

DISASTER, DISEASE AND DISTRESS

**Resources to Promote Psychological
Health and Resilience in Military
and Civilian Communities**

**A Compilation of Fact Sheets for
Healthcare Providers and Families from
the Center for the Study of Traumatic Stress
Uniformed Services University**

Edited by:
James E. McCarroll, Ph.D., M.P.H.
Nancy T. Vineburgh, M.A.
Robert J. Ursano, M.D.



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Foreword

The Center for the Study of Traumatic Stress (CSTS) is pleased to present *Disaster, Disease and Distress: Resources to Promote Psychological Health and Resilience in Military and Civilian Communities*. *Disaster, Disease and Distress* represents a compilation of the Center's public education resources that address the psychological impact and health implications of populations exposed to traumatic events. These events encompass natural disasters and human made disasters including war, terrorism, bioterrorism and public health threats. Over a ten year period, Center experts in the fields of military and disaster psychiatry contributed their knowledge to develop these fact sheets, which have been distributed worldwide to educate military and civilian healthcare professionals and families, government leaders at the federal, state and local level, and stakeholders in workplace mental health, public health, human services and academia. Most of these public education resources were written and disseminated in the form of electronic fact sheets, and many were created in 'real time' to respond to specific disasters, national and international. These resources have been archived on the Center's website, www.cstsonline.org, as 'lessons learned' to help others prepare for, respond to and recover from specific traumatic events such as hurricanes, tsunami, community violence and war.

Section One, *Caring for Our Nation's Soldiers, Sailors, Airman and Marines: The Role of Medical and Social Service Providers*, features content from an educational campaign called *Courage to Care*. *Courage to Care* was the first initiative in the United States to address military-unique health topics, especially those related to the wars in Iraq and Afghanistan. Topics include deployment-related issues and disorders such as dealing with depression, posttraumatic stress disorder, traumatic brain injury, and topics that have been rarely addressed such as the impact of combat injury on intimacy.

Section Two, *Military Family Health*, includes general health care issues for families including the challenges of single parenting, caring for newborns, protecting your family during flu season and the impact of frequent moving on military families and their healthcare routines. It also provides advice on the impact of deployment on military personnel and their fami-

lies: reintegration and relationship challenges and health risk behaviors such as alcohol misuse, reckless behavior, and intimate partner violence.

In Section Three, *Disasters: Leadership, Response and Care*, we focus on responder self-care, disaster care and disaster leadership. We also include several fact sheets on the topic of body recovery for which the Center has pioneered leading research and education in this area to help mitigate the trauma of exposure to mass death.

Lastly, a section on *Special Populations* includes important information to help teachers, law enforcement personnel, business leaders, national guard and reserve component members, to name but a few, deal with the special challenges of human continuity in the face of trauma.

We have many people to thank for this body of resources that have helped so many individuals, families, communities, healthcare professionals and first responders reach out to those affected by trauma with compassion, informed care and sustained support. Please see the Acknowledgements for a list of those who have contributed to this book and its contents.

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There are many individuals and organizations to thank for having written and helped disseminate the fact sheets that comprise this book, *Disaster, Disease and Distress: Resources to Promote Psychological Health and Resilience in Military and Civilian Communities*. We wish to acknowledge the contributions of the following Center scientists who regularly contributed their expertise in military and disaster psychiatry, behavioral health and general health in developing the Center's fact sheets and its *Courage to Care* initiative. They include Drs. Carol Fullerton, David Benedek, Robert Gifford, Derrick Hamaoka, Stephen Cozza, Dan Balog, Brian Flynn and James McCarroll.

Courage to Care, a project of the Center for the Study of Traumatic Stress (CSTS) and Uniformed Services University of the Health Sciences (USU) began in 2004, and was the first educational campaign and outreach to address military-unique health and psychosocial issues related to the wars in Iraq and Afghanistan. *Courage to Care* was the vision of Dr. Robert Ursano, the Center's Director, who recognized the need to raise awareness of military-related healthcare issues to help medical providers better serve our nation's soldiers, sailors, airmen and marines, and to bring this information directly to military families to enhance their health and resilience. Nancy Vineburgh, Associate Director of CSTS and its Office of Public Education and Preparedness, helped spearhead the *Courage to Care* campaign, and supported the efforts of those listed above and those recognized in the Contributors list on the following page.

A number of fact sheets in this book originated from an educational campaign to foster communication around combat injury, *Courage to Care Courage to Talk*. These fact sheets are featured on the Center's website under Resources for Recovery and were developed by Dr. Stephen Cozza, CSTS Associate Director, Child and Family Program. They can be accessed for individual download at www.cstsonline.org/resources. Center fact sheets and *Courage to Care* fact sheets may also be accessed on the Center's website.

We owe a debt of gratitude to the many individuals and organizations that championed these fact sheets and distributed them to military healthcare and military family websites, national and international, as well as directly to

our military healthcare leadership, DOD agencies and organizations, Congress, the workplace, professional associations and academia. Special thanks to Sharon Willis, the USUHS Deputy Vice President for External Affairs; Mary Dix, the Assistant to the USUHS President for Special Projects; Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE); National Child Traumatic Stress Network; American Academy of Child and Adolescent Psychiatry (AACAP) and the Deployment Health Clinical Center.

Lastly, we wish to recognize and thank Marc Kaufman of Digital Design Group who lent his expertise to the graphic design and production of many fact sheets on the Center site and in this book.

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Section 1

CARING FOR OUR NATION'S SOLDIERS, SAILORS, AIRMEN AND MARINES

The Role of Medical and Social Service Providers

Introduction

This section addresses some of the signature wounds of the nation's wars in Iraq and Afghanistan. Combat injuries are life-changing events that affect the service member and his/her family. These injuries include both those that are visible (burns, amputations, etc.) and those that are invisible (traumatic brain injuries, mood disorders, etc.). Through the Center's expertise in the impact of combat injury on service members and families, we present some often forgotten or neglected topics such as the impact of injury on intimacy.

The significance of this section is that many of these disorders and topics can appear years later after a deployment, and can endure and inflict pain on those who suffer and their loved ones. Because service members often move and/or leave the military, the role of healthcare providers and social service professionals in the civilian as well as the military healthcare system is key to helping identify, treat and refer service members to specialty care and resources.

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THE PSYCHOLOGICAL IMPACT OF DEPLOYMENT

Post-Deployment Health and Distress Responses *Overview for Practitioners*

Studies of service members returning from Iraq and Afghanistan have shown that the vast majority will ease back into their day-to-day lives after a period of transition and reintegration. But, some are likely to continue to endorse symptoms that are consistent with emotional problems such as post-traumatic stress disorder (PTSD) or depression. These conditions generally benefit from treatment. Other returning service members may fall somewhere between these two groups or may demonstrate changed behaviors that are worrisome to family members or friends, such as increased alcohol consumption, aggression or reckless driving.

In addition to the serious conditions of PTSD or depression, other distress responses are often forgotten or overlooked, and can compromise the health of the service member and the family. Knowing when a veteran is simply readjusting to life back home or when he or she may require clinical intervention to ease that transition is often confusing for families and medical practitioners.

Distress Responses

Many service members are likely to exhibit some distress responses after serving in a deployed environment. These symptoms are typically mild to moderate in severity and usually remit over a period of several weeks. When these problems last longer than one to two months after returning home, medical attention is important.

- **Insomnia** — Difficulty in falling asleep, sustaining sleep, or awakening early from sleep.

Many service members are likely to exhibit some distress responses after serving in a deployed environment.

- **Motor restlessness** — Jitteriness, fidgety movement, or an abundance of nervous energy.
- **Hypervigilance** — Reduced sense of safety and a need to scan the environment for potential sources of danger.
- **Social Withdrawal** — Avoidance of others and a temporary need to spend time alone.

Health Risk Behaviors

Deployment can sometimes lead to initiation or increase in the frequency of certain behaviors that can result in short or long-term health impairing effects.

- **Smoking or using smokeless tobacco** — Starting or increasing in the combat zone. These behaviors may not remit upon return home.
- **Alcohol use** — While prohibited in theatre, some service members may use alcohol while deployed. The use of alcohol may also be initiated or increase upon return from deployment as a misguided effort to address distress responses.
- **Reckless driving** — Returning veterans experience a transition from the intensity of driving in a war zone to routine driving in a civilian setting. Stress and alcohol are other factors that contribute to risky driving.

More Serious Issues and Conditions

- **Violence** — When irritability or anger escalates into violence there is risk both for the service member and the family. Mixing anger with alcohol can be particularly troublesome since the individual loses the ability to decide how to behave. Conflict that includes violence needs to be addressed quickly and nearly always with outside help. The causes of violent behavior can be many, and require assessment in order to help.
- **Post traumatic stress disorder (PTSD)** can result when traumatic experiences lead to longer standing symptoms that include nightmares, flashbacks or unsettling memories of the trauma; excitability, nervousness or overanxious watchfulness; and a tendency to withdraw or avoid situations or people that remind the individual of the trauma experience.
- **Traumatic Brain Injury (TBI)** can result when service members are exposed to explosions. While many veterans are aware that they have suffered head trauma, some who sustained mild injury may not be aware of the risks. Symptoms of mild TBI can include headaches, impulsivity, anger outbursts, and changes in personality or slowed thinking. These clinical complaints can sometimes be difficult to distinguish from other

emotional conditions. As TBI symptoms can cause problems in the lives of combat veterans and their families, it is important to thoroughly evaluate them when present.

- **Depression** presents as an unchanging, prolonged and painful lowering of mood that does not respond to usual attempts to help a person cheer up. Depression typically leads to changes in an individual's ability to function effectively or a loss of his/her sense of wellness.

Overcoming Stigma to Promote Help-seeking

Stigma can result in individuals not seeking the care that they need and an unnecessary prolonged course-of-illness. Age may be an important factor in acknowledging a mental health problem and willingness to accept treatment. Young adults, regardless of being in the military or civilian population, often feel more invincible and feel they can tough it out. Health care providers can reinforce that emotional conditions are like other medical conditions and respond to treatment.

Resources for Patients

Many resources are available to veterans through the Department of Defense, Veterans Affairs and community agencies.

Warning Signs

Health care providers should be alert to and alert family members to the following symptoms that require attention

- Pronounced desire to avoid other people that continues for weeks or months after return
- Increased jitteriness or jumpiness that does not go away after the initial transition home
- Unsettling memories or flashbacks to uncomfortable wartime events that do not resolve after transition home
- Chronic headaches, unexplained personality or cognitive changes that could indicate TBI
- A pervasive sense of sadness, guilt or failure that does not improve
- Angry outbursts, irritability, escalating family arguments or physical fighting that is uncharacteristic or prolonged
- Changes in alcohol use — increased frequency, increased amounts, guilt about use, inability to decrease or stop use, or family member concerns about use
- Risk-taking behaviors — such as driving reckless driving or other activities that threaten health

- Thoughts of death or a wish to no longer be living (tell patients to seek medical attention immediately or call 911)

For additional information see these websites:

<http://www.militaryonesource.mil>

<http://www.centerforthestudyoftraumaticstress.org>

When problems last longer than one to two months after returning home, it is time to get medical attention.

Evidence-Based Management of Acute Stress Disorder

Acute Stress Disorder (ASD) is characterized by dissociative symptoms (detachment, de-realization, or amnesia) during or after exposure to a traumatic event. From two days to a maximum of four weeks after the traumatic exposure, there are additional symptoms of re-experiencing, avoidance or numbing, and hyperarousal. While not the only disorder seen acutely after exposure to traumatic events, ASD is quite common. The American Psychiatric Association and the U.S. Department of Veterans Affairs Office of Quality and Performance have published Practice Guidelines for the treatment of ASD.

For details see:

- <http://www.psych.org/practice/clinical-practice-guidelines>, and
- http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp

Practice Guidelines do not define the standard of care. However, their synthesis of research and expert consensus augments clinical experience in treating patients, educating the public, guiding research, and establishing credibility for medical care delivery. Essential recommendations of the above noted guidelines for ASD are outlined below.

- **Assessment.** Psychological effects of trauma may result from physical injury. Detailed diagnostic evaluation should be continued only after a physically and psychologically safe environment has been established, the individual's medical condition has been stabilized, and psychological reassurance has been provided. Diagnostic evaluation may be accomplished through individual or group interviews or consultation. Surveillance instruments or screening symptom checklists may aid the process

ASD is characterized by dissociative symptoms during or after exposure to a traumatic event.

and may also be helpful in identifying at-risk individuals for follow-up evaluation when large populations are exposed to trauma such as a natural disaster or terrorist event.

- **Management.** Treatment objectives for patients with ASD include establishment of a therapeutic alliance, providing ongoing assessment of safety and psychiatric status, addressing co-morbid disorders, and increasing the patient's understanding of and coping with the effects of exposure to traumatic events through specific treatment strategies that may include psycho-education, psychotherapy and pharmacotherapy.
- **Psychotherapy.** Early supportive psycho-education and case management facilitate entry into other evidence-based treatments. Cognitive behavior therapy (CBT) may be helpful acutely after traumatic exposure although heightened arousal and anxiety states may preclude some patients from absorbing information or acquiring new coping skills in the immediate aftermath of trauma. Psychological debriefing was developed as an intervention to prevent the development of negative emotional consequences of trauma including ASD, but well-controlled studies using single-session individual or group debriefings have not demonstrated efficacy and some studies have indicated that persons experience these debriefing sessions as helpful. Some individuals will increase their traumatic exposure through participation.
- **Pharmacologic treatment.** Potential benefits of selective serotonin reuptake inhibitors and other antidepressants are supported by limited study in ASD and evidence of their efficacy in PTSD. Benzodiazepines reduce anxiety and improve sleep, but they have the potential for dependence and withdrawal symptoms. Studies indicating greater incidence of PTSD after early treatment with this medication class suggest only transient use in acutely distressed individuals. Combination psychotherapy and pharmacotherapy, although not well studied, should also be considered if initial medication therapy or psychotherapy is ineffective.

Evidence-Based Management of Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD) is characterized by symptoms of re-experiencing, avoidance/numbing, and hyperarousal persisting more than one month after exposure to a traumatic event or events. While not the only disorder seen after exposure to traumatic events, PTSD is among the most widely noted. The American Psychiatric Association and the U.S. Department of Veterans Affairs Office of Quality and Performance have published Practice Guidelines for the treatment of PTSD:

- <http://www.psych.org/practice/clinical-practice-guidelines>, and
- http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp

Practice guidelines do not define the standard of care. However, their synthesis of research and expert consensus augments clinical experience in treating patients, educating the public, guiding research, and establishing credibility for medical care delivery. Essential recommendations of the above noted PTSD Practice Guidelines are outlined below.

- **Assessment.** Psychological effects of trauma may result from physical injury so detailed diagnostic evaluation should be continued after a physically and psychologically safe environment has been established, medical status has been stabilized, and psychological reassurance has been provided. Diagnostic evaluation may be accomplished through individual or group interviews or consultation. Surveillance instruments or screening symptom checklists may expedite the process. These may be helpful in identifying at-risk individuals for follow-up interview when large populations are exposed to trauma (e.g. natural disaster or terrorist event).

PTSD is characterized by symptoms of re-experiencing, avoidance or numbing, and hyperarousal lasting more than one month after exposure to a traumatic event.

- **Management.** Goals of management of patients with PTSD include establishment of a therapeutic alliance, providing ongoing assessment of safety and psychiatric status, addressing co-morbid disorders, and increasing the patient's understanding of, and coping with the effects of exposure to the traumatic event through the implementation of specific treatments (e.g. psycho-education, psychotherapy and pharmacotherapy) for PTSD.
- **Psychotherapy.** Early supportive interventions including psycho-education and case management appear to facilitate entry into further evidence-based treatments. Cognitive Behavior Therapy (CBT) is effective treatment for core symptoms of PTSD. Studies have not yet clarified the critical element(s) of CBT but the element of controlled re-exposure to traumatic recollections is shared with other PTSD psychotherapies with demonstrated efficacy: prolonged exposure, EMDR, imagery rehearsal, and stress inoculation. Psychological debriefings or other single session techniques in the immediate aftermath of trauma are ineffective in preventing the development PTSD.
- **Pharmacologic treatment.** Selective Serotonin Re-uptake Inhibitors are the first-line medication treatment for PTSD. Monoamine oxidase inhibitors and tricyclic antidepressants may also be beneficial. Benzodiazepines reduce anxiety and improve sleep but potential for dependence, withdrawal symptoms, and increased incidence of PTSD after early treatment with this medication class preclude recommendation as monotherapy. Anticonvulsants may be helpful adjuncts and second-generation antipsychotics may reduce symptoms in patients with co-morbid psychotic disorders.
- **Combination psychotherapy-pharmacotherapy.** Although not well-studied, should be considered particularly if initial psychotherapy or medication therapy is ineffective.

Traumatic Brain Injury

Helping Service Members and Families

A significant number of U.S. service members deployed to Iraq and Afghanistan have suffered traumatic brain injuries (TBI) ranging from mild (mTBI) to moderate and severe. While the vast majority of TBI has been mild in the form of concussion, some have suffered moderate to severe TBI. The effects can last a lifetime and dramatically alter the lives of the wounded, their families and children.

TBI can result from blast exposure, gunshot wounds and shrapnel, falls, and motor vehicle accidents. It often coexists with other serious injuries to include loss of limb, sight or hearing, burns, and psychiatric conditions such as depression, anxiety and posttraumatic stress disorder. Like other war injuries, TBI has a recovery trajectory that depends on the severity of injury. While not life-threatening, mTBI can produce serious practical and emotional challenges for families and may also suggest the presence of other conditions such as posttraumatic stress disorder, depression or substance abuse that require further evaluation and treatment.

Moderate to severe TBI occurs when there is prolonged loss of consciousness or amnesia after the event. Because of the widespread nature and prevalence of TBI, especially mTBI, health care and primary care providers should be alert to its potential presence and its implications for families. This fact sheet provides an overview of mTBI and recommendations for care and key psychosocial issues for families and children dealing with more severe TBI.

Symptoms of mTBI (Concussion)

The majority of mTBI resolve within a year, sometimes sooner. Symptoms can appear days, weeks to months after the injury. It is important to convey

TBI can produce serious practical and emotional challenges for families and may also suggest the presence of other conditions such as posttraumatic stress disorder, depression or substance abuse.

that healing takes patience and time.

- Headaches and/or dizziness
- Excessive fatigue
- Problems with concentration or memory
- Irritability
- Sleep problems
- Balance problems
- Ringing in the ears and/or vision changes

Patient Care Recommendations

- Get plenty of sleep at night and avoid overexertion during the day
- Return to normal activities gradually
- Avoid activities that can lead to another brain injury
- Avoid alcohol as it can slow brain recovery
- Write down important things to remember
- Consistently place commonly used items in the same place such as car or house keys
- Focus on doing one activity at a time

Moderate to Severe TBI: Implications for Families

TBI presents a range of behavioral challenges that families must deal with over time. Understanding some of these issues and asking direct questions about the impact of the injury on the non-injured spouse and their children is important.

- **Injury as grief and loss:** When you talk about the impact of moderate to severe TBI, the service member is not who he or she used to be. There is grief and loss of the service member over not being able to return to the developmental pathway that had been there before the injury. There are memories of how the person used to function with direct comparison to present abilities.
- **Inappropriate behaviors:** TBI heavily involves the family that must deal with the injured service member's potentially inappropriate behaviors in public. These may include lack of inhibition, anger, and outbursts, as well as other extremes — withdrawal, apathy, and depression.
- **Implications for children:** The resulting changes a parent with TBI may demonstrate can be confusing to a child. Younger children may assume they are responsible for the problems they see, or even that their injured parent no longer loves them. Efforts should be made to reduce children's

exposure to outbursts. Talking to children can help by explaining that “Dad is grumpy and angry because his brain was hurt. He sometimes says or does things he doesn’t really mean.”

- **Social isolation:** This may be an issue due to the exhausting care-giving responsibilities and fear over how the TBI patient is going to behave. Part of the focus is to help the family avoid social isolation and engage community and other supports.
- **Family management:** For most injuries, the process is about overcoming and adapting to the injury. In the case of severe and moderate-to-severe TBI, the focus should be on the partner’s management of the injured service member.

Health care providers in military and civilian settings are increasingly aware of the prevalence and effect of TBI amongst military and civilian personnel deployed to Iraq and Afghanistan. In the case of mTBI, it is important to communicate self-care, expectation of recovery, and the potential, if symptoms persist, to be something other than or in addition to mTBI. Moderate to severe TBI will have an enduring impact on families who need to understand the critical challenges in order to cope and overcome the burden of care.

Resources

- A guide on TBI for Providers can be accessed at
<http://www.mirecc.va.gov/docs/visn6/TBI-handout-providers.pdf>
- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury:
<http://www.dcoe.health.mil/default.aspx>
- Defense and Veterans Brain Injury Center:
<http://www.dvbic.org>
- For the current numbers of service members suffering TBI and other military health issues, see:
http://www.health.mil/Research/TBI_Numbers.aspx

Addressing Alcohol Misuse through Brief Screening and Counseling

Problem drinking is a persistent health issue. Patients may engage in risky drinking (levels associated with risk for social, legal, economic and health problems) or harmful drinking (having already experienced adverse consequences due to drinking). Primary health care visits offer opportunities to identify and intervene with risky or harmful drinkers to reduce alcohol consumption.

Do you drink? (<http://rethinkingdrinking.niaaa.nih.gov>)

- 35% of U.S. adults do not drink
- 37% drink within low risk limits
- 19% drink more than *either* the single day *or* weekly limits
- 9% drink more than *both* the single day *and* weekly limits

Definitions of safe and at-risk drinking (NIAAA)

- Safe drinking levels in drinks/week
 - » Women and men age 65 or older — more than 1 drink per day or more than 7 drinks/week
- At risk drinking
 - » Men younger than 65: more than 14 per week or more than 4 per occasion
 - » Women more than 7–11 per week or more than 3/occasion•
 - » Men or women age 65 or older: more than 7 per week or greater than 1 per occasion

Interventions are more likely to be successful if they involve at least two or three key elements — feedback, advice and goal-setting.

It is safest to avoid alcohol altogether if you are:

- Pregnant or trying to become pregnant
- Taking prescription or over-the-counter medications that may cause harmful reactions when mixed with alcohol
- Recovering from alcoholism or are unable to control the amount you drink
- Managing a medical condition that may be worsened by alcohol
- Planning to drive a motor vehicle or operate machinery
- Underage

Why Screen?

The purpose of screening is to identify persons who *might* have a disorder. It is not diagnostic, but can suggest the need for referral for more evaluation and intervention.

Barriers to Screening

- Provider time for screening has declined
- Ethical and legal issues (such as insurance payment and commission of crimes) can present obstacles and resistance.
- However, the U.S. Preventive Services Task Force report (see above)

Alcohol Counseling

Alcohol counseling involves 1) educating patients about safe and at risk drinking levels, and 2) providing 'simple advice' about the risks on drinking for their health history or medical condition.

Brief Interventions Can Make A Difference in Promoting Healthy Behavior Changes

In their review of current research, the U.S. Preventive Services Task Force report (Whitlock et al., <http://www.uspreventiveservicestaskforce.org/3rduspstf/alcohol/alcomissum.htm>) found that six to 12 months after good-quality, brief, multi-contact behavioral counseling interventions (those with up to 15 minutes of initial contact and at least 1 follow-up), participants reduced the average number of drinks per week by 13% to 34% more than controls did, and the proportion of participants drinking at moderate or safe levels was 10% to 19% greater compared with controls.. They concluded by stating that behavioral counseling interventions for risky/harmful alcohol use among adult primary care patients could provide an effective component of a public health approach to reducing risky or harmful alcohol use.

Importantly, all interventions evaluated by the Task Force showed significantly significant improvements in alcohol outcomes of any intensity if they included at least two or three key elements — feedback, advice and goal-setting.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has many sources of helpful advice for providers and the public (e.g., <http://rethinkingdrinking.niaaa.nih.gov>). In 2005, the NIAAA released a publication *Helping Patients Who Drink Too Much: A Clinician's Guide* that featured guidelines on screening and brief interventions for primary care and mental health practitioners (http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm).

Reference

Whitlock EP, Polen MR, Green CA, Orleans CT, & Klein S. (undated). “Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use b adults.” U.S. Preventive Services Task Force.

Depression in Primary Care

A Military Health Care Perspective

War greatly affects the health and well-being of the service member and the family. Deployment, redeployment, single parenting, long absences, as well as losses sustained from injury or death are stressors that impact physical and mental health. While most service members and their families are resilient, some may experience mental health problems that require medical attention.

Depression, one of the most common and treatable mental disorders, often presents during a primary care visit. There are many indicators of depression. In addition to the commonly recognized symptoms are also unexplained fatigue and vague aches and pains. Depression can also result from or be exacerbated by the stress of preparing for holidays, increased expectations of family and friends, the sadness of not having a loved one present, or having to say goodbye.

Primary care providers play an important role in early detection and intervention of depression. Early recognition and treatment can often prevent or mitigate long-term health consequences. Due to concerns around stigma and one's career, primary care is often the setting of choice for service members and families to address mental health issues. Primary care is an important site for early identification and intervention.

Militarily Unique Issues for Consideration

Primary care settings should be alert to the following:

There are already avenues for screening for mental health problems. For example, when service members return from deployment, they take a screening instrument called the PDHA (post-deployment health assessment) that includes mental health questions. A similar instrument is administered (the

There are many good treatments for depression mainly including psychotherapy and medication.

post-deployment health reassessment or PDHRA) is administered 90–180 days after returning home. Service members who screen positive are given further evaluation.

However, there are barriers to care include the lack of availability of mental health resources (particularly to family members) at more remote military posts and to reservists and National Guard personnel in locations where there are no military posts or civilian resources. Service members may feel that their careers will be impacted by seeking help. Family members may have a similar perception.

Suggestions for Depression Screening in Primary Care Settings

Observe

The signs of depression may or may not be obvious. It is important to observe changes in demeanor and in mood of patients with whom one is familiar. Depression can also be manifested in fatigue, problems with concentration and sleep, weight loss, and unexplained pains and headaches.

Listen

The patient may have a sense of “I can handle it on my own” or a sense of shame about having feelings that could indicate depression. Being there and listening can be of the greatest assistance. Help seeking begins with self-awareness and a sense of safety, which can be facilitated by provider presence and interest.

Ask

Screening can be simple, quick and to the point. “*How have you been feeling lately?*” can be an excellent lead in to facilitate discussion.

For first time patients, questions such as “*What brings you here today?*”

Two screening questions have been found to detect most cases of depression in primary care settings (see reference, Arroll, Khin, & Kerse, 2003). These questions are, “*During the past month have you often been bothered by feeling down, depressed, or hopeless?*” and “*During the past month have you often been bothered by little interest or pleasure in doing things?*”

These can be followed by “*Are these symptoms or feelings you have experienced in the past?*” to further dialogue.

If depression is suspected, always remember to inquire about thoughts of suicide such as “*During his time have you had thoughts of hurting yourself or thinking that others would be better off without you?*”

The U.S. Preventive Services Task Force recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. For further information on depression screening in various populations, see <http://www.uspreventiveservicestaskforce.org/uspstf/uspSaddepr.htm>.

Treatment

There are many good treatments for depression mainly including psychotherapy and medication. However, depression screening programs that do not provide depression care supports other than those targeted at improving the effectiveness of the primary care provider's depression treatment (without additional staff involvement) are unlikely to be effective.

Reinforce

Treatment is effective. The majority of individuals who seek and receive treatment will get better. Depression also affects one's family. Taking care of one's self protects the health and cohesion of one's family. Adherence to prescribed medication is important. As with many health issues (such as hypertension and diabetes), medication adherence is a challenge. A primary care visit can reinforce the progress a patient has made and the benefits to self and family of adhering to treatment.

Assure

Assure patients that depression does not mean discharge. Explain to service members that many on active duty might be in treatment for depression and continue to work effectively. A diagnosis of depression does not necessarily require medications; mild to moderate depression can be treated with a variety of non-pharmacological approaches. The earlier one receives help for depression the less likely it will develop into a more serious problem that could affect one's job, health, and relationships.

There are many indicators of depression. In addition to the commonly recognized symptoms are also unexplained fatigue and vague aches and pains.

Suicide Facts for Primary Care Providers

Helping Service Members and Families Overcome Barriers to Care

Suicide of our military service members has risen during the course of the wars in the Middle East. Despite increased efforts for mental health prevention and outreach, a military culture that values strength and resilience presents multiple barriers to care. Service members and families are reluctant to seek mental health services for many reasons including shame, guilt and feeling stigmatized by one's coworkers and loved ones, and fear of job loss. Furthermore, frequent military moves can disrupt and impede patient-doctor relationships that enable a provider to know a patient's history and more easily detect changes in his or her physical or mental status and behavior.

Primary care, however, is where patients often present physical and emotional issues that signal distress. Many who commit suicide have seen a health care provider within the month prior to their death. Military spouses, often the first to notice changes in their returning service member, may share information about their service member and seek knowledge about mental health issues including suicidal behavior from their primary care provider. Educating military families about mental health and the need for care for depression and stress can assist in help seeking and the care of service members. In this fact sheet, we provide warning signs and risk factors associated with suicidality.

Suicide Warning Signs

When a patient discloses suicidal ideation, intent, or plan an assessment is required. A safety evaluation should also be undertaken when a provider

Despite increased efforts for mental health prevention and outreach, a military culture that values strength and resilience presents multiple barriers to care.

sees substantial changes in demeanor, or the following signs and symptoms: *extreme anxiety, appearing withdrawn and overwhelmed, depression, or when a patient discloses significant, unexpected, highly important, recent losses (such as relationships, finances, status, and job)*. Importantly, suicide is not only associated with depression, but also with anxiety.

The following risk factors should lead the provider to expand their assessment and questioning about thoughts of self-harm. Remember, these are not absolute indications that someone is suicidal; however, they should be factors to take into consideration in evaluating risk.

Suicide Risk Factors

- Current thoughts of suicide including ideas, plans, attempt
- Past thoughts of suicide: ideas, plans
- Past suicide attempts are a particularly important risk indicator
- Alcohol/substance abuse
- Access to firearms
- Psychiatric diagnosis (e.g., major depressive disorder, bipolar disorder, substance use disorders, anxiety disorders)
- Hopelessness, worthlessness
- Severe anxiety
- Impulsiveness
- Lack of social support
- Widowed, divorce, single
- Family history of suicide, i.e. first degree relatives
- Male gender (males complete suicide more often, females attempt more often)
- Age — young enlisted in the military are at risk. In the civilian world elderly (greatest proportionate risk) and adolescents (highest number of suicides)
- Physical and chronic illnesses, such as pain syndromes, head trauma

Ways to Help

In collaboration with the patient, the provider can enlist the support of the patient's family and identify other immediate supports. Some service members may be reluctant to engage in treatment. It is important for providers to convey that others have experienced similar life events and there is help available to deal with the present crisis.

Restoring hope and the feeling of not being alone are the key interventions to move the patient to the next step of care

Remember, there are outpatient programs available that are suited to meet the needs of service members and families. If there is any question regarding need for further evaluation and more definitive treatment, providers should consult with their mental health providers and/or refer to more emergent care/evaluation.

In emergencies tell the patient or the concerned family member to call 911 or take the individual to the nearest emergency room.

Reference

American Psychiatric Association (APA). Factors associated with an Increased Risk for Suicide. Accessed 21 November 2008. American Psychiatric Association. Available from URL: <http://www.psychiatryonline.com/popup.aspx?alID=56260>

Restoring hope and the feeling of not being alone are the key interventions to move the patient to the next step of care

THE IMPACT OF COMBAT INJURY

Guidelines for Caring for Families of Injured Service Members

While military families are generally robust and resilient, the stress of war, deployment, war injury, illness or death challenges the healthiest of families. War injury is a life-changing event that impacts children, family members, loved ones and friends.

Communication about injuries can be difficult. Injury communication is the timely, appropriate and accurate sharing of information with and among family members from the moment of notification of injury throughout treatment and rehabilitation. It is an essential component of family care. Communication by providers to service members and family should be calibrated to address their anxieties and sustain hope. Because families may be uncertain how to share difficult information with their children, they may benefit from professional guidance on what to say and how to say it.

Parental injury disrupts a family's routines, cohesion and sense of safety. Existing patterns of parenting undergo change as both injured and uninjured parent cope with complex emotions and the complicated reality of medical treatment and rehabilitation. Children are particularly vulnerable and often adults do not know how to speak to them about the injury, or how much and what kind of information to share.

Many military families and children will demonstrate initial distress in response to combat injury that is likely to be temporary. However, a number of children may sustain life-changing trajectories in their emotional development and their interpersonal relationships.

Principles of Caring

The following principles of care for families may help to support their healthy growth and recovery. These principles can be used by hospital and

Injury communication is the timely, appropriate and accurate sharing of information with and among family members throughout treatment and rehabilitation.

community-based health care providers in military or civilian settings. Care and services should be delivered in a manner which:

- **Provides a sense of safety, comfort, information, practical assistance and connection** to appropriate community resources. Medical care for the injured must be family-focused and attend to family needs. The goal is to work toward relieving family distress, sustaining parental functioning, and fostering effective injury-related parent-child communication. These communities reach across professional boundaries throughout the rehabilitation and recovery process.
- **Anticipates a range of responses** to injury. Serious injury will challenge our healthiest families. Most service members, their children and families will adjust to the injuries they sustain. But, others may struggle with the changes they face. Some may develop problems that require additional treatment. Service providers should expect a broad range of responses and be prepared to meet family needs as they are identified.
- **Is longitudinal**, extending beyond immediate hospitalization. Services are tailored to the changing needs of the family throughout the treatment and rehabilitation process. When possible, interventions should attempt to meet the family where it is within the recovery process, recognizing a family's unique strengths and challenges, and anticipating its future needs through transition to a new community or new way-of-life.
- **Respects the unique experiences and traditions of military families.** Care must be culturally competent. Healthcare and other community care providers who interact with families of the injured need to possess the cultural competence to engage families of broad ethnic and religious backgrounds.
- **Anticipates barriers to intervention** that can complicate the healthy recovery of injured service members and their families. These barriers may include a family's difficulty in accessing health care or community services. A community's lack of awareness or misunderstanding of the needs of an injured service member or the family can lead to reluctance to seek assistance. Some may feel that others stigmatize them based on their injury.
- **Provides access to quality educational materials** to address the challenges that confront injured service members and their families. Effective education leads to the development of skills and building empowerment in communities and families. Development of new knowledge is fundamental to meeting the needs of this unique population.
- **Recognizes the needs of children.** Children are a vulnerable population within the family unit. Injury to a parent is a major threat to children of all ages and a challenge for even the most resilient of military families.

Parental injury can alter the child's view of the wounded parent and undermine the child's view of his or her own physical integrity. Programs for children in families of injured service members must be developmentally sensitive and age appropriate to address responses of children of varying age and gender. Most children will remain healthy in the face of this stress, but some children may sustain life-changing trajectories in their emotional development or in their interpersonal relationships.

From Injury to Home

Integrating Networks of Medical and Psychosocial Support on the Road from Battlefield Injury to Recovery

- **Battlefield injury.** Many thousands of service members have sustained injury in the wars in the Middle East. Many of these have been so serious that the service member has been unable to continue to function in the theatre and has required medical evacuation. The injuries include but are by no means limited to traumatic amputations, loss of sight, and traumatic brain injury. The emotionally injured may also be evacuated. Importantly, even severe emotional injuries may not be readily apparent on the battlefield and occur in greater numbers as the return home approaches and the challenges of return meet the worries of lost health and function.
- **Starting the road home.** When battlefield injury occurs far from home, the road to recovery may be long and difficult to navigate. Even with the dedicated support of medical professionals, loved ones, military leadership, and brothers and sisters-in-arms this pathway from injury to home requires caring over time and over miles. Differences in the type of injury, in the nature of support available along the way, and the types of resources and responsibilities waiting at home may dictate different stops along the way for different service members.
- **Systems of care.** Programs and policies that must integrate and synthesize the efforts of command, community, and family resources have to consider the following areas at each stop along the route from hazardous duty to home life. Systems of care must address not only disorders, but the many emotional and behavioral manifestations of distress. They must incorporate health care provided by military, VA, and civilian treat-

When battlefield injury occurs far from home, the road to recovery may be long and difficult to navigate.

ment facilities; facilitate family participation in health care and treatment planning; and engage traditional community resources, such as churches and schools, as well as employee and local, state, and federal programs implemented to provide assistance to returning veterans. Variability in the time and emotional availability and responsiveness of family members requires personal resources and flexibility in order to identify and establish care advocates for the injured service member.

- **Movement.** Medical advances and current practices have altered the amount of time an individual may remain in a specific care environment. Rarely in the modern world of war is the injured person now in theatre or even overseas for long periods of time. Yet healing and administrative processes still take time and hold patients in new settings where family may or may not be present and resources have to be constantly adjusted to meet needs. Resources have to be sufficient and flexibly assigned to meet each level of care in order to sustain the recovery process and be responsive to the cultural context of the injured and geographical considerations such as for those who reside in rural or remote locations.
- **Waiting.** The invisibility of psychological injury presents a complex medical situation in which denial, stigma, fear of painful memories and lack of knowledge of treatment options and efficacy impede help-seeking. Administrative procedures can become part of secondary injury in an already stressed system of care resources. Missed or unavailable appointments can add to fears of stigma and emotional pain. Secondary injury can result from feelings of helplessness, overwhelming stress and indignities resulting from administrative delays, errors and omissions, which may unnecessarily complicate recovery.
- **Reintegration and distress.** Returning veterans, even those not psychologically injured, experience a variety of behavioral and emotional responses secondary to their war experience. Distress symptoms are common and may include insomnia, nightmares or other forms of sleep disorder; hyper vigilance, jitteriness or overexcitement; and avoidance or social withdrawal. Reintegration with family and life is both a goal and can be a challenge.
- **Home and family.** Most serious injuries powerfully impact the children and families of service members. Problems do not immediately resolve and can worsen. Difficulty in readjusting to life back home may alter family relationships and support contributing to a vicious cycle of psychosocial challenges for both the injured service member and the family. The family should be seen as care collaborators in all health interventions and planning.
- **Risky behaviors.** People returning from deployment can sometimes ini-

tiate or increase the frequency of risk behaviors that compromise their health and the health and safety of those around them. Excessive alcohol use may develop as a misguided attempt to reduce stress. Irritability or anger may turn into violence, at times directed to one's family, when there is excessive alcohol use or decreased emotional control that can accompany traumatic brain injury.

- **Time and adaptation.** Navigating the complexities of ongoing medical care and disability evaluation is a health challenge and a health burden. It can be an impediment to the process of adaptation to serious physical or emotional injury. Navigating this complex road requires acknowledging the injury's impact on one's identity, one's future, one's family and one's livelihood. Such knowledge changes how we view our self and our family, and can change how our family and friends view us and our future. This adaptation, recovery and return requires time and community to sustain the process.

The Invisible Injuries of War

Impact on Military Families and Children

The invisible injuries of service members resulting from the Middle East wars pose complex challenges for military families. With injuries such as posttraumatic stress disorder (PTSD) and mild traumatic brain injury (mTBI), there are often dramatic changes in personality and behavior without a change in the veteran's appearance. This injury duality — *looking the same, but not acting the same* — is troubling for family members, friends and co-workers, and can be particularly confusing for children who thrive on parental consistency, trust and safety.

This fact sheet addresses the vulnerabilities of children whose service member parent suffers an invisible injury. This injury may include not only PTSD and mTBI, but also depression and health risk behaviors such as the increased use of alcohol and illegal or prescription medications that are prevalent in many returning service men and women. Health professionals who work with military families and children should be alert to the effects of these kinds of injuries on children and on parenting, as this essential component of healthy development is often disrupted due to the service member's injury experience.

Secondary Traumatization

Many children may develop symptoms that mirror those of their injured parent. An example might be a young child having nightmares because of their parent's nightmares or because they are worrying about their parent's behavior. A child may have trouble paying attention at school or may exhibit new behavioral problems due to thinking about the parent's problems. This impact on a child due to their worry and identification with their in-

The invisible injuries of service members resulting from our nation's war on terrorism pose complex challenges for military families, especially military children.

jured parent is sometimes referred to as secondary traumatization. A child's symptoms can get worse if there is not a parent who can acknowledge the effects of the injury and communicate with their children to help them feel better.

Impact of Invisible Injuries on Children

The following signs and symptoms exhibited by children may indicate distress and require professional assistance.

- Increased acting out behaviors, such as disobedience, tantrums, or risk-taking
- Emotional distress, such as crying, increased anxiety, or withdrawal
- Feelings of loss and grief related to the change in the injured parent
- Feelings of isolation
- Feelings of embarrassment about the injured parents' appearance or behavior
- Misinterpreting parent mTBI-related fatigue and apathy as indicators that the parent no longer loves them
- Feelings of anger or resentment about new responsibilities or changes in the family such as having to care for younger children, even sharing in or taking on the care of the injured parent
- Feelings of self-blame for the injured parents' irritability

Helping Children Integrate the Parental Injury within the Context of the Family

Health care and family support professionals should encourage families to:

1. **Seek out resources** and instrumental support. Families may require that basic needs be met in the areas of finance, medical care, military concerns, housing, education, and child care. Children may need special services to address any behavioral or mental health problems that develop or to connect them with community resources that provide them with social support and structured activities.
2. **Support and monitor their children's stress.** As children deal with stress, they may find it difficult to express emotions, to relax, or to calm themselves. Parents can teach children to label and express their emotions giving them specific strategies (e.g., deep/belly breathing, progressive muscle relaxation, or visualizing a safe space).
3. **Share information with children** about the injury in a way they can comprehend it. Particularly important is information that helps children understand what the injury is, what the effects of the injury are in terms of parent functioning and/or symptoms, and what to expect over time.

Children may need reassurance that the injury is not their fault and that a parent's symptoms and emotional changes in the parent are expected. This helps to normalize and contextualize the family's current difficulties and helps children understand what is happening in their family.

4. **Develop problem solving skills and set goals.** Particularly important is helping children identify relevant problems, name their goals, brainstorm possible solutions, and pick a solution to try out. Goal setting helps families identify how they would like things to be different, and how to monitor change. Parents and children can select family goals together and practice them as they plan for future challenges, recognizing incremental improvements over time.

Resources

- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
<http://www.dcoe.health.mil/default.aspx>
- Defense and Veterans Brain Injury Center
<http://www.dvbic.org/>
- Military OneSource
www.militaryonesource.com

Intimacy and Health

The Impact of PTSD and Other Invisible Injuries On Returning Service Members

The impact of injury on intimacy is an often neglected aspect of healthcare and one that is especially important in caring for our nation's service members and families. Many service members returning from deployment experience what are referred to as "invisible injuries." Invisible injuries include posttraumatic stress disorder (PTSD), mild traumatic brain injury (mTBI), depression and anxiety that can result from combat exposure. Sometimes alcohol, tobacco and drug misuse, as well as impulsive and violent behavior can compound these conditions. All of these problems can compromise intimacy reducing one's ability to enjoy pleasurable relationships and sexual activity.

Whether a returning service member is single, married or married with children, the capacity to resume and establish relationships that provide emotional closeness and sexual togetherness can enhance or undermine individual health, relationship health, and even the health of one's family.

This fact sheet addresses the implications of the "invisible injuries" of war on reintegration and intimacy. There are also "talking points" that providers in settings of primary, behavioral health, rehabilitative and spiritual care can use to facilitate communication around this sensitive and important topic. *As professionals, remember to ask about this important aspect of deployment reintegration. If you don't, the service members and their family members who you serve may never discuss it with you.*

Reintegration, Invisible Injuries and Intimacy

PTSD and/or the conditions mentioned above may make it more difficult for couples to reconnect. Differences in partners' needs and desires for intimacy can over time lead to frustration, rejection, conflict or withdrawal.

The impact of injury on intimacy is an often neglected aspect of healthcare...

- PTSD symptoms including recurrent *nightmares, avoidance of thoughts, feelings or people/social situations, jumpiness or feeling constantly on guard* often interfere with the ability to experience emotional connection or closeness.
- They can inhibit one's ability to 'let go', thus reducing the pleasure of sexual release.
- Service members who feel in some way changed for the worse by their war experiences, may find it hard to share themselves in intimate, physical relationships or they may worry that they will pass on this negative change to their partner through intimacy.
- Medication used to treat PTSD, depression and anxiety can decrease sexual desire or sexual functioning for some period of time.

In contrast,

- Some returning service members may experience sexual urgency (the need to engage in overly frequent or intense sexual behavior) in order feel a high similar to the emotions of combat.
- Others may be sexually controlling or engage in practices atypical of pre-deployment (e.g. pornography) resulting in sexual stimulation taking priority over emotional intimacy.
- Those with mTBI may behave in a less controlled manner or evidence behavioral or personality changes that make them seem very different, even frightening to their partners.

Partners may also contribute to a lack of intimacy

- Some may experience low sexual desire from feelings of detachment from their returning partner, anger at having been left alone for so long, or feeling over- burdened by their responsibilities. Partners with reduced sexual interest who engage in sex to "keep peace" may communicate that sex is simply a chore.
- Others who engage in sexual activities despite a lack of interest may be doing so to help bolster a partner with PTSD or depression.
- Partners may be confused when a service member with PTSD or other "invisible injuries" may alternate between sexual disinterest and sexual urgency. They may try to cope or escape by becoming overly focused on children, church or other activities.

Talking Points for Improving Intimacy

Communication, compassion and creativity, as in finding new ways of expressing sexual and emotional needs upon reintegration help couples re-

build loving and respectful relationships that may result in being as close or even closer than prior to the deployment.

- *Find ways to be close that do not involve sex.* Do thoughtful things for each other such as taking over a chore, leaving an affectionate note, or caring for the children so your partner can have some private relaxation time. Small expressions of affection, such as a hug, kiss, or touch on the shoulder, can go a long way.
- *Spend time together doing things you both enjoy.* Plan a date night, participate in a sport or take a class together. Learning new things can bring you closer.
- *Talk about your feelings, hopes, and desires when you and your partner are both calm and ready to listen.* Communicating, even about difficult topics, can help you feel more connected. In addition, understanding each other's perspective can help you work together to identify solutions.
- *Respect your partner's need to have some alone time and space.* This may in turn encourage emotional and sexual intimacy. Being supportive and recognizing each other's efforts toward building your relationship, no matter how small, is important.
- *Invisible injuries may make it tougher to be spontaneous.* Depending upon energy level and emotional availability, schedule intimate opportunities for times when both of you are more likely to be available and ready to participate.
- *Help your partner redirect sexual, thrill seeking behaviors.* Encourage release through physical exercise and safe recreational activities.
- *Get help.* Talk to your doctor, mental health provider or community-based counselor. They may have ideas, treatment options, to include helpful medications. PTSD, depression, substance misuse, or any other problem that is getting in the way of your relationship requires professional help. Seek couples therapy as appropriate.

Resources

<http://www.vetcenter.va.gov/>

http://www.vetcenter.va.gov/Military_Sexual_Trauma.asp

<http://www.militaryonesource.com/>

Physical Injury and Intimacy

Helping Wounded Warriors and their Loved Ones Manage Relationship Challenges and Changes

The impact of physical injury may challenges the emotional and sexual relationships of injured service members and their loved ones. It is important that providers in primary, behavioral health, rehabilitative and spiritual support settings address concerns around intimacy. For service members who are single, the impact of injury on sexual performance is also an important area of discussion as part of their recovery and perspective on the future.

Physical war injuries include mild to severe traumatic brain injuries (TBIs), spinal cord injuries leading to different levels of paralysis, amputations, burns, disfigurement and others injuries with potentially lasting effects. Emotional disorders such as depression, anxiety, posttraumatic stress disorder (PTSD), misuse of alcohol, tobacco and drugs, or behavioral changes such as increased impulsiveness, aggressiveness or even violent behavior, can also accompany physical injury. Conditions such as these compromise intimacy.

This fact sheet addresses key areas of patient concern around physical injury and intimacy and recommends approaches for the improved care of wounded warriors and their families. A companion fact sheet for injured service members and loved ones, *Physical Injury and Intimacy: Managing Relationship Challenges and Changes*, has useful information and tips for improving intimacy.

Injury may challenge the emotional and sexual relationships of injured service members and their loved ones.

Physical Limitations that Affect Sexual Functioning

Despite the reality that some injuries, by their very nature, make it difficult or impossible to engage in the same sexual activity as before the injury, it is important to let patients know that a satisfying sex life may still be possible. Although many people report a decline in sexual activity following a severe injury, over time sexual activity usually increases again. Couples who reestablish a satisfying sexual relationship may do so by

- Understanding that sex is more than just intercourse
- Redefining the goal of sexual activity as mutual pleasure and expression of love rather than erection and orgasm
- Developing greater variation in their sexual activities
- Experimenting and communicating with their partner about what is pleasurable

Managing Pain

Pain can interfere with the enjoyment of physical affection and intimacy. Both the injured and the partner may hold back because they are fearful of causing pain. Medications used to manage pain can affect sexual desire and sexual performance. If relevant to a patient's care, discuss this with service members and loved ones. Share with them the strategies below to help overcome the challenges of pain.

- **Communication.** Remind patients that partners need feedback from the injured person about what is and is not comfortable
- **Consultation.** Consider consultation with occupational or physical therapists who can suggest other ways to enjoy sex that reduce the likelihood of pain
- **Timing.** Suggest they plan time together when pain is diminished
- **Creativity.** Encourage patients and their partners to explore activities and positions that put less stress on painful areas

Traumatic Brain Injury and its Implications

Explain to patients that certain areas of the brain are important for regulating and controlling many aspects of sexuality. Any slight damage to these areas can impact on how sexual urges are expressed and how the sexual organs will work. Some people with a TBI seem pre-occupied with sex, speak about sex at inappropriate times, or demonstrate inappropriate sexual behaviors, often without awareness that they are making others uncomfortable. They may appear to have greater sexual drive than before, but it is more likely that the part of the brain that helps us hold back or inhibit impulses and urges has been damaged. Responding to inappropriate behaviors in a firm and consistent manner can help improve the situation. These issues can

also be addressed with medications, behavioral programs, and counseling.

In some cases TBI leads to apathy and passivity, resulting in seemingly less interest or motivation to engage in romantic or sexual activities. In addition, personality change, regressed or childlike behavior, and injury-related changes in judgment can lead to role changes within the couple that make it difficult for the partner to see the injured person as a romantic partner. It is important for partners to understand the reasons for such changes so they do not misinterpret the behavior as lack of caring. The non-injured partner may need to initiate romantic activities. In many cases, an overture from the partner is all that is needed to engage the injured person's interest.

Self-image

A physical injury can affect one's self-image in a number of ways. An injured person may believe that he or she is no longer attractive, or worry that a partner will be turned off by the injury. When an injury changes the way a person is able to be sexually intimate, he or she may feel ashamed or question their identity as a man or woman. Communication is a key to overcoming self-image barriers. Talking about these concerns with a partner provides an opportunity for couples to reassure each other and offer support. When a body part is amputated or becomes nonfunctional, it is a loss. An injured person may need to take time to mourn for the loss in order to be ready to move forward.

Some couples find it particularly challenging when the injured person is dependent on a partner for help with wound care, hygiene, or mobility. When couples feel their relationship is primarily one of care giving, it can be difficult to relate to each other as romantic partners. Making time for romantic activities is important. This may require some extra planning. Some couples find it helpful to have another person take over the care giving activities in preparation. Others find ways to combine romance and care giving. Creativity can help couples find solutions that work for them.

It Is Important that Service Providers

- Educate themselves about sexuality and disability. Doctors, nurses, rehabilitation therapists, and behavioral health providers can all play a role in helping patients with this important topic.
- Ask about sexual intimacy concerns at each step. Even during an acute hospitalization or in an intensive care unit, people are wondering as to the future of their marriage, the ability to children or their future attractiveness. Sometimes patients are uncomfortable bringing up the topic, so health care providers may need to start the conversation.
- Validate patient concerns and offer to provide information and helpful resources when appropriate.

- Consider and share with patients the potential impact of prescribed medications.
- Acknowledge challenges, but communicate hope and encourage creativity.
- Share the information in this fact sheet with colleagues who provide care to injured service members and their loved ones. Communicate key points that address physical limitations, managing pain, the impact of TBI on intimacy, and the impact of physical injury on one's self-image.
- Encourage couples to address these issues together in order to prevent emotional erosion.

Provider Resources

- *Back From the Front*. Book by Aphrodite Matsakis, Ph.D.
- The American Association of Sexuality Educators, Counselors and Therapists (AASECT), <http://www.aasect.org/>
- Sexual Health and Fertility After Brain Injury and Spinal Cord impairment <http://www.scisexualhealth.com/sandd.html>
- Resources from Dr. Stanley Ducharme <http://www.stanleyducharme.com/resources/index.html>
- Spinal Cord Injury Information Network <http://www.spinalcord.uab.edu/>

HEALTH BEHAVIORS

Patient Adherence *Addressing a Range of Patient Health Behaviors*

Patient adherence challenges health care providers and our healthcare system. Adherence encompasses a wide range of health behaviors related to routine preventive healthcare (e.g., annual mammogram, yearly physical, and cholesterol check), recommendations (e.g., maintaining appropriate weight and smoking cessation), and ongoing health maintenance (e.g., blood sugar checks, diabetic foot care, taking medications for depression). New medical advances (e.g. oral medications for cancer treatment) have improved the trajectory of many illnesses. The patient's ability to understand, tolerate, and appropriately follow prescribed regimens influences the outcome of treatment. In the pediatric and elderly population, physician communication is an important factor for patient adherence. Equally as important is the doctor's role in anticipating potential obstacles and having sensitivity to the challenges of the prescribed treatments and recommendations.

Taken in a broader perspective, adherence can also apply to recommendations and treatments during widespread events (e.g., exposure to public health epidemics, disasters, terrorism, and war). Adherence during these times is required for accepting and following interventions in order to protect health such as taking medications, willingness to shelter-in-place, or to evacuate one's home or community. Here, we address both approaches to adherence. We identify teachable moments when healthcare providers can educate patients about behaviors with implications for individual, family, and community health.

Patient Health Behaviors: Discreet and Continuing

Patient adherence involves two types of health behaviors: discreet behavior and continuing behavior. Examples of discrete behaviors are yearly

Patient adherence challenges health care providers and the healthcare system.

mammograms and flu shots. Managing diabetes, on the other hand, requires a complex set of continuing behaviors for the diabetic and also for their family. Medical treatments involving discreet behaviors may be easier for patients to follow as they are less likely to disrupt the lifestyle and can be scheduled to accommodate work or social routines. Medical treatments involving continuing behaviors, on the other hand, often shape routines and involve acceptance and commitment. Discussion around these issues may help providers and patients communicate more effectively about healthcare options in which adherence is an integral part of a desired outcome (see table).

Strategies to Improve Adherence

Know Your Patient

- Assess their level of understanding their illness, and provide information at that level.
- Explain treatment benefits and potential adverse effects.
- Respect a patient's autonomy, individual rights and readiness for change.
- Simplify the treatment or intervention.
- Customize the treatment/recommendation to a patient's lifestyle needs.
- Seek to reduce frequency of dosing and number of medications when possible.
- Facilitate access (e.g., timing of refills, locations of available pharmacies and mail-in options).

Anticipate Obstacles

- Address patient concerns, especially fear and stigma, which can impede their willingness to start or stay with a treatment.

Table. Discreet and Continuous Health Behaviors	
Discreet Health Behaviors	Continuous Health Behaviors
Time specific/often time limited	Ongoing and complex
Well described	Requires learning and adapting
Operational	Often involves family/employer support/commitment
Doable	Monitor, change, collaborate with healthcare provider

- Identify approaches (e.g., pill organizers) to help patients overcome forgetfulness, mismanagement or lack of motivation.
- Explain that feeling better is not a reason to discontinue treatment, but is a sign that treatment is working.

Motivate Patients

- Provide relevant examples of improvements resulting from patient adherence.
- Offer available office/clinic resources to monitor their treatment regimen.
- Communicate support and willingness to answer questions after the visit.

Educate Patients

- Recognize and reinforce positive health behaviors.
- Commend patients for both discreet and continuous behaviors.
- Tell patients that their adherence to these health-sustaining behaviors is valuable to themselves, to their families and to the healthcare system.

Communication to Facilitate Adherence

- When and how often to take the medicine.
- The expected time interval before beneficial effects of treatment may be noticed.
- The necessity to take medication even after feeling better.
- The need to consult with the physician before discontinuing medication.
- Steps to take if problems or questions arise.

Patient adherence involves two types of health behaviors: discreet behavior and continuing behavior.

Health Literacy

Addressing Communication Barriers to Foster Patient Self-Care and Family Care

An important study published in *Annals of Emergency Medicine* (Engel et al., 2009) followed emergency room patients after discharge, and found that 78% did not understand:

- Their diagnosis;
- Their emergency room treatment;
- Instructions for their at-home care, or
- Warning signs of when they should return to the hospital.

Nearly 50% did not understand two or more of these of these areas and the greatest confusion involved home care, i.e. medication instruction, wound care, rest and when to schedule a follow up visit.

Traditionally these behaviors have been explained under concepts such as non-compliance, but there is increasing recognition that a patient's lack of preparedness for self-care is most often due to lack of knowledge and understanding of the health care system — that is lack of health literacy.

This can be attributed in part to the anxiety and fear that many patients experience in healthcare settings that interferes with the processing of information. Other factors that contribute to the lack of health literacy are not due to the patient. Health literacy depends also on effective communication skills on the part of a physician or health professional, and importantly, an established relationship between patient and doctor, often difficult to accomplish in the short exchanges of present medical care.

Patients often do not understand their diagnosis, treatment, medications, instructions for self-care and follow-up.

Militarily Unique Challenges for Health Literacy

- A number of these factors can be particularly problematic in military life and culture.
- Frequent family moves present a challenge for patients and doctors to establish relationships over time.
- The military has many young parents who are under great stress.
- There are many single, first time parents who may live apart from extended family support.
- Parents who may not understand health instructions compromise their ability to care for their family.
- Not understanding instructions for the care of a sick child can compromise that child's health and result in additional clinic or emergency room visits.
- Health literacy is also important for the family of the combat injured; they play an essential role in the recovery of the injured soldier.
- Strengthening health communication skills to enhance patient understanding for improved self and family care involves some specific steps. Below are some practical suggestions and a tool — a communication technique referred to as “teach back.”

Action Steps

- Have paper, pencils or pens available for patients to write down important information at the time of their visit.
- Have health literature on the conditions for which you are likely to see patients in accessible places in your office and hand them personally to your patients for whom you believe it will help.
- If your office or clinic has a website that provides patient care information, ensure that your patient knows how to access this. Give them a note with the address on it about when they should access it. This is a personal invitation from you to use it.
- If your clinic or practice utilizes nurse practitioners or case managers, make sure your patients know who they are and how they can contact these individuals with questions about their self-care.

Teach Back: A Communication Plan

Employ the ‘teach back’ approach to patient communication: After you have communicated the diagnosis, the treatment plan, and follow-up information, ask the patient to repeat the instructions to you. This provides an opportunity *to hear what the patient has heard* and to clarify any discrepancies in how they understood the care plans.

Ask the patient if there is anything in the self-care plan that would make it difficult or impossible for them to follow, and then address those issues in a practical and helpful manner. If need be, refer them to the care manager to specifically address these barriers to their health care plan.

Relate the diagnoses and follow-up plans in terms that the patient and family members can understand. If agreeable to the patient, invite in any other family member that has come with them so that two people rather than one, hears the plan and action steps.

If a language barrier is anticipated in the visit, either you or your office staff should ask the patient to feel free to bring a family member or friend who can communicate with the doctor and with the patient. If a patient is older and has hearing or vision problems, suggest that they bring a family member or friend who can assist in the healthcare conversation.

Employ the dual discharge approach: the provider talks to the patient about the results, treatment plan and follow up care; a nurse follows up with discharge instructions and goes over the material again.

Good communication fosters good patient self-care. One of the most obvious but subtle contributors to impaired health literacy is that patients are often *not aware of what they do not understand*. Using the teach back approach can help providers recognize when the patient has not understood and then can clarify information and care instructions before the patient leaves the clinic, emergency room or office. Helping patients to understand such information can optimize health care delivery and better ensure patient health.

Reference

Engel KG, Heisler M, Smith DM, Robinson CH, Forman JH & Ubel PA. (2009). Patient comprehension of emergency department care and instructions: Are patients aware of when they do not understand? *Annals of Emergency Medicine*; 53(4): 454–461.

Advancing the Health of the Family of the Deployed Service Member

Military families face unique challenges in the deployment cycle. There are many stressors on spouses, children, caregivers, siblings, parents and grandparents, as well as on other service members. While sensitivity to these issues is important, it is even more important for healthcare providers to communicate in ways that offer hope and constructive suggestions for mitigating stress and fostering healthy family behaviors.

Reference Points for Providers and Families

Families of deployed soldiers may experience anxiety and a range of other emotions in preparing for a service member's departure, during the deployment and in the process of *reuniting*.

There are three important points to reinforce:

- The deployed parent is trained to do their job.
- The family and children at home also have a job.
- Communication with children should be age-appropriate.

Preparing Children for Departure

Children worry about deployed parents. There are many reactions depending on the age and maturity of the child. For example, they may put themselves in the parent's shoes and feel overwhelmed by their own anxiety of not knowing what they would do in a potentially life threatening situation. It is important to remind children that their parents have been trained, have the skills, and know what they are doing in deployed locations.

Communicating with Children During the Deployment

Experts suggest using the following metaphor when talking to families and children about deployment: just as the deploying parent has a job, so do

Just as the deploying parent has a job, so do the families who remain home.

the families who remain home.

The role of the child during a military deployment can be a tough one, but it is also a real job. Reminding children that “While your mom or dad is away you have your job to do, too.” is a way of valuing the unique role of the child, diminishing the helplessness, and emphasizing the skill set that is required by encouraging children to:

- Be successful in school
- Helping mom or dad out
- Take on new chores
- Maintain a healthy lifestyle
- Not engage in high risk behaviors

Children can feel that they are a contributor to a successful deployment. This metaphor is a positive way for parents to deal with children and family stress.

Reuniting

Parents anticipate the family reunion and often feel pressure prior to and at the time of the homecoming. Children may be slow to warm up to the returning parent. While some children may respond excitedly, others may be more aloof and require more time. Children may have many questions of the returning parent about the deployment experience. These questions need to be respected and answered truthfully, but with the level of information that is appropriate to the children's ages and developmental levels.

Helping children cope with deployment is a challenge and an opportunity. Reminding parents to be in tune with their children and to listen to their concerns when they are ready to express them; limiting television (especially of war coverage) to help reduce anxiety and worries; letting parents know is okay to accept assistance from family members and friends, and that accepting help is also a way of contributing to the health of their families—all are important points to reinforce in healthcare settings.

Resources for Parents: Talking with Children about Traumatic Events

- American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Home.aspx
- Substance Abuse and Mental Health Services Administration (SAMHSA)
<http://www.samhsa.gov/children/earlychildhoodmat.asp>

Resources for Healthcare Providers

- The National Child Traumatic Stress Network has an entire section dedicated to medical traumatization of children, including a toolkit for healthcare providers.

http://www.nctsn.org/nccts/nav.do?pid=typ_mt

Helping children cope with deployment is a challenge and an opportunity.

Facilitating Important Behaviors for Health and Family Function

Helping Patients Ask for Help

Professionals in health care and family support frequently encounter individuals who need, *but do not know* how to ask for help. When people have difficulty asking for help, manageable issues can go unaddressed and eventually require more care. Asking for help and doing so in a timely manner can positively impact the delivery of health care and enhance individual and family well-being.

Asking for help is a skill we learn as a child. We learn to politely ask for help, communicate what we need, and thank the individual who has helped us. As we get older, asking for help becomes more complex as many adults question if they will be seen as weak, incompetent or a burden on others.

Service members and families may be encouraged to ask for help in order to access and utilize valuable support services. Here are four steps to help educate them about and facilitate asking for help.

Asking for Help: A Model for Facilitating Positive Provider-Patient Interactions

The following, four-step model can facilitate effective asking for help. These steps are applicable in other settings including spiritual support, help with daily activities, childcare, and talking with teachers.

1. Identify the Most Immediate Needs
2. Clarify the Need
3. Discuss an Action Plan
4. Act to Address the Need

Professionals in health care and family support frequently encounter individuals who need, but do not know how to ask for help.

- **Identify the Most Immediate Needs:** This is often the most challenging task for individuals seeking help. Many needs may be expressed making it difficult to determine what is most important. There may also be an absence of expressed needs, which may require asking directly: “How can I be of help?” “What do you feel is the most important thing that needs to get done?” or “What can I do to help you right now?”
- **Clarify the Need:** Often thought of as the real planning stage, this is an opportunity to help the person be more specific about his/her needs and thus empower them. “What is it about the assignment that’s difficult?” or “Tell me more about how your sleep could be better?” The person asking for help may, for the first time, be expressing such need in detail, which can help him/her formulate a plan and consider what may be required (e.g., time, other people, money, etc.), and if it is realistic.
- **Discuss an Action Plan:** Discuss is the key word — collaboratively think of ways to help. Resist the urge to impose a plan if there is resistance. Remember, the plan of action has to be acceptable and doable by the person asking for help.
- **Act to Address the Need:** This final step involves doing your part to fulfill the action plan, but it also offers the opportunity for follow-up and feedback.

Talking points that address barriers to asking for help

These questions and comments may encourage individuals to ask for help.

- How may I be of help to you today?
- It’s important to ask for help before anger and frustration make things worse.
- Asking for help is a strength. It shows you know what you need and want to know how to get it done.
- It’s okay to ask for help. Most individuals like being asked to be of help; it gives them an opportunity to provide their knowledge or their assistance.
- Has this visit been of help to you today?

When people have difficulty asking for help, manageable issues can go unaddressed and eventually require more care.

Primary Care Strategies to Foster Male Health Care Seeking

Primary care providers have an important role in fostering their patients' health, and building healthy behaviors. Men, who have served in the Middle East, consistently underutilize health and mental health services putting themselves and their family members at potential risk. Gender roles and socialization may partially explain why help-seeking patterns in men are historically lower than in women, especially related to emotional problems.

The traditional male model of behavior emphasizes characteristics such as strength, independence and emotional control, which may inhibit health care seeking.

One may feel vulnerable seeking help and unable to maintain the view of one's self as powerful, successful and in control. Denial of symptoms, difficulty recognizing the significance of non-specific feelings, and the use of alcohol or drugs to decrease pain are other issues that may influence the ability to know when help is needed.

Military service presents additional challenges to seeking healthcare, especially for psychological problems. Service members may be concerned about harming their career, losing the confidence of buddies, being treated differently by leaders, and being seen as weak.

A number of positive factors have been identified that may motivate men to seek help. This fact sheet describes these positive factors and translates them into talking points that primary care providers can use to influence men to access more timely and appropriate health services.

Promoting Better Health Care Seeking

Four factors have been identified that may reduce the stigma associated with help seeking by men. We present these factors below and provide talk-

Gender roles and socialization may partially explain why help seeking patterns in men are historically lower than in women, especially related to emotional problems and depressive symptoms.

ing points that primary care providers can use in discussions around further evaluation, treatment or services.

External Stress/Events

Men may be more receptive to acknowledging a problem and to seek help if the problem is presented in the context of external events (e.g. environmental causes, an injury rather than an illness), and not as the result of one's failures or lapses. This approach can normalize the problem and reduce feelings of weakness, embarrassment and shame.

Talking Point

"Many service men describe having your feelings have difficulty sleeping, wanting to be alone, and feeling irritable. It's understandable given multiple deployments, stress on families and difficulty coming back to daily routines. If these last for more than a few weeks, it's wise to seek help, and that's what we are here for."

Social Benefits vs. Social Costs

Men often view health seeking in the context of its social costs to them such as being seen as incompetent, dependent, and inferior. A more positive approach is to emphasize the social benefits as involving superiority of judgment, as ensuring competence, and as collaboration in seeking and obtaining care. These traits are highly valued in the military.

Talking Points

"It was a good decision to come in today. We can work together to help you feel better" or,

"Coming here to see us is a good sign — it means that you care about getting better" or,

"I know coming to the appointment today took courage and really shows your commitment to getting better."

Obligation to Stay Healthy

Help seeking can be presented as a legitimate means for men to ensure their physical and mental health, and can be discussed in the context of duty, as in one's obligation to protect self, family and comrades, intrinsic parts of military values and culture.

Talking Point

"By taking care of yourself, you are taking care of your family" or "I know

that you are getting by — but by getting help, you can be doing that much better” or “It was a good decision to come in before things get worse, your work really depends on you.”

The Female Factor

Women are often instrumental in encouraging men to seek medical attention. Helping women who are significant in the lives of service members to facilitate referrals for professional help provides an important link in the chain.

Talking Point

“I value your concern about your husband’s symptoms and his need to seek help. You might tell him that multiple deployments have been stressful on many service members and families, and his feeling better not only will help him, but will help you and the children

Summary

Primary care providers can influence men’s health and health behaviors using some positive approaches. Framing discussions around the need for medical or psychological help in terms of external events, the social benefits of help seeking, fulfilling one’s duty to self, family, friends and community, and as a collaborative process may reduce barriers to seeking care. Health care seeking can be seen as a way to increase self-care and to enhance one’s relationships with family, especially one’s children, friends and work.

Resources

■ **Real Warrior: Resilience, Recovery, Reintegration**

<http://www.realwarriors.net/>

Contains information on psychological health and traumatic brain injury for service members and for clinicians. Features real stories of service members who have sought and received help.

■ **Militaryonesource**

www.militaryonesource.com

Features comprehensive information on all aspects of military life and health, and an 800 24/7 helpline for all services.

Discussion about around the need for medical or psychological help can be framed in terms of external events, benefits of seeking help, and fulfilling one’s duty may reduce barriers to seeking care.

New Communication Technologies for Providers and Patients

The provider-patient relationship is the most important component of ongoing care. It is the basis of practice, sustaining care, providing comfort, relief of pain and the basis of the patient's trust in their care. While patients have always talked with their health care providers in person, they now can talk via telephone, email, Twitter, texting and teleconferencing.

Wide arrays of communication technologies have evolved to become integral components of modern health care delivery. A number of tools and applications are poised to change the way providers and patients interact and potentially change the nature and quality of the relationship. The internet, social networking and smart phones can extend health care communications that once ceased at the end of an office encounter. Now, with ever expanding ways to share, populations are expanding access and have the potential for ongoing communication, support and information sharing beyond the traditional settings.

Service members and their families face the challenge of maintaining continuity of care in the context of frequent relocation, deployment, and the evolving changes of systems of care. As a component of our new mobile health, E-communication tools can bridge gaps and facilitate navigation of complex and often changing systems.

Dedicated Websites

Many medical and social service agencies have websites that offer information on services to enhance communication and care. These websites are particularly well suited to address the needs of patients who often prefer online communication opportunities. Features often include:

While patients have always talked with their physician and health care providers in person, they now can “talk” via telephone, email, Twitter, texting and teleconferencing.

- Practitioner bios, medical services and specialties
- Office hours, location, directions
- Patient portals to facilitate downloading and filling out of forms: registration, insurance, parental consent, privacy policy and authorization for release of medical information
- FAQs for general information such as: seeking medical attention when the office is closed, new patient information, cancellation policies, Medicare and insurance related information
- Doctor-recommended resources to learn more about medical conditions and organizations, local, state and national.

Provider-Patient Communication Options and Preferences

Both patients and providers want to improve communications. However, both parties must decide on the best tools to use. A patient's willingness to expand communication with their health providers can be potentially advantageous for all, creating an atmosphere that improves health outcomes.

Options for Healthcare Practitioners to Expand Communications Include:

- **Email** — Specific guidelines for patients and practitioners are recommended when using email. This method requires both compliance with the healthcare provider's parameters, as well as agreement between doctor and patient regarding its use. Emails should not be used in emergency situations, only for general questions.
- **Patient portals that use personal health record systems.** These systems allow patients more actively to participate in their care, which may be a significant factor in improving health outcomes. They also provide a secure environment to engage health records and information.
- **Videoconferencing** — Interactive programs that support visual as well as voice interaction such as Skype, telemedicine initiatives, and video chats are especially helpful for patients who are homebound or living in rural or remote locations. Attention must be paid to state licensing regulations unless the interaction takes place in a DoD or VA facility.
- **Social media** — Web and mobile-based technologies including Facebook, Google, Twitter and LinkedIn enable individuals to connect with larger communities for information exchange and support.

Risks and Challenges

A variety of new technologies are available for establishing and maintaining doctor-patient relationships. Use of such communication methods requires thoughtful consideration of the benefits and potential risks for de-

livering care. Areas of concern include:

- Establishing and maintaining new patient-professional boundaries
- Patient privacy and HIPAA implications
- User-generated content (social media sites) increases risk of inaccurate information
- Legal issues include medical information privacy, lack of standards for online care, and medical licensing when using telemedicine technologies that cross state lines.

Social Media Guidelines for Providers

There are reasons however why providers should consider engaging in social media. These include expanding partners and collaborators, providing accurate medical information and broadening professional horizons. Providers who want to share peer reviewed technical, scientific or medical information, can do so from a broad array of governmental and professional sources. This route brings expertise on health care issues, and point people toward accurate and reliable resources.

Summary

New e-communication tools designed to enhance providers-patient communications offer many benefits for today's tech savvy and mobile population. Many of these tools can reduce administrative costs and reduce time spent in direct patient care. In addition to being knowledgeable about risks, providers must stay abreast of various professional society guidelines and work to ensure these tools enhance and not hinder communications.

Resources include:

<https://twitter.com/CDCgov>

<https://twitter.com/aaafp>

https://twitter.com/JAMA_current

<https://twitter.com/NEJM>

<https://twitter.com/NIHClinicalCntr>

- Federation of State Medical Boards: Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice
<http://www.fsmb.org/pdf/pub-social-media-guidelines.pdf>
- AMA Policy: Professionalism in the Use of Social Media
www.ama-assn.org/ama/pub/meeting/professionalism-social-media.shtml
- Academic Psychiatry Task Force Report
<http://ap.psychiatryonline.org/article.aspx?articleID=1359982>

Sustaining Healthcare Continuity During Military Relocations

Military families move around the nation and around the globe. While relocation is a part of military life and military tradition, the process is stressful, especially during wartime. Importantly, moving can disrupt individual and family healthcare routines.

Military healthcare professionals can reinforce and facilitate continuity of healthcare for families on the move to strengthen the resilience of our entire military community. This fact sheet addresses some important and practical issues related to health care continuity for providers to help families who are preparing to move.

Helping Families Prepare to Move

- Service members and spouses should participate in briefings related to their medical and dental insurance including portability of TRICARE, medical care en route to their new station, and transportation of medical records.
- Military families, particularly those using civilian primary care managers, should request a copy of their medical records and list of medications before departing.
- Personal documentation such as birth certificates, immunization records, social security cards, passports, naturalization papers and adoption papers (if necessary), school records and copies of orders, should be carried and not shipped.
- Recommend that family members obtain extra refills of any important medications that must be taken regularly in case moving or arrival is delayed.
- Information on support services for children with special needs should be obtained and if possible set up before departing from the old assignment.

Moving can disrupt individual and family health care routines.

- Spouses who are pregnant or have infants should be advised to be especially attentive to routine healthcare immediately upon arriving at their destination.
- Family safety is a health issue. Encourage families to become familiar with any disaster or emergency issues of importance in their new location (moving to an area that is vulnerable to hurricanes or earthquakes for example).
- Attend to the health care of pets and make sure they have any vaccinations and documents required by their new nation or state.

Welcoming New Families

- Fostering a safe and caring environment, especially for new patients to your office or clinic, can help families feel comfortable and more relaxed.
- Acknowledge the challenges of a new healthcare setting and encourage patients to address any outstanding healthcare issues or medical history. They will appreciate your attentiveness and concern as their new health care provider.
- Recognize the normal stress of moving, but try to discern any signs of a more serious mental health condition in the form of depression, anxiety, and substance misuse or health risks that could undermine individual or family safety.
- Schedule a follow up visit for any questionable health, mental or behavioral health issues including expressed concerns around family conflict.
- Suggest that service members or spouses use the confidential telephone and web-based services offered by Military OneSource by calling 1-800-342-9647 or visiting <http://www.mentalhealthscreening.org/military/index.aspx> to take a free, confidential self-assessment for mental health problems.

While relocation is a part of military life, the process is stressful, especially during wartime.

Health Behaviors to Decrease the Risk of Flu Transmission

Good health practices can help reduce the spread of illness. Health care providers are often looked to for guidance, and in this role there is an excellent opportunity to educate and reinforce these practices. The following are some teachable and doable measures that can be communicated to families to help them stay informed and protect themselves.

How Can Patients Stay Informed?

Patients should have a reliable means of staying informed about the flu and any further recommendations or guidance they can use to protect themselves and their families. There are several reliable and well-established sources of information that are updated regularly.

- Centers for Disease Control and Prevention: www.cdc.gov/flu
- American Red Cross: www.redcross.org
- Local American Red Cross chapter: www.redcross.org/where/chapters.asp

What Can Patients Do to Protect Themselves From Getting Sick?

- Wash hands often with soap and water, especially if they cough and sneeze.
- Alcohol-based hand cleaners and wipes are also effective.
- Cover their nose and mouth with a tissue when they cough or sneeze. Throw it in the trash after use. If no tissue is available, then coughing into one's "elbow" is better than using one's hand.
- Avoid touching one's eyes, nose, and mouth. Germs spread this way.
- Try to avoid close contact, less than 6 feet, with sick people.

Patients should stay informed about the flu and any guidance they can use to protect themselves and their families.

- If one feels ill or is ill, stay home from work or school and limit contact with other people to help prevent spreading illness.
- Try to stay in good health by getting plenty of sleep, keeping stress levels down, maintaining a nutritious diet, and drink plenty of fluids.

What Can Patients Do If They Get Sick?

- If they live in areas where flu cases have been identified and become ill with influenza-like symptoms, they should contact their health care provider who will determine whether treatment is needed.
- If they become ill, they should stay home and avoid contact with others as much as possible.

What are the Warning signs that Indicate the Need for Urgent Medical Attention?

In children, they include:

- Fast or troubled breathing
- Bluish skin color
- Not waking up or interacting
- Not drinking enough fluids
- Fever with rash
- Being so irritable that the child does not want to be held
- Flu-like symptoms improve but then return with fever and worse cough

In adults they include:

- Difficulty breathing or shortness of breath
- Pain or pressure in chest or abdomen
- Sudden dizziness
- Confusion
- Severe or persistent vomiting

What Can Families Do If They Must Care for a Loved One?

*There are several helpful recommendations provided by the CDC.**

- **Keep the sick person away from others as much as possible. This may include:**
 - » Keeping the sick person in a separate room away from the common area of the house (and separate bathroom, if possible)
 - » Keep this room's door closed

- » Have the sick person wear a surgical mask if they need to be in the common area of the house
- » Keeping visitors away

■ **Other helpful information includes**

- » Have, if possible, only one adult in the house take care of the sick person
- » Maintain, if possible, good ventilation in shared household areas by keeping windows open when possible in restrooms, kitchen, and bathrooms
- » Use paper towels for drying hands after washing or have dedicated cloth towels for each person in the home
- » When holding small children who are sick, rest their chin on your shoulder so they will not cough in your face
- » Avoid, if possible, re-using disposable face masks

■ **What about Household Cleaning, Laundry, and Waste Disposal?**

- » Throw away tissues and other disposable items used by the sick person in the trash
- » Keep surfaces clean by wiping them down with a household disinfectant
- » Linens, utensils, and dishes used by the sick person do not need to be cleaned separately, but should not be shared without washing thoroughly

Flu Season

Responding to Patient's Questions

The flu season is not just a time of routine vaccination. For military healthcare providers, the flu season can provide patient-centered care opportunities: building new patient relationships; reassuring patients who are feeling the stressors of war and/or its aftermath; and, educating young parents and families about general hygiene.

Health care providers play a significant role in medical intervention (disease surveillance, identification, and treatment) and in individual, family, and public health. Addressing your patient's questions about the flu provides a 'teachable moment' for educating patients, especially parents, about important health habits that can last a lifetime.

Common Questions and Suggested Responses

What is the flu, and how does it differ from the common cold?

The flu is a contagious respiratory infection caused by the influenza virus. It can cause mild to severe illness, and in some instances result in death. The flu is different from the common cold in that people with colds rarely get fevers, headaches or experience extreme exhaustion, which are symptoms of the flu.

How does the flu spread, and how long are you contagious?

The flu is spread through coughing, sneezing, even touching. You can get the flu from the cough or sneeze of someone who has it, or by touching a surface with virus- containing droplets that someone with the flu has touched (such as a door knob, stair railing or telephone) and then putting that finger or hand in contact with your nose, mouth or eyes. People with the

The flu is a contagious respiratory infection that can cause mild-to-severe illness and can result in death.

flu are contagious *one day before* their symptoms start and for up to 7 days *after symptoms appear*.

What are the symptoms of the flu?

The flu starts suddenly and may include some of the following:

- Fever (usually high)
- Headache
- Tiredness
- Dry cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Gastrointestinal symptoms (diarrhea, vomiting, nausea); these are more common in children than in adults.
- Symptoms last for a few days, but coughing and fatigue can last up to two weeks. Children may also get sinus infections and ear infections. Fevers usually begin to go down on the 2nd or 3rd day.

How Can We Prevent the Flu?

Here are some ways for avoiding the flu, which are good health habits to teach your children.

- Avoid close contact with people who are sick, and don't expose others to you or your family if sick.
- Wash your hands often with soap and water or alcohol-based hand-wipes to protect from germs.
- Avoid touching your eyes, nose, or mouth. Germs often spread when you touch something with germs and then touch your eyes, nose, or mouth.

What Should We Do If We Get Sick?

- Get plenty of rest, drink lots of liquids, and adults should avoid using alcohol and tobacco.
- Practice the Golden Rule: Do unto others, as you would have others do unto you, which means:
 - » Stay home from work when you are sick as it puts others at risk, as well as yourself and slows your recovery.
 - » Keep children with the flu at home with childcare. Be familiar with your school district's rules on returning a child to school after the flu.
 - » Cover your mouth and nose with a tissue or your sleeve when cough-

ing or sneezing. This will help keep others from being exposed to germs and getting sick. Be sure to throw away the tissues immediately after use.

Are there medications to take if I get the flu?

Yes, two FDA-approved influenza antiviral medications are recommended for use in the United States during the 2011-12 influenza season: oseltamivir and zanamivir. These require a doctor's prescription and recommended for persons at higher risk for influenza complications. When indicated, antiviral treatment should be started as soon as possible after illness onset, ideally within 48 hours of symptom onset.

Remind patients when taking medications to "Take only as directed." Some patients might think "If a little is good, more is better."

Is there a test to confirm the diagnosis of flu?

Yes. There are tests that can determine if you have the flu as long as you are tested within the first 4 days of illness.

The flu is spread through coughing, sneezing and touching.

Public Health Emergencies *Implications for the Health of Military Families*

Public health emergencies, such as those involving a potential global pandemic, create numerous opportunities and challenges around public health communication, preparedness, and response. Health care providers play a significant role in medical intervention, disease surveillance, identification, treatment and in influencing patient behaviors for protecting individual, family, and public health. Examples are education about basic hygiene, hand-washing and cough etiquette to more complex disaster behaviors such as shelter-in-place or evacuation.

Public health emergencies such as flu pandemic always involve issues of security and defense. Because our military plays a central role in our national security, their health and the health of their families and children is very important. This fact sheet focuses on public health emergencies and their implications for military families and their health.

Unique Characteristics of Military Family Life

The military community is a population on the move. Families may relocate multiple times within short periods of time within or outside of the country. Relocation, especially during times of public health emergencies, may increase exposure to disease. Moving also can be a barrier to health care access and continuity. As families move to new areas, providers may not be familiar with these new families and their specific health needs.

During times of public health crisis, military providers need to be especially sensitive and alert to stressors and issues that relate to military families and military family life. These include:

The primary care provider in times of public health emergencies is critical for disease identification, treatment and surveillance.

- Raised anxiety about the health and wellbeing of loved ones who are deployed. Likewise, those who are deployed will worry about their loved ones back home.
- Single parent families due to deployment often include young caretakers who may lack experience in the role of protecting their family's health, especially during public health crises.
- Military families with special needs children who may require additional medical and emotional support.
- Families, especially those affected by war injury, whose children live with grandparents who may be more vulnerable to influenza.
- Families of the war-injured who may be concerned about health risks visiting loved ones in hospitals or rehabilitation facilities.
- The changing nature of public health emergencies may create the need for additional public health interventions such as travel limitations and quarantine. These can produce more anxiety in families already experiencing stress.

Patients as Public Health Partners

- Advise patients to practice good hygiene: hand-washing on a regular basis, especially after coughing or sneezing; covering one's nose and mouth with a tissue when coughing or sneezing and throwing used tissues in the trash and staying home if sick.
- Recommend that patients monitor information about the health crisis on a regular basis and be alert to changes and prevention measures. (See information links at end of fact sheet.)

Providers as Public Health Partners

The role of the primary care provider, especially in times of public health emergencies, is critical for disease identification, treatment and surveillance. Health professionals can educate patients about basic hygiene including family health behaviors to avoid spread and exposure to disease. Staying alert to changes can impact individual and family health, preparedness, and response.

During public health emergencies, the Department of Health and Human Services coordinates disease surveillance, medical preparedness, and guidance to public health professionals. The Centers for Disease Control and Prevention has responsibility for identifying and tracking the spread of the disease and for communicating health-related information to the government, media, and public. Health care providers who suspect a new strain of flu should obtain a respiratory swab for testing and place it in a refrigerator. State or local health departments should be contacted to help

facilitate transport to and timely diagnosis from a state public health laboratory.

Important Public Health Emergency Links

- Centers for Disease Control and Prevention (English and Spanish)
www.cdc.gov
- American Red Cross:
www.redcross.org
- The local American Red Cross chapter can be located at:
www.redcross.org/where/chapters.asp
- Department of Defense Military Health System
www.health.mil/
- Center for the Study of Traumatic Stress (Uniformed Services University)
www.cstsonline.org

Fostering Safety, Health and Preparedness

Military Transitions and Trauma

Military medical providers play an important role in supporting service members and their families around anniversaries of significant events such as war, disaster, and terrorism. Such events are often catalysts that cause many individuals to re-experience powerful feelings around trauma, loss and transition. For many, disaster anniversaries provide permission to seek help for physical and emotional problems. It is important that military health care settings create a safe environment this fall for service members and their families to feel comfortable about discussing health and safety concerns, which may be more pronounced at that time.

This fact sheet provides information related to individual, family and community preparedness that can foster the health and safety of service members and their families.

Military Transitions

Reunions and reintegration following deployment are military transitions that challenge returning service men and women, their spouses and children. Here are some reminders concerning individual and family health and safety.

Reunions

A homecoming brings together two powerful emotions — the excitement of being reunited and the anticipation of readjusting. This can be especially difficult for military children.

Remind Patients to:

- Be patient and sensitive to children's reactions and permit time to be-

Anniversary events are often catalysts that cause many individuals to re-experience powerful feelings around trauma and loss.

come reacquainted. Young children often act shy and may not remember the returning soldier at first. Older children may express anger at not having had the parent present for important events or worrying about the parent's safety.

Exercise Caution When:

- *Driving.* When people have not operated a conventional motor vehicle in a long time, or have experienced traumatic events on the road while deployed, driving can be hazardous. In the first few days encourage caution driving, and suggest having a family or friend present while driving.
- *Drinking alcoholic beverages.* Since exposure to alcoholic beverages has been limited during deployment, it is important not to over indulge. Excessive use of alcohol can be a warning sign of distress, increase the risk of accidents, and decrease the opportunity to reestablish connection with one's spouse and family.

Reintegration

Military couples need to reestablish a shared sense of purpose and negotiate the difficult transition of reintegration following deployment. *A shared sense of purpose* is a constructive paradigm that addresses emotional changes, expectations and adjustments.

Remind Patients:

- That the biggest task for the returning service member is to transform the sense of purpose created deployment into the routines and safety of everyday life.
- That in their absence, the service member's family has established new routines during the deployment.
- To communicate. Service members often prefer to discuss war stories with military buddies to protect their spouse and family from traumatic memories. Spouses should not be offended. Communication can occur by taking walks, working out together or engaging in a sport. These activities can enhance family communication and health, and help build relationships with one's children.

Routine Health Care

Many young caretakers — mothers and fathers whose spouses are deployed — may be facing family health experiences alone for the first time. Routine office visits provide opportunities to help new and young parents establish important health habits for life.

Remind parents to schedule their flu shots in the fall for themselves and their children.

Disaster Preparedness

Disasters affect families emotionally and physically, and often cause significant elevations in anxiety. Families need to be prepared, especially around their health needs, in the face of natural disasters and terrorism.

Remind Patients:

- At home, to have an extra supply of medications available.
- In the event of separation, family should provide instructions and training (if possible) to the primary care providers outside of the home (e.g., daycare, school teachers). This would be especially important if a family member has specific medical needs.
- Make sure adult children away from home, such as college students, and elderly family members, are prepared.
- A family communication plan is essential for relaying information about the status and location of loved ones. The accompanying Patient Take-away provides details on creating a family communication plan.

Homecoming brings together the excitement of being reunited and the anticipation of readjusting.

Section 2

MILITARY FAMILY HEALTH

Introduction

In 2004, the Center for the Study of Traumatic Stress introduced a public education initiative and campaign called Courage to Care. Courage to Care was the first resource to address military-unique health issues related to our nation's wars in Iraq and Afghanistan. Topics have ranged from the impact of deployment and combat injury on military families and children, to more general health issues such as caring for newborns, especially as a single parent in wartime.

Courage to Care has reached out to two audiences: healthcare providers and professionals who serve the military community, and service members and their families who are the focus of this section. The medium of this information was and continues to be electronic fact sheets that are developed by Center experts in psychological and behavioral healthcare as well as medical experts affiliated with the Uniformed Services University Medical School.

Most of the information presented in this section was originally presented as Courage to Care fact sheets, which can be currently accessed on the Center's website, www.cstsonline.org.

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Tips for Caring for Your Newborn and Yourself

We present common issues that many new parents experience in caring for their newborn. We also present some pointers to help you take care of yourself. Your good health and relaxation are vital to the growth, wellbeing and safety of your new baby.

What to Expect About Newborns

- Newborns learn about the world through you. They are fragile and require patience and gentleness.
- Caring for a baby is a 24/7 job and when an extra pair of hands is not around to help, even the calmest mother can become frazzled.
- Newborns usually spend a lot of time sleeping during the first couple of months.
- Your baby will naturally develop eating skills, either by bottle or breast feeding. Infants should suck and swallow well.
- Keep your baby dry. Newborns need to be changed frequently, usually following a feeding.
- Infants need to be comforted, so hold your baby gently. Don't be afraid of spoiling your newborn by too much picking up or holding when crying occurs. Your baby needs to trust that you are there to care and love and make him or her feel safe.
- Your baby will make cooing sounds and will respond to your voice, even as early as hours after birth. S/he will recognize your voice among others, so sing to him/her and coo back.
- Your newborn also has the ability to follow objects with his/her eyes and is only able to see certain colors. Babies prefer human faces to anything

Your health and relaxation are vital to the growth, health and safety of your new baby.

else and they especially like sharp contrast like black and white and red in different shapes and patterns.

- Your newborn will likely smile even when sleeping as early as the first month of life. That smile will be special for you, so enjoy and smile back (sometimes new mothers suffer from depression after the birth of a baby that makes it hard to smile; see the section on post-partum depression, a treatable condition).
- Just like adults, infants have different personalities. Some will settle into their new lives with ease. Others may have more difficulty adjusting. They may cry more, have feeding problems or be more sensitive to or distressed by their environments.

Your Needs are Important, too! Take Care of Yourself.

- Eat a well-balanced diet, exercise, get regular medical checkups.
- Get enough sleep.
- Accept offers from those you trust to baby-sit and take an occasional break.
- When your child goes to bed, take time for yourself to relax: nap, read a book, listen to music, take a bath, or call a friend.
- The stress of having a new baby and having the additional worry of a deployed spouse can cause some people to start or increase unhealthy behaviors such as alcohol use or cigarette smoking.
- Out of loneliness, spouses of the deployed may seek the company of other adults. But, remember not to expose yourself or your child to individuals or environments that compromise your or your family's health and safety.

Tips to Help You and Your Baby Settle in Together

Be prepared for crying.

It is normal for infants to cry and they may do so for three hours a day or more. Sometimes your baby may not stop crying, even if you have met all of its needs. If you have concerns about your baby's crying or if you feel like you are losing your patience or becoming frustrated, do not blame yourself, and do not go it alone. Ask for help from family members, friends or your health care provider. Infants can easily be injured if handled roughly (a sad and completely avoidable condition is called Shaken Baby Syndrome or SBS). Do not ever shake a baby. Please read about this below).

Help your baby develop a sleep routine.

Create a sleep time ritual that includes special songs or routines. Keep naptime and bedtime the same, as much as possible, each day.

Learn as much about your baby as you can.

Watch to see the skills your baby will develop and when. Spend time observing the way s/he looks at the world and how s/he responds. Is s/he shy? curious? able to let you know when s/he is tired or has had enough? Your baby's personality will unfold from the moment of birth.

Remember, every child is unique.

Be sure to follow your baby's lead to figure out the best way to comfort, play, and communicate with him/her. While you may have had experiences with other children, refrain from thinking that your baby will respond in the same way as another. Even brothers and sisters in the same family are different from each other, and these differences can be seen shortly after birth.

Make family time a priority.

Play with and read to your baby every day. If you have other children plan time each day to spend with them and let them know that you love them equally. With a newborn, do not expect too much from yourself. Housework may need to wait while you take care of your family.

If your spouse is deployed, keep him involved.

Even though your baby's father may not be physically present, help him to stay involved in the progress of your infant. Newborns grow and change quickly. Take and send lots of pictures or keep a journal with pictures so that your baby's father gets to know her as well as you do. When he returns home he may need some help feeling comfortable around his newborn. Help make that connection a special one.

Maintain your baby's health.

Your family pediatrician needs to get to know your baby, too. Well baby checks are an important way for your family doctor to check your baby's health, monitor developmental milestones, screen for common health conditions, and provide vaccinations on time. Even though schedules can be tight, especially during deployment, never miss time with your family pediatrician. Well baby checks keep your baby healthy.

When you have questions, ask.

Even when you know your child well, you may still have questions and concerns. Ask your pediatrician when you need advice. Seek a friend or relative to give you help when you are tired, frustrated or just need someone to talk to. It helps to share those special moments, or those difficult days, with another adult.

Important Health Conditions to Know About Shaken Baby Syndrome

Shaken Baby Syndrome (SBS) is the name of injury to an infant's brain caused when someone shakes a baby. An infant's neck muscles are not strong enough to be supportive of the head. During shaking, the brain can hit the inside of the head, causing swelling, bleeding, and pressure in the brain. *Babies should NEVER be shaken.*

Postpartum Depression

About one in 10 new mothers experience postpartum depression that can occur within days after delivery, even a year later. Postpartum depression is different from the baby blues. It lasts longer and can cause feelings of doubt in the mother about herself and her children.

The symptoms of postpartum depression include:

- Sluggishness
- Fatigue
- Exhaustion
- Feelings of hopelessness or depression
- Disturbances with appetite and sleep
- Confusion
- Uncontrollable crying
- Lack of interest in the baby
- Fear of harming the baby or oneself
- Mood swings — highs and lows

Postpartum depression is treatable and nothing to feel ashamed of. Call or visit your doctor if you have these symptoms.

Newborns learn about the world through you.

Helping Children Cope During Deployment

The best way to help children during a parent's deployment is to:

- Communicate in ways that children can understand according to their age.
- Explain to children that *they, too, have a job* as part of the family at home.
- Reassure them that the *deployed parent is trained* to do his/her job.

Commonly Asked Questions About Children and Deployment

Q. What is the best way to prepare children for deployment?

A. Parents must be honest, and focus on their children's safety, security and continuity of routine. If deployment will change the child's lifestyle such as moving, living with grandparents, or changing childcare, school or community activities, the child needs to hear of these things in advance.

Q. How else can we reassure our children about a deployment?

A. First, parents should digest the information *before* they communicate it to children so they can deliver it in a calm and reassuring manner. Second, children worry about the *safety* of the deployed parent. It is important to let children know that the deployed parent is *trained* to do their job. Third, it is important to communicate in a way that your child will understand based on their age.

Q. How do children signal their distress?

A. As may be the case with adults, children may also complain of headaches, stomach distress and sleep disturbances. They may display moodiness, irritability, low energy, and have more dramatic reactions to minor situations

Emphasize to your children that they have a job to do during the parent's deployment will help reduce their stress. Doing well in school and helping out at home are important jobs for children.

such as stubbing a toe. It can sometimes be difficult to sort out normal distress from more serious problems. If in doubt, seek medical advice.

Q. Are there ways to reduce stress on children during the separation?

A. Yes, one very positive way is emphasize to your children that they have a job that is as real as that of the deployed parent. Stress often comes from feelings helpless or unsure or unclear about a new role or situation. It is important to reinforce that doing well in school, helping out at home and being cooperative is a skill set that is part of *their* job, one that is valued and unique to their being a military child. When children do their job they help support their parent's mission.

Q. How should school problems be handled?

A. If there is concern about a child's behavior at home, parents should notify the school. Many parents may be reluctant to call attention to their child by warning school officials, but it is important for the school to be alert to any unusual changes in behavior. If a child has had behavioral or psychiatric problems before the deployment, they are more likely to have problems as a result of the deployment. It is important to talk to your child about any acting out and to discuss their feelings and issues with them. Your child's school or your primary care doctor can arrange for counseling services.

General Tips for Communicating with Children of All Ages

- Be careful about sharing your emotions with children. Some parents share too much (losing control in front of kids) or share too little (no emotion or giving the message that you can't talk about it). Children take their cues from you.
- Keep up the routine. Activities, such as games, schooling, bed times, are important to keep regular. Continue to celebrate birthdays or other special occasions with enthusiasm.
- Have your spouse before or while deploying record chapter books on a cassette recorder to be played back to young children. This helps with separation and attachment issues. Likewise, help your children create scrapbooks, video or journals to send or share upon return.
- Listen to your children and their concerns. Children may think a lot and have worries AND concerns about their parents that are difficult to express. Be available when they are ready to communicate.
- Limit television and other media coverage of the war to help reduce anxiety and worries.
- Take care of yourself! Find time to rest, see a movie or do something just for you. Accept help from family or friends if feeling overwhelmed or in

need of time out. We are all more vulnerable to stress when we are tired and can manage better when we are rested and in tune with ourselves.

- Seek professional help from your military or civilian community in the event of special circumstances such as serious injury or death of loved ones. Help is available from people who are experienced in such matters and care.

Use Developmentally Appropriate Communication with Children

Parents need to communicate with children in ways that are developmentally appropriate. Timing and what is being shared are important factors. Here are some simple explanations of what children can grasp at certain ages.

Three to four year olds

No concept of time. A three year old thinks that three months is next week. Parents need to use markers such as “Dad or mom will be home right before your birthday or before this holiday.”

Early elementary school

Better understanding of time. They understand that three months is a long time. Calendars are helpful. You can mark the calendar and say “This is the day that Dad or mom is supposed to come home.”

Seven and eight year olds

Understand time and bigger concepts. They will be able to look at calendar and mark it. You can say “This is the day dad or mom is supposed to come home.”

Nine to twelve year olds
Abstract thinking has begun. They are aware of the news and can understand concepts like the national good. You can put out a return date, and they will understand the timeframe. Reinforce this age group’s skills by providing them with pre-stamped envelopes, as well as private email accounts for communicating.

Adolescents

This is a challenging age group. This is an emotional period of time under the best of circumstances. It is an age when children need to identify with their same sex parent. If that parent is deployed, it is especially difficult for the child.

It is important to remember that while deployments are stressful, they also provide opportunities for families to grow closer and stronger.

Additional Resources

For information on talking with children about traumatic events, go to:

- American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Home.aspx
- Substance Abuse and Mental Health Services Administration (SAMHSA)
<http://www.samhsa.gov/children/earlychildhoodmat.asp>

Stress often comes from feelings helpless or unsure or unclear about a new role or situation.

Becoming a Couple Again

How to Create a Shared Sense of Purpose after Deployment

Coming together as a couple after war deployment is not always easy or something that happens naturally. It requires effort and the understanding that each person has grown and changed during the separation. A positive way to think about this is that both of you, the service member and spouse, developed their own sense of purpose in coping with new experiences while apart. What is now important is to come together and create a shared sense of purpose. This may occur quickly or take time, mutual compassion and a desire to do so. Here are four steps to help you.

STEP#1: Understand each other's sense of purpose during separation

The returning service member's sense of purpose may have been shaped by:

- Traumatic events that can be difficult to process and talk about.
- Identification and closeness with their military unit and comrades who have shared similar experiences.
- Regimentation in the form of highly structured and efficient routines.
- Heightened sensory experiences including sights, sounds and smells.
- Expanded self-importance and identity shaped by war.

The spouse's sense of purpose may have been shaped by:

- *New roles and responsibilities.* Many spouses have assumed new or more taxing employment, oversight of finances and child rearing.
- *Community support trade-offs.* Some spouses and children left the mili-

Relationship-breakers and relationship-makers are sign posts on the road to re-adjustment.

tary base to stay with parents and in-laws for various reasons, but will have experienced loss of connection with their military community, its familiarity and support.

- *Emotional changes.* Some spouses may have experienced growing independence and thrived on it; others may have found this a difficult time leading to depression, anxiety, increased alcohol or substance use and abuse, and other symptoms of stress.

STEP #2: Recognize that the following concerns upon return are common, often shared or felt indirectly, and may require mutual adjustments and time:

- *Home.* Life at home does not have the edge and adrenaline associated with wartime duty, which often leads to the service member's let down, disappointment and difficulty shifting gears.
- *Children.* Reconnecting with children is anticipated by the service member. Children react differently depending upon their age and can be shy, angry, or jealous as new bonds are reestablished. Discipline will now be shared, often resulting in conflicting opinions and styles.
- *Relationship.* Concern about having grown apart, growing close again without giving up individual growth and viewpoints, issues of fidelity, and being able to discuss these issues without raising more anxiety or anger may challenge many couples.
- *Public.* While there has been widespread support of the service member, the public has mixed views of the war. Protracted deployment and other concerns may polarize the public, promoting media coverage that can undermine the pride and purpose military families feel about their involvement.

STEP #3: Relationship-breakers: Most couples argue about three things: sex, money and children. Understanding the potential of these issues to divide rather than unite is the key to reestablishing a shared sense of purpose. These issues involve:

- *Intimacy.* Intimacy is a combination of emotional and physical togetherness. It is not easily reestablished after stressful separations creating an emotional disconnect.

Partners may also experience high or low sexual interest causing disappointment, friction or a sense of rejection. In due time, this should pass, but present concerns may include hoping that one is still loved, dealing with rumors or concern about faithfulness, concern about medications that can affect desire and performance, and fatigue and alterations in sleep cycles.

- *Finances.* During the deployment, most service members and families received additional income from tax breaks and combat duty pay. Some families may have been able to set aside appreciable savings; while others may have spent some or all of the money. The state of finances may create disagreement that can hamper the important work of building shared trust. Financial planning is essential to moving forward.
- *Children.* Children have grown and changed during deployment. Some returning soldiers will see children for the first time. It is important to build upon the positive changes in your children, and work as a couple to address issues of concern that need improvement or attention. Discipline of children will now be shared and should be viewed as something that can be built together rather than criticized or ignored.

Step#4: Relationship-makers. Here are some thoughts and tips for building a shared sense of purpose and stronger family.

- *Take Times-Out.* Remember that fatigue, confusion and worry, common during this transition, often lead to short tempers. In that frame of mind, it is easy to revert to the relationship-breaker issues listed above. If this happens, suggest taking time out and return to discussions when both parties feel more relaxed.
- *Enjoy life.* Find activities that are pleasurable such as a movie, a family picnic, bowling or shopping. Create time in your weekly schedule to do something as a couple and as a family.
- *Give thanks.* Together, thank those people, family, friends, co-workers and new service member buddies, who have helped you and your family during this deployment. Showing appreciation through writing notes or calling people or visiting them will bring a sense of fulfillment that reunites each other's experiences.
- *Communicate.* Talk together. The desire to communicate is more important than the details. Service members often prefer to discuss war stories with military buddies to protect their spouse and family from traumatic memories. Spouses should not be offended. Other ways to communicate involve physical activity. Take walks, work out together or engage in a sport. Healthy communication involves discussing feelings learning new information and relieving stress. Read, draw, paint, dance, sing, play an instrument, or volunteer to help keep a sense of perspective and individuality as you grow together as a couple.
- *Let time be your friend.* Time may not mend everything, but it is often one of the most important factors in healing and solving problems.
- *Be positive.* A positive attitude is one of the most important gifts you can bring to each other and your family during this time. Appreciating

what one has gives strength and energy to a family and a couple. Special circumstances such as physical injury and psychological problems are not addressed here, but may require additional support, information and resources.

- *Know when to seek help.* Both service member and spouse have endured a level of stress, uncertainty, worry and loneliness that can affect health. If either suspects they may be suffering from a health or mental health problem, it is essential to seek help. Many service members do not want to seek help for mental health problems from the military for fear of damaging their career. However, the consequences of letting a problem linger untreated can be much more damaging. There are excellent treatments that can help people reclaim their lives and enjoy their families, as they should. You owe it to yourself and your family to be in good health.

Reuniting with Your Loved Ones

Helpful Advice for Families

The Arrival

- Homecoming is more than an event: it is a process of reconnection for your family and your loved one.
- While coming home represents a return to safety, the routines of home are markedly different from regimented life in a war zone.
- In your loved one's absence, you and other family members have probably assumed many roles and functions that may have to be re-negotiated. Be patient during this period of readjustment and recognize that many things often do not return to what they previously were like.
- GO SLOWLY. Your returning loved one, you and your family may need time — time together before exposure to the demands of the larger community—friends, extended family and coworkers.

Try to Observe

- Celebrating is important, and should reflect your family's own style and preferences. Do what feels comfortable and right for you. Tributes might be cakes, yellow ribbons, special dinners, and events that your loved one has enjoyed in the past.
- Talking about war experiences is a personal and delicate subject, and frequently not a part of a family reunion. Many soldiers prefer to share such experiences with a buddy or special friend. Let your returning soldier take the lead here. Listening rather than asking questions is the guiding rule.
- Keeping your social calendar fairly free and flexible for the first weeks after homecoming is wise. Respect the need for time alone, especially time with important people, such as spouses. Explain to those who may

Homecoming is a process of reconnection for your family.

be slighted at not being included that this is a normal requirement of returning personnel.

- Your loved one may need time to become adjusted to the local time zone as well as other environmental changes such as the lack of continual noise. Also, your own family may be keyed up, sleeping poorly in anticipation and in the excitement of the homecoming, and may be exhausted as well.
- Your children's reactions may not be what you, the parent at home, or your returning spouse may have expected or desired. Very often young children will act shy and, not remember the returning parent at first. Older children may feel and act angry because of their parent's absence. Be patient and understanding concerning your children's reactions and give them time to become reacquainted.
- Try to be flexible with reasonable expectations. It is normal to experience some disappointment or let down in the face of this momentous event. The reality of homecoming and reunion seldom match one's fantasies and preconceived scenarios.

Exercise Caution When:

- *Driving.* When people have not operated a conventional motor vehicle in a long time, driving can be hazardous. Driving with someone in the car is the best way to return to driving.
- *Drinking alcoholic beverages.* Since exposure to alcoholic beverages has been limited in wartime, it is important not to over indulge. Persons drinking with the returning service member should be especially careful to help limit the intake. Excessive use of alcohol can be a warning sign of distress, increase the risk of accidents and decrease the opportunity to communicate and reestablish connection with one's spouse and family.

The Departure

- Leaving home and returning to one's unit in a deployed environment is stressful for you, your loved one and your family. You've drawn close, and now you must let go. It's a sad time, and it is natural to feel sad, even to cry. Your loved one may distance himself/herself in preparation for leaving. Try to understand if this happens.
- At the time of departure, it is important to let your loved one know how proud you are of their sacrifice, their commitment to our country and their job. Expressing this pride while saying goodbye is positive, and will provide strength to you, your children and most of all, the departing soldier.

Intimate Partner Violence (IPV)

Understand IPV and Reporting Options in the Military

IPV occurs between people in a close relationship. This could be a current or former spouse or someone you are dating. IPV may happen once or escalate over time to include ongoing abuse.

Victims of intimate partner violence (IPV or domestic violence) often suffer serious mental and emotional distress including major depression, posttraumatic stress disorder, and other forms of anxiety. They also often experience other health issues such as arthritis, chronic neck or back pain, migraine or other types of headache, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion, diarrhea, or constipation. Abused women who are pregnant have higher rates of complications including low weight gain, anemia, infections, and first and second trimester bleeding.

Major risk factors for IPV are early parenthood, problem drinking by males, severe poverty, and unemployment. Victims are often afraid to get help or are ashamed to admit they are in such a predicament. Fear of losing financial support, housing or medical benefits are some of the reasons people stay in abusive relationships. In the military community, some victims fear they will ruin their spouse's career; others may stay in such relationships for the sake of their children.

Your health care provider may be a good person to talk to, especially if you feel your situation is causing you physical or emotional distress. Breaking the silence can be the first step to unburdening yourself and beginning to take control of your health, your safety, the safety of your children, and your future.

Victims of intimate partner violence (IPV or domestic violence) often suffer serious mental and emotional distress.

There are Several Categories of IPV

- *Physical violence* is when a person hurts or tries to hurt a partner by hitting, kicking, or using another type of physical force.
- *Sexual violence* is forcing a partner to take part in a sex act when the partner does not consent.
- *Threats of physical or sexual violence* include the use of words, gestures, weapons, or other means to communicate the intent to cause harm.
- *Emotional abuse* is threatening a partner or his or her possessions or loved ones, or harming a partner's sense of self-worth. Examples are stalking, name-calling, intimidation, or not letting a partner see friends and family.
- *Stalking* is often included among types of intimate partner violence. Stalking generally refers to harassing or threatening behavior that an individual engages in repeatedly, such as sending the victim unwanted presents, following or lying in wait for the victim, damaging or threatening to damage the victim's property, appearing at a victim's home or place of business, defaming the victim's character or spreading rumors, or harassing the victim via the Internet by posting personal information. Stalking and intimate partner violence may co-occur.

The following information is taken from the Military OneSource website, www.militaryonesource.mil.

- *The Department of Defense is committed to addressing and ending domestic abuse and offers victims two different reporting options for seeking help.* With either option, victims have access to victim advocacy services, counseling, and medical care. Victims of domestic abuse may want to talk to a victim advocate from the Family Advocacy Program (FAP) about their options and other sources of support before making a decision.

Restricted Reporting

- *Victims who prefer confidential assistance that does not include notification of law enforcement or military command may contact a FAP supervisor/clinician, victim advocate or a healthcare provider to request a restricted report.*

A restricted report allows victims to evaluate their relationship choices while maintaining control over what and how much information to share with others. Because victim safety is a priority, victims at imminent risk of serious harm cannot use the restricted report option. A restricted report is also not available in cases where child abuse has occurred.

A victim of domestic abuse who makes a restricted report may receive

victim advocacy services without law enforcement notification or command involvement. Victim advocacy services include help developing a safety plan to prevent further abuse, referral to counseling, medical care, information about Military Protective Orders and information about military and local civilian community resources.

Unrestricted Reporting

Victims may contact the FAP, military police, or chain of command to make an unrestricted report if they want an investigation of an abuse incident and command involvement. The command can offer the victim added support and protection. An unrestricted report also gives the command the discretion to take administrative action against the offender.

For victims who choose to make an unrestricted report, a FAP advocate will also assist victims in making a report to law enforcement, provide information on legal rights and offer assistance in applying for Transitional Compensation, if applicable.

If you are in an abusive relationship or if something about your relationship with your partner scares you and you need someone to talk to, visit the National Domestic Violence Hotline online or call 1-800-799-SAFE (7233). If you go to a hospital or to see your doctor, explain what happened. *Ask your doctor to document the incident or injuries in your file. Save any threatening email or voice-mail messages.*

Informational Resources:

- Centers for Disease Control and Prevention — www.cdc.gov
- MilitaryOneSource — www.militaryonesource.mil

DEPLOYMENT DISTRESS, DISORDERS AND CARE

Understanding Post-Deployment Stress Symptoms

Helping Your Loved Ones

Families and friends of returning service members often wonder what to expect after their loved one comes home from a combat zone. They may ask what is typical and when should they become concerned. The question is often “At what point should I be worried about my husband or my son?” and “How can I encourage my wife or my daughter to get the help I think she needs since she returned from deployment?” Service members who have a difficult time after their deployment experience often reveal their troubles to those they most trust— their family or close friends. This can be communicated by what they say or what they do. Increased drinking, anger, irritability, or reckless driving for example can be especially frightening for veteran families, and confuse or trouble their children.

What are the warning signs that may signal problems? If there is a problem, how can we bring it up? How can we encourage them to get help? This fact sheet recognizes the importance of helping your loved one when he or she comes home.

Distress Responses

It is not uncommon for people who have been involved in high stress situations to have distress responses. These may be physical or emotional in nature and are usually mild and go away after several weeks. *If these problems (described below) last longer than a month or two months after returning home, a medical professional should be consulted.* There are effective treatments today that are readily available from primary care physicians or mental health providers. The majority of returning service members are likely to have some of the distress responses described above.

Increased drinking, anger, irritability, or reckless driving can be frightening for families, and confuse or trouble children.

- *Sleep problems* — difficulty falling asleep; staying asleep or waking early and not being able to get back to sleep.
- *Restlessness* — jittery, fidgety or showing a high degree of nervous energy.
- *Overly watchful* — oversensitivity or anticipation about things in the environment (e.g., noise, physical objects) that are viewed as a threat to personal safety.
- *Social withdrawal* — avoiding family or friends, always wanting to be alone, avoiding social activities that he/she use to enjoy.

Risk Behaviors

Returning from deployment can sometimes start or increase the frequency of behaviors that compromise their health and the health and safety of those around them. Examples include:

- *Excess cigarette smoking* — often starts or increases in the combat zone, and continues or increases upon return home.
- *Excess alcohol use* — may start or continue as a means of reducing stress.
- *Reckless driving* — may be part of a transition from the intensity of driving in a war zone to routine driving in a civilian setting. Stress and alcohol are other factors that contribute to risky driving.

More Serious Problems

There are conditions that cause more serious problems for returning service members, their families and friends. Some of these conditions are:

- *Violence* — When irritability or anger turns into violence there is risk both for the service member and the family. Mixing anger with alcohol can be particularly troublesome since the individual loses the ability to understand his/her behavior or its consequences. Conflicts that become violent need to be recognized by family who should seek outside help. Violent behavior can be caused by physical and emotional problems for which there are treatments and require medical assessment. *When violence occurs in families, children are particularly at-risk and need to be protected. Families are urged to get help quickly.*
- *Posttraumatic stress disorder (PTSD)* is a condition that results when traumatic experiences (such as combat) lead to lasting symptoms: nightmares, flashbacks, and unsettling memories of the trauma. Other symptoms that are experienced and can be noticed by others include excitability, nervousness, over anxiousness, Hypervigilance (feeling jumpy), and avoidance of people or social situations that can remind a person of the trauma experience. Symptoms of PTSD are serious and require medical attention, but there is good news. PTSD is a treatable problem and combat veterans can recover. *But, left untreated PTSD can lead to problems in*

day-to-day living, both for veterans and their families.

- *Depression* is different from normal human unhappiness. Depression is a deep, unchanging, prolonged and painful sadness that does not respond to attempts to help a person cheer up. It includes a loss of interest in things one was previously interested in, including family, hobbies, friends and work. Depression typically leads to changes in individual functioning (difficulties with appetite, sleep, concentration and enjoyment of activities once a source of pleasure), as well as a loss of a sense of wellness and self-esteem. *There are excellent treatments available for depression.*
- *Traumatic Brain Injury (TBI)* is a condition that results when service members are exposed to explosive events in the combat theatre. While many combat veterans may be aware that they have suffered from a head injury, some who sustained mild injury may not. Symptoms of mild TBI can include headaches, impulsive behavior, anger outbursts, and changes in personality or slowed thinking. These symptoms can sometimes be difficult to distinguish from other emotional conditions. *As TBI symptoms can cause problems in the lives of combat veterans or their families, it is important to bring any concerns to the attention of a health care provider.*

Warning Signs

Symptoms that may require medical attention include:

- Strong desire to avoid other people, which continues for weeks or months after return
- Increased jitteriness or jumpiness that does not go away after return home
- Headaches or unexplained changes in personality or thinking
- Unsettling memories or flashbacks to uncomfortable wartime events that continue after coming home
- Sense of sadness, guilt or failure that does not improve
- Angry outbursts, irritability, family arguments or physical fighting that is out of character and continues
- Changes in alcohol use — drinking more and more often; guilt about use, inability to decrease or stop use, or family member concerns about use.
- Risk-taking behaviors — reckless driving or other risky activities that have health consequences
- Thoughts of death or a wish to no longer be living (this is serious. Family and friends should call a doctor or 911 immediately).

Seeking Help

It is often difficult for veterans with emotional or behavioral problems to seek the help they need and deserve. People often feel ashamed and view their suffering as a sign of personal weakness — something they can snap out of or tough it out. Family and friends can help by pointing out that emotional problems are no different from medical problems, and must be diagnosed and treated like any medical condition. It is also important to let the person know that their health affects the health and well-being of the entire family and should not be neglected. The good news is that many medical treatments today are very effective for helping with these problems. The military supports help-seeking, especially before problems worsen and interfere with the quality of life.

Resources

Many resources are available to veterans through the DoD, Veterans Affairs (VA) and community agencies. When appropriate, service members and their families should seek out help from health care professionals who have experience in the treatment of combat stress related problems. Sometimes a chaplain, a good friend or a trusted member of your unit can make it easier to arrange for the right kind of help. Service members living in more remote locations (such as National Guardsmen, reservists or those who have left active duty status) should reach out to VA or local (TRICARE) health-care providers in the civilian community where they live.

Facts About Traumatic Brain Injury

Traumatic brain injury (TBI) has become a topic of interest and concern amongst military families, especially those with loved ones previously or currently deployed to Iraq or Afghanistan. Among the causes of war-related TBI are exposure to blast, gunshot wounds and shrapnel, falls, and motor vehicle accidents. The good news is that most of these injuries are mild, and commonly referred to as concussion. Concussion is seldom life threatening, but can result in symptoms that may interfere with one's normal routine. Moderate-to-severe brain injury often occurs in combination with other serious injuries such as those involving amputations and burns. This level of TBI injury can have lasting effects that challenge service members and families over time.

Any medical condition that gains rapid public attention often results in incomplete or inaccurate information. It is important that military members and families understand the facts about TBI, especially the mild form, in order to help recognize the symptoms and provide support. It is also important that families impacted by more severe TBI understand some of its long-term implications, especially on children. This fact sheet describes mild TBI (concussion) and its symptoms in order to help military families identify it and seek treatment. We also describe some of the important issues for families living with more severe TBI.

Mild TBI (Concussion)

Concussion occurs when the head is hit or shaken and leaves a person dazed, confused or with loss of consciousness for a short time. In civilian life, concussion often occurs during sporting events such as a football and soccer. Mild TBI (mTBI) is also referred to as a closed head injury. While concussion is seldom life threatening, it can cause serious symptoms especially for those who may have suffered multiple concussions. People who

Any medical condition that gains rapid public attention often results in incomplete or inaccurate information.

have had a concussion may say that they are “fine” although their personality or behavior may seem to have changed. Symptoms of mTBI can appear days, weeks, to months after the injury. Being aware of the symptoms of TBI can assist in the family understanding and being able to provide support:

Symptoms of TBI

- Sleep problems (either too much or too little)
- Fatigue, feeling tired all the time
- Difficulty organizing/completing tasks
- Trouble making decisions
- Sensitivity to lights/sounds
- Headaches
- Feeling depressed, sad
- Trouble with concentration, memory, and/or attention
- Easily overwhelmed
- Irritable, angry
- Impulsive, outbursts

Do's and Don'ts to Speed Recovery

Just as an injury to a muscle or joint, mTBI requires care to help speed recovery.

Do's

- Get appropriate amounts of sleep and rest
- Get into a regular routine of everyday activities (such as exercise, eating regularly)
- Do one thing at a time (e.g., reduce distractions when working)
- Increase your activity slowly
- Write things down to help you remember important things
- Engage your brain in activities that require fine motor skills and use of strategy (e.g., playing an instrument, games, writing, leisure puzzles)

Don'ts, while the TBI is healing

- Engage in activities that can produce another brain injury, such as contact sports
- Drink alcohol or use excessive amounts of caffeine
- Take over-the-counter sleep medications

Healing takes patience and time. Support from family members and tak-

ing care of oneself can go a long way in assisting in recovery.

If symptoms become more severe or prolonged, it may indicate the presence of another condition such as posttraumatic stress disorder, depression, or substance abuse. If this is the case, you or your family member should tell your primary care provider.

Moderate to Severe TBI: Implications for Families

Serious TBI, often occurring along with complex war injuries, presents a number of challenges that families must deal with over time. Military healthcare providers who have worked with families impacted with moderate to severe TBI have identified some of the issues below as commonly felt by families dealing with this medical condition.

- *Injury as grief and loss.* With moderate to severe TBI, the service member is not who he or she used to be. There is grief and loss of the service member not being able to return to be the normal individual and to family routines. There are memories of how the person used to function with direct comparison to present abilities.
- *Inappropriate behaviors.* The family must deal with the injured service member's potentially inappropriate behaviors in public. These may include lack of inhibition, anger, and outbursts, as well as the other extreme — withdrawal, apathy, and depression.
- *Social isolation.* This may be an issue due to the exhausting care-giving responsibilities and fear over how the TBI patient is going to behave. It is important for the family to avoid social isolation and engage in the community and available supports.
- *Implications for children.* Children, especially younger children, may think they are responsible for the personality changes a parent with TBI has (irritability or withdrawal), or even that the injured parent may not love them. Protect children from outbursts and share calm, loving time with them.
- *Talking helps.* Explain, “Dad is grumpy or angry because his brain was hurt. He doesn’t mean what he often says or does.”
- *Family management.* With moderate to severe TBI, the management of the injured service member often must be delegated to the non-injured spouse. The military healthcare community is engaged in research, education and treatment for TBI in both its mild and more moderate to severe forms. Here are resources to learn more about war-related brain injury.

Resources

- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury:
<http://www.dcoe.health.mil/default.aspx>
- Military OneSource:
www.militaryonesource.com
- For more information about TBI see:
<http://www.cdc.gov/traumaticbraininjury/>

Mild TBI (concussion) may interfere with one's normal routine. More severe TBI can have lasting effects that challenge service members and families.

Understanding the Impact of TBI on Military Families and Children

An important and often overlooked aspect of traumatic brain injury (TBI) is its impact on the families and children of the injured. TBI is unique because it often leads to dramatic changes in personality and behavior without altering physical appearance. Invisible injuries such as TBI can be especially troubling, confusing and embarrassing for one's children and family.

Military families are extremely vulnerable to the effects of TBI due to its high prevalence and range of severity in combat veterans. TBI may result from exposure to blast, gunshot wounds and shrapnel, falls and motor vehicle accidents. In addition to combat, many TBI injuries can occur in garrison during training exercises. TBI can be mild (referred to as mTBI or concussion), moderate or severe. Even in milder forms, when combat veterans say that they are "fine" they may exhibit changes in their personality or behavior. With more serious TBI, often occurring with complex war injuries, profound changes in personality or inappropriate behaviors (lack of inhibition, anger, and outbursts, or possibly withdrawal, apathy, and depression) can be present.

Despite limited research on the impact of TBI on children, clinical case studies, focus groups, and small samples have shown that children's responses to parental TBI vary, and may involve the following:

Impact of TBI on Children

- Increased acting out behaviors, such as disobedience, tantrums, or risk-taking behaviors
- Emotional distress, such as crying, increased anxiety, or withdrawal
- Feelings of loss and grief related to the change in the injured parent
- Feelings of isolation

TBI often leads to dramatic changes in personality and behavior without altering physical appearance.

- Taking on additional responsibilities, such as caring for younger children, household tasks, and caring for the injured parent
- Feelings of embarrassment about the injured parents' appearance or behavior
- Misinterpreting parent TBI-related fatigue and apathy as indicators that the parent no longer loves them
- Feelings of anger or resentment about new responsibilities or changes in the family
- Feelings of self-blame for the injured parents' irritability

TBI affects parenting as both the injured and the uninjured spouse struggle to adapt to changes in personality, family relationships and routines. Being less emotionally or physically available, or less consistent and predictable, can have short and long-term consequences for children's health and development. Family support professionals and stakeholders should be sensitive to the impact of TBI on children and help families access services that sustain effective parenting and support the needs of children affected by parental injury.

Helping Children Understand Parental Injury: An Action Plan

How Families Can Help Children Integrate the Experience within a Family Context

It is important for families to

1. Seek out resources and instrumental support. As families deal with the adjustment to having a changed parent, families may need help in ensuring that basic needs are met in the areas of work and finance, medical care, military concerns, housing, education, and child care. Children may need special services or support to address behavioral/mental health problems that develop or to connect them with community resources (e.g., sports organizations, educational programs, or boy/girl scouts) that provide them with social support and structured activities.
2. Support children by helping them monitor changes or extremes in their emotional states and reduce emotional distress. As children deal with stress, they may find it difficult to express emotions, to relax, or to calm themselves. Parents can help children by teaching them to label and express their emotions and by giving them specific strategies (such as deep/belly breathing, progressive muscle relaxation, or visualizing a safe space) for dealing with strong emotions and/or stress.
3. Share information with children about the injury in a way they can comprehend it. Particularly important is information that helps children understand what the injury is, what the effects of the injury are in terms

of parent functioning and/or symptoms, and what to expect over time. Children may need reassurance that the injury is not their fault and that specific symptoms/emotional changes in the parent are expected. This helps to normalize and contextualize the family's current difficulties and helps children understand what is happening in their family.

4. Talk about the injury with each other and others in the community, including health care and community service providers.. Children should be encouraged to ask questions about the injury among family members and with medical providers, and they should be encouraged to talk about the injury with people they trust (e.g., other family members, close friends, and/or teachers). Children should be encouraged to talk about what they experience and feel so that their concerns can be better understood and addressed.
5. Develop problem solving skills. Particularly important is helping children identify relevant problems, name their goals, brainstorm possible solutions, and pick a solution to try out. This helps children break down problems into manageable parts and gives them the tools they need to plan for future challenges.
6. Engage children in shared family goal setting. Goal setting helps family members prioritize what is most important and to consider what activities they would like to try sooner. Parents and children can select family goals together and practice them as they plan for future fun or challenges, recognizing incremental improvements over time.
7. Remember that adjusting to life with TBI can take time. Families should be patient and hopeful as they learn to live with the changes that result from the injury. While family life can change, parents and children can learn new ways of being together and enjoying each other.

Resources for Military Families:

- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
<http://www.dcoe.health.mil/default.aspx>
- Defense and Veterans Brain Injury Center
<http://www.dvbic.org/>
- Military OneSource
www.militaryonesource.com

Military families are extremely vulnerable to the effects of TBI due to its high prevalence and range of severity.

What Military Families Should Know About Depression

Service members and their families experience unique emotional challenges. Deployment and redeployment, single parenting and long absences of loved ones are a stressful part of military life. At times, these events can lead to sadness, feelings of hopelessness, and withdrawal from friends, families, and colleagues. Parenting can sometimes feel more a burden than a joy. We may feel irritable and even neglectful of our children's needs. When these feelings and behaviors appear, depression may be present. Seeking care for depression, for ourselves or loved ones, takes energy and courage. Depression is one of the most common and treatable mental disorders. Delay in identifying depression often leads to needless suffering for the depressed individual and his or her family.

This fact sheet provides information to help you talk more effectively about depression with healthcare providers, family and friends. Depression can be a part of chronic fatigue or unexplained aches and pains. The earlier depression is detected and treated, the less likely it is to develop into a more serious problem that can impact one's job, career, health and relationships. A primary care visit is an opportunity to explore concerns about the mental health of your yourself, your spouse, or your children. What is depression? How does it appear in adults, adolescents, children and the elderly? The following information might help you or someone you love identify and seek help for depression.

What is Depression?

Depression is an illness that involves one's body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. Depression is not a passing blue mood, nor is it a sign of personal weakness. Depression is a medical illness and a treatable illness just like diabetes or heart disease. Individuals who are depressed often experience more difficulty in performing their job, caring for

Depression is one of the most common and treatable mental disorders.

their children, and in their personal relationships. A family history of depression and negative life experiences such as loss, trauma, serious illness and stress can also contribute to the onset of depression. There are effective treatments for depression including medications and therapy. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression. The majority of people who are treated for depression will improve, even those with serious depression. Unfortunately, one-third of sufferers seek help as they do not realize depression is a treatable illness.

Who Gets Depression?

Depression is one of the most common of mental disorders. Women are at a higher risk and experience depression about twice as often as men. Many women are also particularly vulnerable after the birth of a baby. The hormonal and physical changes, as well as the added responsibility of a new life, can be factors that lead to postpartum depression. While the blues are common in new mothers and go away, a major depressive episode is not normal and requires active intervention.

Depression in men often shows up in the form of alcohol or drug use and working long hours. Men may act irritable, angry, and discouraged when they are depressed. Men are often less willing than women to seek help. Depression commonly affects people between the ages of 30–44. These are prime parenting years and prime working years. Parenting is challenging in good health, but can be more so if one is depressed. As a parent, it is important to seek treatment for depression as this condition affects everyone in your family.

Signs and Symptoms of Depression

There are some common signs that might indicate depression, but getting a doctor's opinion is the first step to evaluation. Signs and symptoms include:

Symptoms of Adult Depression

- Persistent sad or empty mood
- Loss of interest or pleasure in ordinary activities
- Changes in appetite or sleep
- Decreased energy or fatigue
- Inability to concentrate, make decisions
- Feelings of guilt, hopelessness or worthlessness
- Thoughts of death or suicide

Symptoms of Adolescent Depression

- Loss of interest in school and regular activities; drop in school performance
- Withdrawal from friends and family
- Negative thoughts of self and future
- Difficulty making decisions

Symptoms of Depression in Pre-adolescent Children

Children with other psychiatric disorders (ADHD, conduct disorder, eating disorders and anxiety disorders), and those with general medical conditions (diabetes, asthma, cancers and other chronic illnesses) may be prone to depression. The prevalence may also be higher among children with developmental disorders and mental retardation.

- Physical symptoms, like chronic headaches or stomachaches that cannot be attributed to a physical illness
- Aggression and excessive crying
- Irritability, withdrawal, isolative behavior, loss of interest and/or pleasure in previously enjoyed activities
- Sleep disturbance (reduced or increased sleep), changes in appetite (reduced or increased appetite), and reduced energy

Depression in older adults can be disabling and contribute to the inability to perform activities of daily living. Depression in the elderly is complex and difficult to diagnose due to other medical illnesses that may be present. Clinicians need to differentiate between depression and problems such as dementia, stroke, and other types of brain injuries and illnesses.

General Health Tips for the Holidays

Depression is not uncommon during or after the holiday season. Preparing for the holidays, the increased expectations of family and friends, the sadness of not having a loved one present, or having to say good-bye after a holiday reunion, can contribute to depression.

The following health tips are important for managing mild depression and for optimizing one's health, especially during the holiday season:

- Manage your diet n Get adequate rest
- Avoid alcohol.
- Participate in regular exercise
- Surround yourself with people who are important to you
- Communicate your feelings to someone you trust

- Join a social support group in your military community or in your local area

The earlier depression is detected and treated, the less likely it is to develop into a more serious problem that can impact one's job, career, health and relationships.

Helping Loved Ones Who May be at Risk for Suicide

Suicide has increased dramatically in the military since the start of the Middle East wars. Family members and military leaders are all working together to address the needs of service members and to get them the help and care that will restore their hope and relieve their stress.

The causes of suicide are complex, but, the goal of suicide prevention is simple:

- Reduce factors that increase risk, and
- Increase factors that promote resilience.

Ideally, suicide prevention addresses all levels that can exert an influence: individual, relationship, community, and societal.

Suicide is a leading cause of death among Americans. While suicide is a difficult topic to discuss, it is an important one for military families. The increased operational tempo, redeployment, combat exposure injury, and the impact on marital and family relationships create extreme stress and are contributing factors. Additionally, the reluctance of service members to seek treatment plays a role in the delay in getting care.

Suicide is a fatal loss to the family and the nation. It leaves feelings of despair, grief, and anger. Those who attempt suicide and survive can be left with serious injuries such as broken bones, brain damage, organ failure, and permanent physical disability. Like any health problem, it is important to educate oneself and one's family about suicide. The more you know, the more likely you are to identify warning signs and to help prevent the loss or injury of a loved one.

Warning Signs

Thinking about suicide and making suicide plans are the most serious

The more you know about suicide, the more likely you are to identify warning signs and to help prevent the loss or injury of a loved one.

signs and require immediate assistance. These include:

- Talking about, threatening, or wanting to hurt/kill self
- Obtaining means to kill/hurt self (e.g., obtaining firearm, pills)
- Conveying thoughts of death (e.g., such as “Others would be better off without me.” or “Never wanting to wake up again.”)

Other warning signs include:

- Increased alcohol or other substance use
- Hopelessness (e.g., does not see way the situation will change)
- Helplessness (e.g., feeling trapped, “There is no way out of this.”)
- Worthlessness, (feeling not valued — “No one would miss me.”)
- Withdrawal from hobbies, family, friends, job
- Irritability, anger

Risk Factors

Men are more likely than women to die from suicide. However, more women than men attempt suicide. In addition, suicide rates are high among young people and those over age 65.

Several factors can put a person at risk for attempting or committing suicide:

- Prior suicide attempt
- Family history of mental disorder
- Alcohol or other substance abuse
- Family history of suicide
- Family violence, including childhood abuse and neglect
- Firearms in the home, the method used in more than half of suicides

Protective Factors

Protective factors do not guarantee that a person will not attempt or commit suicide, but they provide some degree of protection for the individual.

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes

- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

Action Steps

If you are experiencing any of these signs, please seek help. If someone you know is experiencing them, please offer help. If you think someone is suicidal, do not leave him or her alone. Try to get the person to seek immediate help from his or her doctor, bring them to the nearest hospital emergency room, or call 911. If possible, try to eliminate access to firearms or other potential means for self-harm.

Resources

- National Suicide Prevention Lifeline: 1-800-273-TALK (1-800-273-8255)
- Suicide Prevention Resource Center — www.sprc.org
- American Association of Suicidology — <http://www.suicidology.org/web/guest/thinking-about-suicide>
- Military Onesource: 1-800-342-9647 — www.militaryonesource.com
- For more information on suicide in the United States, see:
<http://www.cdc.gov/violenceprevention/suicide/>
<http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>

The goal of suicide prevention is to reduce factors that increase risk and to increase factors that promote resilience.

Alcohol and Your Health

Drinking and You

Most people who drink alcohol do so socially and responsibly. Stress can make people vulnerable to alcohol misuse or dependence. Some use alcohol in an attempt to cope with depression, anxiety, loneliness or other unpleasant conditions such as work, family separation or reintegration after return from deployment.

Excessive alcohol use over a long period of time or binge drinking affects health, relationships, and job performance.

Excessive alcohol use leads to a higher risk for:

- Injuries from traffic accidents, household mishaps, cuts, falls, drowning, burns, and handling weapons.
- Violence including abuse of intimate partners and children.
- Social embarrassment, regret, and guilt feelings over things a person would have never done if sober.
- Increased risk of sexual assault and risky sexual behaviors such as unprotected sex or sex with multiple partners, unintended pregnancy, sexually transmitted diseases, and physical or psychological trauma.
- Personal losses in relationships, jobs, and living conditions.

Longer-term excessive use of alcohol can also cause or contribute to chronic health problems

- Alcohol poisoning, a medical emergency that results from very high levels of alcohol in the blood, can lead to passing out, coma, and death.
- Worsening of any psychological problems including anxiety, depression and suicide.
- Physical illness and death from a range of medical problems including:

Stress can make people vulnerable to alcohol misuse or dependence.

- » Heart—increased blood pressure, irregular heartbeats, damage to heart muscle, and heart attacks.
- » Brain and nerve damage.
- » Stomach—painful inflammation (gastritis), ulcers, bleeding.
- » Liver damage that can progress to cirrhosis (death of the liver).
- » Cancers involving the mouth, throat, esophagus and other parts of the body.

Signs that you or someone you care about may be misusing alcohol:

- Drinking more over time, getting drunk or drinking more to get the same buzz.
- Drinking to forget about your problems.
- Driving after drinking, DUI, fighting, arrests or legal problems relating to drinking.
- Continuing to drink although it is interfering with family, friends, health, job or other responsibilities.
- Drinking to treat a hangover.
- Drinking more than you planned, or unable to control your drinking.

Take Action

- Don't wait until you or your loved one is suffering from the advanced personal and health consequences of alcohol misuse.
- Talk to your doctor or someone you trust about how you can help yourself or someone else.
- Listed below are some phone numbers and websites that you can go to for more information and help (all are free and confidential).

Post-deployment mental health services

- <http://www.mentalhealthscreening.org/military/index.aspx> provides a self-assessment program for depression and alcohol problems for service members and military families. Callers can be given immediate results and phone numbers where they can call for treatment or educational resources.
- Military One Source: www.militaryonesource.com for information and referral sources for service members and families.
- *Phone numbers for local Alcoholics Anonymous (AA) and meetings for family members (Al-Anon, Alateen)* can be found at or near the first entries of the white pages in any phone directory. Each group also has web links with information, meetings, and much more:

- Alcoholic anonymous — <http://www.aa.org/?Media=PlayFlash>
- Alateen — <http://www.al-anon.alateen.org/>

Some use alcohol in an attempt to cope with unpleasant conditions and situations. Excessive alcohol use over a long period of time or binge drinking affects health, relationships, and job performance.

The Combat-Injured Family

Guidelines for Care

Your military loved one has been wounded and suddenly your world has been turned upside down. Injury can be a life-changing event that impacts a family's routines and its sense of safety and wholeness. Combat injury especially affects children of all ages. Children worry about the effect of the injury on their wounded parent; how that injury will change their bond with that parent and the parents' relationship with each other. Often, caring adults do not know how to speak to children about the injury and its impact on their family or how much and what kind of information should be communicated.

At this time, many resources of care and support will be extended to the service member and to the family. Due to normal distress and anxiety, there may be times when you will not hear, understand or accept all that you will be told.

Do not be shy about writing things down or having an important person in your life accompany you and take notes for you. When you have questions or forget important information, ask doctors and health care professionals to re-explain or repeat themselves so you can better understand the information they have provided. Good communication between you and your spouse's medical team and you and your family is essential for helping coping and making important decisions related to the care of your injured loved one and to the care of your family.

Principles of Caring for Combat Injured Service Members and their Families

Despite the uniqueness of the family situation and the injury, there are certain principles that should inform the care you receive. Understanding

Adults often do not know how to speak to children about injury and its impact on their family or how much and what kind of information should be communicated.

these principles of care can assist you in recognizing what you require and in seeking appropriate services to support your family's long-term health and wellbeing. Care and services should be delivered in a manner which

- Provides a sense of safety, comfort, information, practical assistance and connection to appropriate community resources that can foster your family's healthy recovery. While the major goal of the health care facility is to provide treatment to your loved one, there will be people on staff who can assist in solving some of your family's practical needs.
- Is family focused and understands that you, your family and your children are all profoundly affected by the injury. Treatment should help relieve family distress, support your ability to be available to your children during the stress of injury recovery, and help guide your efforts in communicating with your children about the injury.
- Reinforces your family's strengths and resilience while understanding that each family may respond in a different way to the challenges it faces. Health care professionals must be responsive to the unique impact of the injury on your family and provide appropriate help and support.
- Is sensitive to the unique responses of children of varying age and gender, and recognizes that distress, care needs and communication ability will vary according to the age of your child or children.
- Is tailored to your family's changing needs throughout what may be a long course of treatment and rehabilitation; anticipating future needs as the recovery process unfolds including discharge and transition to a new community or new way-of-life.
- Encourages a partnership and bringing together of services between your family, treatment providers (both military and civilian), as well as community services. Quality care reaches across traditional professional boundaries and levels of care.
- Respects your family's unique background including culture, language, composition (traditional or nontraditional), ethnicity, religion and the traditions of military families.
- Helps your family access care and addresses any barriers to service (unnecessary roadblocks that get in the way of good care), which can complicate the healthy recovery of your loved one and family members. These barriers may include a family member's difficulty in accessing health care or community services, his or her reluctance to seek needed help, or a community's lack of awareness or understanding of the needs of combat injured families.
- Is informed by knowledgeable service providers, professionals, organizations and communities that have access to and provide quality educa-

tional materials to address the challenges that confront combat injured families.

Good communication between you and the medical team is essential for coping and making important decisions related to the care of your injured loved one and your family.

The Impact of Invisible Injuries

Helping Your Family and Children

The injuries of war change the lives of service members, families and children. Invisible injuries such as posttraumatic stress disorder (PTSD) or mild traumatic brain injury (mTBI) can be especially difficult for families because they often result in significant changes in personality and behavior without changes in one's appearance. A service member with PTSD or mTBI may have mood swings, or certain environments may trigger responses that do not seem appropriate to the situation. These kinds of events can be especially troubling for children, and embarrassing for the family. While injuries cannot be compared or judged, invisible injuries, unlike those that are visible (e.g., loss of limb, burns), do not invite the same level of support from outsiders who may not even realize someone has a medical problem. The isolation caused by invisible injuries creates additional stress for families and children.

This fact sheet addresses the impact of the invisible injuries of war on military families and provides some action steps that families can take to manage the challenges of dealing with a parental injury that is not visible to the outside world.

Children's Reactions to Parental Injuries such as PTSD and mTBI

Children may start to have symptoms that mirror those of their injured parent. An example might be a young child having nightmares because of their parent's nightmares. A child may have trouble paying attention at school or exhibit new behavior problems because he or she is thinking about the parent's problems. This impact on a child due to their worry about their injured parent is sometimes referred to as secondary traumatization. A child's symptoms can get worse if there is not a parent who can acknowledge the effects of the parental injury and communicate with their children to help them feel better.

PTSD and TBI are among the invisible injuries of war. Invisible injuries often do not invite the support given to visible injuries.

If children show some of the signs and symptoms below, they may be in distress and need professional attention.

- Increased acting out behaviors, such as disobedience, tantrums, or risk-taking behaviors
- Emotional distress, such as crying, increased anxiety, or withdrawal
- Feelings of loss and grief related to the change in the injured parent
- Feelings of isolation
- Feelings of embarrassment about the injured parent's appearance or behavior
- Misinterpreting parent fatigue and withdrawal as indicators that the parent no longer loves them
- Feelings of anger or resentment about new responsibilities or changes in the family such as having to care for younger children or sharing in taking care of the injured parent
- Feelings of self-blame for the injured parent's irritability

Families Can Help their Children to Understand the Injury and to Cope

It is important for families to:

1. Seek out resources and instrumental support. Basic needs of families may be compromised due to the injury. Family and individual needs such as finances, medical care, military concerns, housing, education, and child-care often need to be discussed. Children may need special services or supports to address behavioral or mental health problems. Community resources that may help them are sports organizations, educational programs, and scouts. Organized activities provide them with support and structure.
2. Support children by helping them monitor changes or extremes in their emotional states. As children deal with stress, they may find it difficult to express emotions, to relax, or to calm themselves. Parents can help children by teaching them to label and express their emotions and by giving them specific strategies (such as consciousness of their breathing, muscle relaxation, or visual imagery).
3. Share information with children about the injury in a way they can understand. Particularly important is information that helps children understand what the injury is, the effects of the injury are in terms of parent functioning and what to expect over time. Children may need reassurance that the injury is not their fault.
4. Discuss the injury as a family and with health care providers. Age-appropriate information should be provided to children and they should be encouraged to talk about what they are experiencing and feeling. Children

should be encouraged to ask questions about the injury among family members and with service providers and encouraged to talk about the injury with people they trust (e.g., other family members, close friends, and teachers).

5. Help children develop problem-solving skills and engage in cooperative goal setting. Goal setting helps families identify how they would like things to be different and how to monitor change. Parents and children can select family goals together and practice them as they plan for future challenges. Goal setting also helps to recognize incremental improvements over time.

Resources

- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
<http://www.dcoe.health.mil/default.aspx>
- Defense and Veterans Brain Injury Center
<http://www.dvbic.org>
- Military OneSource
www.militaryonesource.com

Families can take steps to manage the challenges of an invisible parental injury.

Reintegration and Intimacy

The Impact of PTSD and Other Invisible Injuries

Reintegration is about more than coming home. It is about establishing or resuming relationships that provide pleasure, comfort and support. Intimacy — the capacity to enjoy closeness — is an important part of reintegration whether a service member is single, married or married with children. Intimacy enhances personal health, relationship health and family health.

Many service members returning from deployment will experience what are referred to as invisible injuries. Invisible injuries include posttraumatic stress disorder (PTSD), mild traumatic brain injury (mTBI), depression and anxiety that can result from combat exposure. Sometimes alcohol, tobacco and drug misuse, as well as impulsive or violent behavior can compound these conditions. All of these problems can compromise intimacy reducing one's ability to enjoy pleasurable relationships and sexual activity. Addressing these problems as soon as they occur can lead to more rapid post-deployment adjustment and happiness for the service member and the family.

Intimacy and You

The symptoms of PTSD (described below) or the conditions mentioned above may make it more difficult for couples to reconnect. Differences in partners' needs and desires for intimacy can over time lead to frustration, rejection, conflict or withdrawal.

- PTSD symptoms (often expressed as recurrent nightmares, avoidance of thoughts, feelings or people/social situations, jumpiness or feeling constantly on guard) often interfere with the ability to experience emotional connection or closeness.
- These symptoms can interfere with one's ability to 'let go', thus reducing the pleasure of sexual release.

Intimacy enhances personal health, relationship health and family health.

- When service members feel in some way changed for the worse by their war experiences, they may find it hard to share themselves in intimate, physical relationships or they may worry that they will pass on this negative change to their partner through intimacy.
- Medication used to treat PTSD, depression and anxiety can decrease sexual desire or sexual functioning for some period of time.

In Contrast:

- Some returning service members may experience sexual urgency, or the need to engage in overly frequent or intense sexual behavior driven by a need to seek a high or rush similar to the emotions evoked by life and death combat situations.
- Others may be sexually controlling, focusing on sex rather than their partner's emotional needs, or engage in practices atypical of pre-deployment (e.g. pornography). In such cases, sexual stimulation takes priority over emotional intimacy.
- Those with mTBI may behave in a less controlled manner or evidence behavioral or personality changes that make them seem very different or even frightening to their partners.

Partners may also Contribute to a Lack of Intimacy

- Some may experience low sexual desire due to not feeling emotionally close to their returning partner, feeling angry at having been left alone for so long, or over burdened by their responsibilities. Partners with reduced sexual interest who engage in sex to keep peace may communicate that sex is simply a chore.
- Others who engage in sexual activities despite a lack of interest may be doing so to help bolster a partner with PTSD or depression.
- Partners may be confused when a service member with PTSD or other invisible injuries may alternate between sexual disinterest and sexual urgency. They may try to cope or escape by becoming overly focused on children, church or other activities.

Quickly addressing problems of invisible injuries as well as harmful behaviors like excessive smoking and substance abuse can lead to more rapid post-deployment adjustment and happiness for the service member and the family.

Physical Injury and Intimacy

Managing Relationship Challenges and Changes

The injuries of war are life-changing events for service members and their families. One important area of change frequently not discussed is how physical injuries affect emotional and sexual relationships. The impact of injury on sexual performance is an important issue that is part of one's recovery and likely to become more critical over time.

Physical war injuries include mild to severe traumatic brain injuries (TBI), spinal cord injuries leading to different levels of paralysis, amputations, burns, disfigurement and others injuries with potentially lasting effects. Emotional disorders such as depression, anxiety, posttraumatic stress disorder (PTSD), misuse of alcohol, tobacco and drugs, even violent behavior can also accompany physical injury. Each and/or any of these conditions occurring together compromise intimacy — the ability to engage in and derive pleasure from emotional closeness and sexual activities.

This fact sheet describes key areas of concern around physical injury and intimacy, and provides tips for improving intimacy in the context of a changed relationship. Experts in trauma have prepared this fact sheet to communicate useful information to and hope for our nation's wounded warriors and their families.

Physical Limitations that Affect Sexual Functioning

Despite the reality that some injuries, by their very nature, make it difficult or impossible to engage in the same level of sexual activity as before the injury, a satisfying sex life is still possible. Although many people report a decline in sexual activity following a severe injury, over time sexual activity usually increases again. Couples who reestablish a satisfying sexual relationship do so by:

War injuries can compromise intimacy, but a satisfying sex life is still possible.

- Understanding that sex is more than just intercourse
- Redefining the goal of sexual activity as mutual pleasure and expression of love rather than erection and orgasm
- Developing greater variation in their sexual activities
- Experimenting and communicating with their partner about what is pleasurable

Managing Pain

Pain can interfere with the enjoyment of physical affection and intimacy. Both the injured and his/her partner may hold back because they are fearful of causing pain. Medications used to manage pain can affect sexual desire and sexual performance. Discuss such issues with your doctor who may consider adjusting the medications to decrease sexual side effects.

Helpful Strategies to Overcome the Challenges of Pain Include:

- *Communication:* Partners need feedback from the injured person about what is and is not comfortable
- *Consultation:* Occupational or physical therapists can suggest other ways to enjoy sex that reduce the likelihood of pain
- *Timing:* Try planning time together when pain is diminished
- *Creativity:* Explore activities and positions that put less stress on painful areas

Traumatic Brain Injury (TBI) and Intimacy

The brain regulates many aspects of sexuality. Even slight damage to these areas can affect how sexual urges are expressed and how the sexual organs will work. Some people with a TBI seem pre-occupied with sex, speak about sex at inappropriate times, or demonstrate inappropriate sexual behaviors, often without realizing they are making others uncomfortable. They may appear to have greater sexual drive than before, but it is more likely that the part of the brain that helps us hold back or inhibit impulses and urges has been damaged. Responding to inappropriate behaviors in a firm and consistent manner can help improve the situation. These issues can also be addressed with medications, behavioral programs, and counseling.

In some cases TBI leads to apathy and passivity, resulting in seemingly less interest or motivation to engage in romantic or sexual activities. In addition, personality change, childlike behavior, and injury-related changes in judgment can lead to role changes within the couple that make it difficult for the non-injured to see the injured as a romantic partner. It is important for partners to understand the reasons for such changes so they do not misinterpret the behavior as lack of caring. The partner may need to initiate

romantic activities. In many cases, an expression of interest from the partner is all that is needed to engage the injured person's interest.

Self-Image

A physical injury can affect one's self-image in a number of ways. An injured person may believe that he/ she is no longer attractive, or worry that a partner will be "turned off" by the injury. When an injury changes the way a person is able to be sexually intimate, he/she may feel ashamed or question their identity as a man or woman. Communication is key in overcoming self-image barriers. Talking about these concerns with a partner provides an opportunity for couples to reassure each other and offer support.

Some couples find it particularly challenging when the injured person is dependent on a partner for help with wound care, hygiene, or mobility. When couples feel their relationship is primarily one of care giving, it can be difficult to relate to each other as romantic partners. When a body part is amputated or becomes nonfunctional, it is a loss. An injured person may need to take time to mourn for the loss in order to be ready to move forward.

Making time for romantic activities is important. This may require some extra planning. Some couples find it helpful to have another person take over the care giving activities in preparation. Others find ways to combine romance and care giving. Creativity can help couples find solutions that work for them.

Tips for Improving Intimacy

Reestablishing intimacy after a physical injury is sometimes compounded by stress and/or stress related disorders rather than the physical disability. Posttraumatic stress disorder, depression, anxiety, and alcohol and/or drug misuse interfere with one's ability to enjoy emotional and physical expressions of intimacy, including sexual activity. Here are some tips to improve relationships affected by stress.

- Find nonsexual ways to feel close
- Take time to work on building your relationship by spending time together doing things you both enjoy
- Talk about your feelings, hopes, and desires with your partner at a time when you are both calm and ready to listen
- If your partner needs more time and space, respect that need
- Depending upon energy level and emotional availability, schedule intimate opportunities for times when both of you are more likely to be available and ready to participate
- Get treatment for PTSD, depression, substance misuse, or any other problem that appears to be getting in the way of your relationship

- If medication for depression, anxiety, or PTSD appears to be the problem, talk to your doctor

Resources

<http://www.vetcenter.va.gov/>

http://www.vetcenter.va.gov/Military_Sexual_Trauma.asp

<http://www.militaryonesource.com/>

<http://couragetotalk.org>

Powerful Movies, Powerful Memories

Viewing Advice for Family and Friends of Military Members

Movies depicting war, especially those that include live footage from recent or ongoing events, can be very powerful, but they can also evoke powerful feelings. The public is at once fascinated and distressed by traumatic events that occur on one's soil or elsewhere around the globe. In addition, the fact that many of these events are historic, or that we know individuals who have been or continue to be affected, often creates a sense that we should watch these intense media productions.

The indirect exposure to traumatic events through watching movie and television accounts can be difficult and in some rare instances result in discomfort, distress and more serious psychological consequences. Even those movies and documentaries with favorable reviews can stir powerful memories and emotions that can be accompanied by transient or more long-term anxiety and stress. Each individual and each family should determine their own comfort zone regarding whether to watch or not watch certain movies and television documentaries. This fact sheet provides some guidelines and tips for individuals and families who may want to watch these movies, and for those who decide not to watch.

Many recent movies have received critical acclaim for their moving portrayals of service members. If you have a loved one who is deployed to the conflicts in Iraq or Afghanistan or one that may soon deploy, you may be both interested in and worried about watching such movies. While these films highlight heroism and action, they also may graphically depict the ravages and anguish of war. Viewing these films may stir powerful emotions for both military members and their families. These emotions can range from sadness, worry, fear and anxiety to actual pain and flashbacks. This fact sheet

Viewing war movies may stir powerful emotions for both military members and their families.

offers some points to consider about the possible effects of such viewing. For example, “Should I watch it and, if so, when, and with whom?”

Before Viewing

- First, remember, you do not have to watch the movie, or do not have to watch it right now.
- Consider whether watching the movie now might cause you to worry about things over which you have no control. If so, waiting until a later date may make more sense.
- Consider watching the movie after reading more about what is in the movie. A review in your paper or on the web may help you decide. If you have concerns, watch the movie at a later time.
- Consider recording the movie to watch in the day time rather than the evening.
- If you are watching the movie with someone who has been to this or another war, remember some deployed persons feel they just cannot explain the situation or show their feelings during a movie.
- Therefore, you may want to watch with a friend. It is often helpful to have a friend who understands your family’s experiences and is available to talk with during or after a movie that stirs powerful emotions or memories.
- If your spouse or loved one has been deployed to this or another war, chooses not to watch with you but still wants to watch the movie, encourage him or her to watch with a buddy.

While Viewing

- Talking to another adult during the movie can break the spell of the movie and remind you that you are home or with friends and you or your family member is not in the scenes you are watching.
- Get up and move around during the movie. This can lessen tension.
- Changing your normal viewing position, or watching from a distance, can help to remind you that it is only a movie.
- If you feel yourself becoming overwhelmed by your emotions during the movie, turn it off or walk away. You can always watch the rest at another time.

After the Movie

- Talk about your feelings. If your spouse has returned from this deployment or another, they may need to express their feelings first. But talk with someone — your spouse, significant other, close friend or a parent.

- Talking about strong emotions can be difficult, but it is often a good first step in reducing distress and restoring a sense of normalcy.
- If talking is not working or you cannot find someone to talk to, consider your physician, your clergy (either civilian or military) or contact your local community behavioral health clinic. Medical caregivers, counselors and clergy are trained to assist people in stressful situations.

Children, Movies and Deployment

- Graphic movies are not appropriate for young children (under the age of 12 or 13).
- If you have a loved one deployed to war or in some other dangerous situation, these movies may not be helpful for your family or children of any age.
- War movies are not appropriate for young children and may not be appropriate for older children (e.g. those with a history of emotional problems or traumas, or those that are less mature).
- Remember that in children intellectual maturity is not the same thing as emotional maturity. So, monitor your children's responses.
- Remember that scenes from these movies may increase children's fears and worries rather than teach them about this aspect of their parent's lives. Children may only see the frightening scenes. These scenes may hold extra meaning for children whose parents have deployed, or may deploy. At times of a recent deployment, the child may hold onto these fears.
- Hearing the soundtrack, even if not seeing the video, can be frightening for children. Adults watching these movies should ensure that children do not overhear the soundtrack — which may be particularly frightening.

Seeking Help

- Families want to understand the life of their loved ones and share their joys and sorrows. Sharing the life of a soldier, sailor, marine or airman brings you closer to their fears and joys. Hearing how they may feel after watching movies such as this can be stressful, but also can bring families together.
- To help your loved one, you must also take care of yourself.
- You can (and should) discuss your thoughts about watching the movie with your physician if you have concerns before watching. Of course, you should also let your doctor know about any changes in mood, concentration, or sleep that you notice if you choose to watch. Seeking help for emotional issues related to deployment or reintegration into family

life and one's routine is a positive step, and one that may occur as a result of watching these movies.

Graphic movies are not appropriate for young children.

FAMILY HEALTH ISSUES

Asking for Help *Do You Know How?*

For many people, asking for help is not as easy as it sounds. Yet, not asking for help, or asking too late, can turn a manageable situation into something more serious, which ultimately may require more care, and therefore more time. Not asking for help or asking too late can affect not just one's health and well-being, but also that of the family, especially children.

Asking for help is something we are taught from a very young age. We learn to ask politely, communicate what we need, and then say "thank you" once help is given. As we get older, asking for help is often confused with or feared as a personal weakness or vulnerability. In fact, asking for help is most often viewed as a sign of strength and good judgment.

The stress of deployments, single parenting, family reintegration and changes in family routines due to separations or the injuries of war make asking for help an important skill for service members and military families. This fact sheet provides four simple steps involved in asking for help as well as some reminders on how to ask for help.

Using these steps and reminders will enable you to engage individuals and a multitude of available resources for health and mental health care, financial advice, spiritual support and many aspects of everyday life (child-care, school and community services) that can be of benefit to you and those you love.

Asking for Help: Four Simple Steps

1. *Accept:* This is perhaps the most important step. Acknowledging the need for assistance is important, but equally important is the willingness to accept help. Being able to freely ask for help requires accepting limitations and believing that you are truly deserving of the help.
2. *Assess:* Take the time to think through exactly what you need. This allows you to think about what is 'most important' and help shape your request.

Asking for help is most often viewed as a sign of strength and good judgment.

Most people will be willing to help when you ask. Help them by being specific on how they can help.

3. *Ask!*: This is your time to take action and where you make the request! Remember, in-person requests are best, but not always possible. Being courteous, direct, and specific regarding the request are also parts of the rules.
4. *Again*: As with any skill, it requires practice. So, if it helped, do it again! A nice final touch would not only be to thank the person, but also to share about how much he or she has helped.

Reminders

- *Be resourceful* — Think about who may be able to help (even those who might say no).
- *Be courteous* — Asking nicely goes a long way. Most people are willing to help with both big and small tasks. Always say, “thank you,” whether they agree to help you or not.
- *Be specific* — Most people are willing to help, they just have to know ‘how’. Being specific allows for best results. It helps others understand how they can best help you. Remember, you are in the position of knowing what you need. Others can’t read your mind.
- *Be flexible* — Your plan of how others can help may not be the only one. If different ways to help are suggested, take time to consider these.
- *Be grateful* — Most important for completing the cycle of asking is to say “thank you.” This recognizes another’s contribution and strengthens the relationship (just in case help is needed again).

Just as with any skill, ‘asking for help’ gets easier the more you practice it. Remember — asking for help is a sign of strength. Being able to identify needs and act accordingly are essential for being successful. In many ways, asking for help has many benefits. It can make life easier for you and your family, and give the individual who helps you a sense of accomplishment and goodwill.

How Can I Get Him to Seek Help?

Talking Points for Women

Women can play a key role in encouraging men to seek help for health problems. It is often a wife or important female (girlfriend, mother, sister or aunt) who is the first to notice changes in their loved one's behavior or appearance. These changes may signal a health or mental health problem, or both.

Many service members have been involved in multiple deployments and some have returned with posttraumatic stress disorder, depression, and drug and alcohol misuse. The number of suicides has increased. Physical injuries include traumatic brain injury and war-related injuries such as burns, amputations and wounds.

Men are often reluctant to seek out healthcare services, especially for emotional problems and depressive symptoms. As a result, many men are living with serious health issues that affect their well being and the well being of their families and children.

Talking to a loved one about seeking help isn't always easy. How do you talk to someone about changes in their behavior (anger, withdrawal or risky behaviors such as reckless driving, alcohol and drug misuse), and how do you get them to seek professional help?

When talking to your loved one about seeking help, emphasize:

1. The Role of Outside Events

When talking to your loved one about seeking help, point to the *outside factors* that may have contributed to what you are seeing or to your loved one's symptoms. Men may be more willing to acknowledge a problem in terms of outside events rather than as an illness.

Talking Point

"I've noticed that you are not yourself lately. You are more irritable, withdrawn and seem sad a lot of the time. Given what you have been through — multiple deployments, combat stress and adjusting to being back, it's understandable, but the kids and I are concerned, and we want you to feel better."

2. Help Seeking as a Strength

Many men are concerned that seeking help means they are weak, dependent, and they worry “what will others think of me?” Talk about seeking help as a sign of *superior judgment*, good decision-making and involving collaboration.

Talking Point

“This has lasted a long time —restless sleep, jumpiness, anger. Seeing someone at the clinic would be a good idea and probably the best thing you can do at this time. I know you and the doctor can work together to help you feel better.”

3. One’s Obligation to Stay Healthy

Duty is part of military life and culture. Discuss health seeking as fulfilling one’s duty to self and important people in the service member’s life — family, children and comrades.

Talking Point

“I know that you are ‘getting by’, but by getting help, you can be doing that much better! By taking care of yourself, you are taking care of our family. We both have a duty to stay healthy for each other, for our work and importantly, for our children.”

Remember, women can play an important role in encouraging men to seek help. Here are two approaches that may reduce the stigma many men attach to seeking medical care. When you talk to him, it may be helpful to:

- Describe whatever changes you are seeing as likely due to external events such as the stresses of deployment,
- Talk about help seeking as a sign of courage, good judgment and an obligation or duty to one’s self, family, friends and one’s job.

Resources

Real Warrior: Resilience, Recovery, Reintegration

<http://www.realwarriors.net>

Contains information on psychological health and traumatic brain injury for service members including Guard and Reserve. Features real stories of service members who have sought and received help.

Militaryonesource

www.militaryonesource.com

Features comprehensive information on all aspects of military life and health, and an 800 24/7 helpline for all services and their families.

Military Families on the Move

Tips for Keeping Your Family Healthy

Moving is a stressful event and can be especially difficult for families when service members are deploying or returning from deployment. Part of your checklist before and after a move should be item that help you attend to your family's health care routines and needs.

With so many details demanding your attention — packing, scheduling movers, cleaning your home, saying goodbye and getting resettled — it is easy to forget your own or your family's medical needs. Equally important is being prepared for any health emergency while in transit should there be unexpected delays or occurrences.

Here is some practical advice to make your transition go more smoothly.

Health Care Tips as You Prepare to Move

- Take advantage of all briefings related to your new location such as medical and dental insurance information, TRICARE, and medical care en route to your new station.
- Request a summary of your medical records and any important medications that your family members take. Ask for extra refills of any important medications that must be taken regularly. This is especially important if you use civilian primary care managers.
- Medical records, birth certificates, immunization records, social security cards, passports, naturalization papers and adoption papers (if necessary), school records and copies of orders are all important documents to take with you rather than ship.
- Set up support services in advance. For children with special needs, call ahead and obtain information on services available at the new location.
- Resume routine health care as soon as you arrive at your destination,

Moving is a stressful event and it can be especially difficult for families when service members are deploying or returning from deployment.

especially if anyone is pregnant or you have infants or young children.

- Become familiar with disaster or emergency issues of importance in your new location (i.e., living in an area prone to hurricanes or earthquakes). Disaster preparedness enhances family safety and health.
- Attend to the healthcare of household pets and make sure they have the required vaccinations for your move (some states require special things).

Arriving in Your New Community

- Write down and bring to your first doctor visit any health-related questions or concerns about yourself or a family member to help your new doctors and nurses understand your needs.
- Recognize the normal stress of moving, but communicate any unusual or prolonged symptoms such as difficulty sleeping, loss of appetite, problems concentrating, or not enjoying things that normally give you pleasure.
- Seek out help if you or a family member is at risk for substance abuse or family conflict that often start or worsen as the result of stressful events. Resources are available for you and your family.

Staying the Course

Following Medical Recommendations for Health

While we often look to our doctors and our health care system to take care of us, we have the most important role in this process. Doctors may provide advice: starting a diet to lower cholesterol and weight, getting a yearly mammogram, having a stress test or taking a prescribed course of medication. How many of us have stopped taking medication without consulting our doctor because we began to feel better? It may not have occurred to us that being on the medication is why we are feeling better, a sign that the medication is working. How many of us have stopped taking medication because of unpleasant side effects that we did not share with our doctor? As a result, our doctor was not able to prescribe something else and we may be compromising our health. How can we build a good and trusting relationship with our doctor that supports our health, and helps us stay the course? Here are some tips and advice for achieving both.

Prepare for Your Visit

- Write down your questions and list your symptoms in advance. Bring this list along with a pen or pencil to jot down answers and take notes.
- Provide your physician with a list of all your current medications including the strength and dosage.
- Bring a family member, friend or interpreter (if language or hearing is a problem) to help you process the information and for support.

Communicate Openly with Your Doctor

- Express your concerns and needs. Worry and concerns over side effects and sensitive topics, like sexual functioning and weight gain, are points your provider is ready to discuss.

We have an important role building a relationship with our doctor.

- Ask for clarification. If you do not understand something, do not hesitate to ask again, or ask to have your doctor write it down.

Request a Treatment Suitable for Your Lifestyle

- Think of anything that might present a barrier to following whatever is prescribed (e.g., need for additional medical screening, a health plan, or another medication).
- If you have trouble swallowing a pill, ask if it comes in liquid. If you tend to be forgetful or work in an environment not conducive to taking medication, ask if a medication comes in time-release capsule or less frequent dosing.
- Utilize your doctor's resources (e.g., does your doctor have a nurse practitioner or case manager who is readily available via telephone?).

Reinforce good health habits for your entire family

- Your health behavior is an example to your children. Explain the importance of washing hands, covering one's mouth while coughing, eating to maintain healthy weight and nutrition, and the importance of incorporating these behaviors into your daily routine.

Your health behavior is an example to your children.

Family Planning for Disasters

How to Plan For and Protect Your Family's Health

Major events such as Hurricane Katrina make us think about the impact of such disasters on our family and loved ones and how prepared we would be. Whether we live in areas that are vulnerable to certain natural disasters, we all need to plan for the kinds of disasters, including terrorism, bioterrorism or pandemic threats, that could require us to evacuate our homes. This fact sheet provides information on three aspects of family preparedness planning for disasters. The first pertains to the special health needs of your family. The second involves specific tips around evacuation. The third provides steps for creating a family communication plan.

Health Concerns to Consider in Disaster Planning for Your Family

- Do you or any of your family members have medical conditions that require medication, special medical equipment or diets?
- What might you or members of your family need to do about these health issues in an environment away from home?
- Family members spend a significant portion of the day away from home. Have you communicated your family members' health issues to their supervisors, teachers, or day care professionals?

Steps Families Can Take to Prepare for Disasters around Health Issues

During disasters, health medications and health supplies may be temporarily disrupted.

- At home, have an extra supply of medications available.
- Away from home, provide instructions and training (if possible) to a primary caregiver who would be responsible for your family member at the time of a disaster.

How prepared would we be in the event of a major disaster?

- If that caregiver expresses reluctance or discomfort to administer help, have them identify a person within that environment who would be able to provide assistance with such procedures as injections or other medical requirements.
- Make sure adult children away from home, such as college students, are prepared. Make sure elderly members of your family are also prepared.

Evacuation Planning

Having a prepared plan for evacuation can save valuable time.

- Have a 'ready to go' kit. Essential items include extra water, food, batteries, first aid kit, a flashlight, wind up radio, contact numbers, and medications.
- Plan ahead for family pets by contacting area shelters and have provisions stored for self-care if possible.
- Determine a planned evacuation destination. This includes knowing the location or numbers to call to get such information, having maps, and knowing alternate routes.
- Have at least a half tank of gas in your vehicles at all times. This can be a time saver and help families leave immediately.
- Turn off the gas and water to your home, if possible, prior to evacuating. Remember to call the gas company to turn back on the gas once your family returns.

Family Communication Plan

A good communication plan is essential in disaster planning and evacuation. Knowing where your family is or how to locate them are critical factors for reducing anxiety. To create a disaster communication plan, families must:

- Establish a primary contact and number (preferably a relative or friend in another part of the region or out of state) who family members can call in case of emergencies.
- Every member of the family should know this number.
- In the event that family members are separated, it is also important that daycare, work, school, and neighbors know this number.
- Prepare a list of phone numbers where each family member can be reached during the day. Include a list of relatives, friends and business associates that would or should know your whereabouts in case of emergency.
- During disasters, phone communications may be disrupted. Provide an alternative means for making calls, such as a special 'emergency' calling

card or cell phone. Other vehicles of communication are important such as the Internet, e-mail communication, and HAM radio. The Red Cross is also a resource to help contact loved ones.

- Leave a note at your residence to let others know where you are and how you can be contacted.

Involve Your Entire Family in the Planning and Practice

- Select a time and conduct your own family emergency drill. A good time might be around a family or national holiday.
- Make it fun. Consider asking young children to help create the 'ready to go' kit, including favorite foods with long shelf lives.
- Instill in family the importance of disaster planning as a way to alleviate anxiety, foster family cohesion and be a responsible citizen.

Helpful Web Links:

<http://www.ready.gov>

<http://www.fema.gov/kids/>

<http://www.redcross.org/>

We need to plan for disasters that could require us to evacuate our homes.

Restoring a Sense of Well-Being in Children After a Traumatic Event

Tips for Parents, Caregivers and Professionals

Children are often exposed both directly and indirectly to violence such as school shootings. Many will live in close proximity to a tragic event while others will learn about it through the media or from their parents or friends. Parents and caregivers will need to answer children's questions and reassure them about their safety.

Communicate effectively with your children

- Keep your statements simple, factual, clear and sensitively worded.
- Do not overwhelm children with too much information.
- Children may have ideas or beliefs that are difficult to know unless you ask them what they have heard and what they have questions about.
- Children will get information from other children and adults and from the media. Make sure that your children do not misunderstand this information by asking them what they have heard.

If children are anxious or fearful, let them know that you understand and will help them with their feelings.

- Children's distress responses may be based on a different event. Inquire what their distress is about.
- Distress in such situations is usually very transient. If children's distress persists, seek help from a trusted provider such as their pediatrician.
- Some children may act out as a reaction or may become very quiet. Talk to your child about what is troubling them and not punish or reprimand them for their reactions, but help them to understand that talking may help.

Children are often exposed both directly and indirectly to violence.

A common question is “Why do these things happen?” Here are some possible responses.

- We usually cannot be sure what led a specific individual to act in such a way.
- Such events can result from many causes including mental illness, rage, extreme political or religious beliefs, and hatred.
- Do not stigmatize groups of people who fall the same or a similar demographic group as an alleged offender.
- Help children understand that government authorities work hard to identify and stop dangerous events before they happen.

You can increase your child’s sense of safety by:

- Knowing their whereabouts, who they are with and when they are to return home.
- A clear method of communication in normal and emergency situations (e.g. cell phone and a meeting place if you cannot communicate with each other).
- Keeping them away from places or situations that are likely to put them in danger.
- Being aware of community changes about risks that might surface.

How do you plan for an emergency?

- Discuss possible emergency situations with your children.
- Talk calmly with them about what they can do if they feel they are in danger.
- Instruct them to trust and seek help from police and other authorities.
- Tell your children to say something to an adult when they see something suspicious.

Online Resources

If you have any questions about your child’s health or response to a traumatic event you can seek professional advice from a community primary care or behavioral care provider or review additional resources at the following sites:

- Center for the Study of Traumatic Stress — www.cstsonline.org
- National Child Traumatic Stress Network — www.ncstn.org
- American Academy of Child and Adolescent Psychiatry
— www.aacap.org
- American Academy of Pediatrics — www.aap.org

- American Psychiatric Association — www.psych.org
- American Psychological Association — www.apa.org
- American Red Cross — www.redcross.org

Parents and caregivers will need to answer children's questions and reassure them about their safety.

Caring for Your Family During Flu Season

Public health emergencies, such as flu epidemics, create a call to action for individuals and families to take responsibility for their health. The public is a key partner in addressing public health crises that affect national and international communities. Because health crises impact national security, the health and resilience of our military (its fighting forces as well as families and children) are very important.

Families have a responsibility to protect the health and safety of children of all ages in times of health emergencies and disasters. Flu viruses are extremely unpredictable and variable. While leaders in science, medicine and government closely monitor and seek to find solutions to disease outbreaks, the best way to protect oneself and one's family is through practicing common sense, basic hygiene, staying informed, and following recommendations over the course of the crisis. Here are some important tips for your family's health and safety during a public health emergency.

If you are a mom or dad, grandparent or caregiver, here are some important things you should know about caring for your family during the flu season.

Facts about the Flu

What is the flu?

The flu is a contagious respiratory infection caused by the influenza virus. It can cause mild to severe illness and can result in death.

How is the flu different from a common cold?

With colds, one rarely gets fevers, headaches or experiences extreme fatigue. With the flu, all of these symptoms can be present of the flu.

When and how does the flu spread?

Flu season is generally from November through March. It is spread

The flu is a contagious respiratory infection. Flu epidemics, create a call to action for individuals and families to take responsibility for their health.

through coughing, sneezing, and touching, such as a door knob, stair railing or phone. People with the flu are contagious before their symptoms start and up to 7 days after symptoms appear.

What are the symptoms of the flu?

The flu starts suddenly and may include some of the following:

- Fever (usually high)
- Headache
- Tiredness
- Dry cough
- Sore throat
- Runny or stuffy nose
- Body aches
- In children, sinus infections, ear infections and stomach symptoms (diarrhea, vomiting, nausea) can occur

Everyday Steps to Protect Your Health (Tips to Avoid Getting the Flu)

This is a good time to teach or remind children about good health habits that can last a lifetime.

- Cover your nose and mouth with a tissue when you cough or sneeze
- Wash your hands often with soap and water for 15-20 seconds, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective
- Avoid touching your eyes, nose or mouth. Germs spread this way
- Try to avoid close contact with sick people
- If you become ill, stay out of work or school until you are without fever for a minimum of 24 hours
- Healthcare workers and visitors should stay away from healthcare settings for 7 days from onset of symptoms or until symptom free – whichever time period is longer.
- Avoid close contact with people who are sick, and do not expose others to you or your family if sick.
- Avoid touching your eyes, nose, or mouth.

Make a Kit for School

You may want to assemble the following items to put in your child's backpack or lunchbox to reinforce good health habits, especially during flu season. Make sure your child's school permits such items taken into the classroom. You can put these items in a plastic zipper bag.

- *Tissues.* Different brands come in small sizes. Many have colorful, fun

designs that boys and girls will like and enjoy using.

- *Anitbacterial moist towelettes.* Different brands come in small sizes that can be opened and resealed.
- *Small plastic bottles of sanitizing gel.* Children can rub this on their hands; it dissolves, cleans and requires no tissue or towels.
- *A smaller plastic zipper bag inserted into the larger bag.* Children can put their used tissues into this and seal it. This avoids the spread of germs of tissues thrown into open wastebaskets.

Emergency Warning Signs of the Flu. If your child exhibits any of these symptoms, call your doctor immediately:

- Fast breathing or trouble breathing.
- Bluish skin color.
- Not drinking enough fluids.
- Not waking up easily or not interacting.
- The child being irritable and not wanting to be held.
- Flu-like symptoms improve, but then return with fever and worse cough.
- Fever with a rash.

What Should I Do if My Child Gets the Flu?

- At the first sign, keep your child at home. Sending a sick child to school puts others at risk for getting sick.
- Call your doctor for advice on medications. Adding over-the-counter medications can cause complications.
- Stay home or provide child care for a sick child. Do not leave your child alone.
- Make sure your child gets plenty of rest and drinks lots of liquids.
- Be familiar with your school district's rules on returning a child to school after the flu.

Be Prepared and Take Care of Yourself

Many parents are coping with other issues at home and at work. Such situations add to additional stress and fatigue when illness strikes. Do not be shy about asking for help from friends or family. *Better yet, be prepared!* Stock up on canned soups, fruit juices, and freeze breads and meats so that in the event of illness there will be enough food in your home.

Family Health and Communication

- Keep up with your regular health routines, such as annual check-ups.

- Military families are often on the move. If your move coincides with disease outbreak, make sure you know the location of a doctor or clinic at your new location. Be sure you know of ways to access health care along the way to your new destination.
- If you or your family members regularly take medications, make sure you have an extra supply on hand.
- Establish an emergency family communication plan, such as a primary contact and number (preferably a relative or friend in another part of the region or out of state) who family members can call in case of emergencies. Every family member should know this number.
- Have a 'ready-to-go' kit that includes items include water, food, batteries, first aid kit, a flashlight, radio, contact numbers, and medications.

Involve Your Children

- Schools are a very good source of health information and education. Make sure to read your children's school resources and any specific school recommendations and emergency plans.
- Educate your children on family about health habits that can help during a public emergency.
- Provide extra support to children with special needs during such times to ensure they are protected.
- Remember to plan for childcare in the event of school closure; this may mean taking leave or finding alternate care plans.

Stay Informed

Having a reliable and regular source of information (newspaper, radio, television news, website) is important during a public health crisis. Updated recommendations regarding travel, self and family care, and prevention may impact your planning and that of family members. There are several reliable and well-established sources of information that are updated regularly:

Resources

- Call 1-800 CDC-INFO for more information or visit the following web site, which is updated regularly:
www.cdc.gov/flu
- American Red Cross:
www.redcross.org
- Local American Red Cross chapter:
www.redcross.org/where/chapts.asp

Public Health Emergencies

The Role of the Military Family

Public health emergencies, such as flu epidemics, create a call to action for individuals and families to take responsibility for their health. The public is a key partner in addressing public health crises that affect national and international communities. Because health crises impact national security, the health and resilience of our military (its fighting forces as well as families and children) are very important.

Families have a responsibility to protect the health and safety of children of all ages in times of health emergencies and disasters. Flu viruses are extremely unpredictable and variable. While leaders in science, medicine and government closely monitor and seek to find solutions to disease outbreaks, the best way to protect oneself and one's family is through practicing common sense, basic hygiene, staying informed, and following recommendations over the course of the crisis. Here are some important tips for your family's health and safety during a public health emergency.

Basic Hygiene

Everyday things you and your children need to do to stay healthy:

- Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Wash your hands often with soap and water, especially after you cough or sneeze (alcohol-based hands cleaners are also effective).
- Wash hands after coming home from public places such as a mall, the movies, and playgrounds.
- Avoid touching your eyes, nose or mouth. Germs from others spread to you that way.

Public health emergencies such as flu outbreaks present opportunities for families to review and practice good health habits.

Avoid Close Contact with Sick People

- Influenza spreads mainly person-to-person through touching, coughing or sneezing of infected people.
- If you feel or get sick, stay home from work or school and limit contact with others to keep from infecting them.

Stay Informed

Having a reliable and regular source of information (newspaper, radio, television news, website) is important during a public health crisis. Updated recommendations regarding travel, self and family care, and prevention may impact your planning and that of family members. There are several reliable and well-established sources of information that are updated regularly:

- Centers for Disease Control and Prevention: *www.cdc.gov*
- American Red Cross: *www.redcross.org*
- Your local American Red Cross chapter: *www.redcross.org/where/chapters.asp*

Family Health and Communication

- Keep up with your regular health routines, such as annual check-ups.
- Military families are often on the move. If your move coincides with disease outbreak, make sure you know the location of a doctor or clinic at your new location. Be sure you know of ways to access health care along the way to your new destination.
- If you or your family members regularly take medications, make sure you have an extra supply on hand.
- Establish an emergency family communication plan, such as a primary contact and number (preferably a relative or friend in another part of the region or out of state) who family members can call in case of emergencies. Every family member should know this number.
- Have a 'ready-to-go' kit that includes items include water, food, batteries, first aid kit, a flashlight, radio, contact numbers, and medications.

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Involve Your Children

- Schools are a very good source of health information and education. Make sure to read your children's school resources and any specific school recommendations and emergency plans.
- Educate your children on family about health habits that can help during a public emergency.

- Provide extra support to children with special needs during such times to ensure they are protected.
- Remember to plan for childcare in the event of school closure; this may mean taking leave or finding alternate care plans.

Public health emergencies, while of great concern to all, present opportunities for families to review and practice important steps for good health. It is a time to educate children of all ages about health habits for life. As a military family, your health and the health of loved ones contribute to the health, safety and security of all.

Stay informed during a public health crisis.

Section 3

DISASTER PREPAREDNESS AND RESPONSE

Introduction

Service men and women and their families have a proud tradition of understanding and responding to high-risk situations and environments. These situations encompass war on foreign soil, global peacekeeping missions and duty in the face of national security risks and disasters on the home front.

The special knowledge, skills and behaviors involved in disaster preparedness and response are essential for meeting the military mission. Preparedness allows our active duty, and reserve and national guard component forces to continue to function, despite the disruptions that disasters may bring. Preparedness also builds resilience within the military families and communities in which service members live.

The Center for the Study of Traumatic Stress (CSTS) of the Uniformed Services University of the Health Sciences develops and disseminates knowledge about planning for, responding to and recovering from the health and mental health consequences of exposure to a range of disasters including natural disasters, terrorism and bioterrorism, pandemic threat and war. These resources are unique in content and form and have applicability for both the military and civilian communities. Many materials have been developed in real time through consultation with military and civilian responders to major disasters, and reflect the issues and special needs indigenous to each disaster type. All resources reflect the expertise of military medical specialists including military and disaster psychiatrists, psychologists, researchers and clinicians as well as experts in health communication and public education. These resources were originally in the form of electronic fact sheets and newsletters, CDs and briefings and reports so that they could be easily disseminated. Many are currently on our Center's website, www.cstsonline.org. Because they are in the public domain, they can be downloaded and used for your purposes.

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Sustaining the Psychological Well-Being of Caregivers While Caring for Disaster Victims

The magnitude of death and destruction in disasters and the often difficult nature of the medical response require special attention to the needs of healthcare providers. Supporting caregivers and encouraging them to practice self-care sustains their ability to serve victims of disaster.

Challenges for the healthcare provider in the post-disaster environment

- **Ruined and socially unstable areas.** Disaster areas are often physically and socially unstable. Accessing a disaster area to establish a clinical setting can be difficult due to disturbances of critical infrastructure such as airports, roads and communications. Ensuring the physical safety and security of providers (as well as patients) is a top priority, but can be a challenge.
- **The magnitude of suffering.** The suffering of the large number of people needing assistance, the extreme physical injuries being treated and the almost unbearable losses that many disaster victims have experienced can challenge the fortitude of even the most seasoned healthcare provider and responder. Disasters often produce mass physical trauma, and the injuries seen may be more severe or, because of delays in treatment, more complicated than many providers are accustomed to treating. Disfiguring injuries such as head/facial trauma or burns can be especially difficult emotionally. Disasters may result in the deaths or severe injuries of children, which can be particularly disturbing for all involved.
- **Providing support as well as medical care.** Many patients in the post-disaster setting are distressed and filled with a range of emotions. They

Supporting caregivers and encouraging them to practice self-care sustains their ability to serve victims of disaster.

may not have family or friends. Healthcare providers often take on extra support roles. This is especially the case when the patient is a child who is injured and may have lost or been separated from his/her family.

- **Poorly resourced areas.** Post-disaster clinical settings are often substandard, and healthcare providers must adapt to work in under-resourced environments. Diagnostic tests (e.g. laboratory or radiographic studies) and interventions (e.g. medications or surgeries) that are clinically indicated may not be possible due to limited resources. Disaster victims may die from illnesses that clinicians regard as quite treatable. Some interventions may take place, but in suboptimal conditions. For example, life-saving amputations may need to be performed, even without proper anesthesia. It is difficult for healthcare providers to inflict pain on patients (especially children), even if necessary.
- **Unfamiliar and unexpected conditions.** Working in a disaster setting often means traveling to an unfamiliar place, usually away from one's family and other social supports. Accommodations may be rudimentary and provisions of food and water may be somewhat sparse.
- **Psychological stress of healthcare in disaster settings.** While healthcare providers find the experience of assisting in a post-disaster environment gratifying, many also experience the intense emotions and thoughts of loss and concern as part of their work. Some common reactions include:
 - » Physical and emotional exhaustion
 - » Identification with the victims — “It could have been my child, my spouse...”
 - » Feelings of grief, hopelessness, helplessness, sadness and self-doubt
 - » Difficulty sleeping
 - » Guilt over not being able to do more, or having resources back home that their patients do not
 - » Frustration and anger at the healthcare delivery system

Strategies for mitigating psychological distress in healthcare providers

- **Communicate.** Communicate with colleagues clearly and in an optimistic manner. Identify mistakes or deficiencies in a constructive manner and correct them. Compliment each other—compliments can be powerful motivators and stress moderators. Share your frustrations and your solutions. Problem solving is a professional skill that often provides a feeling of accomplishment even for small problems.
- **Monitor basic needs.** Be sure to eat, drink and sleep regularly. Becoming biologically deprived puts you at risk and may also compromise your ability to care for patients.

- **Take a break.** Give yourself a rest from tending to patients. Allow yourself to do something unrelated to the traumatic event that you find comforting, fun or relaxing. This might be taking a walk, listening to music, reading a book, or talking with a friend. Some people may feel guilt if they are not working full-time or are taking time to enjoy themselves when so many others are suffering. Recognize that taking appropriate rest leads to proper care of patients after your break. Remember that your family and friends are awaiting you at home.
- **Connect.** Talk to your colleagues and receive support from one another. Disasters can isolate people in fear and anxiety. Tell your story and listen to others’.
- **Reach out.** Contact your loved ones, if possible. They are an anchor of support outside the disaster area. Keeping in contact may help them better support you upon return home.
- **Understand differences.** Some people need to talk while others need to be alone. Recognize and respect these differences in yourself, your patients and your colleagues.
- **Stay updated.** Participate in meetings to stay informed of the situation, plans and events.
- **Check in with yourself.** Monitor yourself over time for any symptoms of depression or stress disorder: prolonged sadness, difficulty sleeping, intrusive memories, hopelessness. Seek professional help if needed.
- **Honor your service.** Remind yourself that despite obstacles or frustrations, you are fulfilling a noble calling—taking care of those most in need. Recognize your colleagues—either formally or informally—for their service.

Leadership Stress Management

The magnitude of death and destruction in the aftermath of a disaster requires special measures for leaders to deal with their own stress. Leadership is paramount in maintaining organized, efficient work for continuity of efforts and recovery. Remember that jurisdictional issues between offices will always be present and will not be easily resolved due to conflicts between tasks. One of the risks with a task of this magnitude is leaders being aware of their own levels of stress and taking appropriate measures before problems begin. In order to take care of others you must first take care of yourself.

It is difficult to predict the kinds of psychological problems that any individual leader will have, however, the following management plan can help minimize later difficulties.

- To reduce stress it is critical to lead by example.
- Establish a work-rest schedule for yourself and follow it.
- Get off your feet during breaks.
- Provide a rest area for yourself with fluids and food and protection from news media and onlookers.
- Provide a minimum of 4 hours of sleep during each 24 hour period.
- If possible, return home for food and sleep.
- Drink and eat on a regular schedule — take every opportunity to assure that you are hydrated.
- Drink BEFORE you are thirsty.
- Avoid all beverages containing alcohol.
- Avoid smoking.
- Caffeine is the only safe stimulant but do not forget that it can jangle nerves and dehydrate you.

Disaster death and destruction require special measures for leaders to deal with their own stress.

- In a time of terrible demand, moderation is still a virtue.
- When you notice that others are stressed assume that you are stressed.
- Identify a trusted co-worker who can evaluate your level of effectiveness and consult with them on a daily basis.
- Provide a similar service to a co-worker who trusts you.
- Communicate clearly in an optimistic manner but be sure to identify mistakes clearly for yourself and others and correct them.
- Compliments can serve as powerful motivators and stress moderators.

Emotional Reactions to Human Remains in Mass Death

In your work with disasters, you are likely to see, smell, and handle the remains of men, women, and children of all ages. Working with or around them may arouse strong feelings of pity, horror, repulsion, disgust, and anger at the senselessness of this tragedy. You may feel guilty for not helping enough. These reactions are normal and a part of being human. You may feel emotionally numb, or you may even use “graveyard humor” to make the suffering and death seem less terrible. These are also normal responses. Strong emotions or reactions may be most painful when a victim is a child, or reminds you of someone you love, or of yourself. Even if you’ve worked in disaster environments before you may react differently here than you have in the past. Remember strong emotions are honorable and they confirm your humanity.

Here are lessons learned by other people who have worked with remains in disaster environments. Although these tips cannot make a horrible event easy they will help you continue to work, and to live with your experiences and memories without being haunted by them: Remember the larger purpose of your work.

- By recovering remains for identification and respectful burial you are showing care, giving hope, and preventing disease for the living. Your supervisor must be aware of all body recovery work that you do and coordinate with the local authorities requesting assistance in this important effort.
- It may be difficult to prepare yourself mentally for what you will see and do. Specific information about job requirements and the experience of others can be helpful.
- While on the job wear protective gloves and coveralls to reduce your risk

Working with remains may arouse strong feelings of pity, horror, repulsion, disgust, and anger. These reactions are normal.

of disease, take frequent breaks, maintain hygiene, drink plenty of fluids, and eat good food. Rest (off of your feet) when not working. Facilities for rest, washing hands and face, for showers and fresh clothes should be available.

- Talking with others while working and during down time is very important. This helps prevent getting lost in your own thoughts or emotions.
- Help others in distress by being a good listener. Don't mistake expression of feelings for weakness. Remind others that strong emotions are normal and honorable.
- Humor is a good stress release. Even graveyard humor privately among friends may be helpful but this will be offensive to some. Do not be disrespectful toward the remains.
- Limit your exposure to remains as much as possible.
- Limit the exposure of others, also, by using screens, poncho curtains, partitions, covers, body bags, and barriers whenever possible.
- Since perfumes or aftershaves used to mask odors may trigger later memories, it may be better to breath through your mouth than to use these items to cover up unpleasant smells.
- Be compassionate, but avoid focusing on any individual victim—especially those you may identify with.
- Personal effects found near remains may be important for identification. They may also become important reminders for surviving family members or loved ones so they should not be taken as souvenirs.
- Do not focus on personal effects more than necessary as this can be particularly distressing.
- Remind yourself that remains are not people anymore — just the remains.
- It's OK to say silent prayers, but let local religious leaders conduct memorial services or more public ceremonies.
- Do not focus on personal effects more than necessary as this can be particularly distressing.
- Be respectful of local cultures and religious beliefs that may be very different from your own.
- As time allows, have your team get together for mutual support and encouragement.
- Acknowledge horrible aspects of the work, but do not dwell on memories of the details. You should let your supervisor know if an aspect of your work is particularly difficult or stressful for you — a job change may be helpful.

- Afterwards, do not feel guilty about having distanced yourself mentally from the suffering or tragic deaths of individuals.
- Some people find debriefings with trained counselors helpful but others do not. Participation should be voluntary. Any group debriefings should be with people who shared your experiences.
- Strange dreams or nightmares, feeling tense, or having intrusive memories are common during or shortly after stressful work with human remains.
- Sharing your emotional reactions with loved ones is often helpful, but may be very difficult to do.
- If you cannot talk about your experiences (even though you want to), if your personal reaction is particularly distressing.
- If anxiety, depression, sleep difficulties or irritability persist more than two weeks after your return home you should seek assistance from a counselor or a physician.

Hazardous Materials Clean-Up and Continuous Operations

Hazardous materials recovery teams can perform for long periods of time with the right support. Civilian and military personnel have long been expected to operate at an acceptable level of efficiency in difficult, continuous, and sustained operations. This has led to a large body of studies done on operational requirements. Identified factors that may contribute to various types of performance degradation include: protective equipment and environmental demands (heat, cold, high altitude); extreme environments (undersea, polar, outer space); conditions of low stimulation inducing boredom; night operations; prolonged combat and exposure to life-threatening work; sleep deprivation; and other situations. In non-military settings, workers often have work and union rules, the freedom to quit a job, and they cannot be ordered to perform certain tasks except in very special circumstances. Failure to adhere to performance guidelines can be the result of organizational breakdown. In this way, organizational disruption can lead to sleep loss, fatigue, poor performance, accidents, psychological stress, and reduced effectiveness.

1. Protective clothing for workers

There are many levels of worker protective clothing and equipment depending on the nature of the contaminant, environmental conditions, and available support. If protective suits are required, all aspects of the clean-up operation will be significantly affected. Protective suits require special attention to hydration, temperature regulations, increased workload, and social isolation due to the inability to make eye contact. The experience of sensory input limitation caused by protective gear requires training. These suits and equipment can also impose increased ergonomic demands and may change the needed work/rest cycles.. Decreased ability to communicate clearly due to protective gear can be an increasing issue during continuous operations due to fatigue. In addition, training is needed in order to accurately monitor the performance of individuals wearing protective equipment. This may not be present in times of a disaster when many are recruited

to wear protective clothing to assist in a clean-up operation.

Performance of continuous physical work produces oxygen debt. As a result, body movements are less accurate and effective as muscles become tired. Personnel who perform continuous cognitive tasks for extended periods also show predictable performance decrements. Tasks requiring ongoing attention to detailed procedures generally may be performed without degradation for periods of 4 hours or less. However, breaks are required by four hours. Requirements on the individual vary according to whether the monitoring task is event-driven such as responding to a stimulus in signal detection or operator driven as when a person initiates a task like making telephone calls or entering data.

2. Sleep and sleep loss

Sleep is one of the most extensively studied physiological and psychological processes. It is the most important factor in sustained performance. Sleep loss degrades performance, mood, and attitude. When limited amounts of intermittent and broken sleep are obtained, it is usually of insufficient quality to restore cognitive function and performance to peak levels. When one fails to obtain the proper amount of sleep (7 to 9 hours for young adults), the individual builds up a sleep debt. When that debt accumulates, the individual feels fatigued, exhibits gradual performance degradation, and eventually performs poorly as if the person had been sleep deprived for one or more nights. Sleep loss slows biological recovery including response to muscular exercise; thus a longer recovery period is needed. The chief effects of sleep deprivation, however, are more on psychological and cognitive tasks than on physical. Sleep loss hastens the onset and increases the frequency of cognitive performance decrements, especially on vigilance (e.g., attention-requiring) tasks.

3. Restorative sleep and naps

Naps during the day can supplement or replace sleep lost at night. Naps also serve as a change of pace. If a nap is long enough, it provides restorative sleep that can refresh or recharge the worker. Naps can be scheduled into continuous work-rest cycles and can help sustain performance. Continuous sleep is thought to have greater recuperative power than naps. At least 4-5 hours of sleep should be taken to prevent impaired performance. Some studies indicate that a minimum of 6 hours of uninterrupted sleep is necessary to maintain performance over a long period of time. A sleep inertia effect has been observed in people who awake from naps and try to resume performance. During this period of 15-30 minutes, the person may feel groggy or sluggish and performance deficits are likely to occur. Sleep inertia is increased by the depth of sleep. Sleep inertia should be expected if

a worker is expected to wake quickly and respond immediately. In the military, it is sometimes thought that taking naps does not fit with the military image and traditions. In situations where prolonged and continuous operations are necessary, leaders should be alert to those with a critical view of napping during operations.

4. Circadian rhythms

Work performance varies as a function of time of day, work schedule, and the nature of the task performed. Humans exhibit predictable physiological and behavioral rhythms with a period of about one day. On a normal day-night schedule, alertness, motivation, initiative and performance tend to be best when the body temperature is rising through the day. They decrease slightly in the late afternoon with a moderate decrease in body temperature from about 5:00 to 7:00 pm. Performance, particularly sustained cognitive performance and quick responses, are especially low in the early morning, coincident with the lowest body temperature.

5. Rest breaks, work shifts, and work/rest cycles

Rest breaks and work shifts provide novel stimuli, provide rest from sustained task, and often break the effects of fatigue. Short breaks do not reduce output on paced jobs. Rest breaks in sedentary work provide relief from boredom and subjective factors. Rest breaks in physical work can reduce some physiological effects, muscle fatigue, and cardiac strain. Optimal schedules depend on the kind of work, the health status and physical conditioning of workers, and the work conditions.

6. Pharmacological agents

Medications and drugs have been used to maintain performance in some military groups including pilots and soldiers on long-range reconnaissance patrols. Drugs can be also used to induce or enhance sleep when conditions are not conducive to sleeping. A major concern with such drugs is whether users can respond quickly and normally from a drug-induced sleep in the event of an emergency. Other concerns include lingering performance effects such as delayed reaction time or delayed cognitive processing and the potential for adverse health effects with prolonged and repeated use. Although stimulant drugs can prevent sleep when needed, they also temporarily mask fatigue, may lead to over-stimulation, pose addiction potential, and cause appetite changes when taken chronically. Research in this area is ongoing. Caffeine is the most commonly used and available stimulant. Like other stimulant drugs, caffeine results in disruption of sleep cycles. Non prescribed stimulant and sleep medication use, is also present in settings of high demand and continuous operations.

7. Recognition of degraded performance

Establishing specific guidelines for the duration of continuous work performance can be very difficult in new, unexpected hazardous settings. Therefore, recognition of degraded performance and monitoring and surveillance by supervisors and healthcare givers is important. Degraded performance can be hard to recognize. Markers of degraded performance depend on the task(s) performed. Observable markers of fatigue will vary between tasks. In physical work, lack of motor coordination including stumbling, falling, lack of coordinated motions, and accidents indicate fatigue. Supervisors should also be alert to the potential of increased accidents before and after work as fatigued or sleep deprived workers come to work and return home. Sleep loss may lead to disorientation, dissociation, and other mental symptoms. However, these may be difficult to recognize. When a task requires maximum effort over a long period of time and the mission is critical, such as rescuing victims, people will frequently overwork. Over-dedication to task can be both a result of and a cause of degraded performance. When the task is not critical, an individual's own estimate of fatigue (e.g., ask them if they are tired) is probably the best indicator that it is time to take someone off the job.

Impaired cognition tasks and performance are often more difficult to recognize. Monitoring measures of errors in performance, failures in logical reasoning, slowed reaction time, deterioration in mood and motivation, and mental symptoms such as dissociation, memory lapses, and disorientation can aid in detection of degraded cognitive performance. Other possible psychological disturbances that can occur with severe fatigue or sleep loss include hallucinations, illusions, and other distortions of reality. Changes in cognitive performance are also expected during the normal circadian cycle trough (for day shift people, between 3:00 – 6:00 am). The longer the task, whether physical or cognitive, the more likely are performance decrements, especially under conditions of sleep loss, lack of food and water, and rest breaks.

Table 1. Issues in Hazardous Materials Cleanup and Continuous Operations

- Protective clothing for workers
- Physical and cognitive tasks
- Sleep loss
- Circadian rhythms
- Rest breaks, work shifts, and work/rest cycles
- Pharmacological agents
- Clinical issues

8. Clinical issues and outcomes

Sustained continuous operations and sleep deprivation may precipitate distress reactions or mental disorders. Sleep loss and sleep phase shifting may also worsen pre-operational distress or pre-existing mental disorders. Importantly, the signs and symptoms of sleep deprivation may be confused with other mental conditions. Particular attention is needed to the following disorder related issues.

- **Mood disorders.** Fatigue, decreased concentration, and slowed movements are among the physical signs of depression. In workers with depression (whether or not on medication), persistence of these decrements even after restorative sleep may indicate depression rather than sleep debt. Sleep shift changes, prolonged sleep deprivation, or excessive use of stimulants to continue wakefulness may at times precipitate hyperactivity, excessive talking, irritability, and impulsive or dangerous behavior (e.g. a manic episode). This requires immediate medical attention.
- **Anxiety disorders.** Persons previously treated for generalized anxiety or panic disorder may experience flare-ups of their illness under the stress of prolonged continuous operations (or as a result of a disruption of their medication supply). Exposure to human remains or life-threatening work may cause anxiety reactions in some, or exacerbations of pre-operational illness such as PTSD. Anxiety symptoms also include poor concentration and irritability which may directly compromise mission capability.
- **Substance use disorders.** Workers who abuse alcohol use or certain prescription medications or illicit substances may experience dangerous withdrawal including seizures or delirium if sustained operations interfere with their regular use of these agents. When combined with sleep deprivation use of alcohol or other substances results in greater cognitive impairment.
- **Distress reactions and behaviors.** Anger, irritability, decreased concentration, or avoidance behavior may represent non-specific distress reactions. While these reactions are expected under the stress of prolonged

Table 2. Monitoring Performance Degradations/Effects of Stress

Managers and Supervisors should be alert to:

- Lack of motor coordination — stumbling, falling, accidents
- Cognitive degradations - performance errors and slowed reaction time
- Mental degradation — memory lapses, disorientation, psychological disturbances
- Changes in energy levels

Table 3. Strategies for Maintaining Performance:

- Have sufficient personnel to accomplish the mission.
 - Modify tasks, divide workload and cross train to allow people to rest and take breaks.
 - Lighten mission-essential tasks to the minimum (particularly physical loads).
 - Create teams that will work different day-night shifts and promote sleep when possible.
 - Monitor each other, particularly in tasks requiring high cognitive performance.
-

continuous operations, mission leaders may benefit from consultation. Such consultation can assist in determining whether these reactions will compromise mission capability, respond to restorative sleep, or require further intervention.

References

- Krueger GP. (1991). Sustained military performance in continuous operations: combatant fatigue, rest and sleep needs. In R. Gal and A. David Mangelsdorff (Eds.) *Handbook of Military Psychology*. Pp256-277.
- Fullerton CS & Ursano RJ. (1990). Behavioral and psychological responses to chemical and biological warfare. *Military Medicine*, 155:54-59.
- Levitin HW & Siegelson HJ. (1996). Hazardous materials: Disaster medical planning and response. *Emergency Medicine Clinics of North America*, 14:327-348.
- Naitod P, Kelly TL, & Englund C. (1990). Health effects of sleep deprivation. *Occup Med*, 5:209-237.

DISASTER CARE

How You Can Support Well-Being in Disaster Victims

Psychological First Aid

People often experience strong and unpleasant emotional and physical responses to disasters. Reactions may include combinations of confusion, fear, hopelessness, helplessness, sleeplessness, physical pain, anxiety, anger, grief, shock, aggressiveness, mistrustfulness, guilt, shame, shaken religious faith, and loss of confidence in self or others.

As a healthcare provider, first responder, leader or manager of disaster operations, this fact sheet describes an evidenced-informed approach for helping victims cope in the immediate aftermath of a disaster known as psychological first aid (PFA) and explains how to administer it. PFA aims to mollify the painful range of emotions and physical responses experienced by people exposed to disaster. These reactions include combinations of confusion, fear, hopelessness, helplessness, sleeplessness, physical pain, anxiety, anger, grief, shock, aggressiveness, mistrustfulness, guilt, shame, shaken religious faith, and loss of confidence in self or others.

The primary objectives of PFA are to create and sustain an environment of

- Safety
- Calmness
- Connectedness to others
- Self-efficacy or empowerment, and
- Hope and optimism.

Psychological first aid is an evidenced-informed approach for helping victims in the aftermath of a disaster.

Examples of Do's and Don'ts for Helping Using Principles of PFA

DO

- Help people meet basic needs for food & shelter, and obtain emergency medical attention. Provide repeated, simple and accurate information on how to obtain these (safety).
- Listen to people who wish to share their stories and emotions and remember there is no wrong or right way to feel (calming).
- Be friendly and compassionate even if people are being difficult (calming).
- Provide accurate information about the disaster or trauma and the relief efforts. This will help people to understand the situation (calming).
- Help people contact friends or loved ones (connectedness).
- Keep families together. Keep children with parents or other close relatives whenever possible (connectedness).
- Give practical suggestions that steer people towards helping themselves (self-efficacy).
- Engage people in meeting their own needs (self-efficacy).
- Find out the types and locations of government and non-government services and direct people to services that are available (hopefulness).
- Remind people, if you know that more help and services are on the way, when they express fear or worry (hopefulness).

DON'T:

- Force people to share their stories with you, especially very personal details (this may decrease calmness in people who are not ready to share their experiences).
- Give simple reassurances like “everything will be ok” or “at least you survived” (statements like these tend to diminish calmness).
- Tell people what you think they should be feeling, thinking or doing now or how they should have acted earlier (this decreases self-efficacy).
- Tell people why you think they have suffered by giving reasons about their personal behaviors or beliefs (this also decreases self-efficacy).
- Make promises that may not be kept.
- Criticize existing services or relief activities in front of people in need of these services (this may decrease hopefulness or decrease calming).

Addressing the Needs of the Seriously Mentally Ill in Disaster

In the acute stages of a disaster, those with serious mental illness may function relatively well. Like the rest of the population, they often rise to the occasion to assist themselves and others in a time of great need. However, persons with severe and often chronic mental illness are a vulnerable group whose well-being is especially threatened by the social disruption of the post-disaster setting. Assisting persons with severe mental illness can mitigate or prevent adverse outcomes.

- **Special care and services.** Disaster mental health services designed for the general population, such as those based on concepts of psychological first aid, are equally beneficial for survivors with mental illness. Procedures addressing safety, connecting, calming, learning disaster behaviors and facilitating a sense of hope and optimism are helpful during or immediately after a disaster. Care should be particularly sensitive to not isolate or stigmatize those with chronic mental illness. Pharmacologic formularies in the disaster region should include a broad range of psychiatric medications in order to allow those with chronic mental illness to stay on their prior regimens. The stress of the disaster and disruption in prior treatment may result in the deterioration of mental health status for some. Psychiatric hospitalization may be necessary in these cases to help the persons re-stabilize
- **Responders trained to help.** Disaster responders should be trained to identify and assist persons with signs of active mental illness. They need training to feel comfortable in assisting with appropriate resources including medical and psychiatric referral, when possible. Symptoms of particular concern include: psychosis (hallucinations, delusions, and disorganized thought process), severe depression, suicidal or homicidal

Persons with severe chronic mental illness are a vulnerable group whose well-being is especially threatened by the social disruption of disasters.

ideation or behavior, and substance abuse. Asking if someone has their usual medications and what they for can begin a helping relationship.

- **Social services.** Those with chronic mental illness generally need enhanced social services during the post-disaster recovery stages, including assistance with housing, employment and re-establishment of psychiatric care.

Persons with serious mental illness are vulnerable to disasters.

- **Less prepared.** Persons with serious mental illness are less likely to be prepared for a disaster. Evidence suggests that those with serious mental illness are less likely to have supplies on hand or an emergency plan in place in the event of a disaster. They may be more dependent on others to assist them to evacuate or take other necessary precautions prior to a disaster.
- **Onset of new and recurrent symptoms.** Persons with a history of mental illness are more likely to develop stress-related symptoms or a relapse of prior symptoms following a disaster. Those with a chronic mental illness may have difficulty tolerating psychological distress or a disruption in their social situation. Those with prior the diagnosis of posttraumatic stress disorder may be particularly vulnerable to an exacerbation of symptoms due to an association of the current disaster and response (sirens, for example) to their prior trauma.

Disasters disrupt mental health care and services.

- **Loss of caretakers.** Persons with chronic and severe mental health problems are often cared for by family members. In the wake of a disaster, caretakers may have been killed or injured. Family members may divert their time and energy to basic tasks of recovery such as securing food, water and safe housing, leaving less time and resources to care for their mentally ill family member.
- **Mental health services are disrupted.** Persons with serious mental illness are often in the care of the mental healthcare system. During a disaster, mental health services are often disrupted. This can include the shutting of inpatient psychiatric units and hospitals and outpatient clinics. Pharmacies may be closed or their supply chains interrupted, resulting in patients not receiving their medications. Problems with transportation infrastructure may make it difficult to get to appointments.
- **Loss of hospitals and care facilities.** Many chronically mentally ill live in supported environments, including psychiatric hospitals or other skilled facilities, group homes or shelters. In the aftermath of a disaster, these

facilities may close or be understaffed; residents may be forced to either relocate and/or be underserved.

- **Increased demand for mental health services.** Demand for mental health services often increases in the wake of a disaster due to the mass trauma that has occurred. This greater need for services for many new people may result in a diversion of resources away from care for the chronically mentally ill.

Disaster preparedness and planning.

- Assist those with chronic mental illness and their families to develop a disaster plan including emergency contact information and a supply of medications.
- Identify group residences and shelters that house serious and chronically mentally ill persons in order to facilitate evacuation, rescue or safety check at the time of a disaster.

Assisting persons with severe mental illness can mitigate or prevent adverse outcomes.

Primary Care Screening for Severe Psychiatric Disease in Disasters

Most reactions experienced by displaced individuals in the aftermath of a disaster will be transient or respond to brief supportive interventions. However, primary care providers conducting initial assessments should remain vigilant for mental disorders requiring further psychiatric evaluation and treatment. The following screening questions will help primary care providers determine when additional referral is indicated.

1. Are you seeing a mental healthcare provider such as a psychiatrist, psychologist, social worker, nurse, or mental health counselor?
2. Are you taking any medications?
3. What medications do you take?

If answers to the above indicate a history of psychiatric problems, refer for further psychiatric assessment.

3. During the disaster event, did you think you were going to die or were you fearful for your life?

If yes:

- a) Are you still feeling very frightened or having nightmares?
- b) Are you having trouble sleeping?

If answers to above indicate severe life threat with persistent anxiety/fear and or sleep disturbance, refer for psychiatric assessment.

4. Are you feeling sad or blue?
5. Did you lose, or do you think you may have lost a loved one in the disaster?
6. Are you feeling hopeless?
7. Are you having any thoughts of hurting yourself or others?
8. Do you have a gun or other weapon?

Primary care providers conducting initial assessments should remain vigilant for mental disorders requiring further psychiatric evaluation and treatment.

If the answers to the above indicate possible depression or risk of suicide, or risk of injury to others refer for urgent psychiatric assessment.

9. How much do you usually drink?

10. Do you use any street drugs?

If the above indicate risk of substance withdrawal, refer for urgent psychiatric assessment.

Mental Health and Behavioral Guidelines for Response to a Pandemic Flu Outbreak

Background on the Mental Health Impact of Disasters including Epidemics

Little data exist on the mental health impacts of outbreaks of disease. This is largely because there have been few pandemic health threats in the last century. Since the highly lethal pandemic outbreak of influenza in 1918, there have been few global threats from infectious agents. The outbreaks of SARS in Asia and Canada, which caused global concern, but did not result in large-scale outbreaks nor a global pandemic, gives us the most recent data on the mental health concerns that are relevant in a pandemic outbreak situation.

The data from the SARS outbreaks indicated that upwards of 40% of the community population experienced increased stress in family and work settings during the outbreak; 16% showed signs of traumatic stress levels; and high percentages of the population felt helpless, apprehensive, and horrified by the outbreak.

While there have been relatively few large outbreaks to inform an appropriate response to a potential pandemic flu, the existing data on infectious disease outbreaks, data from natural disasters, and public mental health principles can be brought to bear on the development of such a response. Public mental health measures must address numerous areas of potential distress, health risk behaviors, and psychiatric disease. In anticipation of significant disruption and loss, promoting health protective behaviors and health response behaviors will be imperative. Areas of special attention in-

Even in relatively developed countries, there is very little existing infrastructure in place that can adequately address the mental health needs of victims

clude: (1) the role of risk communication; (2) the role of safety communication through public/private collaboration; (3) psychological, emotional, and behavioral responses to public education, public health surveillance and early detection efforts; (4) psychological responses to community containment strategies (quarantine, movement restrictions, school/work/other community closures); (5) healthcare service surge and continuity; and (6) responses to mass prophylaxis strategies using vaccines and antiviral medication.

The first step in preventing undesirable psychological, emotional, and behavioral response is an effective public health program of risk assessment and communication, public health prevention, and consequence management. These are necessarily premised on having effective political and community leadership, appropriate pre-event organization, and staffing and funding.

Being alert to the interrelationship between psychological, emotional, and behavioral responses and their effect on other elements of the response plan must also be emphasized. While planning can be based on assumptions that public health efforts to stop an outbreak will be successful, the importance of managing the consequences of failure and the subsequent behavioral response to failure is crucial. This can extend from failure to deliver support and services, to failure of a vaccine to prevent illness, to failure of therapies to work.

Recommended steps in response to a pandemic flu outbreak are divided into four phases: preparedness, early outbreak response, later response and recovery, and mental health intervention planning.

Preparedness

- **Education.** Public education must begin immediately, before a pandemic occurs, and be embedded into existing disaster public education campaigns, resources, and initiatives See, , www.ready.gov , Red Cross, CDC public education and preparedness <http://www.hhs.gov/pandemicflu/plan/>). Focus on facts including what is known, what is not known, and how individuals, communities, and organizations can prepare for a potential outbreak. As we know from the SARS outbreak, public education impacts threat awareness, threat assessment, and preparedness behaviors in every phase of an event. Public education in advance of an outbreak should be inclusive of the varying degree of threats, to include those of reasonably low threat potential to those with the highest potential.
- **Leadership.** Leadership preparation includes ensuring that public officials understand which members of the population will be most vulnerable and who will need the highest level of health services, including mental health services. This includes identification of those groups who

may be at greatest risk for problems related to contagion, such as those with psychiatric illness, children, elderly, homeless, and those with losses. Ongoing negative life events also increase one's risk for mental health problems, and may place certain people at higher risk for negative mental health impact of an outbreak. In addition, health risk behaviors such as smoking, drug use, and alcohol use may increase in times of stress, putting some people at increased risk.

- **Sustaining preparedness measures.** Maintenance of motivation, capital assets, equipment, and funding to continue preparedness efforts over the long term must be considered, not just to focus on immediate needs. It is also important to remember that if responses are under-supported and fail, the community anger and lowered morale may complicate the ability of a community to respond to an outbreak, as well as the recovery process once an outbreak has ended.
- **Leadership functions.** Leadership functions require identification of community leaders, spokespersons, and natural emergent leaders who can affect community and individual behaviors and who can endorse and model protective health behaviors. Special attention to the workplace is imperative as corporations have public education resources to potentially reach large populations. The media and celebrity groups constitute important leaders in most modern societies and have a critical role in providing leadership in communication.

Early Pandemic Response

- **Communication.** Wide dissemination of uncomplicated, empathically informed information on normal stress reactions can serve to normalize reactions and emphasize hope, resilience, and natural recovery. Recommendations to prevent exposure, infection, or halt disease transmission will be met with skepticism, hope, and fear. These responses will vary based on the individuals' and the local community's past experiences with government agencies. In addition, compliance with recommendations for vaccination or medication treatment or prophylaxis will vary greatly and will not be complete. The media can either amplify skepticism or promote a collaborative approach. Interactions with the media will be both challenging and critical. The public must clearly and repeatedly be informed about the rationale and mechanism for distribution of limited supplies (e.g., Tamiflu). Leadership must adhere to policies regarding such distribution, as abuses of policy will undercut public safety and public adherence to other government risk reduction recommendations.
- **Tipping points.** Certain events, known as tipping points, will occur that

can dramatically increase or decrease fear and helpful or health risk behaviors. Deaths of important or particularly vulnerable individuals and children, new unexpected and unknown risk factors, and shortages of treatments are typical tipping points. The behavioral importance of community rituals including speeches, memorial services, funerals, collection campaigns, television specials are important tools for managing the community-wide distress and loss.

- **Surges in demands for healthcare.** Those who believe they have exposed, but have not actually been may outnumber those exposed and may quickly overwhelm a community's medical response capacity. Planning for the psychological and behavioral responses of the health demand surge, the community responses to shortages, and the early behavioral interventions after identification of the pandemic and prior to availability of vaccines are important public health preparedness activities.

Later Response and Recovery

- **Community structure.** Maintenance of community supports — formal and informal — will remain important. In-person social supports may be hampered by the need to limit movement or contact due to concerns of contagion. Virtual contact — via web, telephone, television, and radio — will be particularly important at these times. At other times local gathering places — religious, schools, post offices, and groceries — could be points of access for education, training and distribution. In as much as allowed, instilling a sense of normalcy could be effective in fostering resiliency. In addition, observing rituals and engaging in regular activities such as school and work might manage community and organizational distress and untoward behaviors. Providing tasks for community action can supplement needed work resources, decrease helplessness and instill optimism. Maintenance and organization in order to keep families and members of a community together is important especially in the event of relocation.
- **Stigma and discrimination.** Under conditions of continuing threat, the management of ongoing racial and social conflicts in the immediate response period and during recovery takes on added significance. Stigma and discrimination may marginalize and isolate certain groups, thereby impeding recovery.
- **Management of fatalities.** Mass fatality and management of remains, as well as community responses to them, must be planned. Containment measures related to remains may be in conflict with religious, rituals of burial, and the usual process of grieving. Local officials should be aware of the potential negative impact of disrupting normal funeral rituals and

processes of grieving in order to take safety precautions. Public health announcements should include, if known, how long the virus remains in the corpse and what should be done with the remains. In a pandemic, funeral resources will be overwhelmed and mortuaries may not want to handle contaminated remains. Careful identification of remains must be insured and appropriate, and accurate records maintained.

Mental Health Intervention Planning

- **Efforts to increase health protective behaviors and response behaviors.** Individuals under stress will need reminders to take care of their own health and limit potentially harmful behaviors. This will include taking medication, giving medications to elderly and children, and when to go for vaccination.
- **Good risk communication following risk communication principles.** The media can either amplify skepticism or promote a collaborative approach. Interactions with the media will be both critical and challenging.
- **Good safety communication.** Promoting clear, simple, and easy-to-do measures can be effective in helping individuals protect themselves and their families.
- **Public education.** Educating the public not only informs and prepares, it enlists them as partners in the process and plan. Education and communications will need to address fears of contagion, danger to family and pets and mistrust of authority and government. The tendency to expect or act as if these are not present can delay community wide health protective behaviors.
- **Facilitating community-directed efforts.** By organizing communal needs and directing action toward tangible goals, this will help foster the inherent community resiliency toward recovery.
- **Utilizing evidence-informed principles of psychological first aid.** These basic principles include:
 - » Establishing safety; identify safe areas and behaviors.
 - » Maximizing individuals' ability to care for self and family and provide measures that allow individuals and families to be successful in their efforts.
 - » Teaching calming skills and maintenance of natural body rhythms including nutrition, sleep, rest, and exercise.
 - » Maximizing and facilitate connectedness to family and other social supports to the extent possible. This may require electronic rather than physical presence.
 - » Fostering hope and optimism while not denying risk.

- **Care for First Responders to Maintain their Function and Workplace Presence.** This will require assistance to ensure the safety and care of their families. First responders will be comprised of a diverse population, to include medically trained personnel to bystanders with no experience.
- **Mental Health Surveillance.** Ongoing population level estimates of mental health problems in order to direct services and funding. Surveillance should address PTSD, depression and altered substance use as well as psychosocial needs (eg housing, transportation, schools, employment) and loss of critical infrastructure necessary to sustaining community function.

Public mental health measures must address numerous areas of potential distress, health risk behaviors, and psychiatric disease.

Disaster Preparedness for Families with Special Needs

Disasters can affect individual and family health. Existing medical conditions can be imperiled by disasters or the need to evacuate. Healthcare providers can address the need for disaster preparedness during routine office visits. The talking points below can help you ask the questions that will help your patients assess, prepare for and respond to an evacuation, and do so in a way that is responsive to their unique health needs.

Talking Points to Help Families Assess and Plan for Health Needs Around Disasters and Evacuation

Disasters affect families emotionally and physically, and often cause significant elevations in anxiety. Being prepared, especially around health needs, can mitigate stress and maximize positive outcomes. Here are some questions you can ask patients to help them assess and develop emergency preparedness plans responsive to their health needs:

- Do you or any of your family members have medical conditions that require medications, special medical equipment or a special diet?
- What might you or members of your family need to do about these health issues in an environment away from home?
- Have you communicated these health issues to a supervisor, teacher, day care or other professional in an environment in which you or a family member spend a significant portion of the day away from home?

Steps Families Can Take to Prepare for Disasters Around Health Issues

During disasters, medications and health supplies may be temporarily disrupted.

- At home, have an extra supply of medications available.

Being prepared, around health needs can mitigate stress and maximize positive outcomes when disasters occur.

- Away from home, provide instructions and training (if possible) to a primary caregiver who would be responsible for your family member in a disaster.
- If that caregiver expresses reluctance or discomfort to administer help, have them identify a person within that environment who would be able to provide assistance with such procedures as injections or other requirements.
- Make sure adult children away from home, such as college students, are prepared. Make sure elderly members of your family are also prepared.

Family Communication Plan

A good communication plan provides a central role in relaying information about the status and location of loved ones; it will help to reduce anxiety at the time of and immediately following a disaster. To create a disaster communication plan, families must:

- Establish a primary contact and number (preferably a relative or friend in another part of the region or out of state) who family members can call in case of emergencies. Every member of the family should know this number.
- In the event that family members are separated, it is also important that daycare, work, school, and neighbors know this number.
- Prepare a list of phone numbers where each family member can be reached during the day. Include a list of relatives, friends and business associates that would or should know your whereabouts in case of emergency.
- During disasters, phone communications may be disrupted. Provide an alternative means for making calls, such as a special 'emergency' calling card or cell phone.
- It is important to be aware of other vehicles of communication such as the Internet, e-mail communication, and HAM radio. The Red Cross is also a resource to help contact loved ones.
- Leave a note at your residence to let others know where you are and how you can be contacted.

The Debriefing Debate

Disaster Interventions

The magnitude of death and destruction in disasters and the extent of the response demand special attention. Physical safety and security of victims and relief workers must take first priority. After safety is assured, other interventions may begin. Debriefing is a popular, early intervention following disasters in which small groups of people involved in the disaster, such as rescue workers, meet in a single lengthy session to share individual feelings and experiences. However, the effectiveness of debriefing in preventing later mental health problems is much in debate and some studies have found that it can cause harm in some participants. As a minimum, the following should be considered if you include debriefing as part of an intervention plan.

- Rest, respite, sleep, food and water are the primary tools of early intervention.
- It is important to encourage natural recovery processes such as participants talking to fellow workers, spouses and friends. This can decrease isolation and facilitate identification of persistent symptoms and increase the chances of early recovery.
- Debriefing has not been shown to prevent PTSD. For some, it may relieve pain, restore some function and limit disability; however, further study is needed.
- Debriefing groups with individuals having different levels and types of exposures may spread exposure from those with high trauma exposure to those with low trauma exposure resulting in more symptoms in low exposure individuals.
- Debriefing during an ongoing traumatic event may be particularly problematic.

The effectiveness of debriefing in preventing later mental health problems is much in debate and some studies have found that it can cause harm in some participants.

- Debriefing is an opportunity for education about responses to trauma such as emotional reactions to disaster, somatic reactions, violence, substance abuse, and family stress.
- There are a number of early interventions approaches other than debriefing. Among these are early evaluation, close follow-up and reevaluation, case management, problem solving, emotional support training, sleep medication, intermittent psychotherapy, advice giving, and education. These should be considered as intervention plans.
- During a debriefing there is an important opportunity to identify and triage people who are in need of additional assistance/intervention.
- Ongoing groups are more helpful than a one-time meeting.
- Talking in homogeneous groups, such as firefighters, may be more helpful than in heterogeneous where participants are strangers to each other.
- Individuals dealing with the death of a loved one may have difficulty if placed in a group with others who have survived a death threat. Therefore it is generally important not to mix those who have experienced a loss and those who have experienced life threatening exposures.
- Different people have different stories and concerns. Groups often tend to want to all agree on a single perspective. In a heterogeneous group this may lead to isolation and stigmatization of some participants.

Reference

B. Raphael & J.P. Wilson (Eds.), *Psychological Debriefing. Theory, Practice and Evidence*. UK: Cambridge University Press, 2000.

Treating Patients Following a Radiation Event

Health and Behavioral Issues

Introduction

An attack using radiation will create uncertainty, fear, and terror. Following the detonation of a Radiation Dispersal Device (RDD) the management of acute psychological and behavioral responses will be as important as the treatment of RDD-related injuries and illnesses.

Radiation is a dreaded threat, usually seen as catastrophic and fatal. Radiation is invisible, odorless and unknown. These ingredients stimulate worst-case fantasies. People must rely on health care providers and scientists to determine whether or not a person has been contaminated. Radiation exposure may not be manifest immediately. The health effects of radiation can be delayed in time, not only affecting those exposed, but also future generations. Those who have been exposed or anticipate possible exposure feel a sense of vulnerability, anxiety, and a lack of control. The common lack of consensus among experts can increase public fear and anger.

After a terrorist event there are three groups of psychological responses: those who are distressed; those who manifest behavioral changes; and those who may develop psychiatric illness. Distress following a radiation release will be common and manifest as sadness, anger, and fear, difficulty sleeping, impaired concentration, and disbelief. Psychological distress after a radiologic incident may also manifest as somatic complaints for which no diagnosis can be found. This is often referred to as Multiple Idiopathic Physical Symptoms (MIPS). These patients should be managed by general health care providers. Some individuals will manifest changes in their behavior such as decreasing travel, staying at home, refusal to send children to school as well as increased smoking and alcohol use.

For the vast majority of people, distress and psychological and behavioral

An attack using radiation will create uncertainty, fear, and terror.

symptoms related to the traumatic event exposure will diminish over time. For others, however, symptoms will persist and affect function at home and work, and may result in psychiatric illness. While acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) are the disorders most people think of in connection with trauma, major depression, increased substance use, family conflict, and generalized anxiety disorder are also encountered. It is important to remember that people with no prior history of psychiatric illness are also vulnerable to psychiatric illness after a terrorist exposure. In the aftermath of the Oklahoma City bombing, nearly 40% of those who developed PTSD and depression had no previous psychiatric disorder. Those at high risk of developing psychiatric disorders include:

- Those directly exposed, people near the blast and those participating in rescue and recovery operations of people and remains.
- Those who were more vulnerable before the event due to existing mental illness.
- Those who suffered resource losses and disruption of their social supports after the event.

There have been a number of technological disasters, terrorist attacks, and uses of novel weapons in war which suggest that health care providers' offices, medical clinics, and hospitals will be deluged with symptomatic and asymptomatic patients seeking evaluation and care for possible contamination following a radiation event. Some of these patients will be diagnosed as having acute radiation sickness, others will have diagnosable conditions unrelated to radiation, and a large number will be found to have symptoms for which no etiology can be found. A very conservative estimate of unexposed-to-exposed patients seen in medical settings is 4:1. In the acute aftermath, many unexposed patients will fear that they have been exposed because they will misattribute signs and symptoms of autonomic arousal to radiation. In the longer term, patients will present to primary care providers with multiple somatic complaints for which no etiology can be determined. Appendix A suggests strategies for managing these patients.

I. Healthcare Providers and Mental Health Care after a Radiation Event

Following a radiologic event, people will likely turn to health care providers for information and guidance. For example, following the 2001 anthrax attacks, 77% of a representative sample of Americans reported that they would trust their own doctor most as a reliable source of information. Health care providers play a key role in determining how patients and the general public respond to a radiological terrorist event. A well-organized, effective medical response will instill hope and confidence, reduce fear and anxiety, and support the continuity of basic community functions.

Health care providers are also subject to fear and terror. Absenteeism, flight, refusal to see patients, and other fear-organized behaviors have been reported following infectious disease outbreaks such as the outbreak of pneumonic plague in Surat, India, and other instances of new or unfamiliar, life-threatening agents. Some healthcare providers are prompted by concerns for their personal safety. At times health care providers, like others, have fled their health care responsibilities. Many of those who abandon their responsibilities do so because they feel they need to protect their families, often by evacuation.

Ensuring that health care providers understand radiation and countermeasures for protection can minimize role abandonment. Perhaps most importantly, health care providers are more likely to provide patient care if they believe that their families will be taken care of in their absence. The availability of ongoing telephone contact with families and dedication of personnel to assist health care provider's families will be reassuring to health care providers and help them focus on their mission.

II. Triage and Initial Disposition

Triage and disposition is challenging. For example, in the 1987 Cs-137 accident in Goiânia, Brazil, 8.3% of the first 60,000 people screened, presented with signs and symptoms consistent with acute radiation sickness: skin reddening, vomiting, diarrhea, etc. although they had not been exposed. The term worried well and similar disparaging terms should never be used. When labels suggesting "It is all in your head" are used, patients feel stigmatized and that their health concerns have not been taken seriously. The use of such labels contributes to mistrust of the medical community and a loss of its credibility. A non-stigmatizing triage labeling system such as high risk, moderate risk, and minimal risk conveys continued concern and monitoring which is reassuring to patients.

Mental health professionals, ideally psychiatrists due to their background as physicians, should be an integral part of the teams that perform initial screening and triage. Referral to a mental health specialist is usually experienced as stigmatizing. The patient may feel that the physician has missed some important clue of contamination and is dismissing him prematurely.

The establishment of an Emergency Services Extended Care Center (ESECC) offers an important means of monitoring patients, who remain fearful and are not reassured by negative findings. In the event that a patient is misdiagnosed, the patient can be accompanied back to the Emergency Department. Patients with minor physical problems who cannot return home can be referred here. Ideally, there would be simple tasks that the patients can perform while in the ESECC will help them transition out of the patient role and restore their sense of control.

III. Early Psychological Interventions

Early psychological interventions such as psychological first aid may be provided in the first hours, days, and weeks after exposure to a terrorist event. The most important element of psychological first aid is good medical care. In addition, psychological first aid includes other elements to provide and stabilize patient.

Elements of Psychological First Aid

- Reduce physiological arousal — encourage rest, sleep, normalization of eat/sleep/work cycles.
- Provide food and shelter in a safe environment.
- Orient survivors to the availability of services and support.
- Facilitate communication with family, friends, and community.
- Assist in locating loved ones .
- Keep families together and facilitate reunions with loved ones.
- Provide information and foster communication and education.
- Observe and listen supportively to those most affected.
- Decrease exposure to reminders of the traumatic event.
- Advise decreasing watching and listening to media coverage of overly traumatic images and sounds.
- Educate patients to check rumors with available information resources.
- Use established community structures to encourage social conduct and education such as businesses and faith-based institutions.
- Distribute flyers and host websites.
- Encourage talking to and involvement with the patients natural social supports such as families, friends, neighbors, and coworkers. This will encourage discussion of fears, interpersonal support, and early detection of persistent symptoms.
- Offer reevaluation if symptoms persist.
- Educate about the expected natural recovery that occurs for most people over time.
- Debriefing is a controversial acute intervention that is not part of psychological first aid. In order to provide more information, Appendix B discusses the controversies in detail.

IV. Health Care: Evaluation and Diagnosis

- Psychological and behavioral issues of a radiation release from an RDD will generally far outweigh the physical illness management problems.

- Depression, bereavement, family conflict, and somatization will be the more common psychiatric presentations than posttraumatic stress disorder (PTSD).
- Increased smoking and increased alcohol use can be expected, at least in the short run.
- Sleep disturbance, hypervigilance, decreased concentration, and uncertainty will be common early psychological distress symptoms. These should be managed by education, counseling and perhaps brief use of hypnotic medication for sleep.
- Uncertainty about health effects should be recognized and not minimized in communicating to patients and the public.
- The principles of medical care and management of the patient with medically unexplained symptoms (MUPS) include:
 1. Carefully assessing and recording the specifics of the patients' concerns.
 2. Establishing follow-up/appointments rather than instruction to return if there's a problem.
 3. Obtaining consultative medical management as appropriate.
 4. Listening for patient fears and concerns.
- Patients do not process or remember information well when they are very frightened. Handouts on radiation that summarize key points and instruct on how to get follow-up should be used.
- Many people, possibly up to 50% of those in contaminated areas, will be unsure if they have radiation-related illness.
- Both men and women will be worried about the potential for harm to future generations.
- Negative life events occurring after an attack increases risk for psychiatric illness, illness, and injury.
- Distress is decreased by reinforcing self-efficacy and providing information that can be used to protect the individual and the family.
- The psychological value of distributing potassium iodide and other protective mechanisms can be substantial.
- Patients presenting with multiple somatic complaints to primary care provider may have physical illness, or this may be an expression of distress, depression or demoralization. Accurate differential diagnosis and management of these individuals will require education of primary care providers.
- Lack of baseline health data in exposed populations will lead to the misattribution of illness to radiation exposure by individuals and communities.

- Those with the additional negative life events, either before or after an RDD event, will have more psychological distress and psychiatric illness.

V. Patient Education

- Repeated education about risks and protective countermeasures will help diminish fear, concern, and distress.
- Health care providers should anticipate questions about the safety of their food and water supplies and whether homes are contaminated.
- Educate patients that distress is universal and that they may experience common responses such as sleep disturbance, loss of appetite, and diminished concentration that should resolve over the next several weeks. If these symptoms persist or begin to affect their function at work or home, they should return to their health care provider.
- Fears and preoccupation with cancer will remain high for years. Responding accurately, empathetically and recognizing what is not known is important.
- Many people fear radiation. The images and history attached to the issues of radiation and nuclear power enhance these fears.
- Patients should be counseled to expect to hear conflicting views by experts and, ideally, how to sort through it.
- Health care providers should understand the basic areas of disagreement about radiation's health consequences and be ready to explain them to patients in a very straightforward and simple manner. Uncertainty about health effects should be acknowledged and not minimized in communicating to patients and the public.
- The concept of a threshold dose of radiation below which risk is not changed is difficult for many to understand. Similarly the concept of half life of radiation is not easily transmitted to communities. Simple metaphors or other messages to explain these complex scientific ideas must be developed for healthcare providers to use with their patients as well as in the media. An example is to say "This is like as liquids evaporating at different rates".
- Stigmatization of those exposed or traveling from contaminated areas can be expected. This will affect the relocation and entry of new students into school systems.
- Outreach health education to school systems, parent-teacher education programs and through school nurse training can allay community anxiety.

VI. Special Issues — Children and Pregnant Women

- Parental concern for children will be high. This will be true for children exposed and not exposed.
- Reports by parents of child distress, fears, and worries contain both accurate observations and the fears of the parent.
- Direct assessment of children and adolescents is important to determine the child's mental health because of the high levels of distress in the parents.
- Pregnant women and women with small children will have high concern following a radiation incident. Pregnant women may seek abortion to avoid expected or feared possible child malformations. Special education and counseling will be needed.

VII. Public Health and Mental Health

- Establishment of a clinical registry and appropriate health surveillance are important psychological interventions. Patients who have their contact information recorded in a database will feel more assured that follow-up will be available.
- Smoking cessation programs can be an important public health intervention.
- Handouts on stress and fear management techniques and activities should be available for distribution.
- Public health outreach to senior citizens will be important since their distress may heighten their withdrawal and staying at home. Door-to-door contact programs for this group and those with chronic medical needs who stay at home will be needed.
- Family concerns about genetic effects on future generations will be high.
- People will want to move away from contaminated areas both immediately and over time.
- Many will believe the federal government should pay for their relocation and the cost of lost property.
- Who delivers risk information is as important as, or more so, than the content for whether the information is believed and trusted.
- Contamination of food supplies, in particular milk and ethnically important foods (e.g., reindeer in Norway following the Chernobyl disaster) create acute and long-term education needs and potential health surveillance needs.
- Contaminated communities may manifest cohesion or anger, low morale, and decreased social service due to distress and economic losses.

- Relocation of families is complicated and requires particular attention to familial needs and social justice. Maximizing the choices of families is important. Some will not want to move.
- Expect concern over whether there is equitable distribution of health care resources to those affected or believed to be affected such as food and health care. A perception of inequity will stress social fault lines and may divide communities.
- The rationale underlying prioritization of services must be explained to the public and must be reasonable to those designated as lower priority.
- Expect and plan for ongoing health surveillance for months to years.
- Fears of radiation will mobilize both heroism and avoidance in first responders. Both can have important positive or negative effects on performance.
- Distribution of protective mechanisms including potassium iodide must be closely watched for abuse and exploitation.
- Stress in and around contaminated areas is increased by the often-present need to stay in the location due to jobs or inability to sell one's home. This will have long-term psychological and possibly physiologic health costs.

APPENDIX A

Communication between Primary Care Providers and Patients: Education Strategies after an RDD Event Background

- The virtual imperceptibility of low-level radiation exposures may cause many to develop persistent health concerns or to arbitrarily link idiopathic symptoms to benign or improbable exposures.
- A high percentage of the general population will visit their primary care provider each year, making primary care a crucial setting for dissemination of accurate health risk information following suspected community radiological exposures.
- Even under usual circumstances, a third of primary care patients present for assistance with medically unexplained physical symptoms like idiopathic fatigue and pain.
- Therefore, communication and education plans for primary care health care providers working with health care seeking populations are needed to ensure appropriate medical care and assistance.
- This is one part of the public health response after an RDD.

Primary Care Communications Triage

- After suspected exposure, it is useful for primary care clinics to routine-

ly assess the degree of concern about exposure-related illness, separate from actual exposures, “Is your visit today related to terrorism or radiation concerns?” at the beginning of every visit.

- It is important for all patients visiting primary care, regardless of the reason, that their exposure to the radiation or other toxic agents be determined. In some settings this will be by using technology, and more commonly it will be by the patient’s history of time and place/location over a critical period of time.
- Patients who respond “Yes” or “Maybe” to the questionnaire on their concern about exposure-related illness should receive extra primary care assessment to elucidate the nature of the their concerns and expectations of and goals for the medical visit. These concerns and expectations guide medical triage and the intensity of risk communication efforts.
- Assessment of symptoms and possible disease after an RDD event will include physical and psychological symptoms and disease. Assessment for posttraumatic stress disorder, depressive or anxiety disorders, and altered alcohol or smoking are important.
- Based on this initial primary care assessment of exposure, concern, presence or absence of symptoms, and the presence or absence of medical and psychiatric disease, patients may be assigned to categories for treatment, follow-up, education, and counseling on risk, symptoms, concern, and/or disease findings.
- Often, the primary care provider has the most difficulty in communicating with those who are:
 1. Possibly exposed but unconcerned and with no symptoms or disease.
 2. Either exposed or unexposed with a high level of concern, but with no symptoms of disease.
 3. Either exposed or unexposed with a high level of concern and unexplained symptoms, but no disease. These patients are often categorized as having Multiple Idiopathic Physical Symptoms (MIPS).

Communication Interventions for Critical Primary Care Groups

- *Possibly exposed, but unconcerned with no symptoms or disease* — Many patients will deny or neglect personal medical needs. Assuming medical needs are subacute, careful contact information should be obtained and entered into a local registry to facilitate follow-up to ensure patient has attended appropriately to injuries and exposures.
- *Either exposed or unexposed with high levels of concern, but asymptomatic* — Some patients amplify concerns and repeatedly resist clinician reassurances. In a mass casualty situation, these patients can disrupt de-

livery of critical medical care; plan for these patients by dedicating staff and an area to their care. Development of a careful contact registry with dedicated efforts to provide follow-up contact and care is one way of communicating compassion and concern without succumbing to risky or unnecessary testing. Research suggests that a negative test offers only transient reassurance. False positive results are likely to increase illness concerns. Discussing the basis for patient concerns and exploring what tests the patient thinks he or she might need prevents many patients from feeling that the clinician has not taken them seriously. Planned contingent follow-up reduces worry, increases satisfaction with care, and may mitigate downstream litigation conflicts and concerns.

- *Either exposed or unexposed with high levels of concern and unexplained symptoms (no disease, MIPS)* — As with the asymptomatic concerned patient, the patient with idiopathic symptoms can disrupt delivery of critical medical care. These patients may invoke more clinician anxiety because unlike the patient with isolated concerns, these patients are often visibly suffering and symptoms like chest pain and sweating may sound potentially catastrophic.

In addition to a dedicated area, staffing, contact registry, and redoubled primary care follow-up efforts, intervention for patients concerned with unexplained symptoms should involve brochures, fact sheets, and literature about self-management approaches to medically unexplained symptoms. In the acute crisis, it is helpful to triage these patients to an area distinct from the area used to care for acutely ill individuals, but the area should not be labeled or perceived as a psychiatric care area for patients with unexplained symptoms so it remains maximally acceptable. Many of these patients fear their symptoms represent a harbinger of impending medical catastrophe. Patient resentment can result in a contest in which patients may exaggerate their symptoms until they are afforded medical legitimacy. Therefore, patients with unexplained symptoms should receive early and frequent validation from the clinician that symptoms are important and will be followed up quickly and carefully. The care of patients with unexplained symptoms is frustrating for primary care physicians, especially if the physician feels that these types of presenting patient problems are distracting them from more needed acute care. The use of an onsite ombudsman or advocate who can help patients with unexplained symptoms to overcome perceived barriers to care helps to defuse patient notions that no one cares and affords clinicians' a mechanism to reduce the pressure to meet these patients' needs. The ombudsman can make special efforts ensure that symptoms are acknowledged and their issues are carefully discussed. As with concerned, but asymptomatic patients, planned follow-up time is key. If symptoms persist and expla-

nations for symptoms remain unclear, some of these patients may mistrust clinician motives and develop improbable conspiracy theories. Advocacy for these individuals may reduce the likelihood of eventual litigation including class action lawsuits.

APPENDIX B

The Debriefing Debate

The magnitude of death and destruction in disasters and the extent of the response demand special attention. Physical safety and security of victims and relief workers must take first priority. After safety is assured, other interventions such as debriefing may begin. Debriefing is a popular, early intervention following disasters in which small groups of people involved in the disaster, such as rescue workers, meet in a single lengthy session to share individual feelings and experiences. The effectiveness of debriefing in preventing later mental health problems is much in debate. As a minimum the following should be considered if you include debriefing as part of an intervention plan.

- Rest, respite, sleep, food and water are the primary tools of early intervention.
- It is important to encourage natural recovery processes such as participants talking to fellow workers, spouses and friends. This can decrease isolation and therefore facilitate identification of persistent symptoms and increase the chances of early referral.
- Debriefing has not been shown to prevent PTSD. For some, it may relieve pain, restore some function and limit disability; however, further study is needed.
- There are a number of early approaches other than debriefing such as continued follow-up and reevaluate, case management, problem solving, couples emotional support training, sleep medication, intermittent psychotherapy, psychoeducation, and giving advice. These should be considered in an intervention plan.
- Debriefing during an ongoing traumatic event may be particularly problematic.
- Debriefing is an opportunity for education about responses to trauma such as emotional reactions to disaster, somatic reactions, violence, substance abuse, and family stress.
- During a debriefing there is an important opportunity to identify and triage people who are in need of additional assistance.
- Ongoing groups are more helpful than a one-time meeting.
- Talking in homogeneous groups such as firefighters may be more helpful

than in heterogeneous groups in which people are strangers.

- Individuals dealing with the death of a loved one may have difficulty if placed in a group with others who have survived a death threat. Therefore, it is generally important not to mix those who have experienced a loss and those who have experienced life-threatening exposures.
- Debriefing groups with individuals having different levels and types of exposures may spread exposure from those with high trauma exposure to those with low trauma exposure resulting in more symptoms in low exposure individuals.
- Different people have different stories and concerns. Groups often tend to want to all agree on a single perspective. In a heterogeneous group this may lead to isolation and stigmatization of some participants.

References

- Bromet EJ, Goldgaber D, Carlson G, Panina N, Golovakha E, Gluzman SE, Gilbert T, Gluzman D, Lyubsky S, & Schwartz JE.. (2000). Children's well-being 11 years after the Chornobyl catastrophe. *Archives of General Psychiatry*; 57: 563–571.
- Collins DL. (1992). Behavioral differences of irradiated persons associated with the Kyshtym, Chelyabinsk, and Chernobyl nuclear accidents. *Military Medicine*; 157: 548–552.
- Green BL, Korol M, & Gleser GC. (1999). Children's responses to a nuclear waste disaster: PTSD symptoms and outcome prediction. *Journal of the American Academy of Children*; 38: 368–88.
- Ginzburg HM, Reis E. (1991). Consequences of the nuclear power plant accident at Chernobyl. *Public Health Reports*; 106: 32–40.
- Ginzburg HM. (1993). The psychological consequences of the Chernobyl Accident — findings from the International Atomic Energy Agency study. *Public Health Records*; 108: 185–192.
- National Institute of Mental Health. *Mental Health and Mass Violence: Evidence Based Early Psychological Intervention for Victims/Survivors of Mass Violence*. A Workshop to Reach Consensus on Best Practices. NIH Publication No. 02–5138, Washington, DC, U.S Government Printing Office, 2002 and online at <http://www.nimh.nih.gov/research/massviolence.pdf>.
- North CS., Nixon SJ, Shariat S, Mallonee S, McMillen LC, Spitznagel EL, & Smith EM. (1999). Psychiatric disorders among survivors of the Oklahoma City bombing. *Journal of the American Medical Association*; 282: 755–762.
- Pastel RH, Kahles GR, & Chiang J. (1999). The medical and psychological consequences of radiation dispersal devices. *AFFRI White Paper on Medical and Psychological Effects of RDDs*, Armed Forces Radiobiology Research Institute.

- Raphael B & Wilson JP. (Eds.) (2000). *Psychological Debriefing. Theory, practice and evidence*. London: Cambridge University Press.
- Ursano RJ. Post-Traumatic Stress Disorder. (2002). *New England Journal of Medicine*; 346: 130–132.
- Vyner HM. (1983). The psychological effects of ionizing radiation. *Culture, Medicine, and Psychiatry*; 7: 241–61.
- Vyner HM. (1988.). The psychological dimensions of health care for patients exposed to radiation and the other invisible environmental contaminants. *Social Sciences and Medicine*; 27: 1097–1103.
- Weinberg A, Kripalani S, McCarthy P, & Schull J. (1995). Caring for survivors of the Chernobyl: What the clinician should know. *Journal of the American Medical Association*; 274: 408–412.
- Yehuda R. (2002). Post-Traumatic Stress Disorder. *New England Journal of Medicine*; 346: 108–114.

After a terrorist event there are three groups of psychological responses: those who are distressed; those who manifest behavioral changes; and those who may develop psychiatric illness.

DISASTER LEADERSHIP

Grief Leadership

Leadership in the Wake of Tragedy

In a world where we learn about traumatic events quickly and suddenly through television, social media, or newspaper coverage, many people can be suddenly and deeply affected by grief over the loss of loved ones, friends or relatives. Leaders play critical roles in the recovery of communities and individuals after disasters. Leaders identify the way forward, and hear and understand the present emotions and needs of their community. They communicate and reflect the community's feelings and shared experience in order to lead the community in recovery.

Understanding how people react to tragic events and the roles leaders play in recovery is critical to effective leadership. In the aftermath of traumatic events, many children and their parents, even those not living in close proximity to the event, want to hear guidance from their community's leaders. In this acute phase, leaders must attend to many responsibilities, including effective communication to people who have questions, seek reassurance, and want to take action.

As shock and horror turn to sorrow and mourning, leaders are responsible for identifying the timing of when a community is ready for the next step forward and how best to speak the language of each community to help individuals, families and care providers.

Understanding Traumatic Grief

People vary in their reactions to experiencing or learning about traumatic losses. Most will do fine over time, while for some the immediate reactions can last longer than normal and interfere with their return to their work and families. In the short term, many people experience transient, but powerful, grief symptoms. Early grief can include:

- Waves of sadness
- Intrusive images of the traumatic event and lost loved ones
- Withdrawal from close relationships with family and friends
- Avoidance of activities that are reminders of the event

For some people, grief can be delayed. For others grief may not ever be evident.

Communicate Effectively with Your Community

Worry and distress can spread within and among communities, resulting in rumors and distortion of the facts of the event. Therefore, special attention should be given to optimizing communication with members of your community and with those outside of your community. Formal and informal leaders can be role models for the importance of sharing grief, communicating hope, identifying facts, managing rumors and providing support to others as needs change over time.

Immediate Responses

- **Be visible—Make public announcements and appearances**
By providing useful and accurate information, leaders can re-establish a sense of safety and enhance the community's trust in leadership.
- **Provide Accurate, timely information on what is known, what is not known, and when more information will be communicated**
Press briefings, use of social media and community meetings can reassure families and dispel rumors. Always say when more information will be available.
- **Understand that people process information differently in high stress situations**
Keep messages as simple as possible, repeat frequently, and emphasize positive messages (people tend to focus on negative information when stressed).
- **Use multiple channels of communication**
People Seek information from multiple sources depending on culture, ethnicity, geography, community composition and history. TV, newspapers, radio, ministers, teachers, firefighters and local places of gathering (e.g. post office, grocery, PTA) provide channels for communication.
- **Speak calmly and encourage working together**
Leaders promote calmness, empathy, optimism, a can-do attitude and collective healing and recovery. Direct communication between parents and children is important. Return to school nearly always calms children but can be stressful for parents.
- **Know the status of existing and available resources**
Monitor emerging needs, support fellow community leaders and structures (such as schools, health, public safety).
- **Provide policy and guidance without micromanagement**
Provide support to workers and volunteers with a framework for or-

ganizing and communicating policy. Recognize you cannot be “at the front” everywhere and others must make the tactical decisions. Foster initiative and cooperation.

- **Organize memorial services and sites recognizing the diversity within the community**

Respect the desires and needs for families who have sustained losses. The timing of services is important.

- **Attending funerals is important**

Tears and grieving in public by leaders gives permission to others to express grief and humanizes unthinkable tragedies.

Recovery

- **Focus on future goals**

Reorient the community to future objectives, enhanced preparedness, and “we can do it.”

- **Acknowledge those from within and outside the community who want to and do help**

Establish a climate of healing and community support.

- **Provide common goals for future direction**

Redirect energy into needed recovery projects and respectful remembering and rebuilding efforts.

- **Avoid blaming**

Blame directed towards groups or individuals leads to stigma, anger, and desire for retribution. Redirect energy to providing support and future needs.

Growing

- **Work to return community activities to normal, but tolerate if recovery is slow.**

- **Recovery takes time, is not linear, and is influenced by future events that are always unknown.**

- **Set and celebrate achievable goals.**

- **Community rituals provide an opportunity for individuals and families to heal and reflect on their experience in their own style. These can cross racial, cultural and socioeconomic divides.**

- **Beware of identifying a “we and they”.**

- **Be alert to the fault lines such as racial or socioeconomic differences of the community. These tend to expand and become areas for conflict.**

- **Expect community disappointment and anger after the initial sense of**

togetherness. Help the community understand the changing trajectory of recovery.

- Take care of yourself. You need supporting staff, friends, family who remind you to rest and can objectively advise you about things you do not see or do Not recognize the importance of. Keep your advisors informed and listen to their perspectives.

Resources

Center for the Study of Traumatic Stress	www.cstsonline.org
National Child Traumatic Stress Network	www.ncstn.org
American Academy of Child and Adolescent Psychiatry	www.aacap.org
American Academy of Pediatrics	www.aap.org
American Psychiatric Association	www.psych.org
American Psychological Association	www.apa.org
American Red Cross	www.redcross.org

Leadership and Supervision in Mass Death Recovery Operations

Large scale recovery efforts when there has been mass death require special measures for the recovery of human remains. Physical safety and security of body handlers takes priority over providing psychological counseling. Provide a management structure to direct workers to where they are needed and provide supervision. One of the risks with a task of large magnitude is workers getting lost with no one who knows who or where they are. Supervision is paramount in maintaining an organized, efficient work party for recovery efforts. Jurisdictional issues will be present and will not be easily resolved due to conflicts between investigative and recovery tasks.

It is difficult to predict the kinds of psychological problems that any individual will have, however, the following management plan can help minimize later difficulties. Working with human remains may arouse strong feelings of pity, horror, repulsion, disgust, and anger. When the magnitude of death and destruction from an event is on a large scale, many different groups of workers are involved and often work in isolation from each other. The following management practices can help to minimize difficulties on site and after the event.

- Limit times of exposure to the dead and to the scene and require rest periods for workers.
- Get people off their feet during breaks.
- Provide some immediate change of clothing, such as socks, t-shirts, and underwear, a rest area with fluids, food, cots, facilities for washing and showering, and protection from news media and onlookers.
- If possible, have people return home for food and sleep.
- Over-dedication to the task of recovery is a risk factor for disability. Per-

Working with human remains may arouse strong feelings of pity, horror, repulsion, disgust, and anger.

sons who have difficulty with the recovery tasks often do not want to be dismissed, which may contribute to a sense of failure. Assign them to another task in which they can contribute, but do not use the individual's desire to continue work as the sole factor determining assignment of duties.

- Dealing with personal effects is one of the most difficult aspects of body recovery especially if people personalize or identify with the deceased. Discourage personalizing the deceased.
- Allow people to vary their tasks so they can adjust their exposure. A person who has difficulty with one task may be able to perform successfully in another area.
- Pairing workers with a buddy can help learning the job, combating potential overwork and having to deal alone with the stresses of the work.
- Each person will have a personal way of approaching a scene. It is not advisable to expect the same feelings or actions of everyone. Try to understand each.
- Workers should be advised not to personalize the remains or the situation. They can be told "Think of it as a job!"
- Conflict over jurisdiction can hinder recovery efforts. Assure that workers are performing under proper authority and leadership. National and local authorities are almost always in charge.
- If possible, insist on having a knowledgeable local consultant to assist in understanding cultural practices that pertain to the dead. Take into account the beliefs of the population, but beware of myths and superstitions.
- Risks present and protective measures should be determined by competent authority.
- There is usually negligible risk for disease due to dead remains. Risk of disease from handling dead remains depends on the diseases that are present in the area, the adequacy of sanitation, and the health practices of the population. (For additional information on health considerations on handling human remains, see <http://www.bt.cdc.gov/disasters/pdf/handleremains.pdf>.)
- The health and welfare of the living will be given priority over the recovery of the dead.
- There is always pressure to complete a recovery effort quickly. In spite of pressure, limit the times of exposure of workers to the dead and require regular work shifts and rest periods.
- Leaders and supervisors should visit work areas frequently and engage workers in conversation of the worker's choosing.

- To provide support, engage workers in conversation of their choosing – not necessarily about their feelings or the scene. Talking about the events of life is central to health.
- Praise people's work and reward their efforts. Awards, letters, certificates are all appropriate.

In mass death recovery, a good management plan can help minimize later difficulties.

Media Management in Remains Recovery in Mass Death Operations

The media are often the major means of communication about disasters. Accurate information about such events is critical for the public perception of what has transpired and likely next steps. It is the responsibility of all persons involved in the recovery of remains from mass death to provide truthful and accurate information to the media. However, there should be only a limited number of persons who are authorized to provide information to the media. Such information, while accurate and truthful, must respect and be sensitive to the dead, the living, and the workers. Guidelines are applicable before, during, and after the event. The following information applies to United States authorities. These practices may help you to provide the media with the best possible information.

- Preparation is the key to success in any encounter with the media. Develop information in pro-active manner (i.e., anticipate what you will be asked and prepare an answer). Also prepare answers to questions you do not want to be asked.
- Know what to release and what not to release. Some information is protected by statutes such as the Freedom of Information Act and the Privacy Act and others.
- Distinguish between information that is internal (part of the organization's operations), external (what is going on at the site), and community (what is going on around the site). Remember that it is almost impossible to keep the internal from becoming external.
- Treat the media as an ally. They are there to tell your story. If you help them, they will most likely help you. Do not treat the media as an enemy without cause.
- Know local practices including how death is discussed in the culture. If possible, have a knowledgeable local consultant to assist you.

Preparation is the key to success in any encounter with the media.

- In giving an interview, remember the following:
 - » Keep answers brief. Answer in sound bites that you want the media to use rather than providing long answers to attempt to tell everything. In such responses, your own expertise can be your enemy.
- Stick to the issue at hand. Know and communicate the who, what, when, where, why, and how of your organization's involvement in the event. Avoid speculation and personal opinion.
- Provide action communications: what you bring to the situation and what you are doing about the problems. Always be polite and friendly. Keep your cool.
- Explain the importance of your actions and how they fit into the larger context.
- Provide a message along with a fact. A message is what you want the public to hear. This is sometimes called "the care factor." Example of a message: "We are doing all in our power to see that the remains are being handled as local customs dictate."
 - » Do not be afraid to say "I don't know, but I will try to find out the answer for you."

Treat the media as an ally. They are there to tell your story.

Notifying Families of the Dead or Missing

This document is written for leaders, healthcare providers, and disaster workers who assist local and national authorities following natural disasters, terrorist actions, or other events that result in large numbers of dead, injured, and missing persons.

In a natural disaster of great magnitude and scope, multiple countries are directly affected and many nations' citizens from outside the region are killed or missing. In such an event, providing information to families whose loved ones are missing is accomplished by government organizations including embassies, state department consular staff, and military services as well as a number of non-governmental organizations such as the Red Cross. Nations have different organizations that are likely to be involved. Procedures for notification of the next of kin when a family member or loved one is missing or has been confirmed dead are usually highly structured, formal and depend on the particular citizen's country's laws, customs, procedures, and traditions.

Non-local disaster workers will be most successful when acting through local authorities. In the absence of official authorities, guidance can be sought from local personnel who hold a respected place in the affected communities. Local officials should perform the notification whenever possible. Local customs will usually dictate who does the informing, who in the family is informed, documentation of the circumstances of the death (manner and cause of death, condition and location of the remains) and actions yet to be taken, if any, before the body is returned to the family.

When a person is missing, the following information will help authorities to communicate with family members: the circumstances at the disaster site, status of efforts to recover remains, and how remains will be returned. Do not offer guarantees about the time required or assurances that a body will be recovered.

Procedures for notification of death are usually highly structured and formal and depend on the particular citizen's country's laws, customs, procedures, and traditions.

The following Dos and Don'ts are general recommendations for those who assist local and national authorities following mass death.

Do

- Educate yourself on local attitudes and beliefs regarding death and the dead
- Locate local authorities who can inform you about customs and procedures and introduce yourself. These are important relationships that facilitate the work.
- Determine the type and location of local/national and international sources of assistance to the families
- Be sensitive and consider that cultural and religious beliefs about post-mortem examination of the dead vary widely. Be prepared to explain why special procedures such as autopsies may be necessary.

Don't

- Inform anyone outside of local authorities or the family of the death. Your local contacts can help you determine who are the appropriate family members to inform.
- Offer information, goods, or services that you cannot deliver or confirm
- Institute procedures that conflict with local customs
- Tell the news media names of victims, circumstances of death, or condition of remains

For Personnel Who are Participating in the Actual Notification of Family Members

Do

- Make sure you are speaking to the appropriate next of kin
- Make the notification in person and in a private area with all parties seated whenever possible.
- Be accompanied by clergy or other appropriate sources of spiritual support
- Inform in a simple, measured straight forward fashion. "I'm afraid I have some very bad news for you. (pause) As you know there has been a (disaster) in ____ .(pause). Your_____has died. (Your_____is missing and presumed dead)."
- Be warm, compassionate, and prepared for intense feelings. Comments such as "I am so sorry" or "I know this is very hard" are helpful.

- Answer all of the questions that you can simply and honestly.
- Ask if the survivor has another family member or friend who can stay and help with the initial adjustment
- Inform the family of additional people to contact and who will contact them regarding disposition of remains.

Don't

- Offer clichés such as “Things will get better” or “I’m sure it will all work out”.
- Offer false assurances such as “The embassy will take care of everything,” or “I’m sure you’re going to be OK”.
- Offer unsubstantiated comments about the circumstances or experience of the deceased “I’m sure he didn’t suffer”.
- Leave someone alone without arranged contacts.

Funerals and Memorials

A Part of Recovery

A memorial service is an important step in the chain of events that occurs after a death. For many, it may be difficult because it brings reminders of the loss and fears of the future. Funerals and memorials provide an opportunity to show appreciation for the person, to grieve together, and to make a new beginning. At funerals and memorials, attendees will encounter families as well as the religious and patriotic symbols, music, ritual, and ceremony, the personal effects and the history of the deceased, and will hear about the deceased's place in the family, community, organization, and nation.

The following are important elements in most funerals and memorials.

- Leaders should not be afraid to show their humanity through some displays of emotion and providing comfort to others. It is helpful to not worry about having the right words as much as just being yourself.
- Funerals and memorials bring powerful reminders of the humanity of the deceased. Sadness, tearfulness, and anxiety are common feelings.
- Pictures and remembrances from the person's life and favorite objects may be displayed. They are powerful symbols.
- Pictures and personal possessions may be passed on and an individual's history recounted by survivors.
- Family, friends, or co-workers may provide details of the person's history, the last time they were together, or their favorite memory.
- When due to violent death, remains are seldom viewable.
- Saying goodbye may be more difficult for many in this setting. The presence of pictures and remembrances may be particularly important.
- Families may request an object from the location where the person died as a remembrance.

Funerals and memorials provide an opportunity to show appreciation for the person, to grieve together, and to make a new beginning.

- Leaders should actively support family, friends, and coworkers of the deceased.
- Communities (such as the, police, firefighters, or a corporation or business) often extend beyond local geography and encompass vast numbers of people of all faiths, races, ages, and personal histories.
- It is important for leaders to remember that they provide support to a diverse audience.
- This support network often provides hope that people are remembered and that they left a legacy of family, friends and associates.
- The many differences within and between faiths on how funerals and memorials are conducted need to be recognized and respected.
- If the attendee is not familiar with the type of service being conducted or different ways of expressing grief, it is wise to inquire beforehand what to expect.
- It is helpful to ask the person who conducts the ceremony to give an explanation of the ceremony for others who are not familiar with that faith or its rituals.
- Leaders who are asked to officiate or speak at such events are likely to fear faltering and failing to say the right words. Often, there are no right words; the human presence speaks for itself. Sometimes presence is all we have to offer, but presence is powerful.

Managing a Workplace or an Organization after Disaster

A disaster such as an earthquake or hurricane creates unusual challenges for management. You and your staff may find yourselves suffering from its effects. Emotional stress, physical injury, bereavement, loss of property, and disruption of normal routines may limit the availability and energy of your work group. At the same time, the group may face new responsibilities — caring for its own members and facilitating community recovery. Besides meeting customers' special needs for assistance following a disaster, personnel are often called on to support local authorities in providing community services. Much of the human suffering associated with a disaster happens after the event itself, and can be mitigated by effective management. The following can help you structure your response.

- **Take care of your people first.** First locate your staff and assure that they and their families have necessary medical care, housing, food, and other necessities so they can be effective in the workplace. This task will be easier if you have planned for it in advance. Modify office rules and procedures that are counterproductive after a disaster. Dress codes, rules about children in the office, and restrictions on using telephones for personal business, for example, may need to be adjusted in the post-disaster period.
- **Take steps to prevent accidents and illness.** Review the workplace for physical risks recognizing that attention and energy will be less than usual. Reinstate training for emergency response and communications for help. People who are exhausted often forget to take necessary steps to prevent injury and illness. Reminders and retraining can be valuable.
- **Prevent overwork and exhaustion.** After an initial crisis period during which overwork may be necessary, develop procedures to assure

Disasters create unusual challenges for management.

that employees do not work too many hours without rest. It is particularly important to prevent the overwork and exhaustion that can occur as people throw themselves into disaster recovery operations, because exhaustion raises the risk of accidents in the already dangerous post-disaster environment. Exhaustion and lack of sleep can decrease alertness, impair judgment, and make people more vulnerable to accidents. Establish work and rest times. Rest is best when it is away from work unless safety at work is greater.

- **Attempt to provide adequate staffing** for all new responsibilities created after the disaster, and for usual responsibilities that become more demanding as a result of the disaster. Prior planning and cross-training can make a big difference. Set clear priorities, including identifying work that simply will not be done in the short term. Be sure that no employee has an essential task that no one else knows how to do, or that person will surely be overworked.
- **Train managers to monitor their subordinates.** Ensure that none are working excessive hours, and check for signs of exhaustion. In stressful times, leaders and highly dedicated employees are more likely to overwork than other personnel. It may seem ironic, but senior leaders need, after a disaster, to pay more attention to the conscientious individuals who normally need the least supervisory attention. Point out to subordinate leaders that they need to model healthy behaviors; this will help them monitor their own tendencies to overwork.
- **Encourage and facilitate healthy, safe behavior.** Remind employees of the importance of getting adequate sleep and rest, drinking enough water, and taking whatever precautions are necessary in the environment. Pay close attention to information from local public health officials since risks may change as the situation develops.
- **Do not only tell people what to do; make it easy for them to do it.** Provide safe drinking water and remind employees to drink water regularly. It is not uncommon to become dehydrated under stress. If your building's water supply is unsafe, don't just tell people not to drink it. Physically block water fountains with tape, cardboard, etc., and post prominent signs above washbasins. Getting a quick drink of water is such an automatic behavior that people will forget to change their habits without an immediate, vivid reminder.
- **Avoid unnecessary travel.** When travel is necessary, try to organize carpools with a well-rested driver who knows the area rather than sending each employee off alone. Consider alternative work arrangements that can reduce the time employees spend commuting.

- **Most people are resilient and will recover from their traumatic experiences.** To facilitate the recovery process, survivors of disasters often need to talk about what they have gone through, compare their reactions with those of others, exchange information, and provide one another with support and consolation. The most effective way is usually to make it easy for people do it when they feel ready, not to pressure them to talk about the traumatic situation at a time when they feel the need to be silent.
- **Provide an informal break area** where employees can gather for snacks or lunch and spend a little time talking with their co-workers. Whenever possible, try to keep existing work groups together to build on the strength of existing ties among co-workers. If an employee must be deployed alone or with strangers, find a way for them to communicate with the larger organization, get information about how their co-workers are faring, and be assured they are still part of the group. Visits by management to the site of deployment can help improve morale.
- **If you have a mental healthcaregiver** such as an employee assistance professional (EAP), make that person available in an informal way to talk with employees where they work. Most people will not need extensive personal counseling, but will appreciate information and advice about issues such as how to deal with their children's reactions to the disaster. A few people may need more extensive mental health assistance. EAPS are traditionally well informed and resourceful about locating professional care for those who need it.

Section 4

SPECIAL POPULATIONS

Introduction

This section, Special Populations, provides information for teachers, law enforcement, business leadership, workplace mental health professionals, and victims and witnesses who must testify in criminal mass casualty trials. The workplace was the target of the events of 9/11, as well as the anthrax attacks on our nation's Capitol. Workplace violence has also become an all too common disaster. Disaster preparedness and response is an important component of workplace mental health and safety. First responders, especially those in law enforcement, are an integral part of disaster response frequently working long hours to fulfill community needs around tragic events. The information in this section recognizes the important role many professionals have when those they serve are affected by stressful events that require informed and compassionate outreach to sustain people of all ages and environments affected by trauma.

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Teachers Listening and Talking After a Traumatic Event

The magnitude of death and destruction in a traumatic event require special attention to communicating with children and adolescents. Physical safety and security always take priority. School is an important normalizing experience for children and adolescents. It is difficult to predict the kinds of psychological problems that children and adolescents will have; however, the following management plan may help minimize later difficulties:

- Every student has a different way of responding to trauma. It is not advisable to require the same response of everyone. Listen to your students' stories.
- Maintain daily routines to the extent possible. Now is not the time to introduce new routines. Familiar schedules can be reassuring.
- Your response to the disaster will affect your student's response; therefore, it is helpful to discuss your own reactions with other adults and teachers before talking with your students.
- Provide structured time to discuss the event in the classroom. Be alert to students expressing overwhelming feelings in discussions. Limiting time can help the student express what they wish and not more than they might wish they had.
- Maintaining the usual classroom routines can be comforting. Even regular schoolwork can also provide some sense of familiarity and comfort to some students.
- Encourage school faculty and staff to discuss and plan classroom interventions together.
- Be available to meet individually with your students.
- Discuss the event in an open honest manner with your students. Chil-

Every student has a different way of responding to trauma. Listen to your students' stories.

dren might want to talk intermittently, and younger children might need concrete information to be repeated.

- Limit exposure to television and other sources of information about the disaster and its victims. Too much exposure increases distress through over-identification.
- Help students limit the extent to which they personalize or identify with the victims or the situation. Remind students that they are safe at school. To decrease over-identification with the victims provide concrete information about how they differ from the people involved in the disaster.
- Engage your students in conversations of their choosing — not necessarily about their feelings or the scene. Talking about the normal events of life is central to health.
- Increase your students' sense of control and mastery at school. Let them plan a special activity.
- Older children and adolescents may feel stirred up. Helping them understand their behavior and setting limits at school can help.
- Some children may respond by being distracted or having trouble remembering things. These should be tolerated and understood.
- Be alert to changes in students' usual behavior such as a drop in grades, loss of interest, not doing homework, increased sleepiness or distraction, isolating themselves, weight loss or gain).

Teachers Helping Students: Talking Points for the Classroom

For Younger Students

- Reassure younger students that they are safe and that their parents and other adults will take care of them.
- Fearful younger students may need to touch base with their parents from time to time throughout the day during the early stages following the crisis.
- Acknowledge questions about the death and the destruction.
- Acknowledge your student's feelings: "You sound sad (angry, worried,...)"..."Are you sad (angry, worried)?"
- At a time when you are feeling calm and able to listen and share with your students, acknowledge that you, too, may feel sad, angry, or worried. Lead discussions that will help younger students gain a sense of mastery and security. "You have asked good questions." "That was a good idea."

For Older Students

- Acknowledge the importance of peers in helping to reestablish normalcy.
- For many teens, their cognitive abilities are often greater than their emotional capacity to manage highly stressful situations. Expect emotional swings.
- Remember the importance of providing emotional support by naming the expectable reactions of sadness, numbness, anger, fear, and confusion. Explain how inappropriate giddiness, laughter, or callousness are often used to distance ourselves from becoming overwhelmed.
- Help your middle and high school students reframe their expressions of rage or despair. Focus on helping them to find positive solutions to the situation. Coordinating memorial ceremonies or special school assemblies or donating their time and creativity to fundraising, blood drives or other activities in which they feel that can help others are ways your students can learn the benefits of altruism.

Helping National Guard and Reserve Service Members Reenter the Workplace

This fact sheet explains some of the emotional and psychological issues that National Guard and Reserve service members may experience transitioning from active duty into the workforce — be it their former job or a new position. It is written for both the military and civilian community. The veteran's return to work is an employment transition. He/she often brings new skills of leadership, teamwork and a broadened perspective from having served our nation, which can be invaluable to the civilian organization. We hope the following information can help your company welcome home all service members.

Background

Over one million Reserve and National Guard troops have served in the U.S. military today. Of the American service members who have served in Iraq and Afghanistan, a high percentage of both groups have been from Guard and Reserve units. They may have been activated for long periods of time away from their family, workplace and community.

The Following Tips May Be Helpful in Preparing Your Workplace:

- **Dispel myths.** There are numerous myths about returning soldiers, sailors, airmen and marines — that they will be changed, unable to adjust or troubled. In preparing your workforce for return of military members, it is important to set a climate of positive expectations for all employees emphasizing productive, supportive and effective work relationships and performance.
- **Foster respect and reintegration.** Meet beforehand with colleagues of the returning service member to discuss the transition, its impact on

There are emotional and psychological issues that reservists may experience transitioning from active duty into their former job.

your team and related concerns. Planning a welcoming event such as a breakfast, lunch or office party is an appropriate gesture that can foster cohesion and a sense of community.

- **Prepare the transition.** The transition back to work involves realignment and renegotiation of roles and responsibilities — old tasks return to the employee and new ones are added. Prepare the returning soldier for any significant changes, as he or she will be alert to whether or not “The things I used to do” are still in place.

Prepare the person who may have occupied the position during the military member’s service. Understand that they too have a process of readjustment. Acknowledging this and expressing appreciation for their work will further assist in setting a climate of respect, trust and acceptance.

The transition can take time. Job-related training and education in areas such as new software programs or administrative management can help the returning military member feel confident in his or her skills and knowledge.

Plan special accommodations for those who have been injured. Self esteem is greatly tied to being able to work. Thoughtful and timely planning to accommodate injury will send a positive message to the entire workforce.

The transition will go very well for the vast majority of returning individuals. A small number who have been exposed to combat or other threats to life and those who have personal issues such as divorce or financial problems are likely to experience additional stress. Persistent sadness, withdrawal, sleep problems, family or work place conflict as well as any alcohol or other substance abuse problems require early attention and referral for medical support. It may be helpful to reinforce how to access services for evaluation and treatment and the confidentiality of employee assistance.

Workplace Reintegration Roadmap for Managers

It is helpful to view the return and reentry as a process in which some or all of the following phases and issues may unfold:

- **Anticipation.** There is always anticipation in returning to one’s family and workplace. The transition back to work is as important for many as returning to one’s family, and for some even more meaningful. Providing information through thoughtful and supportive communication is important in reducing anxiety and welcoming back the returning service member. Supervisors and managers need to share information about workload, policy and personnel issues and changes that have taken place during the individual’s absence.
- **Homecoming.** Celebrating is important. Let the service members know you are proud of their sacrifice. In many ways, the immediate return period is a honeymoon of sorts. Sooner or later the reality of homecoming is contrasted to the hopes and expectations of what life would be like

after the war. It is normal for the service member to experience some disappointment or let down in the process of returning home and to the workplace.

- **Coping with change.** Some people take deployment and the return home in stride, without missing a beat, while for others it becomes a defining point in their lives. It is only natural to experience a sense of change after returning from a deployment. Individuals re-connect with their past life and attempt to integrate their experiences of deployment with the rest of their life. Training and education can aid this transition by providing structure, growth and a concrete sense of accomplishment during this period. Supervisors and managers should recognize the acquisition of new skills — leadership, teamwork and problem-solving— that have taken place during deployment and seek avenues for their expression and recognition in the returning soldier's job and workplace.
- **Range of reactions.** Coming home represents a return to safety, but the routines of home and work are markedly different from regimented life in a war zone. Upon return, service members may miss the focus and intensity of missions during war. There may be ambivalence about these feelings or reluctance to discuss them for fear of offending those who awaited their return. It may be helpful to reinforce the confidentiality of your employee assistance program, its array of services and how to access help.
- **Successful readjustment.** Work provides meaning and gratification in life. It is one of the most important components of successful readjustment to civilian life. The returning service member will appreciate the efforts of management, colleagues and your organization.

The following websites have additional information:

- **Employer Support of the Guard and Reserve**
Facts sheets and resources for employers and Guard and Reserve on all aspects of workplace reentry: its implications for employers and employees at:
<http://www.esgr.org>
- **The Real Warriors Campaign**
Fact sheets and information for employers
<http://www.realwarriors.net/guardreserve/reintegration/employers.php>

Business Leadership in Terrorism Preparedness

“Leaders may possess brilliance, extraordinary vision, fate, even luck. Those help: but no one, no matter how gifted, can perform without careful preparation, thoughtful experimentation and determined follow-through.”

“Prepare Relentlessly” Leadership, Rudolph W. Giuliani

Why Business Leaders Should Prepare

The workplace has been the primary target of terrorism in the United States: 9/11, the anthrax attacks of 2001, the Oklahoma City bombing, and the 1993 World Trade Center bombing. The goal of terrorism is to erode our sense of national security, disrupt the continuity of society and destroy social capital—morale, cohesion and shared values. In taking a proactive role to protect their organization’s security, business continuity and employee health, business leaders should be aware that the workplace:

- Is a newly recognized environment for preparedness.
- Has existing resources to facilitate preparedness.
- Can reframe preparedness to promote resiliency, business continuity and social cohesion.

However, managers should anticipate resistance to attempts to prepare.

Workplace Recognition

The Institute of Medicine report: *Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy*, recognizes the workplace as an important environment for addressing the psychological consequences of terrorism” (IOM, 2003). The IOM report:

- Recommends a public health approach to workplace preparedness encompassing pre-event, event and post-event planning and responses.
- Presents a critical incident business model. Address preparedness as con-

The workplace has been the primary target of terrorism in the United States.

sequence management that recognizes responses to disasters, terrorism and bioterrorism affect as involving employees and their families, leadership and their families, policies, markets and partners.

Workplace Resources

- The corporate infrastructure has available resources for preparedness and response.
- They include corporate security, health promotion and employee assistance resources, human resources, business continuity and asset management, and engineering and facilities.
- Integrating these resources and functions maximizes disaster response.

Workplace Resistance

- “Preparation will raise more anxiety.”
- Employee may resist practice drills and fitness issues.
- Corporate continuity silos may operate autonomously. Examples are security, employee assistance, medical, human resources.
- Diversity of workplace culture, and physical plant may require different approaches.
- Attitudes of “Takes too much time, cost and there is nothing we can really do”.

Workplace Resiliency: Reframing Preparedness

- Resiliency is a topic of interest in the workplace.
- Resiliency is the expected outcome of disaster.
- Resiliency crosses domains: productivity, employee health, business continuity.
- A corporate resiliency model reframes negative implications of preparedness to engage participation and lessen anxiety.

Business Preparedness Leadership: Public-Private Sector Partnering

Roughly, 80% of America’s critical infrastructure is managed by the private sector. A partnership between the public and private sectors in responding to the threat of terrorism strengthens homeland security infrastructure. The federal disaster response system is geared to intervention and treatment of immediate needs. Business leadership in preparedness education, event crisis management and post-event evaluation complement federal resources and contribute to social cohesion and morale.

“Creating reasons for those who work for you to establish their own culture of preparedness is part of being a good leader...”

“Prepare Relentlessly” Leadership, Rudolph W. Giuliani

Resources

Center for the Study of Traumatic Stress at <http://www.cstsonline.org>

Terrorism and Disaster, Ursano, R J, Fullerton CS, Norwood, AE Cambridge University Press, 2003

Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy, The National Academies Press, 2003

Pandemic Planning and Response

Critical Elements for Business Planning

Pandemic preparedness and response is a shared responsibility involving local, state and federal governments and the private sector. A pandemic has the potential to be a disaster of unprecedented scale. An example of a pandemic is a national or worldwide influenza outbreak.

While many businesses have extensive contingency plans in response to threats from diverse natural and manmade disasters, pandemic planning must address health and mental health impact assumptions and containment strategies.

A pandemic will likely reduce dramatically the number of available workers in all sectors, and significantly disrupt the movement of people and goods, which will threaten essential services and operations across the nation. The ability to implement effective pandemic preparedness plans, continuously monitor all business activities, and effect rapid adjustments based upon observed and anticipated impacts will be the hallmark of the business that copes most effectively during a pandemic. The following points related to an organization's human continuity are often forgotten and must be incorporated into workplace pandemic planning to sustain employee health, mental health and productivity.

Pandemic Planning and Response for Human Continuity in the Workplace

- Distress behaviors and resilience, not just illness, are critical targets for workplace planning and response efforts. Health risk emotions and behaviors to be mitigated include worry, fear, insomnia, difficulty concentrating, avoiding certain situations at work, and increased use of alcohol or tobacco. These do not constitute disease but nonetheless disrupt and diminish social and occupational functioning.

Pandemic preparedness and response is a shared responsibility involving local, state and federal governments and the private sector.

- Employee health protective behaviors such as movement restriction or home quarantine must be encouraged to reduce disease spread, but these behaviors will impact productivity.
- All workers and workforces are not the same. Small businesses often do not have internal or employee health assistance resources for psychosocial support that larger workplaces may have. Smaller companies do not necessarily have access to professional security, occupational health or employee assistance programs.
- Sustained support over the trajectory of a pandemic will require considerable resources and a shifting of emphasis over time. The impact of a pandemic is not the same as a single-event disaster and requires planning for a prolonged or extended impact.
- Family care and support are critical to business continuity.
- Leadership endorsement of and participation in prevention and preparedness are necessary for success. Grief-related distress is likely to be a significant contributor to the overall emotional and behavioral toll of a pandemic.
- Business-community integration and pooling of resources must be explored. Businesses must address identify who will comprise their human response teams to conduct critical incident needs assessment (CINAT) during pandemic and facilitate adaptive response.
- Knowledge of and delivery of psychological first aid (PFA), an evidence-informed intervention favored over debriefing in the immediate aftermath of disaster, must be considered in workplace pandemic planning and response.
- Continuation of worker productivity is not only important to national infrastructure and security, but an important contributor to the sustained mental health of the population.

Recovery in the Aftermath of Workplace Violence *Guidance for Workers*

Returning to work routines following any violent incident at the workplace can be very challenging. Even after the work area is secured, and victims or perpetrators are no longer present, emotional reactions and distress may reduce concentration, motivation, and performance. However, there are steps you can take to reduce the negative impact of your traumatic experience.

The first requirement for individual and office recovery after violence is assuring safety. You should know that victims, intended victims, colleagues and bystanders may experience significant emotional distress whether or not they were physically injured. People closest to the event or those with close relationships to the victim(s) or perpetrator(s) will likely be most affected. For the majority of people the cornerstone of emotional recovery is talk. You can help yourself and your colleagues by talking with them. When you demonstrate your willingness to discuss the event and your own emotions you help others do so. Some people will not want to participate in group discussions.

If you are very uncomfortable in group settings it is important to be able to speak one-to-one to a supervisor. After workplace violence many supervisors have an “open door policy” to allow this to happen. Since a sense of “normalcy” and a return to normal work schedules and routines helps most people adjust after violence, your supervisors will encourage this. A sense of normalcy occurs gradually. The more traumatic and dramatic the event, the more likely that people will be emotionally affected, and these memories and reactions will only gradually fade. Most people move on to integrate a tragedy or otherwise significant event into their consciousness without con-

Returning to work routines following any violent incident at the workplace can be very challenging.

tinuing mental distress or disability. The actions below will help you develop a sense of safety and speed return to normalcy.

Immediately after the event, make sure that:

- All employees or others at the workplace are accounted for.
- Medical attention has been received or ordered for all who need it.
- You have a way to contact family and friends.
- Others who are distressed have someone to look out for them.

As soon as possible after the event:

Returning to work routines following any violent incident at the workplace can be very challenging.

- Help clarify what actually occurred and provide accurate information. Help supervisors discuss:
 - What is known about the event?
 - Who was the victim?
 - Who was the perpetrator?
 - How did the incident happen?
 - Why did the incident happen?

Before you leave work on the day of the incident,

make sure your questions have been answered about what is known and further instructions. Try to provide as much information as you can about what occurred. When you go home:

- Limit your use of alcohol, tobacco, and junk food to usual levels.
- Drink water.
- Limit unnecessary driving.
- Talk to your family and friends about what happened.
- Sleep and rest.
- Exercise can also help reduce distress.

Days following the event:

If you are close to someone has been killed or injured in the event a hospital visit with family members may be helpful to you and the family. If a friend or loved was killed or injured, or if you were directly exposed to the violence, you may experience strong emotions, difficulty concentrating, or hopeless thoughts. It is important to talk with a counselor or seek medical attention if these symptoms persist. If your workplace is closed due to damage or an ongoing investigation your employer should provide instructions

about alternative meeting places to discuss events and to keep work flowing. Returning to work is important to recovery, and work routines contribute to the sense of normalcy.

When your work group meets again,

your supervisor will probably review what was known at the time, review security and safety procedures, and update you on new developments. Listen to others who were present during the incident to get a full perspective. Feel free to provide input and answer questions but do not be afraid to say “I don’t know.” If there are legal (privacy) issues, you should be informed about limits on what you can talk about. Meetings should be short. If more discussion seems necessary, additional meeting times will be scheduled. Talk to your supervisor about attendance at funerals or memorial services. These may be difficult—but also helpful.

Advice for workers who must continue to function following an incident:

- Try to pace yourself and pace your decisions.
- Consider different courses of action.
- Avoid snap decisions that may have to be changed).
- Take breaks when possible and relax ways that helped in the past. Exercise helps.
- Rest and relax off of your feet when there are opportunities.
- Identify a trusted co-worker to bounce ideas off, serve as a buddy and look out for after you.
- If you must continue to work immediately after workplace violence limiting alcohol and tobacco use, excessive junk food, and unnecessary driving are particularly important.
- Do not overwork. Trust others to help and get the job done.

Recovery in the Aftermath of Workplace Violence *Guidance for Supervisors*

Supervisors face particular challenges following any violent incident in the work setting. Even after the work area is secured, and victims or perpetrators are no longer present, emotional reactions and distress behaviors may compromise performance. Leaders may take steps to reduce untoward consequences for employees and for the workplace.

The first requirement for the office staff recovery is assuring safety. Leaders should be aware that victims, intended victims, colleagues and bystanders may experience significant emotional distress whether or not physically injured—but those closest to the event, or with close relationships to the victim(s) or perpetrator(s) will likely be most affected.

For most employees, the cornerstone of emotional recovery is talk and leaders can best assess their employees by talking with them. Leaders should demonstrate their willingness to discuss the event and their own emotions. As some people will not want to participate in group discussions it is essential that supervisors speak with these individuals one to one to gauge their feelings and mental state. An open door policy and management presence or informal checking in may be helpful.

The second most important leader action in recovery is promoting a sense of normalcy and a return to normal work schedules and routines. A sense of normalcy is achieved gradually. The more traumatic and dramatic the event, the more likely that people will be emotionally affected and these memories will only gradually fade. Most people move on to integrate a tragedy or otherwise significant event into their consciousness without continuing mental distress or disability. The actions below will help managers foster a sense of safety and of return to normalcy.

The cornerstone of emotional recovery is talk and leaders can best assess their employees by talking with them.

Immediately after the event, make sure that

- All employees or others at the workplace are accounted for.
- Medical attention has been received or ordered for all who need it.
- Employees are encouraged to, and have a way to contact family and friends.
- Those who are distressed have someone to look out for them.

As soon as possible after the event,

clarify what actually occurred and provide accurate information to the staff

- What is known about the event?
- Who was the victim?
- Who was the perpetrator?
- How did the incident happen?
- Why did the incident happen?

Before staff departs on the day of the incident,

gather facts and solicit staff input. Try to provide as much information as you can about what occurred, and provide the following guidance to employees:

- Limit consumption of alcohol, smoking materials, and caffeine, and junk food beyond usual levels.
- Drink water.
- Limit unnecessary driving.
- Talk to family and friends about what happened.
- Sleep and rest.
- Exercise can also help reduce distress.

Days following the event:

If staff have been killed or injured in the event, a personal call or hospital visit if possible from a senior leader to close family members often reduces anger. If the office is closed due to damage or an ongoing investigation, determine alternative meeting places at which to discuss events and keep the work flowing. Returning to work is important to people, and work routines contribute to the sense of normalcy.

When the office staff meets again,

review what was known at the time and update the staff on new developments. Solicit input from others, including persons who were not present during the incident. Security procedure reviews are practical safety measures, communicate leadership concern, and encourage staff input. Answer

questions truthfully and do not be afraid to say “I don’t know.” If there are forensic, legal, ethical or privacy issues, make people aware of them and what should not be said because of these constraints. Limit meetings to approximately an hour. When more discussion is necessary divide meetings into morning and afternoon sessions. Limit discussions when workers are distraught, tired, sick, or otherwise less likely to benefit. If deaths have occurred, supervisor attendance at funerals and initiation of memorials demonstrates concern and promotes expression of emotion among workers.

Advice for leaders who must continue to function following an incident:

- Promote a sense of calmness and control.
- Avoid snap decisions that may have to be changed.
- If distressed, take breaks and relax in ways that helped in the past. Exercise helps.
- Rest and relax when possible.
- Identify a trusted colleague to bounce ideas off and serve as a buddy (i.e., someone to look after you).
- Follow the same guidance you have given your employees about alcohol/tobacco use, excessive junk food, and unnecessary driving.
- Do not overwork. Trust others to help and get the job done.
- Reward/compliment others for their work, particularly in a crisis situation.

Disasters and Poverty

Natural Disasters Disproportionally Affect the World's Poor

Over 90 percent of deaths due to natural disasters occur in poor countries. Even in developed countries, poor citizens are most affected by disasters. Poor residents of New Orleans bore the heaviest loss of life, health and property due to Hurricane Katrina. An event of similar physical magnitude is likely to cause more deaths in a developing country than in a developed country. The disparity in disaster outcomes between rich and poor can be understood as a function of both pre-event vulnerability and post-event response. Factors such as geography, personal resources, community infrastructure and political stability all impact the occurrence and consequences of natural disasters.

Social instability may also accompany poverty particularly when there are large disparities in the distribution of wealth and income. Such disparities may be marked by different language preferences. For example, in Haiti, the poorest nation in the Western Hemisphere, French is often taken as the language of the privileged and Creole the language of the poor. “Just because you speak French does not mean you are smart” can be a call of the poor and disadvantaged who are also stigmatized and denied services as well as respect.

- **Geography:** The poor are more likely to live in less expensive and environmentally vulnerable areas such as flood plains, volcano bases, seismically active areas or tornado alleys. Environmental exploitation, often made for economic reasons, for example, deforested hillsides, increases vulnerability to landslides.

Factors such as geography, personal resources, community infrastructure and political stability all impact the occurrence and consequences of natural disasters.

- **Personal resources:** Poverty is a well-known determinant of poor physical health, and the poor may therefore be more vulnerable to adverse physical health outcomes in the wake of a disaster. Malnourished, non-immunized and chronically ill persons may be less able to withstand the physical stress of a disaster. Furthermore, poor persons who have been focused on daily survival are less likely to have resources—extra food, fuel or money—to use in the event of a disaster. When provided sufficient food, the body's response of moving from famine to adequate nutrition can bring its own physical changes and at times symptoms.
- **Infrastructure:** The poor often live in sub-standard housing that is more vulnerable to collapse and destruction during an earthquake or other disaster. Building codes are often not adopted or enforced. Poor communities often lack transportation and communication infrastructure to facilitate an adequate disaster response. Health systems in poor countries are often under-resourced even prior to a disaster, and are quickly stretched beyond capacity in the face of increased injuries and illness.
- **Political instability:** Political instability in many poor countries can hamper the ability to organize a coordinated disaster response. Limited resources can also expose intra-community schisms—sometimes along racial, ethnic, or religious lines—that further complicates necessary community coordination. Disasters open these fault lines of a society composed of differences in economic privilege, race and religion. Immigration out of disaster areas by those able to do so can be dramatic after a disaster. At times this further exacerbates the economic disparities as the wealthy are able to leave and the poor are not. The poor may also use illegal and risky means of immigration in order to find safety, nutrition, health and work for themselves and their families.
- **Vulnerable populations:** In the face of scarce resources, women, children, the elderly and the mentally or physically ill, may be particularly vulnerable to neglect and exploitation. Children and women of poverty are particularly vulnerable to exploitation as they try to obtain food and safety in a disaster community with none.
- **Recovery from disaster:** When other countries bring resources to disaster impoverished nations, they can also create expectations that cannot be sustained after the responders leave. Working with the disaster regions populations and recognizing the need for sustainable recovery is a critical ingredient of recovery over the years that are required after a major disaster.

Safety Prevents PTSD

Injury Prevention Starts at Work

Injury is a leading cause of posttraumatic stress disorder (PTSD). Preventing injury can prevent PTSD. Employers, supervisors, and providers in employee assistance, primary care, and mental health can help by focusing on preventing injuries like falls, motor vehicle accidents, occupational injuries and advocating for a safe work environment.

The U.S. government Occupational Safety and Health Administration reported that 4,609 workers were killed on the job in 2011 and nearly 4 million people suffer a workplace injury

Hundreds of U.S. workers are hospitalized each day. Worksite injuries are not accidents or just part of the job. Employers and employees can work together to build safer and healthier work environments. Taking action, both big and small, to prevent injury in the workplace is common sense and effective.

Here are a few tips to get you started:

If you are an employer/supervisor:

- Educate employees about workplace regulations and train employees to recognize unsafe or unhealthy settings.
- Create an employee reporting system to allow workers to report hazardous working conditions.
- Create safe work environments by identifying and fixing workplace hazards such as unstable surfaces and malfunctioning vehicles.
- Conduct personal safety training programs that teach employees how to recognize, avoid or diffuse potentially violent workplace situations.

Preventing injury can prevent PTSD.

If you are a health care provider:

- Support your family, friends and neighbors when they try to improve health and safety at their workplace.

If you are a mental health clinician:

- Include understanding of safety, injury, and accidents, as part of your work with patients on their mental and behavioral health.

For more information, please see:

<http://www.osha.gov/oshstats/commonstats.html>

Law Enforcement and the Stress of Community Work

Law enforcement officers fill many roles in the community. Often community members expect a great deal of law enforcement — perhaps more than can be done by any one person or even a group. Movies and TV may give unrealistic expectations of what can be done and at times reinforce fears and prejudices about law enforcement professionals by depicting them as over-reactive or corrupt. Crimes are solved and perpetrators apprehended within 60 minutes on television and in the movies. Most of the public are unaware of the constraints that law enforcement personnel face. The high-cost, high-tech forensic labs of TV are not part of most communities. Members of communities also have conflicting viewpoints as to the priorities of law enforcement. Some are more concerned about nuisance crimes like drunkenness, rowdiness, or abandoned vehicles within their neighborhood, whereas others are focused on stronger measures to curb serious and violent crimes. This distance between the public's views and hopes for law enforcement and the actual tasks, jobs, priorities and resources of our law enforcement forces creates tension, can lead to conflict, and can diminish community-law enforcement partnerships for the joint goals of a safer community.

What can law enforcement professionals do to decrease stress and increase community support and involvement in policing and law enforcement to protect our communities?

- Provide brief informational presentations and reports for local radio, television stations, and newspapers. This will help give communities a clear understanding of the role of law enforcement.
- Inform yourself of the concerns of your community. Make attempts to address even apparently minor situations that cause concern within the community.

Often community members expect a great deal of law enforcement — perhaps more than can be done by any one person or even a group.

- Be aware that police goals of maintaining the peace and providing security may be experienced as impinging on personal rights. When you are working a challenging shift it may be tempting to believe you do not need to explain your actions to the public. Taking a moment to listen can go a long way in building trust.
- Recognize the disparity between critical law enforcement objectives and public concerns which may be in conflict these objectives — particularly in times of disaster or large-scale emergency.
- Ally yourselves with young persons at every opportunity. Participate in after-school programs for youths within the neighborhood to develop relationships and familiarize yourself with their struggles.
- Volunteer to speak at local schools and community events. The more the community is aware of the identities and concerns of its officers, the more community relations will improve.
- Remember that we must all be on the same team when confronted with threats to national security, the proliferation of illicit drugs, and violent predators. Focus on the task at hand and avoid negative thoughts of blame or guilt.
- Educate the community on what its members can do to reduce crime and help with ongoing investigations
- Be aware not only of your skills but also your limitations. Holding unrealistically high personal or team expectations can lead to unproductive interactions and compromise your efforts.

Managing the Challenges of Shift Work in Law Enforcement

Law enforcement officers frequently work either the day shift or night shift for weeks at a time. If officers working nights keep the same sleep-wake patterns on days off as they do on work nights, sleep will be more restful and efficient. Officers working nights may change their hour on off-duty days to take advantage of social opportunities or outdoor activities during day time. Required court appearances, mandatory training, or administrative tasks can also disrupt optimal sleep-wake cycles. These alterations may result in sleep difficulties and decreased performance. For most law enforcement officers, night shift work will be required for some periods during their careers. Large scale public emergencies such as natural disasters or terrorist attacks may require extended shifts and altered duty hours. However, several strategies can be used to mitigate the adverse effects of altered sleep-wake cycles that result from night duties, shift changes, or extended operations:

Strategies

1. Eat nutritionally balanced meals. Good Nutrition is important to optimal performance under stress (including sleep deprivation).
2. Avoid use of alcohol to facilitate sleep. Though onset of sleep will occur more quickly, sleep will be less restorative. Avoid the use of stimulants including caffeine and energy drinks as their effects may persist beyond the duration of your shift.
3. Consider meditation or relaxation exercises as these may speed onset of sleep.
4. Routine exercise enhances sleep onset and quality (even when work requires sleep during daylight hours) Avoid heavy exercise just prior to bedtime — this may prolong wakefulness.

Alterations in work and rest cycles result in sleep difficulties and decreased performance.

5. Consider “power-naps” of 15–30 minutes when time allows. The effective length varies among individuals.
6. Be alert to cumulative effects of sleep deprivation such as irritability, headaches, poor concentration, and forgetfulness. If symptoms develop seek medical assistance.
7. Since there is more background environmental noise during daytime, earplugs may facilitate sleep during daylight hours.
8. Avoid unnecessary changes between day or night shifts (or working excessive overtime). Adjustment to new sleep-wake cycles commonly requires at least one week.

Optimizing Law Enforcement Officer Performance in Disasters

Disasters are experienced as chaotic and filled with uncertainty. In preparing for and responding to disasters, law enforcement officers work with numerous other first responders and community components to ensure safety, health and the continuity of community

function. In addition to routine law enforcement, officers may be called on to assist with search and rescue, body recovery, and the distribution of essential supplies to survivors. Leaders of first responder organizations face unique challenges including high operational tempo, long hours, and diminished resources. Response and coordination is even more complex when units or teams are dispatched from outside local, state or federal agencies to assist in recovery operations. Usually, large scale disasters required the integration of local, state, federal and National Guard response teams. The following tips may help managers and supervisors manage and limit disaster-response stress for their officers.

- Conflict over jurisdiction can hinder recovery efforts. It is important for law enforcement officers to be aware of the specific mission and identified chain of command for each agency.
- Maintaining the health of responders is critical. Attention to health basics such as using only potable water, providing sanitation, using protective equipment or clothing, and ensuring that adequate food, rest and proper shelter are available reduces the risk of disease and performance breakdown among officers.
- Remind officers that maintaining the peace and providing security can be experienced by some as impinging on personal rights. In such cases, those in need may not respond positively to offers of assistance. Awareness of this prior to the beginning of work encourages calm reassurance in responders who may be otherwise demoralized by lack of community support for their efforts.

Disasters are experienced as chaotic and filled with uncertainty.

Law Enforcement Officers and Court Testimony

Managing the Stress of Court Appearance

Testifying in court is often stressful for law enforcement officers. Trials may occur months after an arrest and memories of the details fade with time. Leading or ambiguous questions posed by defense attorneys are particularly stressful. At times it may seem to the officer, rather than the accused, is the one on trial. For officers working night shifts, but testifying during the day, sleep deprivation may also contribute to courtroom stress. Here are some tips to prepare for courtroom testimony and reduce the stress of courtroom appearances.

- Take advantage of departmental training for courtroom testimony, such as moot court. Observe how other law enforcement personnel testify. Skill and comfort in courtroom testimony comes with learning from and observing others, practice and experience.
- Prepare required written reports as soon as possible after the incident and the investigation. Memory for details deteriorates over time and having to reconstruct what one heard or saw takes additional time and is often stressful itself.
- Officers often rely on notes or reports when testifying. Pay attention to and document details when taking notes and preparing reports of investigative procedures and interviews.
- Cases may not come to trial for a multitude of reasons. Do not assume that an arrest without further prosecution reflects problems with your work on the case.

Testifying is stressful for law enforcement officers. Questions posed by defense attorneys may seem that the officer, rather than the accused, is the one on trial.

- Large scale evacuation orders create strain between officers and those they serve. Citizens are reluctant to leave their homes, belongings, live-stock and pets, even when their own lives and health are at risk. Officers should be aware of whether an ordered evacuation is mandatory or voluntary and what level of force is authorized to use in the event of a mandatory evacuation.
- Proper sleep, nutrition, and exercise are critical to sustaining the efforts of first responders. Leaders must maintain awareness of physical limitations, sleep-rest cycle needs and potential for injury among officers and serve as role models by demonstrating appropriate self-care.
- Maintain open channels of communication between leaders and subordinates during the disaster response both up and down the chain of command. Alterations in mission, responsibilities and task requirements are inherent as the recovery effort evolves. Take the time to walk around and talk with your officers. A proactive approach is more effective than maintaining a routine open door policy. Do not forget to listen as new information is made available to you, and remember that those working for you are trying to help you do your job.

Criminal Mass Casualty Trials

Enhancing the Psychological Health of Victims and Witnesses

Criminal trials are an integral part of the US criminal justice system. They involve multiple parties participating in many diverse roles. The goal at trial is to insure just outcomes for all involved. The participation in trials by victims and witnesses is an integral part of these processes. While the testimony of victims and witnesses is often central to achieving just outcomes, few victims and witnesses have experience with these proceedings. They may have very limited understanding of the process and players.

Victims may have very unrealistic expectations of what trials will be like or how the outcome may affect them. For these reasons, victims and witnesses may experience significant stress before, during, and after trials. These stresses are likely to be exacerbated when the events precipitating a trial involve numerous deaths or wide-spread injury, are especially symbolic or meaningful such as the deaths of children or first responders, or when trials are likely to generate intense and prolonged public exposure and attention. Behavioral health professionals, prosecution teams, victim services providers and advocates are an important part of managing the stress of victims and witnesses.

The term victim, as used here, is broadly defined and may include family members of deceased victims, injured survivors, first responders and witnesses to an incident. If you are a consultant to the trial process, here are some tips for assisting those who are victims of a criminal act or who participate in the trial.

Before the Trial

- Provide information on mental health services, including informal sup-

Criminal trials in mass casualty events involve multiple parties participating in many diverse roles.

port services such as victim advocates, chaplains and peer support.

- Inform and assure access to victim assistance staff in various agencies (see Resources section).
- Establish a mechanism to identify and respond to unmet needs that may have resulted from the incident.
- Provide victims with spiritual support, when applicable. Often, it is through the lens of these beliefs that victims begin to find understanding and meaning in what they have experienced. The faith community of the victim's choosing can be a frequent source of support to victims in all phases of recovery.
- Screen and evaluate spontaneous offers to assist and support victims. Focus on appropriateness of the offers and the group offering in order to reduce potential for exploitation.
- Educate victims on dealing with the media. Assist, if needed/requested, in shielding victims from unwanted media attention.
- Coordinate access to prosecutorial staff who can provide case status, explain processes and legal terms and their implications.
- Anticipate logistical concerns that may impact on trial participation such as transportation, lodging, child care, access to closed circuit television.
- Help victims identify their expectations of the trial and its various results. Educate to ensure these expectations are realistic. Help prepare victims for undesired outcomes such as a not-guilty verdict, a plea bargain, or dropped charges.
- Prepare victims for information so that what they may hear and see at trial is not inconsistent with their understanding of what occurred.
- Prepare victims for the reality that victim impact statements may have little or no bearing on sentencing. Preparation of victim impact statements, while often therapeutic, can also be enormously stressful.

During the Trial

- Organize and coordinate medical and mental health services for victims. This includes support immediately available to victims during the trial in case it is needed.
- Prosecutors should keep victims updated on trial activity and progress throughout the trial period.
- Dispel misunderstandings about the justice system and provide realistic expectations. For example, the relationship between victim and prosecutor is not the same as relationship between defendant and defense attorney.

- Inform victims and families that unless they are actually testifying, the only real input they might have to the judicial process will be in the form of a victim impact statement.

Following the Trial

- Assure access to medical and mental health services for victims and their families.
- Educate victims in understanding post trial legal processes including the sentencing phase, associated civil trials, a reduced sentence, probation and parole, and release dates.
- Know the psychosocial aspects of restitution to victims, where applicable.
- Include victims in planning memorials, anniversary events, and remembrances. Symbols and rituals are often comforting to victims. They cross boundaries of culture, language, profession and class.
- Facilitate opportunities for victims to gather in group settings for mutual support if they wish.

Special Issues for First Responders to Criminal Events

First responders to criminal events often experience exposure to events quite differently than most victims. They may simultaneously be witnesses and victims. Their exposure is the result of specific responsibilities and occupational roles during and following events. They may, but not always, have the benefit of specialized training and more experience with trials and the trial experience.

At the same time, stigma concerning mental health and the psychological sequellae to traumatic events is often high in first responders. Sometimes, this stigma is intensified by concerns about their fitness for duty assessments that may affect their ability to do their job. This assessment may directly impact a first responder's income, employment, and workplace support and status. Attending to these concerns of stigma and practical impact are important to assure care and support for first responders.

Resources

1. Responding to Terrorism Victims: Oklahoma City and Beyond, Office for Victims of Crime, Office of Justice Programs, USDoJ, NCJ 183949, 2000.
2. Office for Victims of Crime — Directory of Crime Victims Services <http://ovc.ncjrs.gov/findvictimservices/>
3. National Organization for Victim Assistance (NOVA) <http://www.trynova.org/victiminfo/>

