Disaster Psychiatry: Principles and Practice

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DISASTER PSYCHIATRY: PRINCIPLES AND PRACTICE

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DISASTER PSYCHIATRY: PRINCIPLES AND PRACTICE

INTRODUCTION

A wide host of traumatic events can surprise and stun communities. Natural disasters that strike without much notice, such as tornadoes or earthquakes, represent such traumas. In addition, man-made traumas such as transportation disasters, factory explosions and school shootings have become part of life. Many believe that the probability is high that terrorists will use biological or chemical agents at some point here in the United States.

Psychiatrists have many skills that can assist individuals and communities recover from disasters. The term, "disaster psychiatry", has been coined to describe an epidemiological approach to understanding and treating the effects of mass casualty situations.

The goals of psychiatric intervention are to: minimize exposure to traumatic stressors; educate about normal responses to trauma and disasters; provide consultations to other health care professionals and community leaders; advise people on when to seek professional treatment; assist in resolution of acute symptomatology; reduce secondary morbidity; and identify those who are at higher risk for the development of psychiatric disorders and to treat those who develop them. This article will review basic principles of disaster psychiatry and suggest ways in which psychiatrists can intervene following community catastrophes.

DEFINITION OF DISASTER

The term "disaster" derives from the Latin dis, "against", and astrum "stars" and is translated as "the stars are evil" (1). While there are many definitions of disaster, a common feature is that the event overwhelms local resources and threatens the function and safety of the community.

Disasters are frequently divided into the categories of "natural" / "acts of God" (hurricanes, floods, earthquakes) or "manmade" / "acts of man". However, this distinction is somewhat arbitrary - often the impact of natural disasters is very heavily shaped by humans. Common examples of this include building homes in unsafe areas such as flood plains or upon steep hillsides where mudslides have occurred. Poor construction and high-density buildings can increase the number of people injured and killed exponentially following an earthquake. Man's interactions with his environment have also been postulated to contribute to natural disasters through poor land management policies and through practices that contribute to global warming (2).

PRINCIPLES OF DISASTER PSYCHIATRY

Paradigm shifts

Disaster Psychiatry entails a number of paradigm shifts for psychiatrists involved in clinical practice. The first major paradigm shift involves a focus on health rather than disease. Most clinicians' practice entails treating people who are identified as ill (patients). In disaster situations, the vast majority of people will experience transient psychological and behavioral symptoms that represent normal responses to an abnormal event. In disaster settings, then, care is given to avoid the use of diagnostic labels prematurely. In the acute phase, the psychiatrist primarily educates and facilitates the natural recovery process rather than treating pathology. The final major departure from one's usual practice in the acute phase of a disaster is that one leaves the office. In disaster psychiatry, outreach is key. The overarching goal is to facilitate normal recovery processes and prevent or diminish psychiatric morbidity. The psychiatrist practices primary prevention, often through consultation to primary care providers and disaster agencies, reducing the number of individuals who will develop psychiatric morbidity.

The Preventive Medicine model of an infectious disease outbreak investigation and intervention provides a familiar organizing structure for conceptualizing behavioral and psychological responses to a disaster (3,4). In this model, one identifies the pathogen, its source, and those exposed to it. To adapt this for psychiatric responses to disasters, one thinks of the psychological, physiological, and social stressors associated with the disaster as the pathogens. One then identifies groups of people that are most highly exposed to these stressors. Detailed reconstruction of the event in space and time and examination of the subsequent cascade of actions taking place in its aftermath ensures that traumatized groups are not overlooked. This is an iterative process. In the course of interactions with those involved in the disaster, one learns of additional traumatic stressors and additional groups who were exposed to them.

Familiarization with Responses to Trauma and Disasters

Adults

A host of psychological and behavioral responses are seen in adults following trauma and disaster. These include anger, disbelief, sadness, anxiety, fear, irritability, arousal, numbing, sleep disturbance, and increases in alcohol, caffeine, and tobacco use. For most individuals, acute post-traumatic psychiatric symptoms resolve over time. For others, however, the psychological and behavioral changes persist and may meet the criteria for psychiatric diagnoses. For some, disasters may have beneficial effects. More attention is being given to the possibility of severe traumas serving as organizing events and providing individuals with a sense of purpose as well as other positive growth experiences (5-9).

In the acute aftermath of a disaster or trauma, the psychiatrist must be alert to organic mental disorders secondary to head injury, toxic exposure, illness, and dehydration. When communities are hit by large-scale disasters, it is always important for the psychiatrist and other physicians to consider that behavioral symptoms may also be due to the simple loss of the patient's usual medications.

Persistence of symptoms over time, accompanied by a high level of severity and impaired function, can lead to a wide variety of psychiatric diagnoses. Post-traumatic Stress Disorder (PTSD) is, perhaps, the best-known psychiatric diagnosis that is associated with trauma response. It is characterized by exposure to a serious event in which threat to life or physical injury (to self or others) is accompanied by intense feelings such as terror, helplessness, or fear (10). In addition to the threat criterion, the individual must have experienced distressing symptoms of intrusive thoughts of the event, avoidance of reminders, and physiological arousal (such as exaggerated startle). Symptoms must have been present for more than one month. Delayed onset PTSD has been described but "true" delayed PTSD (rather than subthreshhold that later meets criteria) appears to be much more uncommon than previously reported. Clinically, in cases of late-onset PTSD or reactivation of previously resolved PTSD, it is important to explore current life events (11). At symbolically charged times, such as receiving a diagnosis of cancer or retiring from a long military career, emergence of PTSD symptoms may be thought of as the mind's way of expressing metaphorically in the present significant traumatic events in the past that evoked intense feelings. In such cases, exploration of the patient's current situation is generally more productive than focusing on the past.

Acute Stress Disorder (ASD) was introduced into our diagnostic nomenclature in DSM-IV (10). ASD is a constellation of symptoms very similar to PTSD but persists for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the trauma. The only difference in symptom requirements between the two diagnoses is that dissociative symptoms must be present in order to diagnose an individual as having ASD. The dissociative symptoms can occur during the traumatic event itself or after it.

Other psychiatric diagnoses are also seen in the aftermath of significant trauma. These include adjustment disorders, substance use disorders (including increased tobacco use), major depression, complicated bereavement, and generalized anxiety disorders. Importantly, injured survivors may have psychological factors affecting their physical condition (12-16). Psychiatrists and physicians should also be alert to the occurrence of family violence in disaster situations that bring significant stressors to families (17).

Children and Adolescents

Child and adolescent development can be significantly altered as a consequence of traumatic exposure. The onset of a wide range of symptoms and behaviors has been noted in children exposed to disasters and other traumas (18,19). As in adults, the greater the traumatic stressor, the more likely children are to develop persistent psychiatric difficulties. Posttraumatic stress disorder, depression, and separation anxiety disorder have been noted (20). The reactions of significant adults, e.g., parents and teachers, affect children's responses to trauma (21).

Children may develop avoidant behavior to specific reminders of the tragedy (e.g., avoiding areas of the playground where someone has been killed). Other reactions commonly seen include fear of recurrence, grief reactions, guilt, and worries about the safety of others. Children's reactions to trauma are affected by the developmental stage they are in. Preschool children through second graders commonly experience, fear, helplessness, confusion, sleep disturbance, separation anxiety, and regressive symptoms. They may have difficulty identifying and talking about what is troubling them. Third through sixth graders may have sleep disturbances, difficulty concentrating, somatic complaints, and concerns about their safety and the safety of others (22). They can be preoccupied with their actions during the shooting and reenact and retell the event through traumatic play (22). Adolescents' responses more closely approximate adults. They may experience profound changes in their attitudes towards life and their future. Of special concern are increased risk-taking behaviors sometimes seen in adolescents following trauma (22).

It is important to prevent secondary complications stemming from disaster exposure. For example, chronic disturbed sleep may interfere with school performance. The child then can experience further blows such as school failure and its attendant damage to self-esteem.

Communities

With the advent of instantaneous communication and media coverage, word of the disaster is disseminated quickly. The community is soon flooded with outsiders: people offering assistance, curiosity seekers, the media, etc. This sudden influx of strangers affects the community in many ways. Probably the most visible change is the presence of large numbers of media representatives. Aggressive news reporters can be experienced as intrusive and insensitive. Hotel rooms contain no vacancies, restaurants are crowded with unfamiliar faces, and the normal routine of the community is shattered. At a time when, traditionally, communities have turned inward to grieve and assist affected families, the normal social supports are strained and disrupted by outsiders.

Inevitably, after any major trauma, there are rumors circulated within the community about the circumstances leading up to the traumatic event and the government response. Sometimes there is a heightened state of fear. For example, a study of a school shooting in Illinois noted that a high level of anxiety continued for a week after the event, even after it was known that the perpetrator had committed suicide (23).

Another common response is outpourings of sympathy for the injured, dead, and their friends and families. Impromptu memorials of flowers, photographs, and memorabilia are frequently erected. Churches and synagogues play an important role in assisting communities' search for meaning from such tragedy and in assisting in the grief process.

Over time, anger emerges in the community. Typically, there is a focus on accountability, a search for someone who was responsible for a lack of preparation or inadequate response. Mayors, police and fire chiefs, and other community leaders are often targets of these strong feelings. Scapegoating can be an especially destructive process when leveled at those who already hold themselves responsible, even if, in reality, there was nothing they could have done to prevent adverse outcomes.

There are many milestones along the way which affect the community. There are the normal rituals associated with burying the dead. Later, energy is poured into creating appropriate memorials. Memorialization carries the potential to cause harm as well as to do good. There can be heated disagreement about what the monument should look like and where it should be placed. Special thought must be given to the placement of memorials. If the monument is situated too prominently so that community members cannot avoid encountering it, the memorial may heighten intrusive recollections and interfere with the resolution of grief reactions. Anniversaries of the disaster (one week, one month, one year) often stimulate renewed grief.

Assessment of the Traumatic Stressors

Just as its virulence and mode of transmission can characterize an infectious agent, disasters can be characterized by generic traumatic elements that are most likely to engender psychiatric morbidity. To understand the nature and degree of patients' traumatic experience, psychological stressful dimensions of the disaster should be assessed (24).

Threat to life has been shown to be associated with perhaps the highest risk of psychiatric morbidity (25,26). Those persons who actually sustain injuries are at greater risk of developing psychiatric sequelae than those not injured. Exposure to the dead and mutilated increases the potential for adverse psychiatric events (27-29). Groups routinely exposed to the dead and injured: first responders (fire, police, and EMT's), hospital workers, and mortuary volunteers, should be remembered in designing assessments and interventions.

Increasingly, traumatic bereavement is recognized as posing special challenges to survivors (30,31). While the death of loved ones is always painful, an unexpected and violent death can be more difficult to assimilate. Family members may develop intrusive images of the death based on information gleaned from authorities or the media.

Witnessing or learning of violence to a loved one also increases vulnerability to psychiatric disorders. The knowledge that one has been exposed to toxins (e.g., chemicals or radiation) is a potent traumatic stressor (32,33). Often times these events are clouded in uncertainty as to whether or not exposure has taken place and what the long-term health consequences of exposure might be. Living with uncertainty can be exceedingly stressful. This particular stressor dimension is the focus of much concern in the medical community preparing for responses to terrorist attacks using biological, chemical, or nuclear agents (34,35).

Causing death or severe harm to another is a risk factor for the development of psychiatric illness. This dimension is often examined when evaluating military personnel. However, it is often forgotten that there are many cases in civil life where human error costs lives. Transportation accidents, hazardous spills, and construction mishaps are common situations in which blame and guilt arise.

The deliberate infliction of pain and suffering is a particularly potent psychological stressor. The Oklahoma City bombing vividly demonstrated strong psychological and social responses engendered by terrorism and other criminal acts (12,36,37).

Delineation of "At-Risk" Populations

The psychiatrist must begin to prioritize those who should be assessed. A guiding principle should be that the greater the "dose" of traumatic stressors, the more likely an individual is to develop psychiatric morbidity. While each disaster has its unique aspects, certain groups are routinely exposed to the dead and injured and, therefore, are at risk for psychiatric sequelae. Adults and children who were in danger and those who witnessed the events should be identified and given high priority in subsequent interventions.

Similarly, police, paramedics and other first responders who assist the injured and evacuate them to medical care, and hospital personnel who care for the injured are all groups that should be offered opportunities to process what happened and provided education on normal responses and when to seek further help. Those who are charged with cleaning up the site of the tragedy are also vulnerable to persistent symptoms. Inevitably, each disaster situation will contain individuals who are "silent" victims and often overlooked. By paying close attention to the response process, the psychiatrist may identify these individuals and ensure that they receive proper care, too. Other vulnerable populations include the elderly and the very young.

THE PRACTICE OF DISASTER PSYCHIATRY

Disaster Preparedness

Involvement in pre-disaster planning in the school system and at the broader community level pays an important dividend critical to successful intervention in the aftermath of tragedy. Psychiatric involvement in developing disaster response plans in the schools and in the community is an ideal way to develop working relationships with local government, police, fire and school officials. As in other types of disasters, entrée to key decision-making officials is critical to influencing immediate responses following a mass casualty situation in a school shooting.

As in other areas of medicine, the best prevention is primary prevention -avoiding the disaster or limiting the numbers affected by it. At the community level, the psychiatrist can work with local government agencies responsible for developing a disaster response plan. Since every hospital must have and exercise a disaster response plan in order to meet JCAHO requirements, psychiatrists should ensure that plans include psychiatric considerations. Another primary prevention effort is providing grand rounds talks on psychiatric aspects of trauma and disaster to other health care providers, especially primary care providers. Psychiatrists can also make major contributions to community recovery by offering to speak in non-medical venues such as PTA meetings and to the media.

Child psychiatrists, in particular, can make important contributions to preparations for responding to traumas and disasters that affect schools. A major intervention is to help school officials "think the unthinkable" by asking about disaster preparedness plans and ensuring that they address potential scenarios. Such plans should include ways to protect oneself, evacuation protocols, a system for tracking people, a plan for notifying and educating parents, a plan for reducing traumatic reminders at the school, and a plan on how to handle the media (21). The psychiatrist can also stress the importance of realistic disaster drills as training is an important protective factor in preventing or mitigating physical and psychiatric sequelae (21).

Emergent Interventions

Emergent interventions take place in the minutes to hours following a cataclysmic event. Activities generally focus on the disaster site, hospitals to which the injured have been evacuated, and areas where survivors and family members congregate. A psychiatrist's basic medical skills in the provision of acute aid to the injured may be the most critical contribution in the first minutes to hours of the disaster.

The psychiatrist may be asked to assist at the scene of a disaster. At this early stage, the psychiatrist should remind those in charge that it is important to limit and minimize exposure to the dead and to other images that are disturbing, thereby, reducing the number of individuals exposed to traumatic stressors. Efforts should be made to gather survivors in areas where evidence of the tragedy is not visible. It is also important to establish order and restore a sense of safety (38).

The psychiatrist can assist school personnel in delivering information to the children about what has happened in a fashion that is appropriate to their stage of development. It is important to tell the truth. Lying, in an attempt to protect people, only serves to destroy trust and will complicate efforts to develop a supportive recovery environment. It is prudent to recommend to parents that they limit children's exposure to television until news coverage of the story has subsided. A growing number of studies have found that exposure to graphic depictions of trauma heightens children's distress (39,40).

Another important intervention during this early stage is providing victims and their families' privacy from onlookers and, more importantly, the media. At this very vulnerable time, it is important to create a holding environment in which emotions can be expressed without worries that they will later be broadcast nationwide.

The assessment process begins at this emergent stage. While the psychiatrist is at the disaster site, he should begin to gather data about who has been exposed to the trauma. The identification of "at risk" individuals in an essential element of successful interventions.

Psychiatrists can also provide important interventions at the hospital since the injured are at higher risk for the development of psychiatric disorders in the long term. All injured in a disaster should have a psychiatric assessment and follow-up. Often, merely, "come back in a month and let's be sure all is on track," is the right prescription after an assessment of high-risk individuals with no present symptoms. It may be helpful, for example, to recommend that survivors be placed together in rooms to reduce their isolation and to facilitate natural debriefings. Even among very experienced rescue workers and hospital personnel, exposure to dead and injured children is universally described as being especially difficult to cope with. Psychiatrists need to remember that people assisting injured children will likely experience significant distress. Special attention should be given to ensure that no group is overlooked in the provision of emotional first aid.

Acute Interventions

Acute interventions begin after the emergent activities have resolved. They begin within hours after a disaster and can last for several months. Goals of acute interventions include decreasing exposure to secondary stressors (e.g., struggles to obtain insurance monies, difficulties in obtaining housing), encouraging return to school and work, education of teachers and parents so that they can better support children, and encouraging the media to shift attention to stories focusing on recovery and rebuilding rather than the disaster itself.

Obtaining consultation from experienced disaster psychiatrists is an exceptionally helpful tool. Even for seasoned disaster psychiatrists, it is invaluable to talk with a colleague. While it is ideal to have this exchange take place in person, telephone consultation can be highly effective. Consultation over the course of the disaster can guide intervention efforts and address unique challenges and dilemmas. As a member of the impacted community, the local psychiatrist is also affected by the trauma. The opportunity to reflect on the experience with an empathic psychiatrist who has been in similar situations can be extraordinarily reassuring and helpful. The consultant can also remind the psychiatrist to attend to his own needs for sleep and respite and the importance of making himself available to his own family.

One means of obtaining consultation is to contact the American Psychiatric Association's Committee on Psychiatric Dimensions of Disaster. Many committee members are experienced in responding to a wide variety of disasters. In addition, they can recommend other psychiatrists who have expertise in particular areas that are most relevant to the disaster at hand. The Committee can also facilitate a telephonic consultation. There are a wide range of publications that can be tailored to the traumatic event and mailed out. Overview articles on disaster psychiatry, recommended readings, and links to other websites are available through the Committee's page on the American Psychiatric Association's website (www.psych.org).

In the aftermath of highly publicized mass casualties, there is usually an outpouring of mental health professionals offering pro bono or fee-for-service assistance. This can require active community management to ensure this help does not become an additional stressor or prematurely label feelings of fear as a diagnosis of Anxiety Disorder. Another valuable outcome of consultation can be the accumulation of information about experienced organizations and mental health care providers who are well regarded in the field of trauma management. The local psychiatrist can then advise local leaders on choosing who should have access to schools, hospitals, and first responder organizations in the community.

Often requests are made by mental health experts to research the impact of the trauma and subsequent interventions on longer-term mental health outcomes. The consultant can provide advice on how to assess proposals from researchers. Carefully designed studies that are conducted in a sensitive fashion can assess the effectiveness of interventions and increase knowledge about how to intervene more effectively in similar situations.

Community Interventions

Consultation to community leaders

The psychiatrist may provide interventions himself or may serve in a consultant role to assist decision-makers about what sort of interventions should be provided and who should conduct them. The psychiatrist can make important contributions to disaster responders and critical incident management teams by reminding leaders to ensure that their subordinates get sufficient rest and respite. A more difficult task is convincing the leaders, themselves, to make sure they take time to eat, sleep, and stay in touch with their families. Overdedication can lead to poor decisions as well as fatigue, irritability, and errors.

When small communities are targets for national and international media, it becomes important to protect leaders from misadventures with the media. Generally, it is helpful to advise the mayor and other visible leaders, such as the principal or superintendent, to use spokespersons to brief the press at regular intervals rather than to attempt to do so themselves. The use of a spokesperson frees up the key leaders to continue to prioritize and respond and diminishes the opportunity of saying something they will later regret due to fatigue and stress.

Public education and outreach

Psychiatrists can use media opportunities such as radio, television, and newspapers to educate the public on normal responses to traumatic events such as school shootings. This is a good time to draw upon the materials that have already been prepared by the American Psychiatric Association and other organizations. The Center for Mental Health Services website lists a large number of available materials. (Go to www.mentalhealth.org, click on the "publications/catalog" icon, select the "KEN's publication list", and, finally, select "Disaster Relief and Crisis Counseling.") Review of these prior to a disaster can identify the "wheat from the chaff."

Reassuring the public that a wide range of feelings and thoughts are common can diminish individuals' fears that they're "going crazy." The sense that one's experience is not abnormal facilitates discussion with others and promotes the use of social supports.

Interventions with "At-Risk" Populations

Generally, early interventions for "at-risk" children and adults focus on providing an opportunity to review what happened and their responses to the event. Their behavioral and psychological responses to the event are "normalized" through education that explains their reactions as "normal responses following abnormal events." Interventions also are used to identify individuals that seem to be especially disturbed and should be offered further assessment on an individual basis. Expectancy is conveyed that over weeks and months disturbing thoughts and feelings will dissipate for most people. The format of interventions differs somewhat between adults and children. Often, early interventions are conducted in a group format. This offers the

advantage that participants can gain validation for their symptoms and potentially have cognitive distortions corrected. Group interventions also afford the most efficient use of resources for those most in need.

Adults

A wide range of interventions can be offered. These range from group interventions such as debriefings and educational meetings to individual treatment.

Debriefing is a group intervention although the same principles can be applied in individual meetings. Debriefing is specifically designed to be used with persons who have been exposed to a trauma. While it is in common use, there are mixed conclusions regarding debriefing's efficacy in preventing or diminishing psychiatric disorders (41). However, many practitioners and researchers note that debriefings are generally well received by voluntary participants who find it emotionally rewarding and educational.

Debriefings are usually held within several days of an event. This enables the participants to have a chance to recover physiologically. Debriefings generally proceed from a more cognitive, factual level to a review of feelings, thoughts, and behaviors at the time of the event and since then. Most debriefings include an educational component that prepares individuals for common feelings, behaviors, and thoughts people have following trauma. The educational portion is reinforced by group members talking about their own experiences. The sharing of such thoughts and feelings normalize common experiences and diminish the individual's fears about "going crazy" or "falling apart".

Debriefings can help correct cognitive distortions especially in situations when many people have witnessed or participated in a common experience. Gathering multiple perspectives can be helpful in correcting unrealistic beliefs. For example, time distortions are quite common. The common experience of time moving more slowly than it does in real life can cause individuals to believe that they failed in making a critical intervention when in real time it would have been impossible. Feedback from other group members that can provide a more accurate depiction of the events may help reduce a group member's misplaced feelings of culpability.

There are many models of debriefing that have slightly varying goals and methods. Often they are composed of members of a work group such as EMTs or police. There is some difference of opinion as to whether it is better to include supervisory individuals in groups with their subordinates or to have two separate groups. Some argue that putting both in the same group allows exploration of issues that can facilitate future work together. Others point out that this may hinder the debriefing because leaders may fear appearing "weak" to employees, while supervisees may fear jeopardy to their careers if they are candid.

Although debriefing's role in prevention of PTSD may be limited, it may serve to decrease disability by maximizing an early return to one's social and work groups (42). Debriefings also serve an assessment function. They enable the early identification of individuals who may be especially vulnerable to longer-term sequelae. Gaining a sense of the "dose" of trauma that members may have been exposed to as well as the coping strategies they employ may help in such predictions.

Eye Movement Desensitization and Reprocessing (EMDR) has received a great deal of publicity. It has been proposed as a technique for working with trauma patients. At present, EMDR is not a standard part of disaster psychiatry. Recent reviews have indicated that what is new in EMDR does not appear to be helpful, and what is helpful is what we already know about relaxation, education, and psychotherapy (37,43).

Children

Grouping children by classrooms is an ideal way to begin assessment and intervention. Psychological first aid and therapeutic consultation to children's classrooms are very successful interventions. Importantly, models for working with teachers and school systems are critical following natural disaster as well as school traumas (18,19). A drawing-and-story-telling technique has been described (44) that facilitates children's discussion about the traumatic experiences and facilitate children's work on issues relating to grief and mourning (22). Death is discussed in an age-appropriate fashion and children are helped to understand death's finality (22). It is important to avoid the exploration of deeply disturbing material in the classroom setting. For example, rather than helping a child elaborate on a highly charged drawing as would be done in an individual session, the child's anxiety can be reduced by encouraging him to draw another picture that is more calming (22). Similarly, for the class as a whole, it is important to diminish anxiety and foster closure. Children should be encouraged to draw or enact reparative scenes after they have explored the anxiety-ridden materials associated with the trauma. As with adults, early identification of those in need of extra attention is an auxiliary goal.

Longer-term Interventions

In the long-term, disaster psychiatry more closely resembles a typical psychiatric practice. For some individuals, psychiatric disorders will have developed that will need treatment. Psychotherapy of PTSD is an active area of empirical research (45). Across all studies, ongoing exposure/discussion of the traumatic event in a safe environment is a major component of all successful treatment. It is still valuable, however, to perform outreach in the community to increase the likelihood that those who are suffering psychiatric sequelae from the disaster seek appropriate assistance. Once again, grand rounds to primary practitioners and consultations to school nurses can be helpful reminders to consider psychiatric issues in patients with somatic complaints.

Ways to Learn More about and Get Involved in Disaster Psychiatry

Each District Branch of the American Psychiatric Association (APA) has received mailings from the Committee on Psychiatric Dimensions of Psychiatry. The packets have contained key readings, videotapes,

audiotapes and slides relating to Disaster Psychiatry. There are many excellent books covering disaster response, in general, and psychiatric responses and interventions, in particular. The Disaster Committee's page at the APA's website (www.psych.org) is also a valuable resource.

There are also courses and workshops offered at the Annual Meeting of the American Psychiatric Association which can increase understanding of both theoretical and practical issues involved in disaster response.

Psychiatrists offer unique expertise for responding to biological and chemical terrorist attacks. The Army provides a website that contains a wealth of information on chemical and biological agents. It would be well worth a few minutes browsing it (www.nbc-med.org).

In addition to educational activities sponsored by professional organizations, there are non-government organizations that provide education. The National Organization for Victims Assistance (NOVA) offers training programs on mental health aspects of disasters. For those wishing to volunteer with the American Red Cross, where one serves as a disaster counselor but not a psychiatrist, a two-day course for mental health providers is available. The focus of this course is learning the Red Cross organization and its rules on how to work within the American Red Cross to help its staff and volunteers as well as to assist disaster survivors. The Red Cross relies on local practitioners to provide long-term assistance to the community. Psychiatrists, dually trained in a primary care specialty, can play a role in local chapters of the Red Cross by seeking the role of Medical Director or Associate Medical Director where the issues are broadly on the medical health of volunteers.

The American Red Cross provides assistance at all major disasters within the United States. Recently, it has been charged with providing for the psychological needs of victims and their families following transportation disasters. It should be noted that the charter of the Red Cross prohibits the dispensing of medications. Suggestions have been made that in times of disaster local APA district branches could locate psychiatrists near Red Cross shelters to be available for medical and psychiatric consultation. This can facilitate referral of persons needing further assessment and treatment and offer a means of prescribing medications.

CONCLUSION

Psychiatrists have many important skills that can assist communities and individuals in the wake of catastrophe. The epidemiological outbreak investigation model is a useful tool for modifying standard psychiatric practice to more effectively meet the demands of communities overwhelmed by disasters. Involvement in disaster planning is an excellent way for psychiatrists to help their communities prepare for the unthinkable.

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Disaster Psychiatry: Principles and Practice

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Abstract:

Increasingly, trauma and disasters are part of everyday life. Psychiatrists can play an important role in assisting individuals and communities to recover. They bring a unique set of skills and experiences that can be invaluable in minimizing morbidity and facilitating recovery. This paper discusses psychological, physiological, behavioral, and community responses encountered in the aftermath of a disaster. A preventive medicine model of understanding disaster response is discussed in which the psychiatrist delineates traumatic stressors and high-risk populations. The importance of psychiatric participation in disaster preparedness is emphasized. Psychiatric interventions targeted at the various longitudinal phases of disaster response are reviewed.

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