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Welcome

Welcome to the Winter 2012 issue of the *New York DMH Responder*, our quarterly newsletter for the Disaster Mental Health Community. This issue focuses on a threat that has been visible in the media recently, though thankfully so far not in real life: **viral pandemics**. Healthcare facilities certainly must prepare for the medical response to potential outbreaks, but it's also essential to plan for the extreme anxiety and psychosocial distress these events, and the measures that could be necessary to contain them, will cause among members of the public.

Responding to a pandemic would also take a significant psychological toll on healthcare and mental health workers, so our *Research Brief* presents findings on the impact of the SARS outbreak of 2003 on the professionals involved.

For the latest in our year-long series of articles on **assisting special populations**, we'll examine the special needs of children and families in disaster. While children were once thought of as highly resilient, we now recognize that they're actually extremely vulnerable to both short- and long-term negative reactions to

traumatic experiences, so attending to their needs is critical for avoiding lasting developmental disruption. We discuss the current Disaster Mental Health training schedule, and also invite you to register for the upcoming Institute for Disaster Mental Health annual training on April 20, 2012.

As always, your feedback and suggestions for topics to cover in future issues are welcome. Please email any comments to Judith LeComb at DOH and/or Steve Moskowitz at OMH.

The *DMH Responder* is a quarterly production of...

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The Mental Health Response to Public Health Emergencies

First the good news: To date, the 2011-2012 influenza season has been uneventful (though the Centers for Disease Control and Prevention (CDC) note that flu activity generally doesn't peak until February or March). As of the end of January, no wide-spread activity or pediatric deaths had been reported.

Despite that reassuring seasonal flu status, potential pandemic flus and other public health emergencies have played a prominent role in the media recently, in both entertainment and the news. Fall 2011 saw the release of the blockbuster movie *Contagion*, which depicted the official and social responses to a global pandemic caused by a highly transmissible and highly lethal virus. While the featured strain is fictional (though based on the real Nipah virus), the movie's writers and director worked closely with scientific advisors to ensure the accuracy of their depiction of both medical and governmental aspects of the outbreak. They vividly depict social reactions such as competition for limited supplies of vaccine, looting, and the spread of rumors and conspiracy theories among an anxious public.

Then on the heels of the unnerving and thought-provoking scenario depicted in the movie, news reports in late December announced that researchers at a Dutch medical center had genetically altered the A(H5N1) virus to make it airborne. This means that

this naturally occurring bird flu virus, which causes an extremely high death rate of over 50% in the rare instances it infects a human, now could potentially spread easily from person to person without even requiring exposure to droplets from a sick person's coughs or sneezes. In other words, the researchers demonstrated that an extremely lethal but non-contagious virus can be manipulated to make it transmissible via air, creating potential for a highly deadly pandemic should the mutated version escape the lab or evolve naturally in the wild.

The debate about whether this kind of research (which has been suspended) is safe or appropriate is beyond the scope of this newsletter, but knowing that a virus could potentially mutate to create the kind of outbreak shown in *Contagion* highlights the need for healthcare professionals to prepare for the psychological impact of a pandemic as well as the medical demands. Lessons from previous smaller-scale public health emergencies point to two key psychosocial issues to consider.

Perceptions About Vaccines: The public reaction to the H1N1 outbreak of 2009 suggests that two opposing issues may arise around vaccinations: Perceptions of unfair access to limited supplies, and mistrust in the safety of rapidly produced drugs.

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Assisting Special Populations: Helping Children and Families After Disasters

Note: This article is adapted from the “Disaster Mental Health: Assisting Children and Families” training curriculum, which was funded by NYS DOH.

Children used to be viewed as highly resilient in the face of loss and trauma, able to bounce back naturally from negative experiences like disasters – an optimistic but misguided belief that mental health helpers now recognize as largely inaccurate. In fact, children are particularly vulnerable to experiencing problematic trauma reactions because they have fewer coping skills and emotional resources than adults. They may be unable to physically escape a situation, which can make them more susceptible to injury and exposure to disturbing sights and sounds. And their negative reactions can have lasting consequences, as children may suffer disruption to their normal psychosocial development, which can lead to prolonged social-emotional difficulties. Finally, children depend on their caregivers for physical and social-emotional safety. If caregivers are physically or psychologically unable to tend to them, children are at greater risk of physical and social-emotional suffering.

This means that children must be viewed within the context of the family system when you try to help them post-disaster. In many cases, parents and children have experienced the same event, so each person’s experiences have the potential to impact everyone else’s reactions. While parents are experiencing their own responses to disaster (e.g., stress, physical ailments, anxiety, depression, and concerns about their children’s physical and mental well-being), their children are also responding to disaster in complex ways (e.g., confusion, emotional or behavioral changes, physical ailments, academic problems, social withdrawal). Even if parents weren’t directly impacted by the event the child experienced, they may question their ability to effectively meet the child’s physical and emotional needs. This self-doubt can compound the situation since children look to their parents for cues about how to react. When parents are extremely distressed or overwhelmed, children observe this response and experience increased distress because they’ve internalized the emotion that they perceive in their parents. In turn, when children experience responses to trauma that feel overwhelming to their parents, parental distress may increase.

However, this cycle also works for **positive** psychological adjustment: When parents are calm and reassuring, children absorb these emotions and are likely to experience lower levels of distress. And when parents feel prepared to respond to children’s reactions to trauma, parental distress decreases. So, since parents play such a large role in the psychological functioning of their children, one of the



best ways to assist families is to provide caregivers with information and tools to help them feel competent in meeting the needs of their children.

In particular, note that many parents will be unfamiliar with common reactions to trauma in children, so providing them with information about expectable reactions at different ages – and emphasizing that these reactions usually improve over time – can be very helpful and comforting. In general, trauma-related stress symptoms or reactions will affect the child’s behaviors, cognitions, and emotions. How general trauma symptoms manifest in a child are specific to age and developmental level, but may include:

- Reenactment of the disaster/trauma in play
- Intrusive imagery (i.e., flashbacks, disturbing imagery, unwelcome thoughts)
- Sleep disturbances (i.e., nightmares, insomnia)
- Somatic complaints (i.e., headaches, stomachaches)
- Anxiety responses (i.e., hypervigilance, avoidance, fear, separation anxiety)
- Strong emotions such as guilt and anger
- A disruption in normal social and developmental tasks or performance, such as a decline in school performance or loss of recently acquired skills like toilet training

Parents may be especially troubled by children’s regressive behaviors and increased clinginess or neediness. This can try caregivers’ patience at a time when they’re already feeling stressed, so encouraging them to try to be patient is important. It’s also essential that caregivers restore a sense of routine and stability as soon as possible post-disaster, even if that means adapting routines to a changed environment (i.e., reading familiar bed-time stories in an emergency shelter). It can be tempting for parents to relax the usual rules or expectations for behavior after disasters, but this only serves to further disrupt children’s equanimity.

Finally, it’s important to inform caregivers that children may not experience problematic symptoms at all, or they may experience symptoms immediately after a disaster or months or years later. Helpers can support families by normalizing each of these potential responses, by providing parents and children with factual information about how trauma affects children, and by instilling hope about treatment options and recovery. There are effective treatments available for children who develop clinical-level reactions like PTSD, but the goal should be to prevent those serious reactions by equipping caregivers with the tools and knowledge to provide a supportive recovery environment for their children. To that end, all families can benefit from responders validating their experiences, building on the strengths of the family, and connecting families with resources within their communities.

Additional Resources for Assisting Children and Families

The following organizations provide free tip sheets and other resources for helpers and caregivers:

American Psychological Association: Children and Trauma
www.apa.org/pi/cyf/child-trauma/update.pdf

The National Child Traumatic Stress Network
www.nctsn.org

The National Association of School Psychologists
www.nasponline.org

The American Academy of Child & Adolescent Psychiatry
www.aacap.org

Research Brief: The Impact of Responding to Health Emergencies on Helpers

While we're considering the psychosocial impact of infectious disease outbreaks on the general public, let's be sure not to minimize the effects on healthcare workers and others who will be directly involved in the response. Again, the SARS outbreak of 2003 provides valuable insight into the specific stressors faced by those treating patients with a highly contagious disease.

Early studies of healthcare workers involved in the SARS response found that emotional distress was common and was most associated with fear of contagion, job stress, perceived stigma, and the experience of being quarantined. Hospital employees who had been quarantined during the outbreak emphasized the difficulty of balancing the needs of work and family, as well as conflict about whether healthcare workers have a duty to treat high-risk patients (Robertson et al., 2004). For some these two issues were intertwined: They were prepared to risk exposure themselves, but worried deeply about subsequently infecting family members. Another stressor was the inadequate or conflicting information they felt they were receiving, while camaraderie with colleagues provided a protective effect.

To assess the longer-term impact of the experience, Maunder et al. (2006) surveyed 769 hospital workers in Canada 13 to 26 months after the outbreak there. Relative to workers who had not treated SARS patients, those who had direct contact reported significantly higher levels of psychological distress, posttraumatic stress, and burnout. These negative outcomes were more likely among workers who reported general psychological distress and those who reported using maladaptive coping

strategies such as avoidance, hostile confrontation, and self-blame.

These two studies suggest measures that managers should attempt to include in the response to public health emergencies in order to maintain worker resilience:

- Provide reliable and timely information, both to inform workers about best practices and to counter stigma they might face from the general public.
- Provide opportunities for social support from families and colleagues.
- Create a system for referrals for those workers who require mental health services.
- Create a working environment that fosters positive working relationships.
- Encourage adaptive coping mechanisms such as advanced planning for future outbreaks.

Of course, these actions may be difficult to implement once an outbreak begins so ideally they will be part of pre-pandemic planning, as will the development of good self-care practices for all professionals. **If we don't take care of ourselves, we won't be able to care for others in a time of extreme need.**

Sources:

Maunder et al. (2006). Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. *Emerging Infectious Diseases*, 12, 1924-1932.

Robertson et al. (2004). The psychosocial effects of being quarantined following exposure to SARS: A qualitative study of Toronto Health Care Workers. *Canadian Journal of Psychiatry*, 49, 403-407.

"To keep the body in good health is a duty... otherwise we shall not be able to keep our mind strong and clear."

-Buddha

Disaster Mental Health Training Begins

The 2011-2012 Disaster Mental Health training, including two half-day-long modules is currently underway, and there's still time to register for deliveries in central and upstate New York. "Assisting People Exposed to Radiation," from 8 a.m. to noon, is intended to address the psychosocial needs of individuals exposed to radiation through an accident, dirty bomb, or other incident. In-class exercises will offer an opportunity to practice the skills needed to work with individuals and their families in the aftermath of radiation exposure.

"Disaster Mental Health: Essential Principles and Practices" is a new four-hour module that will be offered from 1 to 5 p.m. This module is meant to reinforce participants' core knowledge about disaster mental health and to bring them up to date on the most current developments and practices in the field.

The recommended prerequisite for both modules is the completion of the "Disaster Mental Health: A Critical Response" course which provides the basic fundamentals of disaster mental health. Please note that the modules will *not* be offered in a "train the trainer" format; this will allow a staff person to attend without being required to follow up with a provider course in their facility.

Remaining dates are:

- Albany - February 7
- Lake Placid - February 8
- Buffalo - March 27
- Rochester - March 28
- Syracuse - March 30

For further information regarding registration, please email:
prepedap@health.state.ny.us

Registration is Now Open for the Institute for Disaster Mental Health 2012 Conference

Building Capacity: Managing and Mitigating Responder Stress

Friday, April 20, 2012

Sponsored by the NYS Office of
Emergency Management

The ninth annual Institute for Disaster Mental Health conference at SUNY New Paltz will focus on building responder capacity and resilience through effective stress management and self-care strategies. Disaster response, emergency management, and trauma work are intrinsically and uniquely stressful, and it's essential that the occupational hazards be reduced through proactive self-care and stress management strategies. The care that responders provide to others can only be as good as the care they provide themselves.

Featured presenters and workshop leaders include:

- **Charles Figley:** Mitigating occupational hazards of disaster response
- **Richard Tedeschi:** Post-traumatic growth
- **Rob Yin and Valerie Cole:** New American Red Cross models for reducing responder stress
- **Dianne Kane:** Self-care for first responders
- **Monica Indart:** Culturally responsive self-care
- **Stephanie Speer:** Mindfulness-Based Stress Reduction for helpers

What's YOUR Critical Response?

Your feedback, comments, ideas for future topics, or suggestions on how to improve DMH training are welcome.

Email to:

prepedap@health.state.ny.us
and/or

Steven.Maskowitz@omh.ny.gov

The Mental Health Response to Public Health Emergencies

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Unlike seasonal flu vaccines which are formulated, produced, and distributed in advance of expected need, the development and production of effective prophylaxis for an emerging strain would take some time (a process that was depicted in *Contagion*). Difficult decisions will need to be made about allocating limited supplies to high risk populations, and the rationale for these decisions will need to be communicated to the public to explain why they may have to wait for access. The wait may cause particular unrest if people perceive – accurately or not – that some groups (politicians, wealthy people, etc.) are being given preferential treatment, as occurred early in the H1N1 outbreak when news spread of New York City investment banks receiving supplies before the general public. The banks countered that they intended to restrict their supplies to staff members who qualified as vulnerable (i.e., pregnant women, people with pre-existing health conditions), but the news was met with outrage among the public, further fueling general anxiety about the situation.

At the same time, many people chose **not** to get vaccinated against H1N1 once they did have access; often because they believed widespread rumors that the vaccine was somehow dangerous or tainted. Others chose not to be vaccinated themselves and did not have their children vaccinated because, according to a University of Michigan poll, they didn't perceive the threat of the disease as serious despite its increased risk among children. In both cases, misinformation caused people to avoid accepting care that could protect them personally and limit the spread of disease.

This H1N1 example demonstrates that clear and accurate communications will be essential for addressing issues around vaccine access and for attempting to overturn rumors, though these are increasingly difficult to contain in the era of Twitter and the Internet. Providing timely and credible information is also extremely difficult in the case of a rapidly changing situation like the early stages of a pandemic; authorities will have to balance the need to ensure accuracy against public perceptions they're concealing or withholding information.

Stigma and Scapegoating: Whether or not measures like isolation, quarantine, or social distancing rules are enforced to contain an outbreak, the human need to find someone to blame for misfortune virtually guarantees that some individuals or group will face hostility or rejection for their perceived responsibility for the disease. While it's an understandable defense mechanism that provides some psychological comfort or sense of control, this scapegoating can actually fuel the spread of disease, as people who fear being stigmatized may avoid seeking medical care. Of course, if they do then become sick and are perceived as exposing others, the resulting blame will be intensified.

This was clearly seen in the global outbreak of SARS (Severe Acute Respiratory Syndrome) in 2003. In fact, CDC researchers Person et al. (2004) describe fear and stigma in response to SARS as an "epidemic within the outbreak." As they note, "public health strategies that deal with rapidly evolving disease outbreaks of new and emerging infectious diseases require a delicate balance between protecting the public's health and initiating exclusionary practices and treatments that can lead to fear and stigmatization of, and discrimination against, specific populations." Since SARS began in China and initially spread through Asia, the authors report some people in the U.S. becoming suspicious or fearful of anyone who appeared Asian, regardless of whether they actually had any risk factors for the disease. And some individuals isolated themselves after traveling to areas where the disease was present, even if they had not been exposed to anyone who was ill.

To address this issue during the SARS epidemic, the CDC's National Center for Infectious Diseases formed a Community Outreach Team that worked directly with Asian-American populations to build resilience and encourage health-seeking behaviors for those exposed; the team also targeted the general population with information, attempting to dispel myths and prevent discrimination against those perceived as responsible. As this example indicates, the official response to a major disease outbreak needs to directly address the issue of stigma and scapegoating – whatever unfortunate group is selected as the target of blame. Attempting to ignore this aspect of the public's psychosocial reaction could lead to hostility and divisiveness at a time when cooperation will be needed more than ever.

While the movie *Contagion's* tagline, "Nothing Spreads Like Fear," may be a product of Hollywood melodrama, the CDC's Person et al. (2004) observe that "as we prepare for the next new or reemerging disease outbreak, we should also be preparing to deal with the fear epidemic that will likely accompany it." Lessons from SARS and H1N1 – as well as the worst-case scenario of the movie – provide a good reminder that preparations for the potential physical devastation of a pandemic also need to address the psychosocial reactions that will undoubtedly increase distress and complicate the professional response.