



NY DMH Responder

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Introduction

Welcome to the Fall 2019 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. This issue covers an unfortunate reality for many disaster responders: dealing with survivors of trauma and loss, as well coping with their own reactions to being in these stressful situations. We begin with some best practices for supporting and understanding survivors after traumatic loss, and how to assist from afar with the use of telephone and text hotlines, including the national Disaster Distress Helpline. Then, we include a case study that highlights the effectiveness of a response utilizing these interventions during Hurricane Katrina. Rounding out this issue, our Research Brief examines responders' secondary traumatic stress and resiliency factors, as well as a tip sheet for preventing and managing stress before, during, and after a deployment.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Tom Henery at DOH or Steve Moskowitz at OMH.

Understanding and Responding to Traumatic Loss and Bereavement

After some losses, the resulting intersection of trauma and grief can impede recovery. Traumatic bereavement can be defined as the "persistent experience of trauma and grief following the sudden death of a significant other due to unnatural causes," in which "the survivor has not yet accommodated the death and the trauma and grief interfere with the survivor's ability to live life fully." In this situation, the interaction of trauma and grief both interfere with and potentiate each other. The individual experiences post-trauma symptoms like those that characterize PTSD and grief symptoms such as yearning, sorrow, and anger, all set among a shattering of the assumptive world characterized by struggle with faith and meaning, feelings of guilt and blame, and a preoccupation with the deceased person's suffering.

Traumatic bereavement is more likely to occur following deaths that are abrupt, untimely, human-caused and violent, and those perceived as preventable or random. This reaction can be notably persistent, lasting

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Understanding and Responding to Traumatic Loss and Bereavement, *continued*

for years or even decades, especially in response to homicides – with the emotional reaction in these cases often compounded by the desire for retaliation and by the need to participate in a legal system that is not generally sensitive to their needs. Survivors may have unrealistic expectations for what kind of satisfaction they can expect from legal proceedings, as well as frustration at how long the process can take. These fatalities are perceived as untimely and

at not being able to provide this final service for the deceased, and who are deprived of the social and spiritual support these rituals normally provide.

Traumatic bereavement is also highly pervasive, affecting multiple realms of the survivor's life including interpersonal relations and daily functioning. Members of a family may respond very differently to a shared loss, creating friction and distress as the family struggles to reorganize around the missing member.

children," unwelcome religious platitudes like "She's a flower in God's garden," unhelpful advice like "You shouldn't be going to the cemetery every day," and even comments such as "Your wife may be dead but at least she's not a vegetable."

There are many secondary losses that accompany the primary loss of the deceased person including the emotional support they provided, the practical support such as shared decision-making, the physical contact with the person, financial position and material possessions like a house one can't afford without the partner, as well as less tangible things like one's sense of humor and joie de vivre, and one's hopes and dreams for the future. Survivors can also lose essential roles or parts of their identity, like being a parent or spouse. Parents who have lost a child experience a particular pain around facing unassuming questions like "How many children do you have?"

The complexity and intensity of these interwoven trauma and grief symptoms mean that survivors often become stuck in their mourning process. To begin to overcome this, survivors need interactions like those in the RICH model proposed by Saakvitne, Gamble, Pearlman, and Lev in *Risking Connection* (2000):

- **Respect**
Control, recognition, acknowledgment, justice
- **Information**
About what happened, coping strategies, resources, paths to recovery



unfair, and often intensify feelings of disbelief, shock, and anger. The risk of complicated grief and bereavement are increased. The need for funerals and memorials is magnified but holding them may not be possible due to the physical state of remains or the general conditions in the community. The inability to follow traditional mourning rituals adds another level of despair for survivors who may feel distressed

Social support may be perceived as absent or inadequate – partly because mourners tend to withdraw and isolate themselves, but also because the broader support network is often also impacted by the death. Additionally, many people are simply inept at knowing what to say after a death. Survivors often encounter well-intentioned but unhelpful statements such as "You need to be strong for your

Understanding and Responding to Traumatic Loss and Bereavement, *continued*



- **Connection**
Human contact, social support, engagement with experience
- **Hope**
All of the above plus return to routines, meaning engagement, spiritual engagement

All therapeutic interactions can strive to incorporate these elements in order to begin to reverse the feeling of a loss of control that is common after

trauma. This can be as simple as asking someone their name and then asking them how they would like to be addressed as a sign of recognition and respect.

There are several unhelpful myths about loss that are still prevalent in the field. These including the concept of “closure” as well as the classic Kubler-Ross stage model of grief, which is inaccurate to the extent that it does away with individual differences – which we know

characterize all human behaviors, not only reactions to loss. It is also inaccurate that maintaining bonds with the deceased person is an indication of pathological grief; people want and need to maintain those bonds, though it may be helpful to try to shift how they are defined. For example, a counselor might help reframe a belief from “he was the only person who could ever understand me” to a thought like “he was the love my life” or “I loved him and he loved me” which maintains the original connection, but doesn’t preclude the survivor from ever seeking a new relationship. Finally, the myth that time heals all wounds is not true with this population, who can remain stuck for a very long time after their traumatic loss.

Some of the information in this article is based on the work of Dr. Laurie Anne Pearlman, lead author of *Treating Traumatic Bereavement: A Practitioner’s Guide*. To learn more, two presentations by Dr. Pearlman can be found at:

- [Pearlman Workshop](#)
- Pearlman Keynote

Supporting Survivors after Traumatic Loss

Whether deaths are due to a mass shooting, a transportation accident, or any other disaster that causes many fatalities, it’s important for disaster mental health responders to be prepared – as much as is possible – to support survivors with traumatic losses. While responding to

traumatic grief over time is not often the role of disaster mental health, responders to any of these types of events are likely to find themselves talking to people in the raw state of early bereavement. Regardless of your professional role in the response, you may be able to provide a

degree of comfort to the newly bereaved, compensating at least partially for their inability to turn to natural support systems in the disrupted post-disaster environment. Many people will simply want someone to talk to about the deceased person, so being a willing listener can

Supporting Survivors after Traumatic Loss, *continued*

provide a more valuable service than you might imagine. However, the act of listening to highly distressed people who are just beginning to confront their grief can be disturbing and may place you at risk for burnout or vicarious traumatization. It's important to prepare yourself to take on this role, and to pay attention to your own functioning and take a break or seek out someone to talk to yourself when needed.

Some points to keep in mind when talking with loved ones about a death in the family:

- The emotional phases in a mass casualty event may be very different from other disasters; don't expect to see a "honeymoon phase." Depending on when you speak with family members you'll see very different kinds of emotions. Early on you're more likely to see shock and disbelief, followed later by sadness and grief. Anger may also be present at any point, and may occasionally be misdirected at helpers simply because they're there and the truly responsible party isn't.
- Although feelings change over time, everyone copes and grieves differently. There are enormous cultural and gender differences, particularly in terms of expressiveness. Some responders react to extreme emotionality with fear and can wrongly assume that the individual is more disturbed than he or she is. Others believe that people must experience and express intense emotionality or they're not processing the death properly. Don't judge survivors

Consider offering these statements of condolence and support: *"I'm so sorry for your loss."*

"I can't imagine what you're feeling right now, but I will be here to help you however I can."

if they show significantly more or less emotionality than you think is appropriate.

As previously mentioned, the notion of grief as a series of stages of mourning one must "work through" in order to successfully adjust to loss has been dismissed by experts as a myth. However, survivors sometimes feel they're not mourning correctly if they don't pass through a culturally imposed series of stages. The following are some questions concerning culture and ritual that you might consider asking when speaking with survivors. The nature of these questions will change depending on how long after the death you meet with family members, and the attitudes and culture of the survivors:

- According to your culture/ religion, what happens after death?
- What are your religious or cultural beliefs about how to best mourn a death? Have you been able to fulfill these expectations?
- Are family members in agreement about handling the funeral or mourning rituals?
- Are there funeral or memorial rituals you'd like to perform but have not been able to accomplish?

Answers to these questions may point to tasks you can assist with or resources you can connect the

survivor with and talking through them can also help survivors structure their thoughts and begin to take planning into their own hands.

Finally, as noted above, there are some common statements people often default to when they don't know what else to say after a death. Though well-intended, platitudes provide little real comfort and should be avoided. These include statements such as:

- "You'll be alright."
- "You must be strong for your children / parent."
- "This too shall pass."
- "I know how you feel."
- "It could have been worse."
- "At least he's no longer suffering / you had X time together," or anything else beginning with "at least."

Also avoid religious statements like "It was God's will" or "She's in Heaven / in a better place / with God now" unless you know for sure that this is in keeping with the person's values or beliefs – and be cautious even then. Someone who usually takes comfort in their faith may currently be feeling betrayed or abandoned by it. Instead, consider offering these statements of condolence and support:

- "I'm so sorry for your loss."
- "I can't imagine what you're feeling right now, but I will be here to help you however I can."

Disaster Distress Helpline: An Essential Service in Disaster Emotional Care

By Christian Burgess, MSW
Director of the Disaster Distress Helpline for
Vibrant Emotional Health

Overview

The national Disaster Distress Helpline (DDH) is dedicated to providing 24/7, year-round, crisis counseling and emotional support to survivors, responders, and anyone struggling with distress or other mental health concerns related to any natural or human-caused disaster. Hotline calls (1-800-985-5990) and texts (text TalkWithUs to 66746) are answered by trained counselors from a network of independently operated crisis centers located across the country. The DDH is a program of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the not-for-profit Vibrant Emotional Health. Vibrant also administers the National Suicide Prevention Lifeline for SAMHSA, of which the DDH is a sub-network.

in social work and other mental health disciplines. No matter the educational background of crisis counselors, all receive an average of over 70 hours of initial training in supportive counseling techniques before taking their first call or text. As a sub-network of the Lifeline, DDH counselors are also trained in suicide prevention and crisis assessment, intervention, and referral.

As a disaster emotional care (DEC) resource, DDH counselors receive even more foundational training, starting with NCTSN's Psychological First Aid (PFA), as the underlying principles informing this widely used curriculum¹ also serve as the philosophical underpinnings of what we seek to provide for anyone who reaches out to the DDH:

- A sense of safety
- Calming
- Sense of self- and collective efficacy
- Connectedness
- Hope



These values inform the intended outcomes for many types of DEC services, with the primary difference in how DDH counselors provide supportive counseling to people impacted by disaster being that rather than engaging in-person through various field-based settings, our contacts all take place either over the phone or via text.

Therefore, building on both standard crisis counseling training and PFA, Vibrant Emotional Health created a curriculum for its DDH call and text centers that takes the principles of PFA and applies them to call/text settings. We call the curriculum *Just In Time: Disaster Crisis Counseling for Crisis Contact Centers*, because the training is meant to prepare counselors for supporting DDH callers and texters no matter when they reach out to us for support, or why. DDH counselors are always ready and able to support people in

disaster-related distress, “just in time.” The person could be struggling with distress related to a disaster that occurred 10 years or a week ago, and after any type of natural or human-caused disaster, from house fires and transportation accidents to an incident of mass violence or a wildfire or hurricane.

Like other providers in disaster preparedness, response, and recovery, DDH counselors are as diverse as the communities they serve. Many are volunteers driven by passion for helping people in crisis, while others are part-time or full-time paraprofessionals or professionals with degrees

Disaster Distress Helpline: An Essential Service in Disaster Emotional Care, *continued*

Moving Forward on the Path of Recovery

For all DDH crisis contacts, our goal is to utilize two common elements of any supportive counseling contact – active listening & psychoeducation – throughout four stages of a crisis call or text session:

- 1) Engage (beginning the session with an affirming, welcoming tone)
- 2) Explore (actively listen to presenting concerns, gently ask questions as appropriate, explore coping, offer validation and empathy in helping to understand distress reactions)
- 3) Connect (based on presenting concerns, offer and educate on available resources and help to identify other supports available)
- 4) Conclude (review ‘next steps’ plan if one was made, encourage person to reach out again should they need to, at any time)

Ultimately, DDH supportive counseling contacts (calls, texts) can look very similar to DEC contacts that occur in the field, in any setting. Contacts can last anywhere from 5 minutes to an hour; they may focus more on helping the person with practical needs versus digging deeper into their emotions; they might involve helping the person identify ways they can cope following a disaster for themselves or loved ones (whether before, during, or after the event, including long term recovery); and so on.

It is also important to understand that DDH calls and texts, like your typical DEC contact in the field, are not psychotherapy nor is a substitute for therapy. When a DDH caller or texter exhibits symptoms of acute distress or other potentially more serious or persistent behavioral health concerns (depression, substance abuse, anxiety, suicidality, etc.) the goal is to provide a supportive intervention for that individual (utilizing our “two by four” method) including crisis intervention if potential threats to self or others are present.

In these instances, a part of the intervention – just as when PFA is provided in the field – also typically includes referring (or, in the case of hotline calls, directly transferring) the individual to local behavioral health resources for follow-up care and support.

How the DDH Fits Into the Overall Scope of DEC Services

The national Disaster Distress Helpline, while exclusively dedicated to supporting disaster survivors and responders and guaranteeing that everyone in the United States and territories has access to immediate crisis counseling and support throughout any phase of a natural or human-caused disaster, is also just one of many hotline-based or similar crisis contact services available to people impacted

by disaster. Local and statewide crisis line and/or information & referral (“I&R”) services often train their counselors in evidence-informed DEC interventions as well, and therefore also serve as important community resources throughout the disaster cycle and are integral within the overall scope of disaster emotional care offered to individuals, families, and communities impacted by disaster.



This “two by four” method of our DDH Just In Time training serves as an apt metaphor for the work we do in supporting callers and texters: Helping people to draw from their foundation of resilience (“building blocks”, just like the boards commonly used as foundations in building and strengthening homes) so they can move forward on the path of recovery.

Disaster Distress Helpline: An Essential Service in Disaster Emotional Care, *continued*

Disaster Distress Helpline

SAMHSA's Disaster Distress Helpline provides 24/7, 365-day-a-year crisis counseling and support to people experiencing emotional distress related to natural or human-caused disasters.

The Disaster Distress Helpline, [1-800-985-5990](tel:1-800-985-5990), is a 24/7, 365-day-a-year, national hotline dedicated to providing immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster. This toll-free, multilingual, and confidential crisis support service is available to all residents in the United States and its territories. Stress, anxiety, and other depression-like symptoms are common reactions after a disaster. Call [1-800-985-5990](tel:1-800-985-5990) or text **TalkWithUs to 66746** to connect with a trained crisis counselor.

Counseling Services

The Disaster Distress Helpline puts people in need of counseling on the path to recovery. Our staff members provide counseling and support before, during, and after disasters and refer people to local disaster-related resources for follow-up care and support. Since its launch in February 2012, the Disaster Distress Helpline has provided counseling and support in response to disasters such as Hurricane Sandy, the Boston Marathon bombing, and the Ebola outbreak.

As a part of the National Suicide Prevention Lifeline, Vibrant Emotional Health DDH staff work to support all Lifeline-networked centers across the U.S. (currently 170 centers), both year-round and following major disaster events, through providing access to training and technical assistance support in disaster behavioral health and other relevant resources.

The Disaster Distress Helpline and other crisis contact/I&R services:

- Often serve as an initial and/or primary point of contact for people experiencing disaster-related distress, offering referrals and a gateway to community-based healthcare and other supports (including to the aforementioned local/state crisis and/or I&R services)
- Enhance access to disaster emotional care for people who may have difficulty reaching brick-and-mortar support services, including when transportation is limited as a result of disaster, etc.
- Offer 24/7/365 direct counseling support in Spanish, and can connect hotline callers in over

100+ other languages with counselors via 3rd party interpretation services, also 24/7

- Can provide emotional and crisis support to people who are Deaf, hard of hearing, or who have other speech disabilities via text, preferred Relay service connection to our hotline, and via TTY (DDH TTY: 1-800-846-8517)
- Are open and affirmative to all regardless of gender, sex, race, ethnicity, immigration status, sexual orientation, religion or spiritual beliefs and other essential identities
- Offer services that are confidential and often anonymous, unless the caller or texter presents an immediate threat to themselves or others, in which case counselors will explore options with the individual, which may include notifying third parties for emergency intervention.

For these reasons and so that you can offer the DDH as a 24/7/365 resource for individuals, families, and communities served, field-based DEC providers should always be equipped with DDH information and resources:

- Bookmark the [SAMHSA DDH website](#)
- Download the [SAMHSA Disaster App](#)
- Email the DDH any time for questions; to learn who your nearest DDH- and/or Lifeline-networked crisis center is; and/or to have DDH brochures and wallet cards (available in English, Spanish, and other languages) at ddh@vibrant.org.

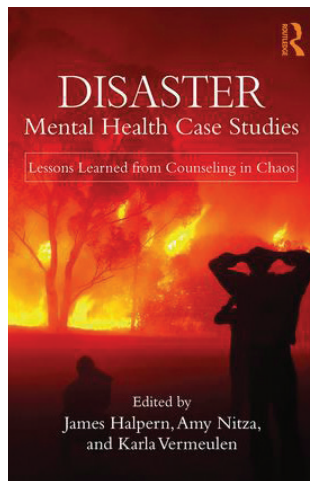
When we think of the impacts of disaster, understandably we often first think of supplying or restoring essential, basic needs such as food, clothing, and shelter. Our emotions are also a basic need, and so DEC services, no matter whether they're offered in person or over the phone or by text, are also essential and must be planned for, promoted, funded, included, and utilized, throughout the disaster cycle.

Christian Burgess, MSW, has been Director of the Disaster Distress Helpline for Vibrant since its launch in 2012. Prior to working for Vibrant, he worked for over 10 years in youth violence prevention and trauma intervention.

Lessons Learned from Counseling in Chaos

Excerpts from Disaster Mental Health Case Studies

*This series will highlight chapters from the 2019 book **Disaster Mental Health Case Studies: Lessons Learned from Counseling in Chaos**, edited by IDMH experts Founding Director Dr. James Halpern, Director Dr. Amy Nitza and Deputy Director Dr. Karla Vermeulen. In these chapters, disaster mental health responders outline their experiences before, during, and after disaster responses in order to provide guidance and identify lessons learned from these critical events*



2005 Hurricane Katrina in Louisiana
by Gerald McCleery

In this chapter, Dr. Gerald McCleery, former CEO of Link2Health Solutions and Deputy Director of the Mental Health Association of NYC, described his experience responding to Hurricane Katrina in 2005. This storm had a widespread impact along the Gulf Coast, including Mississippi, Alabama and Louisiana, with the storm surge and resulting infrastructure failure causing devastating effects on the city of New Orleans, including a death toll reported to be over 1400 people.

With previous experience operating and staffing call centers including LifeNet, the National Suicide Prevention Lifeline, and call centers after the 9/11 attacks, McCleery responded after United Way solicited volunteers from his organization to help.

With his mind focused on the logistics of physically getting to his work location, he had little time to prepare psychologically for the task ahead. McCleery arrived in Louisiana, at a United Way call center in a city 300 miles away from New Orleans, just five days after Katrina made landfall and just two days after he agreed to volunteer.

“I was working from a safe and secure location, with a place to sleep and food to eat. I found taking repeated calls from people who were not in the same circumstances to be profoundly difficult.”

He described his initial impressions of the space he would be working in as “40 call station desks, mostly unmanned. There were wires everywhere. There were many sheets of newsprint pasted somewhat haphazardly on the wall at the front of the room with information about local resources.” The local staff had been working around the clock, and the people who were there were community members with limited to no experience, who were “trying to be helpful in any way they can be.”

In other recollections of this space, McCleery said that “although it was impacted by the hurricane, it experienced nothing close to the effects that were felt in New Orleans.” His physical separation from the primary area of impact took a psychological toll on him; at one point he mused, “I was working from a safe and secure location, with a place to sleep and food to eat. I found taking repeated calls from people who were not in the same circumstances to be profoundly difficult.”

The work at the call center was non-stop, with phones ringing again immediately after hanging up from another call. The devastation of the area, the disruption of regular systems (health clinics and schools), and the overwhelmed first response systems meant that the call center was inundated with a variety of calls and needs. McCleery received phone calls from:

- People in life-threatening situations
- People looking for food and water
- People from outside of the area looking for missing loved ones
- People in shelters looking to process the trauma they experienced
- People with goods to donate

In one case, he received a phone call from a truck driver with coffins to donate and no place to bring them. In another, he spoke with a woman who was at her home which was surrounded by water, and whose husband had used up his last tank of oxygen.

Lessons Learned from Counseling in Chaos, *continued*



In many cases, while he could not fix the problems people were experiencing, he could offer a calm and compassionate presence to the people who called. “I communicated that they could call back as often or for as long as they needed to, and that someone would be available to speak with them. I did get a sense that for many people, our willingness to listen compassionately did offer some comfort in very difficult circumstances.”

In addition to this phone work, McCleery started a once-a-day support group for the volunteer staff who were overwhelmed by the volume of calls and by the limited support they could offer. In addition, some of the volunteers were personally affected by the disaster, having had their homes severely damaged or destroyed in the storm. McCleery says he felt “buoyed” by the goodness of these volunteers, a poignant and perhaps accidental metaphor to describe his experience responding to a disaster that left whole communities underwater.

During one of McCleery’s last phone calls, a gentleman staying in a shelter described that his wife, who was suffering from a terminal illness, had died in a nursing facility during or immediately after the storm. In the weeks before she passed, the caller had been saving her hair and nail clippings so that he would still have a “piece of her” after she passed. All of those items had been in his home when it was

destroyed and he found the compounded losses devastating. This call had a profound impact on McCleery, “I remember getting up, walking outside, sitting on the curb, and crying uncontrollably. In that moment, I decided that I had given all that I could. I went back to my room that night and drove back to Little Rock the next morning.”

Lessons Learned

McCleery offers several pieces of advice for disaster mental health responders working in call centers or other telehealth settings:

- The primary point of contact following many disasters is over the phone. If you are asked to provide mental health support at a call center, understand that although you will not be at the physical center of the disaster, you will be in the middle of the action and doing very important crisis counseling.
- Doing this work by phone, rather than face-to-face, comes with its own challenges. First, over the phone there are no visual cues to guide the work or to see how something you have said or asked has affected the caller (either positively or negatively). In addition, you may have only one opportunity to get the support intervention right- it can be challenging for a caller to reach the same phone support staff member in a call center environment if additional or other follow up contact is desired.
- Many calls are requests for practical information (e.g., what roads are open, where is the nearest shelter, where to get food and water, where is the closest open pharmacy or clinic). Although you may not have much information especially in the early stages, it is important that you get and disseminate as much of this accurate information as possible. In the early stages of disaster, this is often the most important mental health intervention.
- Perfection is usually impossible to achieve. Take comfort that you will be making a meaningful, humane contribution in support of people who likely have suffered considerable trauma.
- Know this can be extremely stressful work. Plan to limit your exposure to manageable periods.

Research Brief

Secondary trauma and posttraumatic growth among mental health clinicians involved in disaster relief activities following the 2011 Tohoku earthquake and tsunami in Japan

Yoshiki Tominaga, Toyomi Goto, Janine Shelby, Atsushi Oshio, Daisuke Nishi & Satoshi Takahashi (2019) Secondary trauma and posttraumatic growth among mental health clinicians involved in disaster relief activities following the 2011 Tohoku earthquake and tsunami in Japan, Counselling Psychology Quarterly, DOI: 10.1080/09515070.2019.1639493

Working with survivors of disaster, whether natural or man-made, comes with unique challenges. One such challenge is that of secondary or vicarious trauma, or the indirect experiencing of posttraumatic stress symptoms following empathically connecting with someone who directly experienced an extremely stressful event. However, just as those who directly experience the event will react differently depending on individual differences and resiliencies, so do the responders who are assisting them.

Posttraumatic growth is described as “positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi & Calhoun, 2004). This resiliency in the face of adversity holds true for responders as well as survivors, even in the harshest of environments.

Tominaga, Goto, Shelby, Oshio, Nishi, and Takahashi (2019) examined such phenomena among first responders following the 2011 Tohoku earthquake and ensuing tsunami in Japan. In working with a cohort of 230 mental health clinicians, Tominaga et al. administered

an online survey assessing levels of posttraumatic growth, compassion satisfaction, compassion fatigue, and burnout approximately five months post-disaster and two months after the conclusion of their relief work.

Their findings regarding posttraumatic growth were clear and remarkable: Certain types of intrusive thoughts foster healthy cognitive processing. Typically, rumination is thought about negatively in relation to affective disorders, however some researchers have argued that this cognitive processing can manifest as both intrusive rumination and deliberate rumination. These differ in that intrusive rumination involves unwanted thoughts invading one’s mind, while deliberate rumination is a subsequent examination of the traumatic events that were experienced. Some have proposed that posttraumatic growth is higher among those who have less intrusive rumination while also having more deliberate rumination. This adds to the litany of evidence that posttraumatic symptoms can have both positive and negative outcomes.

The study also found that clinicians’ reported level of

pre-disaster knowledge and skills was positively correlated with compassion satisfaction. In line with these findings, it was also the case that those who had specialized training in trauma had enhanced levels of compassion satisfaction. However it should be noted that almost 70% of clinicians who participated had reported zero previous disaster relief experiences, and only about 11% reported one or more previous disaster experiences.

The online survey also assessed levels of responder burnout. Their largest finding was that responders’ prior knowledge and skills again had the largest association with reduced burnout. This is consistent with the findings relating to compassion satisfaction in disaster settings, as well as in prior studies of lay trauma counselors. The authors emphasized the importance of preparation and training in the prevention of responder burnout.

Finally, compassion fatigue was found to be predicted most strongly by the severity of intrusive rumination and avoidance symptoms present. Avoidance symptoms were more prevalent among responders who worked at sites with higher levels of severe, indirect trauma exposure. Another positive correlation, although a weak one, was the indirect exposure to a child’s missing status or death.

Research Brief, *continued*

Although there are warranted concerns regarding indirectly exposing disaster mental health workers to traumatic stress events, the results here support the evidence that rumination and intrusive symptoms can have a resiliency building effect. However more research is needed to distinguish between adaptive and maladaptive forms of post-disaster rumination.

Tedeschi, R. G., & Calhoun, L. (2004). Posttraumatic growth: A new perspective on psychotraumatology. *Psychiatric Times*, 21(4), 58-60

Secondary Traumatic Stress

aA parallel process in which responders empathically experience the psychobiological impact of trauma on survivors

Burnout

A prolonged response to chronic, job-related emotional and interpersonal stressors which typically has a gradual onset. Can involve exhaustion, frustration, anger and depression

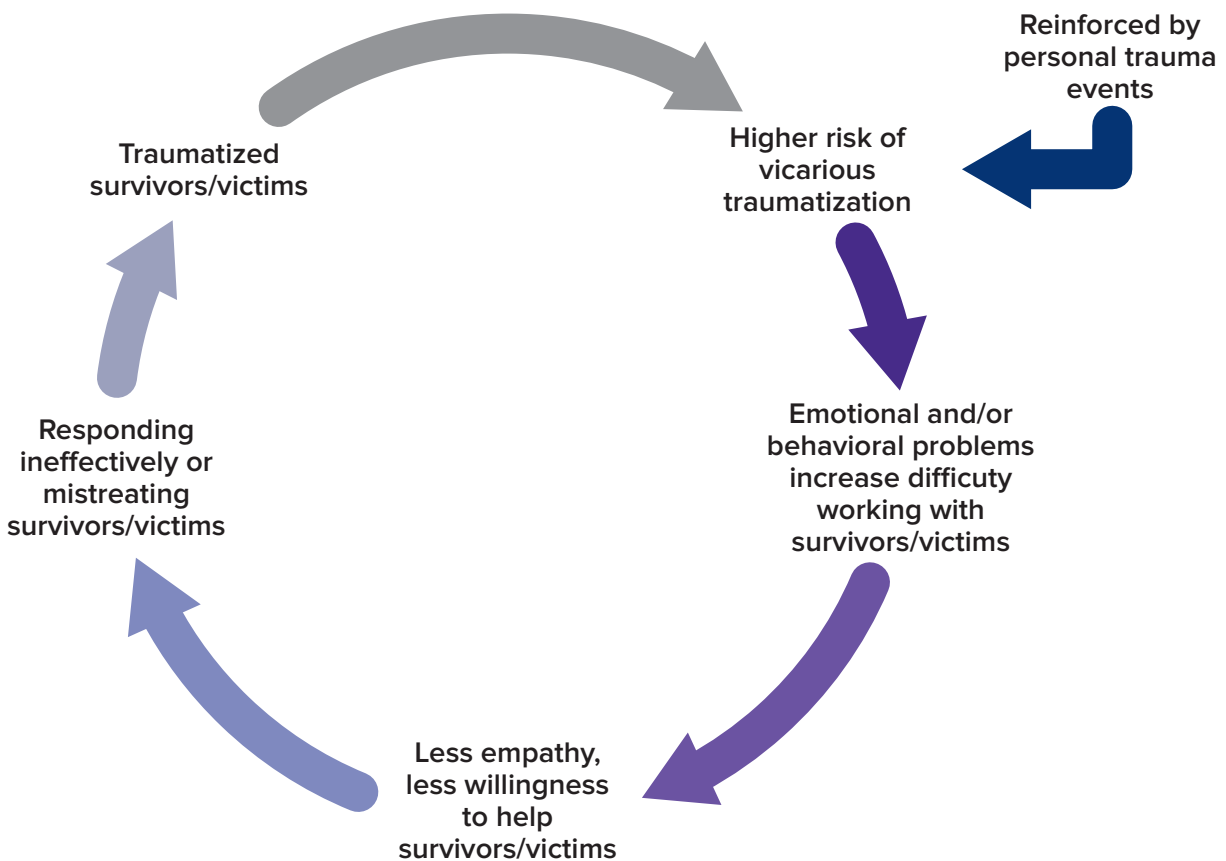
Compassion Fatigue

A posttraumatic reaction to indirect trauma exposure composed of a combination of Burnout and Secondary Traumatic Stress

Compassion Satisfaction

The positive feelings that are derived from helping others through traumatic situations

The Cycle of Vicarious Traumatization



Preventing and Managing Stress

The following are strategies recommended by SAMHSA to prevent and mitigate stress, and minimize the impact of burnout, compassion fatigue, and secondary traumatic stress. These are abridged from SAMHSA'S "Tips for Disaster Responders: Preventing and Managing Stress" resource tip sheet. To view the whole document, visit: <https://store.samhsa.gov/system/files/sma14-4873.pdf>

Before Your Assignment

Know Your Job

- Train hard and know your job well. You will perform at peak capacity, with more confidence and less stress, if you know you are as ready as you can be.
- Participate in exercises and simulations that expose you to disaster stressors. This will strengthen your skills and prepare you to deal with the unexpected.

Practice Stress Management

- Select and practice constructive ways to release stress, such as the following:
 - Choose physical activities that can be done safely while on deployment, like walking, stretching, and taking deep breaths.
 - Read or listen to music that is timed to your breath.
 - Practice healthy sleep behaviors. Train your body to downshift by getting into a routine sleep pattern.

Prepare and Plan with Your Loved Ones

- Reduce your concerns by preparing your loved ones and protecting your home and your possessions for possible emergencies.
- Create a communication plan that allows you to stay connected to your loved ones, whether you are responding to a disaster close to or away from home.

During Your Assignment

- Mentally rehearse your disaster response role as you approach each scene.
- Communicate and check in with your buddy, teammates, and supervisors regularly.
- Take breaks regularly. Pace yourself.

- Limit time spent working in very high-intensity settings (e.g., "ground zero," "hot zone")
- Try to eat nutritiously and avoid excessive junk food (especially foods high in sugar), caffeine, alcohol, and tobacco.
- Reduce physical tension by exercising, stretching, taking deep breaths, and walking.
- Use time off for reading, listening to music, talking with family, and thinking calmly.
- Recognize your personal stress signs—and those of your teammates. Agree with your buddies that you will accept each other's instruction when signaled to stop and take a "stress break" to calm down.
- Avoid over-identifying with survivors' grief and trauma. For example, remind yourself this is not happening to you or your loved ones.

Signs of Stress

- Bodily sensations and physical effects
- Strong negative feelings
- Difficulty thinking clearly
- Problematic or risky behaviors
- Social conflicts



After Your Assignment

- Take time away from the scene. Alternate between on-scene and off-scene duty, and between time spent doing physically exhausting work or working with highly stressed survivors and time on less stressful tasks.
- Use stress management skills like deep breathing as often as you can. Focus on reintegration with friends, loved ones, and coworkers who did not share the experience with you. Pay extra attention to rekindling relationships.