assignments should be time-limited.

TABLE 5: INDIVIDUAL APPROACHES FOR STRESS PREVENTION AND MANAGEMENT

Dimension	Immediate Response	Long-Term Response

Management of Workload	• Clarification with immediate on-site supervisor regarding task priority levels and work plan • Recognition that "not having enough to do" or "waiting" is an expected part of crisis mental health response • Existing "regular" workload delegated so workers do not attempt disaster response plus usual job	• Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") • Periodic review of program goals and activities to meet stated goals • Periodic review to determine feasibility of program scope with human resources available
Balanced Lifestyle	• Nutritional eating and hydration, avoidance of excessive junk food, caffeine, alcohol, or tobacco • Adequate sleep and rest, especially on longer assignments • Physical exercise and gentle muscle stretching when possible • Contact and connection maintained with primary social supports	• Family and social connections maintained away from program • Exercise, recreational activities, hobbies, or spiritual pursuits maintained (or begun) • Healthy nutritional habits pursued • Over-investment in work discouraged
Stress Reduction Strategies	• Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) • Using time off to "decompress" and "recharge batteries" (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times	• Cognitive strategies employed (e.g., constructive self-talk, restructuring distortions) • Relaxation techniques (e.g., yoga, meditation, guided imagery) explored • Pacing self between low and high-stress activities, and between providing services alone and with support • Talking with coworkers, friends, family, or counselor about emotions and reactions
Self-Awareness	• Early warning signs for stress reactions recognized and heeded (see "Signs and Symptoms" section) • Acceptance that one may not be able to selfassess problematic stress reactions • Over-identification with or feeling overwhelmed by victims' and families' grief and trauma may result in avoiding discussing painful material • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995)	• Exploration of motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) • Understanding when "helping" is not being helpful • Understanding differences between professional helping relationships and friendships • Examination of personal prejudices and cultural stereotypes • Recognition of discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety which interferes with the capacity to "be" with clients • Recognition of over-identification with survivors' frustration, anger, anguish, and hopelessness resulting in loss of perspective and role • Realizing when own disaster experience or personal history interferes with effectiveness • Involvement in opportunities for self-exploration and addressing emotions evoked by disaster work

Self-awareness involves recognizing and heeding early warning signs of stress reactions and understanding one's countertransference reactions. Countertransference refers to the impact that the survivor and his or her situation has on the mental health provider. Depending on the provider's history and vulnerabilities, countertransference reactions might involve: survivor guilt; helplessness at not being able to protect child victims from being killed; feeling heroic, altruistic, and indispensable to the response operation;

finding the anguish of bereaved parents to be intolerable; or questioning human nature, God, or one's basic assumptions about the world. These reactions may not be fully conscious yet they can erode the provider's perspective and ability to maintain balance.

As a result of over-identification with survivors, mental health responders may not exercise appropriate personal and professional boundaries in their work. This is especially dangerous for those who seek to "fix" survivors' problems or try to right the wrongs experienced by them. The unfortunate reality is that many survivor losses are permanent and survivors will never be as they were before the event. These realities can be difficult for providers to accept, especially when their lives and sense of self are tied to "making" survivors feel better. Supervisors must recognize these understandable tendencies and assist workers with setting realistic goals and expectations.

Alternatively, mental health providers may distance themselves to avoid experiencing survivors' anguish and rage and unconsciously restrict survivors' emotional expression (Wilson and Lindy, 1994). During the immediate response, when mental health workers are typically engaged for a time-limited assignment, it may be less crucial or appropriate to explore providers' countertransferential reactions in depth. However, it can be extremely useful to identify and label these reactions and to help the responder put them in context. This may occur in defusing sessions, supervisor support contacts, or debriefing sessions.

Clinical supervision and case consultation help mental health workers identify, understand, and address countertransferential reactions. When providers have a grounding in clinical theory and can view their work from a theoretical perspective, they are better able to maintain their professional role and "psychological space." Group case consultation built on solid clinical principles, safety, and trust can infuse necessary social support and human connectedness into work teams.

Training staff to identify vulnerabilities and measure stress symptoms helps workers to monitor themselves and each other. When the psychological demands are great and the mental health response is prolonged, a systematic approach involving ongoing assessment and educational and therapeutic interventions with staff may be indicated.

Mental health responders must maintain genuine empathic engagement with survivors and bereaved family members and "be willing to enter their affective space...to join and hold them in their loss in an effort to understand their experience and help them tolerate it" (Charney and Pearlman, 1998). Figley (1995) describes four reasons why trauma workers are especially vulnerable to compassion fatigue: (1) empathy is a necessary skill, yet it inducts traumatic material from the survivor to the provider; (2) many workers have personally experienced some type of trauma; (3) unresolved trauma will be activated by reports of similar trauma by clients; and (4) children's traumatic experiences are provocative for caregivers. This normalization of compassion fatigue can provide the foundation for a proactive and responsible approach to addressing staff stress, in much the same way that survivors' responses are addressed.

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Signs and Symptoms of Worker Stress

Educating supervisors and staff about signs of stress enables them to be on the lookout and to take appropriate steps. When mental health response programs emphasize stress recognition and reduction, norms are established that validate early intervention rather than reinforcing the "worker distress is a sign of weakness" perspective.

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Mental Health Provider Stress Reactions

Psychological and Emotional:

- Feeling heroic, invulnerable, euphoric
- Denial about one's stress level
- Anxiety and fear

- Worry about safety of self and others
- Anger or irritability
- Restlessness
- Sadness, grief, depression, moodiness
- Distressing dreams
- Guilt or "survivor guilt"
- Feeling overwhelmed, hopeless
- Feeling isolated, lost, or abandoned
- Apathy
- Identification with survivors
- Feeling misunderstood or unappreciated

Cognitive:

- Memory problems and forgetfulness
- Disorientation and confusion
- Slowness in thinking and comprehension
- Difficulty calculating, setting priorities, making decisions
- Difficulty concentrating
- Limited attention span
- Loss of objectivity
- Inability to stop thinking about the disaster

Behavioral:

- Change in activity level
- Decreased efficiency and effectiveness
- Difficulty communicating
- Outbursts of anger, frequent arguments
- Inability to rest or "letdown"
- Change in eating habits
- Sleep disturbances
- Change in patterns of intimacy, sexuality
- Change in job performance
- Periods of crying
- Increased use of alcohol, tobacco, or drugs
- Social withdrawal, isolation
- Vigilance about safety or environment
- Avoidance of activities or places that trigger memories
- Proneness to accidents
- Blaming and criticizing others

Physical:

- Increased heartbeat, respiration
- Increased blood pressure
- Upset stomach, nausea, diarrhea
- Change in appetite, weight loss or gain
- Sweating or chills
- Tremors or muscle twitching
- "Muffled" hearing
- Tunnel vision
- Feeling uncoordinated
- Headaches
- Soreness in muscles, back pain
- Feeling a "lump in the throat"
- Exaggerated startle reaction improve with sleep
- Decreased resistance to colds, flu, or infection
- Flare-up of allergies, asthma, or arthritis

As with trauma survivors, assessment hinges on the question of "How much normal stress reaction is too much?" Each worker has his or her own pattern of stress responses. Some may respond physically with headaches or sleep problems; others may have trouble thinking clearly or may isolate themselves from others. Mental health responders commonly experience many of the reactions listed with limited job effects.

However, functioning is likely to be impaired when responders experience a number of stress reactions simultaneously and with moderate intensity. When this stress overload occurs over an extended period of time without adequate rest and rejuvenation, the worker may experience adverse health and more pronounced psychological effects. Taking a break from the disaster assignment for a few hours at first, and then longer if necessary is often helpful. Using the stress management strategies described in this chapter can help counteract stress effects.

Clinical supervisory support benefits mental health workers when their personal coping strategies are wearing thin. Over time, mental health providers may engage in more concrete "doing for" assistance as an antidote to feeling helpless to relieve the seemingly bottomless pain of some victims and families. Supervisors and consultants may intervene by exploring the provider's underlying feelings and motivations, identifying appropriate roles and boundaries, and redefining the goals of mental health interventions.

Clinical support also might involve an exploration of distressing aspects of assignments and their meanings, the worker's prior related experiences and vulnerabilities, and his or her personal coping strategies. Supervisors can make suggestions for stress reduction activities. These supportive contacts might also include the validation and normalization of reactions. In most cases, stress symptoms gradually subside when the worker is no longer in the emergency response environment or has achieved a balance of time off and outside, nonrelated activities. When symptom reduction does not occur, professional mental health assistance is indicated.

IN MOST CASES, STRESS SYMPTOMS GRADUALLY SUBSIDE WHEN THE WORKER IS NO LONGER IN THE EMERGENCY RESPONSE ENVIRONMENT OR HAS ACHIEVED A BALANCE OF TIME OFF AND OUTSIDE, NONRELATED ACTIVITIES.

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Rewards And Joys of Disaster Work

Most people find it enormously rewarding to help survivors, family members, and communities following tragic incidents involving mass victimization. Responders witness both gut-wrenching grief and sorrow and the power of the human spirit to survive and carry on. Assisting people as they struggle to put their lives back together is fundamentally meaningful. Mental health workers learn about their own strengths and vulnerabilities. They may be reminded of the preciousness of human life and their significant relationships. Many workers have said their view of human nature has been changed through the community outpouring of kindness, generosity, and the power of simple gestures following a mass tragedy.

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Recommended Reading

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