Disaster Mental Health Assistance in Public Health Emergencies: Evidence-Informed Practices for Public Health Workers

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Evidence-Informed Practices for Public Health Workers

Across the nation today, local public health agencies are struggling – struggling to protect the public’s health with a workforce that is both aging and shrinking. A recent estimate suggests that about half of the employees in state health departments nationwide will be eligible to retire within the next few years.\(^1\) After workers in the Baby Boomer generation retire from service, the average age and experience of public health workers is likely to drop significantly. Given the general economic recession and shrinking Federal pass-through funding to local departments for preparedness and response activities, history suggests that many of these positions probably will not be re-filled. It also means that even larger agencies will find it increasingly difficult to maintain a cadre of “preparedness specialists.” As a result, even workers with job duties and core skills unrelated to preparedness will, of necessity, be called out in response when a major disaster hits.

To paraphrase an old joke, we see a day when there will be two categories of local public health workers:

- those who have been involved in response to a public health emergency, and
- those who will be involved in the response to a public health emergency.

As an experienced public health professional, you may find yourself drawn into the response(s) to a wide range of disasters, disease outbreaks, and other large-scale events. While the rewards of helping others in these situations can be rich, the associated stressors can be intense at both the personal and organizational levels. If you have supervisory duties, your staff will be experiencing these same stressors, and you will want to monitor their functioning as well.

This training and series of tipsheets will help you prepare for the psychological reactions you may encounter post-disaster in those you serve in the community, in your staff and colleagues, and in yourself, so you and your agency can continue to function effectively when you’re most needed. This document was developed for the New York-New Jersey Preparedness & Emergency Response Learning Center (NY•NJ PERLC) by the Institute for Disaster Mental Health at SUNY New Paltz, and the information reflects the most current research and evidence-based practices.

\(^1\) The Public Health Workforce in Crisis - American Public Health
As you absorb this information, bear in mind that while all disasters can cause a range of negative effects among those who experience them, events that directly impact people’s health often create more intense psychological reactions, in addition to distinct logistical response needs, such as large-scale sheltering or rapid distribution of medications or supplies. This is not to downplay the distress people experience from disasters that primarily cause property damage without causing illness or injury (for example, a slow-moving flood that destroys homes but that allows enough warning to successfully evacuate people and pets). Survivors of these disasters may have experienced significant fear and anxiety during the event and they must adjust to losses afterward. Public health professionals may play an essential role in addressing needs for clean water, mold mitigation, and other response demands. However, emergencies that involve human pain and suffering are generally correlated with more intense posttraumatic psychosocial reactions, which are the focus of these tipsheets.

**Toolkit Contents**

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An hour-long webcast overview of tipsheet content is archived at: [http://newpaltz.mediasite.suny.edu/Mediasite/Play/290ca54cd64946f5b6592ea3616d47951d](http://newpaltz.mediasite.suny.edu/Mediasite/Play/290ca54cd64946f5b6592ea3616d47951d)

**References and Resources**

Contents of these tipsheets are based on the following publications, which reflect the most current evidence-based guidance on disaster mental health reactions and interventions. For public health workers who would like to learn more about the psychosocial response to disasters and crises, these publications and the subsequent list of websites offer credible and detailed guidance.
Selected References


Additional Resources

Antares Foundation
www.antaresfoundation.org
This non-profit organization focuses on improving management and staff support and care in humanitarian and developmental organizations, but their publications and podcasts on stress management apply to everyone in the helping professions.

National Center for PTSD
www.ncptsd.va.gov
This branch of the US Dept. of Veterans Affairs offers online trainings, research, and other resources for professionals involved in assisting people with posttraumatic stress disorder.

National Institute of Mental Health
www.nimh.nih.gov
The NIMH site includes information on a range of mental health issues relevant to disasters and public health emergencies, including anxiety, depression, substance abuse, and PTSD.

World Health Organization
www.who.int
WHO offers a global perspective on health issues, including resources for field workers post-disaster.

This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany, with a subcontract to the Institute for Disaster Mental Health at SUNY New Paltz. The contents do not necessarily represent the official views of CDC or either of the host institutions.
Tipsheet #1
The Psychosocial Impact of Biomedical Emergencies, HazMat / Industrial Incidents, and Radiological and Other CBRNE Events

Critical emergencies often are characterized as “CBRNE” events (chemical, biological, radiological, nuclear, and explosive) based on the dominant exposure hazard. In this tipsheet we introduce the categories of emergencies that we’ll be touching on directly or indirectly throughout the series, in order to describe the unique characteristics that account for their notable traumatic impact. Subsequent tipsheets will explain typical and extreme reactions to these events, and what you can do to mitigate psychosocial reactions as a public health professional.

Categories of Event Types:
Research on disasters indicates that some response demands will be tied to the cause of the event.

Biomedical Emergencies can include both naturally occurring events like pandemic flu and human-caused events. Fortunately most of the latter prove to be unintentional, even though intentional emergencies, such as the post-9/11 anthrax attacks, occupy a larger space in the public consciousness.

The nature of the biological agent greatly influences the time needed to identify the classic epidemiology triad of Agent, Host, and Environment factors to characterize the outbreak and institute control measures. In many outbreaks of communicable diseases, a point source can be identified quickly, and control measures put in place...
immediately. Other outbreaks take extended intensive investigation. An outbreak of typhoid fever across New York State in the summer of 1989 first appeared in two firefighters in Syracuse, but isolated cases were eventually identified in firefighters all around the state. Their common occupation quickly pointed to a state firefighters’ convention weeks earlier in the Catskills. Nevertheless, typhoid’s long and variable incubation period (2 to 4 weeks) made it difficult to track backwards to characterize the specific exposure, which was eventually ascribed to a single, large batch of orange juice contaminated by deplorable sanitation practices in the restaurant in one of three conference hotels.

Fortunately, although uncommon in the US, typhoid is easily diagnosed and treated. Thus the two weeks or so between the first two cases being diagnosed and the public release of the epidemiological findings did not raise any public concern in this instance. But uncertainty in identifying the biological agent, the mode of transmission (“host”), or the environment in which it’s found can cause that concern to escalate precipitously – sometimes abetted by the news media. During the recent *Listeriosis* outbreaks, for example, ABC News led the story with the headline, “Killer Cantaloupes.”

Public health officials may find themselves embroiled in controversy, and sometimes pulled in opposite directions by a concerned public. In extreme situations, quarantine or other social distancing measures may be needed to stop or slow the spread of an epidemic. There will often be constituents calling for these actions long before they are needed, and whether it would be efficacious or not. Conversely, that level of response may be perceived by other members of the public as excessive or as infringing on their civil rights. Whether the political climate remains calm or degrades into hysteria may hinge on how the agency handles the public release of information, especially acknowledging the legitimate concerns and dispelling the misinformation.

Some groups may be scapegoated and perceived as spreading the disease. Anger can also be directed at officials who are viewed as unfairly or inadequately distributing medicine or resources, while fear about the safety of vaccinations or medications may cause some people to resist getting preventative care or treatment. Medical professionals as well as patients may be stigmatized due to contagion fears, and doctors and public health managers may need to make difficult triage decisions in response to shortages of prophylactic or curative medications or medical equipment.

**HazMat / Industrial Incidents** that involve the release of toxic chemicals or other dangerous substances share some characteristics with biomedical emergencies. But concerns about chemical exposure include not only worries about immediate health effects, but also anxiety about long-term harm such as cancer or chronic respiratory diseases. There also may be concerns about longer-term environmental damage such as poisoned drinking water or crops. These incidents may require the evacuation of impacted areas until the substance dissipates or the area is decontaminated, so they may create sheltering demands as well as health and mental health reactions.

**Radiological and Other CBRNE Events:** The lack of understanding and the anxiety about consequences that characterize biomedical and hazmat events are likely to be even more present and distressing in the case of radiological exposure or other CBRNE events. This is especially true for nuclear accidents or “dirty bombs” (radiological dispersal devices, RDDs) that use conventional explosives to spread radioactive material. Radiation is invisible and odorless, so people may be exposed without knowing it, or more likely given the limited
dispersal power of RDDs, they may believe they’ve been exposed when they haven’t. Most people have little understanding of the differences between radiation exposure and contamination, or about the level of exposure needed to cause either immediate or long-term harm. Beliefs about the decontamination process are sometime inaccurate and exaggerated, though it’s certainly true that decontaminating large numbers of exposed people would cause great stress. In addition to immediate fears about radiation poisoning and long-term fears about cancer, anxiety about exposure may extend across generations as people worry about future fertility and birth defects. Pregnant women are likely to be particularly anxious and should be given access to medical professionals who can assess the risk to the fetus given the gestational stage and the amount of exposure the woman received. The need for mental health assistance in the event of a radiological event will be intense.

Additionally, CBRNE events and disease outbreaks often include a characteristic that generates great fear and anxiety in the lay public, for an understandable reason: Most people don’t know with certainty if they’ve been exposed to something harmful, or what the consequences may be. The thought that you have taken something into your body that might make you sick either soon or long into the future is terribly unsettling. This worry often leads people to experience physical symptoms out of anxiety, and they may flood emergency departments that are already overtaxed treating those who have actually been injured or sickened. While those with psychosomatic symptoms might be viewed as a burden on the system, their suffering is genuine and their psychological distress should not be minimized or dismissed. As one set of guidelines for physicians puts it: “Once the danger is removed, other specific psychological responses develop. Anxiety is the most salient, but others may include survivor guilt, scapegoating, grief, withdrawal, magical thinking about microbes (in biological or chemical attacks), and loss of faith in social institutions” (Fetter, 2005).

As this suggests, the uncertainty associated with these events can cause extreme stress and anxiety for all affected. The resulting traumatic impact on survivors is likely to be intense – as are the stressors on those who try to help, including those in the public health field.

**Event Characteristics:**

Looking beyond specific event types, patterns of psychological reactions are often tied to broader event characteristics, so consider the following as you prepare to react to a disaster.

**SIZE:**
- How many casualties are there (people injured, ill, and/or deceased), and how does that relate to the available response capacity?
- What was the geographic area impacted? Are regional resources (first responders, hospitals, etc.) available for mutual aid or are they occupied with their own local response to the same event?
- Does the event have closed boundaries? In other words, was it contained in a specific area (a plane, a building, a sports stadium, etc.) or are boundaries open, meaning it may expand to other regions or populations (such as a radiological release or communicable disease)?
TIMING:

- Was the event sudden and unexpected, like a hazmat release? If so, survivors had no opportunity to prepare and may be stunned or overwhelmed by their sudden loss, and helpers may need to scramble to organize the response.
- Did it develop gradually, like a pandemic flu outbreak? If so, there may be widespread anxiety in the community, leading to a surge of “MUPS” (people with Medically Unexplained Physical Symptoms, sometimes referred to as the “worried well”) that taxes healthcare facilities that are already busy tending to those who are actually ill.
- Is it over? If there’s a clear end-point to the event, people can begin to regain the sense of safety that’s essential for recovery. If there’s uncertainty – for example, about whether there will be another terrorist attack or repeated disease event, or about long-term health consequences from exposure to radiation or hazardous chemicals – it’s far more difficult for people to begin to recover. An ongoing threat also may place responders at risk for exposure, and concerns about whether the threat remains may discourage some helpers from responding.
- How long will the recovery period last? It may be relatively short (a day or two, for example) or very lengthy and unknown, such as with a devastating hurricane or earthquake.

CAUSE:

- Was it clearly a natural disaster, like a flu outbreak? If so, reactions tend to be less extreme since there’s no one on earth to blame, though people who believe in a higher power might blame or question their God. However, people may experience a sense of helplessness as there’s no way to prevent a recurrence.
- Was it clearly human-caused? If so, what was the level of intentionality – accidental, negligent, or intentional? Not surprisingly, negative reactions are likely to be the worst in response to intentional malevolence. But even in the case of accidents, survivors will often search for someone to blame or punish, and will feel that “someone” should have prevented the event. Human-caused events also may mean that the site must be treated as a crime scene, complicating the response and potentially leading to a culture clash between public health professionals and law enforcement agencies that may be in charge of the response.
- Many disasters result from a combination of causes. In so-called “Na-Tech” events, a natural disaster leads to a technological failure, like the Fukushima tsunami leading to a nuclear meltdown or Hurricane Katrina leading to failure of poorly maintained levees. In other events human factors exacerbate natural disasters, as when population density or poor sanitation increases disease transmission. In these cases, survivors’ perceptions of whether the cause was natural or human are important predictors of reactions.

MEDICAL CONCERNS:

- If victims are ill, what is the nature of the sickness?
- How lethal is it? What are the symptoms? What level of medical care do they need, for how long, and is it available? What is the prognosis for length and extent of recovery, or for decline?
- Is it communicable? If so, what is the etiology, particularly the incubation period? What personal protective equipment is recommended? Is medical isolation needed?
• If victims are injured but alive, what is the specific nature of the injury? Are there extensive amputations, crush injuries, chemical or thermal burns, or other wounds? Are people at risk of infection or other secondary problems? Are they in severe pain? Do they need treatment in hospitals with special care facilities, such as a burn unit?

• If victims have died, what is the condition of their remains? Are bodies intact and accessible or have remains been fragmented or destroyed? Can they be visually identified or will DNA identification be needed and/or possible? These are issues of tremendous importance to families as they’re connected to perceptions of how the victim may have suffered in death, as well as influencing acceptance that the person has indeed died.

• Can the remains be released to families for completion of death rituals? For example, some faiths require burial within 24 hours of death, which may not be possible.

• Do the remains need to be held as evidence? Do concerns about contamination or an unmanageable number of bodies mean that actions like mass burials are enforced? The inability to complete comforting rituals like funerals often adds greatly to survivors’ distress.

As these questions indicate, the public health response to a large-scale disaster is likely to be logistically complex, and highly stressful for everyone involved. That’s particularly true if the event occurs in your own community, requiring you and your staff to juggle personal and professional demands. It’s essential to recognize and address that stress in both responders and the public, as failing to do so will compound suffering and delay recovery among survivors, and it can impair your ability to perform your job as a public health manager. This toolkit is intended to help you understand and prepare for those likely stressors so you’ll be better equipped to help those in need after a disaster, while maintaining your own mental health and professional capacity to aid others.

This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
Think about the vast range of damage that can be caused by disasters: Loss of life, of health, of home and property, of access to food and water – the list is endless. And accompanying those tangible losses are internal wounds that can be just as difficult for survivors to cope with, like the loss of one's basic feeling of safety or belief that the world makes sense. People who have personally experienced a public health emergency also may be coping with serious physical pain or illness, and/or with traumatic bereavement if a loved one was killed. Survivor guilt may also be present for those who wonder why they lived while others didn't. And public health professionals and other responders certainly are not immune to those same reactions, particularly if the event occurred in their own community.

When and if you become involved in the response to a disaster, you’ll need to be ready to help not only the public but also your staff to deal with all of these losses and the resulting reactions, while also coping with your own experience and with the new challenges produced by the recovery work. A first step to being an effective manager in times of crisis is to understand the personal challenges competing with staff members’ professional demands, so this tipsheet focuses on typical psychological reactions to highly stressful events that you are likely to encounter in personnel as well as in direct survivors in the community. Three main propositions can guide your understanding of post-disaster reactions.
1: Reactions vary by individual, and generally lessen over time.

Disasters and crises cause a range of reactions which vary not only from person to person, but within an individual over time as the survivor begins to cope with his or her experience and losses. Initially survivors may be in shock or generally anxious and hypervigilant, with a heightened startle response and problems sleeping. Those who survived the event personally may re-experience it, especially when triggered by cues in the environment (for example, loud noises after a bombing), while those who are absorbing news of a loved one’s death may think constantly about what that person might have suffered. Over time these reactions will start to fade for most people, becoming less frequent and less intense. The disaster becomes a “normal” though painful memory that’s accessed from time to time, but remembering the event doesn’t cause the same distress as the original experience did. Still, initial stress reactions are painful and upsetting for those experiencing them, and people may feel like they’ll never feel secure again.

Tips for Public Health Managers:

• Whatever your designated ICS role, keep in mind that providing a sense of safety and a supportive recovery environment as quickly as possible is essential.
  • This may include addressing logistical demands like helping to organize an emergency shelter or evacuating people to a safer region, acquiring supplies of food and water, and obtaining medical care for the injured and sick.
  • It also may include addressing more psychosocial needs, like helping survivors understand that they’re safe, reconnecting them with loved ones, and providing access to spiritual care and/or mental health providers as appropriate (see tipsheet on Psychological First Aid for details). If this is not possible within the definition of your position, encourage the appropriate person(s) that revision of the Job Action Sheet is needed to assure that this support function gets implemented.
  • Be sure to pay attention to how the event is impacting you personally so you can maintain your own resilience while you assist others. Your focus may need to be on addressing the public’s needs post-crisis, but you will not be able to do so indefinitely if you disregard your own needs.

2: Reactions occur in a number of realms of functioning.

Psychologists typically group post-disaster reactions into five realms of functioning: physical, emotional, cognitive, behavioral, and spiritual. The presence of these common or typical reactions does not suggest that the individual is at risk for developing lasting emotional or psychological problems. Instead, these reactions “make sense” given the nature of disaster exposure and some combination of symptoms should be expected in anyone who experiences extreme stress. Of course, a given survivor is not likely to experience all of these reactions, and it’s important to note that one’s expression of distress may be influenced by gender and by culture.
### Typical Post-Disaster Reactions

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<tr>
<th><strong>PHYSICAL:</strong></th>
<th><strong>BEHAVIORAL:</strong></th>
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<tbody>
<tr>
<td>Jumpiness, edginess, agitation, increased startle response</td>
<td>Avoidance of reminders of the disaster</td>
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<tr>
<td>Appetite change (general increase or decrease, craving for sweets)</td>
<td>Change in sleep habits (sleeping too much or too little)</td>
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<tr>
<td>Increased desire for caffeine, nicotine, alcohol</td>
<td>Change in diet (eating too much or too little, seeking comfort in unhealthy foods)</td>
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<tr>
<td>Cardiovascular symptoms (palpitations, breathlessness, rapid and shallow breathing, light-headedness)</td>
<td>Hypervigilance, inability to relax</td>
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<tr>
<td>Gastrointestinal distress</td>
<td>Social withdrawal, isolating oneself</td>
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<tr>
<td>Sleep disruption (fatigue, exhaustion, insomnia)</td>
<td>Increased conflict with family, co-workers, outbursts of aggression</td>
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<tr>
<td>General somatic symptoms (muscle tension or pain, headache)</td>
<td>Immersing oneself in activity to avoid thinking about event</td>
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<tr>
<td>Worsening of chronic health conditions</td>
<td>Crying easily</td>
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<td></td>
<td>Trying to over-control relationships</td>
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<td></td>
<td>Change in sex drive</td>
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<th><strong>COGNITIVE:</strong></th>
<th><strong>EMOTIONAL:</strong></th>
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<tr>
<td>Disbelief, sense of unreality</td>
<td>Depression, sadness, tearfulness</td>
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<tr>
<td>Worry, rumination, preoccupation with situation</td>
<td>Anxiety, fear, panic</td>
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<tr>
<td>Difficulties with memory or concentration</td>
<td>Guilt, shame, self-doubt</td>
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<tr>
<td>Reduced ability to focus, solve problems, or make decisions</td>
<td>Apathy, emotional numbing</td>
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<td>Confusion, slower processing speed</td>
<td>Feeling overwhelmed, hopeless, out of control</td>
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<td>Cognitive misappraisals (inappropriately blaming self or other, all-or-nothing thinking)</td>
<td>Irritability, impatience</td>
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<td></td>
<td>Anger, hostility, rage, resentment</td>
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<tr>
<td></td>
<td>Blaming (of self or others)</td>
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<td></td>
<td>Mood swings</td>
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<th><strong>SPIRITUAL:</strong></th>
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<tr>
<td>Change in relationship with higher power (increase in faith, questioning of faith)</td>
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<tr>
<td>Change in religious practices (increase or decrease in prayer or attending services)</td>
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<tr>
<td>Questioning of belief in a just world</td>
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<tr>
<td>Struggle with questions about reality, meaning, justice, fairness</td>
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**Tips for Public Health Managers:**

- Understand that extreme or on-going stress often impairs people’s ability to concentrate and to make good decisions. You may find that your staff members – and you yourself – are unable to function at your usual level, just when extraordinary performance is needed. Addressing personnel’s mental health needs to the extent possible is not merely a kindness, but an essential step that will help them recover their professional capacity.

- Survivors are often shocked at the strength and variety of negative reactions they experience in response to a highly stressful event, so it may be helpful to provide “psychoeducation” – information (like the above table) about typical reactions so people understand they aren’t overreacting, being weak, or going crazy.

- Helpers sometimes refer to “normal reactions to abnormal events,” but these symptoms feel anything but normal to those experiencing them, and describing them as such may undermine a survivor’s trust in your understanding. It may be more useful to:
  - Describe reactions as painful but understandable under the circumstances;
  - Explain that many people experience similar feelings and that most people feel better once some time has passed; and
  - Provide information about finding someone to talk to if they would like help now or do not start to feel better soon.

This approach acknowledges and validates the person’s current suffering while creating an expectation of recovery.

3: **Understanding how reactions evolve will help you plan how to address needs in upcoming stages.**

Disasters and emergencies unfold over time, and understanding common patterns will help you plan how to address survivors’ needs in upcoming stages. While you will most likely be working with survivors during the post-impact stage, it is important to understand their experience in the pre-impact and impact stages as these will help shape their reactions.

**Before Impact:** Was a warning received in advance? Warnings help to activate coping mechanisms, allowing people to prepare cognitively and emotionally. If there was little or no warning, there may be more initial shock, disbelief, and fear as people struggle to grasp what has occurred. If a warning was received but ignored, people often experience shame or self-blame.

**During Impact:** As the disaster unfolds, the fight, flight, or freeze response is triggered, leading to magnified arousal levels while the focus is on survival. Contrary to stereotype, panic is not a common response; purposeful and productive actions are more the norm. However, especially if the event was sudden and unexpected, people may be in shock, unable to function well until they absorb what has occurred. How competent or helpless people feel and act at this time can play a key role in how they process the disaster experience later. They may experience guilt or shame over their actions (or lack thereof), and they often express unrealistic beliefs about what they could or should have done to help others, when in reality those fantasized actions would only have increased personal risk.

**Beyond Impact:** The recovery period following a disaster can be divided into several phases, each associated with a shift in survivor emotions. The length of each stage varies depending on the scope, intensity, and duration of the catastrophe as well as the resources available for recovery.
• **Heroic:** In the immediate aftermath of disaster, those impacted respond to rescue and assist each other; often before outside aid has had time to arrive.

• **Honeymoon:** Survivors feel unified by their involvement and optimistic about their ability to recover. There is often an influx of attention, media, money, and personnel to help those directly affected. Social barriers and other differences are minimized and a collective community spirit rules.

• **Disillusionment:** Realization of the full extent of losses and the barriers to recovery begin to sink in, and community members may feel abandoned by the media, the public, and the aid agencies that had previously been helpful. The communal spirit begins to erode as disparities in damage and resources become apparent. This phase is often the lowest emotional point for survivors as they come to terms with the permanent impact of the disaster, recognizing and accepting what they’ve lost.

• **Reconstruction:** Survivors attempt to create a “new normal.” Depending on the scope of the event and the resources available, this phase can last for a few months or extend to decades. Survivors who are recovering as expected may benefit from receiving on-going psychoeducation and support, and those in need of clinical help should be identified and assisted.

Note that this stage model may be less applicable during a slowly unfolding crisis like a disease outbreak than to a specific incident like a hazmat accident or terrorist attack. It’s also clear that not every survivor passes through all stages (for example, someone who has lost a loved one is unlikely to experience a honeymoon period), and the progression may not be strictly linear as anniversaries reawaken painful memories and milestones are experienced in a new setting or without a lost loved one. Still, this model is useful to consider as it suggests what survivors may feel at the different points in the process of recovery, and allows you to anticipate what they are likely to need next.

**Tips for Public Health Managers:**

• Plan ahead so you have resources in place to support personnel and survivors through the difficult disillusionment stage. Also plan for the possibility that those resources may not be available as expected, so having a back-up plan for support will allow everyone to rest more easily.

• If possible, organize ceremonies where your staff can come together – first to acknowledge and mourn shared losses, and then to mark positive developments as the recovery continues. Even if progress is slow after a large-scale event, celebrating small milestones can help keep staff members focused on recovery rather than dwelling on what was lost.

• Depending on cultural and religious beliefs, trauma survivors often become very focused on finding someone to blame for negative events. As a public health manager, you may be seen as representing the government or other authorities and may be used as a target for survivors’ anger or vengeance if they believe your organization was somehow responsible for the disaster. Do your best to remain patient and not take this blaming personally, but it may be difficult to get past this anger to address survivors’ other immediate needs.

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This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
Extreme Reactions: Signs that Professional Assistance May be Required

While for most people symptoms of post-disaster traumatic stress improve over time, this natural recovery process does not occur for some individuals who will go on to develop posttraumatic stress disorder (PTSD) or other serious conditions that can severely impair their functioning. Certain groups (including children, elderly people, people living in poverty, and those with serious mental illness, physical disabilities, or substance dependence) are more vulnerable, but anyone can potentially develop PTSD if an experience is sufficiently traumatic.

These extreme reactions impair a survivor’s natural recovery and often require professional assistance, so you should become familiar with indications that an individual is in need of treatment. Extreme reactions you may see in disaster survivors include posttraumatic stress disorder, complicated grief, and substance abuse conditions. While it is not your role as a public health worker to diagnose or treat these conditions, this tipsheet will familiarize you with them so you can try to connect at-risk patients, survivors, and staff with the appropriate professional care as quickly as possible, before the conditions become more difficult to treat.

Posttraumatic Stress Disorder:

PTSD is one of the more serious clinical diagnoses associated with exposure to a disaster, but the label is often misapplied in popular use. At its most basic, PTSD is an inability to integrate an event of unusual intensity and meaning. Rather than recognizing that an event is over and can cause no further harm, people with PTSD continue to feel threatened by the trauma and are unable to feel safe enough to begin to move on. Rates of PTSD tend to be much higher after human-caused events, especially intentional violence, than after natural disasters.
PTSD can only be diagnosed after symptoms have been present for 30 days; in some cases, symptoms do not occur until well after the traumatic experience. A PTSD diagnosis requires all of these criteria:

1. The person experiences exposure to a traumatic stressor, with a reaction of intense fear, helplessness, or horror.

2. The presence of a specific number of symptoms in each of three groups:
   - **Re-experiencing:** People with PTSD don’t simply remember the traumatic event as something in the past, but they feel as if it is happening again, with the same physiological fight-or-flight reaction and a return of the initial fear, helplessness, or horror. This reaction can occur as nightmares, flashbacks, or rumination (an inability to think of anything else).
   - **Avoidance:** In order to prevent the painful re-experiencing symptoms, the person stays away from any reminders of the traumatic experience – including places, conversations, media exposure, and anything else that may “trigger” memories. Such avoidance tends to become generalized beyond direct reminders, leading the person to limit participation in relationships, work, and other key aspects of life.
   - **Hyperarousal:** A person with PTSD is constantly on guard, “threat monitoring” for any signs of danger. It’s as if their fight-or-flight response never turns off, leaving them agitated and prone to over-reacting to any perceived threat. Sleep is usually disrupted.

3. The individual has clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Many people with PTSD also experience symptoms of serious depression and anxiety. Given the nature of the core symptoms, PTSD tends to become self-reinforcing and increasingly difficult to treat. Over time, individuals progressively narrow their lives to avoid exposure to triggers of the traumatic memory, resulting in a withdrawal from normal activities and relationships and a constant state of anxious arousal that many sufferers attempt to blunt with alcohol or drugs. This process can have a serious impact on personal relationships. To avoid this escalation of symptoms and the resulting impaired functioning, identifying and treating the condition as early as possible is essential before symptoms become entrenched and more difficult to reverse. The good news is that there are effective treatments that can fully cure PTSD when delivered by a trained professional.

**Complicated Grief:**

Grief is not a mental disorder, but a painful and expected process in response to the death of a loved one or to other significant loss. Usually grief is followed by a gradual return of the capacity for engaging in new interests, activities, and relationships, but if this process does not evolve over time, the grieving process may be considered to be “complicated.”

Complicated grief is marked by the presence of intrusive memories or fantasies related to the lost loved one and the relationship, with strong emotions characterized by intense longing, loneliness, and emptiness. Complicated grief can look like PTSD, but anxiety and heightened arousal are absent. Instead, the avoidance of activities in complicated grief is not fear-based but rather related to a wish to avoid people, activities, or places that evoke painful memories or reminders that the loved one is gone. For example, a widow may avoid social activities that remind her of her changed role. Loss of interest in activities and disrupted sleep are common, as is intense sadness and yearning for the loved one.
Complicated grief is not an official diagnosis, so timing guidelines regarding how soon after a loss it should be considered are not established; a range between 6 and 14 months has been suggested by various researchers. That is not to suggest that survivors should be “over” the loss entirely by that point, but that the intensity of their mourning should be lifting. If they’re not progressing in their adjustment, treatment for complicated grief should be considered.

**Substance Abuse:**

Sometimes people who have been through a traumatic experience turn to alcohol or drugs (either buying illegal drugs or misusing prescription medications) to help cope with their distress. New cases of substance abuse and dependence after disaster exposure appear to be rare, but those who had problems with alcohol or drugs before a disaster are at risk of having those problems recur or get worse. Therefore, it may be helpful to obtain a sense of substance use patterns among disaster survivors and to provide information on positive coping that steers those at risk away from overindulgence. Providing information about local Alcoholics Anonymous and other 12-step meetings and resources is also strongly recommended.

**Indications that Immediate Referral to a Professional is Needed:**

While most extreme reactions that merit professional assistance take some time to develop, there may be individuals who are experiencing such strong acute stress reactions shortly after an event that they should be connected with mental health services immediately. Be on the lookout for behaviors that indicate problematic psychological responses, including people who are:

- threatening harm to self or others
- expressing irrational thoughts or beliefs
- experiencing significant cognitive impairment
- enacting ritualistic behaviors (for example, rocking back and forth incessantly, or speaking or writing something over and over)
- hysterical or panicking
- dissociating (seeming unaware of their surroundings, feeling numb or disconnected from reality)

Survivors who are displaying these behaviors should be referred to a professional or other qualified helper as they are at high risk of serious negative reactions.

**Tips for Public Health Managers:**

- Be aware that anyone who experiences extreme or ongoing trauma can develop PTSD or other serious reactions, but people often feel weak or ashamed if they don’t “bounce back” on their own. Providing information about these reactions and emphasizing that they are not an indication of weakness may help to reduce stigma about seeking assistance.
- Prepare and plan in advance for how you will handle extreme reactions in yourself and your staff and colleagues as well as the general public.
- Develop and demonstrate willingness to acknowledge emotional distress and respond supportively and non-judgmentally.
• Know how to refer individuals to an appropriate counsellor.
• Ensure staff knows how and to whom to report extreme reactions and seek support.
• Act as a liaison and an advocate, prepared with referral resources that include a list of professional helpers (psychiatrists, psychologists, social workers, etc.) in your area that you can provide to personnel as needed.
• Many distressed people prefer to talk to a spiritual leader, friend, or family member rather than a mental health professional. These sources of support can be very effective at helping people with less extreme reactions, but curing PTSD in particular may require training in specialized interventions. If possible, work with local clergy and media to educate them about these issues and to enlist their support for more formal psychosocial treatment for those in need.
• In the case of a large-scale event that leads to an influx of offers of help from various organizations, be cautious about whom you allow to provide psychosocial assistance to your staff and community. Some organizations continue to use discredited or unsupported interventions, so be sure you’re partnering with helpers who use evidence-supported treatments.

Hotline for People Needing Professional Assistance:
Substance Abuse & Mental Health Services Administration Disaster Distress Helpline
1-800-985-5990
Text TalkWithUs to 66746
TTY for Deaf/Hearing Impaired: 800-846-8517
www.disasterdistress.samhsa.gov/

This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
Research shows that certain populations have more intense needs during disasters, and they’re more susceptible to extreme reactions afterwards. These groups include children, older adults, and people with health conditions or physical or psychiatric disabilities. (Other vulnerable groups to be aware of but which are not addressed here include recent immigrants and those who do not speak English, and members of ethnic or religious groups that may be discriminated against, scapegoated, or targeted for violence.) Disaster planning should include careful attention to each group’s unique needs so you’re prepared to respond to post-disaster demands in your community. Also, as a manager you should be aware that people on your staff may be responsible for family members or others who are part of these groups, and they may require time and resources to address the resulting personal demands before they’re able to focus fully on their professional response role. Establishing connections with sources of practical support (i.e., childcare services, restoration of needed medications) and psychosocial support (i.e., connection with trained professionals with expertise assisting these populations) will help public health workers cope with their own distress and increase their ability to function professionally during and after a crisis.
Children:

Children are physically vulnerable during and after disasters because they’re often limited in their ability to protect themselves, and they’re also highly sensitive to the disrupted routines disasters often cause. It’s essential to frame children’s needs within their families. Families can be thought of as a system, and when one part of a system changes it affects all other parts. When children and caregivers experience a disaster together or find out about the death of a loved one, they share the same loss. However, their subjective experience of that loss as well as how they react and cope with it may be very different. While adult caregivers are experiencing stress, physical ailments, anxiety, depression, and concerns about their children’s physical and mental wellbeing, their children may be responding in unique ways including confusion, emotional or behavioral changes, physical ailments, academic problems, and social withdrawal.

After a disaster, children look to their parents for how to react, even though the parents may question their ability to effectively meet their children’s physical and emotional needs. If caregivers are distressed and overwhelmed, their children will observe this and, as a result, may experience increased distress themselves. In turn, when children develop overwhelming responses to trauma, their caregiver’s distress level may also rise. However, the same is true for positive socio-emotional adjustment: When caregivers are calm and reassuring, their children may perceive these emotions and may experience less distress. In addition, the caregivers’ level of distress decreases when they feel prepared to respond to children’s experience of trauma. Therefore, your most efficient use of resources will likely be on helping caregivers feel competent in their ability to assist their children. This tipsheet includes brief suggestions you can share with parents depending on the child’s age and developmental level.

As with most adults, with appropriate care and support, for the majority of children exposed to trauma or loss the common stress and grief reactions will resolve on their own over time. However, for others, reactions may not resolve and thus may necessitate professional help. It is especially important to provide support for children. Those with complicated trauma reactions experience a variety of biological, psychological, and social difficulties that can impede not only their recovery, but their healthy long-term development.

Tips for Public Health Managers:

- Be sure that preparations for emergency response and sheltering include appropriate supplies (child-safe cots, diapers, appropriate foods, etc.). It may well be someone else’s responsibility to assemble supply kits, but if you’re the manager who will have to cope with any short-changing of supplies, it’s recommended practice to “trust but verify” that kits’ contents are as planned in order to avert some stress for you and your staff in the field.

- Provide psychoeducation to parents about children’s typical reactions to extreme stress and how they can best comfort and support children at each age.

- Since children who do not recover as expected can experience lasting developmental disruption, it’s essential to educate parents about when a referral to a child specialist may be necessary, and to make information about appropriate sources available. Be familiar with how to make appropriate referrals to local mental health professionals who are trained in working with children.
• If appropriate, plan for how you'll handle your own children's needs in a time of crisis. Who will take care of them if you're required to work long hours? How will you stay in touch with them? Support your colleagues and/or staff in establishing similar plans. You will all be better able to focus on your work if you're not worrying about your children's wellbeing.

Older Adults:

When it comes to crises and disasters, many older adults are a vital source of knowledge, experience, skills, and wisdom as they have usually lived through both personal and larger impact losses. They have direct experience with the types of situations that younger adults may feel unprepared to address. However, the insight gained through aging is often accompanied by health or mobility problems that may compromise their safety, and that of those around them, on the front-lines of an event. In many cases, it's advisable to let them continue contributing to the effort in a safer worksite.

The particular risk factors that result in increased vulnerability of older adults can be divided into the following categories:

• **Physical factors**: Sensory limitations; decreased physical mobility and agility; increased risk of injury and illness; chronic medical conditions requiring treatment and monitoring or reliance on assistive devices; frailty; cognitive decline, including age-related dementias such as Alzheimer’s disease

• **Psychosocial factors**: Depression; grief in response to the multiple losses that can occur in emergencies and disasters; experiences of being a burden upon others, whether perceived or real; anxiety related to the disruption to routine and prolonged uncertainty involved in disaster recovery

• **Socioeconomic factors**: Poverty; reliance on family members or government assistance for financial support; vulnerability to physical maltreatment and financial exploitation; experiences of marginalization and stigmatization

Depending on their pre-existing level of health and general functioning, and the degree of support they are receiving, older adults may be no more or less susceptible to extreme negative reactions to stress than the general public, and their emotional resilience should not be underestimated. However, the physical and logistical demands produced by disasters and emergencies tend to coincide with the areas where older adults experience functional limitations, increasing their risk of harm and complicating their recovery. As some must with their dependent children, public health workers who are caring for a parent or other older adult with these risk factors may need time off, logistical assistance, or other forms of support in order to stabilize the elderly survivor before they can concentrate fully on work.

**Tips for Public Health Managers:**

• Recognize that being displaced from home can be particularly distressing for older adults, so they may resist evacuating or relocating, preferring to risk dangerous conditions than to leave their home or community. It may be difficult to balance respect for their autonomy with concern for their safety.
• If older adults must relocate to an emergency shelter, try to ensure that conditions are as comfortable as possible for them in order to avoid increasing physical harm and cognitive confusion. Address special dietary needs if feasible, and try to restore access to medications and assistive devices (cane or wheelchair, hearing aids) as soon as you can.

• Recognize that older adults may be reluctant to seek mental health counseling, seeing such services as not helpful or perceiving the need for assistance as a personal or spiritual failure. Some may be more willing to speak to a spiritual care helper than a psychosocial professional, so try to connect them with clergy if appropriate.

• Consider how older adults may be able to participate in recovery tasks (for example, by helping to cook or provide childcare in a shelter or by calling on their historical memory of the community as you plan memorial events). This will not only provide needed assistance to others but will enable the older person to feel valued and productive.

**People with Disabilities:**

Individuals with physical, psychiatric, cognitive, or intellectual disabilities should be viewed as people first, with needs and rights like those of the general population. Nevertheless, many do face special challenges that must be acknowledged. Their psychosocial reactions to the disaster may not differ from the typical symptoms we would expect in anyone who has experienced a traumatic event; but in some instances symptoms may be related to the disability and require additional measures to help the person return to pre-event functioning. For a refresher on the characteristics of mental and physical disabilities, see the end of this tipsheet.

**Tips for Public Health Managers:**

• During planning, when selecting sites to be used, as much as possible ensure that Points-of-Dispensing, emergency shelters, and other facilities’ conditions are appropriate, without physical barriers like steps, and with accommodations like special sleeping arrangements for those with limited mobility.

• Determine what treatment and supports the person was receiving before the event and try to restore that as soon as possible.

• Try to connect individuals and/or caregivers with organizations that can restore access to needed:
  - critical medications (including psychiatric medications)
  - assistive devices, such as crutches or hearing aids
  - caregiving services, such as an aide for personal hygiene or a sign language interpreter

While children, older adults, and people with physical or mental disabilities can present as particularly vulnerable demographic groups and may require additional services, it is also essential to recognize the strengths and abilities these survivors do have. Your role as a public health worker will be to mobilize whatever resources are needed to restore the pre-disaster adaptation and independence of members of these groups and to help parents feel up to the challenge of supporting their children.
<table>
<thead>
<tr>
<th>AGE</th>
<th>CHILD'S RESPONSE</th>
<th>SUGGESTION FOR PARENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 3 years</td>
<td>• Can be irritable, cry more than usual&lt;br&gt;• May act like a younger child; they may return to bed wetting after they have been toilet trained&lt;br&gt;• May be frightened to be without parents nearby</td>
<td>• Hold your child more often to reassure and soothe the child&lt;br&gt;• Keep the child with parents and other family members&lt;br&gt;• Keep them away from loud noises and chaos&lt;br&gt;• Keep a regular feeding and sleeping schedule, if possible</td>
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<tr>
<td>3-5 years</td>
<td>• These children can remember events&lt;br&gt;• May see death as a reversible condition&lt;br&gt;• May be concerned that the event will occur again, which can prompt angry or sad feelings</td>
<td>• Listen to child's retelling of event&lt;br&gt;• Respect child's fears; give child time to cope with fears&lt;br&gt;• Increase monitoring and awareness of child’s play; set limits on scary or hurtful play&lt;br&gt;• Let child try out new ideas to cope with fearfulness, such as extra reading time, or having a radio on in the middle of night to undo effects of fearful nightmares&lt;br&gt;• Stick to regular routines as much as possible, and allow play and relaxation time&lt;br&gt;• Give simple answers about what happened without scary details</td>
</tr>
<tr>
<td>6-12 years</td>
<td>• At this age, the child will begin to understand the permanence of loss&lt;br&gt;• May become preoccupied with the trauma and talk about it over and over</td>
<td>• Encourage child to talk about traumatic events with family members&lt;br&gt;• Provide opportunities for young person to spend time with friends who are supportive&lt;br&gt;• Reassure that strong feelings (guilt, shame, wish for revenge) are normal following a trauma&lt;br&gt;• Do not offer false reassurance&lt;br&gt;• Encourage pleasurable physical activities such as sports and exercise</td>
</tr>
<tr>
<td>Adolescence</td>
<td>• Adolescents will realize that death is permanent, but may deny it&lt;br&gt;• May engage in dangerous or risk taking behaviors as a way to deal with strong emotional reactions&lt;br&gt;• May not be able to talk about intense feelings; therefore, the adolescent may emotionally withdraw and avoid social activity&lt;br&gt;• May seek additional information about the event</td>
<td>• Be aware that even though responses may be adult-like, the adolescent may not actually be coping well&lt;br&gt;• Encourage your adolescent to talk with friends, other family members, and individuals at school or in the community&lt;br&gt;• Find opportunities for adolescents to be helpful</td>
</tr>
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Refresher on Characteristics of Mental and Physical Disabilities

MENTAL DISABILITIES:

The term mental disability comprises a wide range of different diagnoses. Within each diagnosis individuals may experience symptoms on a spectrum of severity. This spectrum is due in part to natural variations in the disease process, and in part to the effectiveness and availability of treatment. The primary categories of mental disability include:

- **Intellectual Disabilities:** These can be caused by genetic conditions like Down syndrome, problems during pregnancy or birth, severe malnutrition or certain illnesses in childhood that impact brain development, or childhood exposure to environmental toxins like lead. Severity can vary widely and can impede an individual in areas such as the ability to care for oneself, communicating, social skills, and learning. Because their effects typically begin early in life, children with intellectual disabilities may experience delays in development of skills, and they may require additional time and support to learn to speak, walk, read, and achieve other milestones. Depending on the severity and the available support, they may eventually catch up to peers, or they may remain dependent on caregivers for assistance with some or all activities of daily living into adulthood. If that support is not available due to the disaster, people with intellectual disabilities may be particularly vulnerable to negative psychosocial reactions.

- **Other Cognitive Disorders:** Traumatic brain injuries and Alzheimer’s disease and other dementias can occur later in life and cause a sudden or progressive loss of skills. As a result, a family must adapt to the changing role of the person with the condition, so there is emotional distress as well as the practical need to provide care. This can create a significant economic burden due to the likely loss or reduction of income (of the person with the disorder, and/or of another family member who stops work to become a caregiver) or the need to pay for care. As with people with intellectual disabilities, those with serious cognitive disabilities are at risk if needed support systems are disrupted by disaster.

- **Psychiatric Disabilities:** Diagnoses that are most likely to affect people’s functioning during and after disasters include schizophrenia, depression, and pre-existing posttraumatic stress disorder. People with all of these conditions may benefit from taking appropriate medications, so you should be sure to inquire whether they have been taking medications and if so, if they currently have access to them.

All forms of mental disabilities can impact disaster survivors in ways that are minimal or profound – especially if they’re dependent on a support structure that is disrupted by the event. A condition that was well controlled before a disaster may become a disability after it if treatment is unavailable or the distress of the event causes a spike in symptoms.

PHYSICAL DISABILITIES:

Like mental disabilities, the range of possible physical disabilities is wide, in both type and extent of impairment. Physical disabilities can be broadly categorized by the type of functional impairment they cause:

- **Mobility impairments** may limit a person’s ability to walk or run, stand or sit, or otherwise perform typical activities of daily life. They may be caused by spinal injury, an injured limb or muscle, a condition like arthritis that causes severe pain, a congenital condition like cerebral palsy, or myriad other problems. Many people with mobility impairments rely on assistive devices such as wheelchairs, canes, and the like, and those...
whose impairment causes pain may be dependent on painkillers to improve functioning. It can be difficult for this group to take protective action before or during a disaster, increasing the risk of additional injuries and distress. Mobility impairments also may make sheltering and recovering post-disaster difficult due to inaccessible facilities, or loss of assistive equipment or pain medication. Environmental conditions post-disaster also may exacerbate mobility issues.

- **Sensory impairments** primarily affect vision and hearing. People with sensory impairments may be reliant on family members or neighbors to alert them about disaster warnings, and to assist them with evacuating or taking other protective actions. Like mobility impairments, vision and hearing limitations can make life in shelters difficult, and people with sensory disabilities may require additional help such as a sign language interpreter.

- **Illness** is not necessarily categorized as a physical disability, but it clearly can create related difficulties during and after disasters. If someone is sick – either from a chronic condition like cancer or an acute one like influenza – do they have the energy or strength to take protective action? Does a disaster disrupt necessary treatment like chemotherapy or dialysis, or access to needed medications like insulin? If a person has a contagious condition like influenza or cholera, how can he or she be sheltered without exposing others? And even if a condition is not communicable, there is often stigma around visible illness, with irrational but very real fears about contagion or contamination that may make other survivors hostile towards the ill person. Environmental conditions post-disaster, such as the presence of mold or smoke, can also intensify many illnesses.

Disabilities can also be categorized as chronic (long-term or permanent), acute (currently present but perhaps temporary), or intermittent (sometimes present, sometimes not). While those with chronic disabilities would appear to face the biggest difficulties, they may actually have adapted effectively to their limitations and be better able to function than someone with a more acute injury. Regardless of cause or temporality, all of these disabilities increase the risk of exposure to disaster, and they create additional challenges in the recovery process.

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This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
Psychological First Aid: Providing Basic Care

Providing assistance during or after a disaster is challenging even for the most experienced professionals. Independent of the setting (i.e., Point-of-Dispensing, shelter, headquarters, or Emergency Operation Center), there might be a need for you to provide emotional and practical support to survivors and/or staff. Survivors could display shock and extreme emotionality, and the assistance they might require could last for a few minutes or many months, while you and your co-workers may be struggling to balance professional obligations with processing your personal experiences of the event.

Most people exposed to disasters will recover on their own, but your ability to help promote a positive recovery environment will be crucial to this outcome. In fact, your ability to supply effective psychosocial support to your staff may be among your most important responsibilities and can contribute greatly to their long-term well-being, allowing them in turn to assist survivors in the community throughout the perhaps lengthy recovery period. In this tipsheet we present the principles and practices of Psychological First Aid. If you keep these principles and practices in mind during and after a crisis, you can provide effective assistance even if you are not a trained mental health counsellor. In fact, PFA like any type of First Aid can be learned and practiced by non-professionals. It can prevent long term problems and promote healing.

Principles of Early Intervention
The actions used to establish this positive recovery environment stem from principles that have received broad empirical support from research on stress, coping, and adapting after disasters and mass casualty events. According to a landmark study by 20 international experts in disaster and trauma treatment (Hobfoll et al., 2007), there are five essential elements that should be included in any comprehensive psychosocial response to disaster or mass trauma. Put into action, these principles can improve the lives of staff and survivors.
• **Promote Safety:** After a disaster, in order to reduce the physiological responses to fear and anxiety, you should do all you can to promote safety by removing actual or perceived threats. If the threat is on-going you should do all you can to reduce the danger and encourage safety.

• **Promote Calming:** Anxiety and distress are typical and understandable responses to disasters, but once the immediate danger has passed, heightened anxiety or arousal can become dysfunctional. You should promote calm by serving as a role model, reassuring survivors that it’s safe for them to relax or lower their arousal levels. Even if the danger is protracted, when there’s relative peace, remind people to relax.

• **Promote Efficacy:** Complex emergencies can cause survivors and staff to feel helpless. Promoting self-efficacy can begin with restoring a survivor’s ability to regulate negative emotions and solve practical problems. It can also include facilitating community activities like mourning rituals or getting children back in school. Efficacy is promoted by encouraging survivors to take as much control as possible over their own actions and decision-making.

• **Promote Connectedness:** Your regular contact with your staff supplies one important connection. However, it’s also important that you promote connections between survivors and their natural, positive support system. You should do all you can to connect children with parents and neighbors with neighbors. Remind your staff to talk with and stay connected to family and friends.

• **Promote Hope:** Hope may be defined as the belief that one’s actions can bring about a positive outcome. For some, hope involves a belief that luck or the government will address needs. For many, hope arises through a belief in God or a higher power. Your realistic hopefulness that the situation can improve or that recovery is possible provides an effective role model.

How can these principles be applied to assist survivors of disaster or catastrophe? In fact, they provide the theoretical basis of the early intervention that is most recommended by trauma experts, Psychological First Aid (PFA).

**Psychological First Aid**

The National Institute for Mental Health (2002) defines Psychological First Aid as “evidence-informed and pragmatically oriented early interventions that address acute stress reactions and immediate needs for survivors and emergency responders in the period immediately following a disaster. The goals of psychological first aid include the establishment of safety (objective and subjective), stress-related symptom reduction, restoration of rest and sleep, linkage to critical resources and connection to social support.” PFA interventions are meant to address the interrelated practical, physical, and psychological needs of survivors, making it consistent with the principles described above. PFA's premise is that attending to basic needs (i.e., providing food and water; restoring a sense of calm, safety and hope; connecting survivors with a source of social support; providing information and psychoeducation) as quickly as possible after someone experiences a traumatic event will help to lower their arousal level and prevent them from developing long-term negative emotional reactions, just as receiving prompt medical treatment for a wound can prevent it from becoming infected. PFA is not a process, but a toolkit of components to be used as needed, in any order appropriate.
Here are the components of PFA:

- **Be Calm:**
  One core aim of PFA is to reduce the physical and emotional arousal level that was increased by the disaster. Because emotions are contagious, you can reduce the arousal level by maintaining a calm presence. It’s important to maintain calm without being emotionally distant and to remain steady in order to help survivors master or regulate their experiences. Remember to breathe.

- **Provide Emotional Warmth:**
  Disasters can shake survivors’ trust in humanity. You can help to restore that trust by being thoughtful, patient, and kind. Compassion and kindness are expressed in attentiveness, open posture, soothing tone of voice, and acceptance of anything the survivor says. However, accepting and understanding survivors’ feelings does not mean you should support inappropriate or unhelpful actions.

- **Provide Acknowledgement and Recognition:**
  While you want your staff and survivors to remain calm, you should not minimize the gravity of the situation. Survivors require acknowledgment and validation that they’re in a very difficult situation or that they’ve experienced a trauma and their stress reactions are understandable and to be expected. If the significance of the trauma is downplayed, survivors may not take the necessary time to rest and recover, and it may undermine their trust in your willingness and ability to help them.

- **Express Empathy:**
  If survivors or staff members want to describe what happened to them, be prepared to listen. Concentrate and attend to all aspects of their communication at both the emotional and cognitive levels. Respond by restating or reflecting on what the person said with statements such as “I hear you saying...” or “So you think that...” Such “active listening” allows people to feel known and understood which can help them to cope with current stressors or to heal from one that passed.

- **Show Genuineness:**
  It’s not easy to be warm and empathic if you’re exhausted or impatient. A fake smile is not helpful. Only genuine empathy and warmth are helpful for survivors. Genuineness does not mean being blunt or indiscreet. To be sincere in your caring for others requires attention to the occupational hazards discussed in the tipsheet on Self-Care. Know your limits so you can stay genuinely empathically and warmly engaged.

- **Empower the Survivor:**
  Here’s another juggling act: At the same time that you acknowledge the fragility and vulnerability of those who are under stress or experiencing fear or loss, it’s also important to support their resilience. Acknowledging and supporting a survivor's strength, competence, courage and power – his or her resilience – can begin to restore a sense of control. Allow survivors to determine the kind of assistance they receive, the pace of any kind of self-disclosure, as possible. Ask: “How have you gotten through tough times before?” or “What skills do you have that will allow you to get through this?” It may be helpful for staff to continue normal work routines so they feel useful even in difficult circumstances.

- **Attend to Safety Needs:**
  Survivors will recover much more quickly if they feel safe. They also need to feel that their loved ones are safe and out of danger. You should do all that you can to ensure that survivors and their loved ones are as safe as they can be during or after an emergency. Protect survivors from any threat or danger from the ongoing disaster, especially those
who may be so disoriented that they’re not able to care for themselves. There are situations where it’s impossible to provide this kind of safety, but it’s reassuring to people to know that this is your highest priority.

- **Attend to Physiological Needs:**
  If you hear or observe that staff or survivors are injured or ill you should do what you can to get them medical attention. You might provide assistance in problem solving as you help survivors to find basic necessities such as food, water, or shelter. If the crisis is a medical emergency such as a pandemic, while it’s important to be empathetic and calm, it is more important to do all you can to ensure the physical health of community members. This may involve finding out where to get vaccines or antiviral or antibiotic medication.

- **Help Survivors Access Social Support:**
  Social support can be expressed in different ways, but all can help a survivor to cope with the stress of disaster and tragedy. **Instrumental support** can be practical in nature, taking the form of money or help with tasks and chores. Survivors might need instrumental help repairing their homes, arranging travel, or doing needed paperwork, and staff members might need services like safe childcare in order to allow them to focus on their work. **Emotional support** provides a survivor with warmth, caring, understanding or acceptance, and a sense that they are valued and important. **Informational support** can include advice or guidance that’s intended to help people cope with difficult circumstances. While you may be able to provide all three forms of support directly, you should also encourage survivors to seek it from neighbors, friends, and family members. These personal connections can be valuable resources in providing accurate information on current local conditions (such as where to obtain medical care, which roads are closed, where to obtain fuel or other supplies, if business hours have changed, and so on), as well as sources of comfort and solidarity. One caveat: Don’t make the mistake of urging survivors to contact family and friends without being sure that these contacts will be trustworthy and helpful. Remember that not all relationships are supportive – in fact, some family members are significant sources of stress and misery.

- **Assist Survivors with Traumatic Grief:**
  For some managers, being with a staff member or survivor who has just lost a loved one is the most challenging experience they ever face. Often there are practical problems. You might be able to help people with tasks such as identifying remains, making funeral arrangements, repatriation, and legal, financial, and benefit issues. If the county has a Medical Examiner’s Office, they are experienced in these matters; if they’re not included in the plan, other than in physical recovery, they should be consulted or invited to join in a survivor support role. Although this assistance is practical it is also psychosocial, in that accurate information and practical resources are consoling. Psychosocial support for those who are grieving often involves little problem solving. You might say “I am so sorry for your loss,” “Is there anything I can do for you now?” “Is there someone you would like me to call?” “Do you need me to notify anyone?” As a supportive presence you can offer much comfort. You also might be called upon to provide assistance at memorials, which could be held soon or sometime after the disaster. The bereaved are often very thankful if you simply provide a visible but unobtrusive compassionate presence.

- **Remember to be Kind, be Calm, be Informed and be Present.**
  That includes being an active listener, making eye contact (unless that causes discomfort for the person you’re talking to), using relaxed body language, allowing silence, and attending to non-verbal cues. Also try to paraphrase the speakers’ words and reflect their feelings so they know that you fully understand them.
Provide Information and Orientation to Services:

Accurate information is an important antidote for the uncertainty and anxiety that survivors experience during or following a complex emergency, but release of that information is sharply limited during an emergency. Any time responders are asked for information about the event – i.e., “What happened?”, “How many survivors are there?”, or “Why didn’t Agency X respond sooner?” – the first question they must ask themselves is “Am I permitted to answer this question, per the Agency Emergency Response Plan?” In these examples, the answer is almost certainly, “No!” Communication about the event is strictly and universally limited to the Public Information Officer or his designee(s), even when the person asking questions is not from the press.

Beyond being sure that the press has accurate and timely information, it is important to realize that controlling the release of information has humanistic reasons as well. Imagine being a family member of a victim, just arriving at the site of a plane crash, with no information on the fate of your loved one. You walk past a responder talking with another victim's family member, and you hear him say, “No, I’m sorry, there were no survivors.” Information given with the purest intentions can have irrevocable, devastating impacts. To avoid this, long before any event occurs you should review the pertinent emergency plans and assure that you and your staff are clear on your scope of authority for releasing information at an emergency event. Knowing those limits when you walk onto the site for the first time will help you to focus on what you are authorized to do to help those impacted.

One category of information has more urgency than any other: when survivors are missing loved ones. Family members in this category will want frequent updates about what happened and what is being done to search for the missing person. Even when there is little hope that a loved one will be found alive, relatives still may want details about the recovery process. Remember that whether the information you’re providing is about a missing loved one or a more routine matter, it is important that all communication be framed in simple language. The stress of disaster or trauma can impair cognitive ability, so you need to be certain that the information you provide is received. You may need to summarize or review what is being said, or provide it in writing as well as verbally. If you’re working with non-native English speakers, every effort should be made to communicate in the survivor’s native language, especially since language skills are often impaired by stress.

The following resources provide additional guidance on providing Psychological First Aid:


This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number SU90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
Tipsheet #6
Other Early Interventions

While the tipsheet on Psychological First Aid describes essential basic tools for supporting survivors and staff, this one presents additional tools you can use to provide assistance during or after a public health emergency. These tools include psychoeducation, correcting misperceptions or distorted beliefs, rumor control, assessment, and referral. It’s important for you to understand these tools; however, you should use your judgment about when to ask for the help of a mental health professional to address the psychosocial needs of survivors and staff.

Psychoeducation:
As the name implies, psychoeducation involves educating people about psychological aspects of their experience. Two of the most helpful forms of psychoeducation in the early aftermath of disasters are providing information about predictable stress reactions and providing information on effective and ineffective means of coping with stress.

• Anticipating and normalizing stress reactions: Some survivors or staff members may be concerned about their own intense emotions. Others might be troubled that while everyone around them is very emotional, they are feeling numb. Survivors with typical stress reactions sometimes think that they’re “going crazy” or are weak. You can reassure survivors that reactions, such as having trouble concentrating or being easily startled, may be troubling, but are typical reactions to atypical events and almost always subside over time.

• Effective and ineffective coping: You can caution survivors and staff about the use of self-defeating coping mechanisms that might provide fleeting relief from acute stress, but will ultimately cause additional problems, such as overworking or consuming too much food or alcohol. You can encourage them to find effective ways to cope with stress. Remember that everyone has different strategies and that what works for one person may not work for another. One survivor might relax by watching sports, another through prayer, and yet another by speaking with family members. Perhaps the best approach to helping survivors to reduce stress is to ask how they’ve always sought peace or reduced stress and, if it’s not self-destructive or counter-productive, encourage them to continue to do this or more of it.
Correcting Misperceptions and Distorted Beliefs:

As they try to process their experience, those who have been through a traumatic experience often think in ways that are distorted and not helpful. Any of the following thoughts or beliefs may be detected when you speak with someone who has been through a traumatic experience:

1. It was my fault; I cannot trust anybody; I want to get revenge
2. I am in danger; I will never be safe and never get over this
3. I am shameful, stupid, weak, or inferior; I cannot protect myself or my family

When you listen to survivors or staff, you may discover one or more of these distorted and unhelpful thoughts. The first group indicate excessive blame towards self or others, because attributing responsibility – even to oneself – provides a sense of control that many people find easier to cope with than accepting that the event may have been a random act of nature or a senseless act of human violence. As survivors struggle to find a cause, they may try to make sense of it by blaming themselves. You could attempt to help them find a more helpful perspective that is also consistent with reality. Then there are those who excessively blame others. A disaster caused by malfeasance or malevolence can lead to appropriate blame and a desire for justice. However, for some survivors the desire for vengeance can blind them to their own needs and those of loved ones. Over time you may be able to assist survivors to find a way to balance these needs.

The second group of statements illustrates how survivors continue to feel unsafe when there is little danger. If they appraise the environment as less safe than it is, their recovery will be protracted. You might help a survivor to restructure the thought to “The danger has passed” or “It’s over, I’m safe now.” As survivors begin to more accurately appraise their environment, they will resume normal activities, which aids in healing.

The helplessness, weakness, and loss of control that is seen in the final statements are a result of how extreme stress can overwhelm coping mechanisms and lead to strong feelings or thoughts of inadequacy. Help your staff to take actions so they feel that they can have some impact on the environment. By doing so, they can begin to regain a sense of adequacy.

Rumor Control:

Rumors are common in disasters, wars, public health emergencies, and other times of uncertainty. Remember that in times of extreme stress, people don’t always think clearly and critically, which may cause them to pass along the most questionable tales. Rumors can be perilous. They can create a false sense of danger, causing some survivors to flee a safe place. They can also feed the desire to find someone to blame for a disaster, leading to animosity and potentially even violence against members of certain religions, ethnic groups, or others selected as scapegoats. Rumors may be spread more easily today through cell phones, text messages, blogs, Twitter, or other forms of social media.

Remember to caution staff members about the probability of rumors and misinformation, and encourage them to tell the Public Information Officer about misperceptions that need to be countered with official factual information. If there’s dire but confirmed information, the PIO should provide it, since failing to do so will undermine trust and open the door for rumors to fill in the information vacuum.
Group-Level Assessment:

If your role is to assess the needs of survivors and staff members during or after a public health emergency, keep their psychological and emotional well-being in mind. You should be asking yourself if the environment is suitable for psychological recovery. Is it physically safe? Is it unnecessarily noisy or chaotic? Is information being provided regularly? Even such practical issues as making sure that food is appropriate to survivors’ cultural and dietary preferences can provide comfort. You should be asking yourself “What is needed and where are the gaps in care?” As the relief operation proceeds, there should be on-going monitoring of the stress level of survivors as well as your own and your team members’ stress.

Individual Assessment:

In addition to the more general needs assessment, you should also be aware of the emotional and behavioral functioning of survivors and staff members at the individual level in order to identify anyone who is in need of more support. Over time, the natural resilience of most people allows them to recover on their own. However, some people may need more than the basic help. How can you best identify these at-risk survivors and ensure that they get the additional help they need?

Since the emotional reactions of those impacted can be intense, but normal and transient, you may have a difficult time sorting out who is showing the most distress from who needs the most help. Here are some evidence-based risk factors you can consider in deciding who needs to be more carefully monitored or given more support or attention. You don't need to ask these questions directly, but through conversation, you may discover answers that could demonstrate the need for more support or referral.

Did or does a survivor or staff member:

- Feel extreme panic?
- Feel a direct threat to their own life of the life of a family member?
- See or hear of the death or serious injury of a family member?
- Lose a loved pet?
- Sustain a significant illness or injury to themselves or to a family member?
- Become trapped or experience a delayed evacuation?
- Have a family member missing or unaccounted for?
- Have a home that is not liveable?
- Become separated from their family during the event?
- Have a prior history of mental health care?

If someone has any of these risk factors, you should provide additional support and monitoring or referral to a mental health counsellor. This need increases if the survivor has multiple risk factors.

The most important risk factor is a positive answer to the following question:

- Is the person a danger to self or others?

If you have reason to believe someone will injure himself or others, you should get help immediately! Planning for and educating staff about how to do so in shelters and other settings should be a high priority.
You should also be alert for behaviors that indicate other serious problems. If you notice significant cognitive impairment such as psychotic symptoms (for example, someone who is hallucinating or acting irrationally), major memory disturbance, an inability to make simple decisions, or obsessive thoughts or acts, a referral to a counsellor is indicated. If you notice serious withdrawal or repetition of ritualistic behaviors, or aggressive behavior (screaming, slander, threats), a referral would be in order as these are not typical reactions. Although very intense reactions such as hysteria or panic are not uncommon following traumatic experiences, you should be sure to get support and assistance for anyone who is in significant psychological pain.

Also note that there are certain populations considered to be more in danger than others for developing long-term problems during or after a complex emergency. Of course not every member of these groups is vulnerable, but understanding which populations are at risk can help guide your efforts. They include:
- Children (especially those missing parents or whose parents were injured or died)
- Medically frail adults and children
- Those with a physical disability or illness (including mental illness)
- Mothers with small children
- Adolescents and adults with substance abuse problems
- Those exposed to grotesque scenes or who thought their life was threatened
- Groups traditionally marginalized or economically disadvantaged, or those with few or dwindling resources

**Making a Referral to a Mental Health Professional:**

Weeks or months after the disaster, some survivors may tell you that they’re suffering or not functioning well and want more intensive assistance. However, you should be sensitive to the fact that those who need long-term treatment may feel ashamed and embarrassed about needing help. Many survivors of traumatic events are reluctant because there’s often a stigma associated with such help-seeking. You may need to sensitively encourage a staff member or survivor to get more help. As part of preparing to respond to an emergency, you should know where and how to make a referral for follow-up mental health care.

**Some Things Not To Do:**

- Do not force or pressure people to share their stories with you. Do allow people to self-disclose at their own pace and in their own way.
- Do not provide naïve reassurance such as saying “Although you’re badly injured, you’re still alive” or “At least some of your family survived” or “I’m sure everything will be alright.”
- Do not tell survivors how you think they should feel or what they should have done differently.
- Do not explain to survivors why you think they experienced this disaster based on your opinions or beliefs.
• Do not make promises that you can’t keep. For example, don’t confidently reassure survivors that assistance or resources will soon arrive or that you’ll be available to help them over a long period of time if you don’t know for sure. Similarly, don’t promise access to information that may not exist or may not be cleared for release.

• Do not criticize relief workers and agencies that are offering assistance as survivors may be depending on their services.

Do remember to take care of yourself when you are assisting survivors or staff members.

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Self Care: Costs and Rewards of Trauma Work

When disaster strikes and you and your staff are consumed with helping those in need, you might overlook how important it is to care for yourselves. Remember: **The care that responders provide others can only be as good as the care they provide themselves.** This tipsheet provides an overview of the occupational risks and rewards of working in disasters and other periods of intense stress, including warning signs and risk factors, followed by self-care recommendations to employ before, during, and after crises. Through regular self-care practices, the benefits of working in disasters can outweigh the potential risks.

**Commonly Cited Rewards:**

During a crisis may not be the best time for workers to focus on the positive aspects of helping others. However, before and after a disaster, workers can bolster resilience by remembering the satisfactions and rewards that come from providing critical and supportive services in challenging circumstances. Cultivating the satisfaction that comes from exercising compassion in this way serves to protect and sustain workers during times of increased stress and work demands. The following aspects of helping in emergencies are most frequently cited by workers as those they find rewarding:

- Personal satisfaction and enjoyment of the work
- Relief from routine work; variety
- Feelings of empowerment during times of crisis and chaos
- Emotional connection with survivors, colleagues, and the community
- Sense of competence and mastery in overcoming unique challenges
- Sense of privilege and honor to serve during times of need
- Increased self-knowledge and self-awareness
- Promoting healing in unique and moving circumstances
- Personal growth
- Being part of a meaningful effort larger than oneself
The Cost of Caring:

Helping those in pain is difficult work. Workers can experience acute stress, chronic stress, traumatic stress, or all three. Stress, if not managed, can result in a variety of conditions that are similar and not mutually exclusive. Various terms refer to the occupational hazards that can occur when providing supportive services to highly stressed or traumatized individuals or communities, including Burnout, Compassion Fatigue, Secondary Traumatic Stress, and Vicarious Traumatization.

Perhaps the most serious occupational hazard is Burnout. In its fullest manifestation it involves a complete emotional and physical collapse, often accompanied by depression, suicidal thoughts, and the need to temporarily or permanently discontinue work in the field. Burnout develops gradually, sometimes over years, and can be prevented through early detection. One way to recognize advancing Burnout is simply by noticing that you’re neglecting your own needs. Compassion Fatigue is the general term used to describe the emotional exhaustion that comes from overextending yourself to aid others. Vicarious Traumatization or Secondary Traumatic Stress can occur if you’re exposed to intense or repeated stories of traumatic experiences and they begin to impact you as if you suffered the traumatic event yourself. This can take a serious emotional toll, changing your beliefs about fairness, justice, or good and evil in the world. All of these occupational hazards can not only cause you misery but also limit your ability to help others effectively. However, these hazards can be prevented by practicing effective coping methods and good self-care.

Risk Factors for Occupational Hazards:

Anyone who is committed to helping survivors may be vulnerable to these occupational hazards. However, you’re more at risk if:

- You are exposed to multiple trauma and grief experiences
- The event causes injuries, death, or grotesque images or sounds
- The event impacts children
- There are many chronic (on-going) or acute stressors or demands in your life
- You have your own unresolved trauma or grief reactions from current or past losses
- You feel helpless to assist others or to save lives

Additionally, especially in the event of large-scale disasters, helpers often need to tolerate a great deal of ambiguity and uncertainty. In many cases you may not know the outcome of contact with those you’re trying to help, which can add significantly to your stress level.

Risk factors can also be summarized according to personal characteristics as well as the characteristics of the disaster. All staff will be more at risk if the disaster is large in scope, high in intensity, and long in duration; and most staff members will need support if there are deaths and injuries. However, some individuals need little help even in dire circumstances, while some personnel need support with a small-scale event, especially if they’re inexperienced or struggling with other life stressors. While all staff members are at risk for occupational hazards, there are specific factors to consider in assessing the level of support and assistance individuals may need to prevent advancing stress reactions:
### Errors in Thinking that Put You at Risk:

The challenges of responding to crises and fulfilling related responsibilities can be exacerbated by “errors in thinking.” The following are common misbeliefs that may increase your risk of Burnout or Compassion Fatigue during a response.

1. **In an emergency there won’t be petty bureaucratic obstacles.**
   
   There will be. Even in the most critical situations there may be forms that need to be filled out, equipment that isn’t functioning, or phone connections that don’t work. In normal circumstances these frustrations can be bearable, but in an emergency they can be much more frustrating.

   **Tip:** Prepare as much as you can to have materials ready for an emergency, but know that you can’t predict everything and will have to cope with small or perhaps significant bureaucratic problems.

2. **All tasks are mission critical.**
   
   They are not. If all tasks are viewed as urgent, you and your colleagues will work through breaks and days off. If everything is considered mission critical, then nothing is.

   **Tip:** Divide work into mission critical vs. non-critical tasks – and then put self-care at the top of the mission critical list. Be sure that you and your colleagues are taking breaks, getting adequate sleep, and taking scheduled days off.

3. **You are irreplaceable.**
   
   You are not. Yes, at the beginning of an emergency, you may need to work long hours. But if you’re not careful, exhaustion and burnout will severely limit your capacity.

   **Tip:** As part of your preparedness planning, you may need to plan for long and even 24-hour shifts. Select someone who can stand in for you and train them in the critical tasks they will need to know in emergencies.

### GENERAL FACTORS
- Personal history
- Defensive coping style
- Current life context
- Training/career history and status
- Availability of resources or social support (e.g., supervision)
- Nature of clients served
- Nature of work and workplace

### DISASTER-SPECIFIC FACTORS
- Size and scope of the disaster/event
- Personal and direct connection to disaster/event
- Mass casualty event or events caused by intentional violence
- Disasters with many injuries
- Grotesque images and sounds
- Witnessing impact of events upon children
Warning Signs for Occupational Hazards:

If you and your colleagues are under extreme stress, sometimes the warning signs emerge slowly and sometimes they can hit suddenly. Remember that if any worker is feeling really bad, having unexplained physical symptoms, is quick to conflict, or is showing up late to work, that person could be experiencing symptoms of extreme stress or trauma. Stress reactions and warning signs of occupational hazards are individual. One person may over-eat, while another may under-eat. All staff should become familiar with and have plans for monitoring and responding to one another’s individual warning signs.

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Self-Care Recommendations:

Public health workers who must report to work during disasters all need to understand and practice self-care so they themselves can “survive” and be available and effective for their patients, colleagues, and their families. Effective self-care reduces the risks of compassion fatigue and enhances the potential for compassion satisfaction. The principles and practices of self-care before, during, and after a crisis are presented here.

When disaster strikes, especially if there is significant property damage or if lives are lost or threatened, it’s understandable that workers put their own needs on hold while they attend to the crisis. However, no matter how dire the situation, the most dedicated staff cannot work 24-hour days, seven days a week, without compromising their health, wellbeing, and effectiveness. **Self-care has personal benefits but it is also essential for maintaining professional competence.** This is sometimes referred to as the self-care imperative.

Competence is an ethical matter of protecting not only yourself, but your patients, colleagues, and their families. Self-care is not selfish. It is an integral aspect of maintaining competence.

The core of self-care is effective stress management, which requires continuous attention. Good stress management activities both improve the way you feel and allow you to function more effectively. Ineffective activities (like eating or smoking too much, or bullying people around you) might make you feel better temporarily, but they don’t help you function successfully in the long run.
Self-Care Before Disaster Strikes:

Stress management should be a part of your daily activities, not something that’s practiced only once in a while or postponed until you really need it. This means that good self-care strategies include activities that you will do every day, not unrealistic goals you can’t meet. It’s nearly impossible to begin using new coping methods during the hubbub of a disaster, so developing good habits in advance will help you be more prepared for the challenges you will face in a crisis. This will allow you to adapt quickly to challenges and recover from their potentially negative effects.

**Tip:** Your first step should be to examine your current coping mechanisms and determine which are effective, which are not, and what you might do to increase the helpful ones. The following are some strategies that are often recommended, but it’s most important to develop practices that you will actually use:

**KNOW WHAT WORKS FOR YOU, AND WHEN YOU’RE STRESSED, REMEMBER TO DO IT OR DO MORE OF IT.**

- Get sufficient sleep
- Take regular breaks
- Exercise
- Eat a balanced diet
- Connect with others
- Have some time alone
- Limit TV and internet exposure
- Pray or follow your other usual spiritual practices

Some of the strategies listed may not be realistic at certain times in an emergency, but could be used later. Other strategies might be used from the start. For example, in the early stages of a disaster, you should not go home after working and watch television covering the event. You need a break! Many strategies can and must be adapted in order to utilize them in emergency settings. You may not be able to follow your usual exercise regimen, but perhaps you can do a few minutes of stretching or take a short walk.

It can also be helpful to discuss your plan with family, friends, and colleagues so they can support you, and to have a logistical plan for the practical issues that may arise during an event. For example, if you’re called on to work long hours after a disaster, who will care for your children or attend to other needs? How will you modify established self-care practices that you enjoy so they can be maintained during periods of increased stress? Having a plan in place in advance will reduce your personal stress when something does happen, allowing you to function better professionally.

Stress Inoculation:

It’s important to remember that the goal of effectively dealing with extreme stress is not to get rid of it, but rather to manage it. Stress Inoculation can help you to identify potential stressors and coping strategies. This process can serve a protective role when you’re exposed to extreme stress. The goal of Stress Inoculation is to allow you to continue to work
during the event and, ideally, to avoid occupational hazards like Burnout and Vicarious Traumatization so you remain able to respond during later crises and emergencies.

**Identifying potential stressors** can allow you to prepare for and have realistic expectations of your own response. Thinking about potential stressors allows for a sort of rehearsal and gives you a chance to predict what may happen and how you could most effectively respond. Stressors can be broken down into four categories, each of which can impact you differently. Consider a specific crisis that might occur while you’re on the job. Then consider the following types of stressors you’re likely to experience:

- **Environmental stressors** vary depending on the nature of the event and your level of exposure. Witnessing or hearing about extensive death or injuries during or after the event can be extremely difficult to handle, especially for someone who has never dealt with death or severe injuries before.
- **Organizational stressors** will also vary depending on the event; these factors will strain the entire operation. This can be especially true early in the emergency when staff is in short supply and the organizational structure is in formation. These stressors include working long shifts, having more work than can be completed, and living in situations that are cramped and uncomfortable. A chaotic and ineffective chain of command may add to difficulties especially in the early stages.
- **Personal stressors** depend on individual factors and can greatly impact each person’s ability to manage stress. The sights, sounds, and smells of disaster may trigger past trauma reactions which can interfere with effective functioning. Cultural differences between the responder and those impacted by the event can increase the stress level. There may be personal boundary and space violations that can greatly increase stress levels if not anticipated and managed.
- **Political stressors** can also be difficult to manage. Various stakeholders, such as representatives from different organizations, can have difficulty working together. Having to negotiate these working relationships can put a strain on all responders, regardless of position within the organizational structure. You may also be working in a community that has a different culture and different traditions from your home area.

Before you respond to a particular event, consider how each of these types of challenges will impact you. By anticipating the stressors and your reactions you can then think about your coping strategies.

**Coping Strategies** can be problem-focused if action is helpful and emotion-focused if nothing much can be done to impact the situation.

- **Problem-focused coping**: When some aspect of the event or response can be changed, a coping strategy that focuses on making those changes is an effective method to employ. During these situations, taking large problems and breaking them down into manageable parts will allow for a sense of control and effectiveness. Problem-solving and brainstorming skills become important in generating multiple alternatives to consider.
- **Emotion-focused coping**: This approach is most appropriate when changes are not possible and there are aspects of the event or response that are out of your control (for example, a staff member is injured and has been hospitalized). Emotion-focused coping strategies like relaxation techniques and emotional regulation (e.g., prayer or exercise) will allow for stress reduction in the face of unchangeably stressful circumstances. Anger management and distraction skills can also help people tolerate difficult situations.
Self-Care Strategies When the Danger has Passed:

Although the mind and body do need to relax after an intensely stressful period, this does not mean that you should stop the self-care practices that have kept you going throughout the response. Now, more than ever, you need the routine of regular self-care practices. Resuming normal work responsibilities, devoid of the intense pressures but also perhaps of the intense purposefulness that characterized working in a crisis, can present unexpected challenges. Some managers have reported feeling disoriented, and having difficulty focusing on what is important and adjusting to relationships that have changed at home and at work.

Tips for Public Health Managers:

Specific suggestions for effective post-disaster adjustment include:

- If possible, take some time off
- Engage in activities that are both enjoyable and feel restorative
- Use positive coping mechanisms
- Consider when to use problem-solving or emotion-focused coping
- Write about your experiences
- If you find that you are struggling, you do not have to be alone:
  - Reach out to friends, family, colleagues, faith-based resources
  - Seek professional help if needed
- Do not underestimate the impact of your experience

Overcoming Barriers to Self-Care:

There are many barriers to self-care, and many public health workers are susceptible to neglecting their own needs while helping others. In emergency situations, there may be a lack of resources, time, or adequate supervision. The needs of patients, colleagues, family, and community members can seem so great that your needs pale by comparison, and if others are suffering, you might feel guilty if you attend to your own needs. It’s essential that you accept your own limits and do not see yourself as indispensable to the response operation as that can quickly lead to Burnout.

Hotline for People Needing Professional Assistance:

Substance Abuse & Mental Health Services Administration Disaster Distress Helpline
1-800-985-5990
Text TalkWithUs to 66746
TTY for Deaf/Hearing Impaired: 800-846-8517
www.disasterdistress.samhsa.gov/

This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
Effective Leadership in Crisis

During any disease outbreak, terrorist act, or other crisis, important decisions must be made quickly, despite uncertainty and time pressure. There is often ambiguity in terms of cause, effect, and means of resolution as well as urgency to resolve the situation as quickly as possible. The stakes involved can be extraordinarily high with the lives and welfare of personnel and community members potentially at risk. Even if you’re not normally a manager in your organization, in extreme circumstances it’s possible that you may find yourself in a leadership position. If this occurs you can play an important role in minimizing harm and restoring calm. This tipsheet will examine leadership styles, qualities or traits of effective leaders, how emotions relate to effective leadership, and how to be most effective at assessing information and making decisions in a crisis situation.

Be Aware of Your Leadership Style

Leaders demonstrate very different styles, and depending on circumstances and personalities one approach can be more effective than another. Consider the following styles and try to be aware of your effectiveness when using them with those you’re supervising.

- **An autocratic** leader keeps control over staff by following regulations, policies, and procedures faithfully. This type of leader goes “by the book” and closely supervises staff. Autocratic leaders who rely on punishment to control staff, allowing little or no participation, can create a climate that is both distressing and nonproductive.

- **Laissez-faire** leaders delegate tasks to staff with little or no direction. This approach can be effective when staff is highly educated, competent, and motivated to succeed on their own. This “hands-off” approach is most successful when the leader provides direction, support and guidance when staff asks for or needs it. A laissez-faire approach is least effective if the leader is too withdrawn from staff which can lead to a lack of efficiency and satisfaction.

- **A democratic** leader shares decision-making with staff members, encourages discussion, debate, and sharing of ideas, and helps staff to feel good about their contributions. This leadership style appears to be most effective in generating better ideas and creative solutions from staff members. However, there may be circumstances where there is not sufficient time for discussion and debate. In such situations leaders may need to be more autocratic.
A common mistake when there is a crisis situation is to be either too hands-off or over-controlling. If you’re too laissez-faire, staff will be looking to you for further guidance. If you’re too autocratic, staff can feel bullied, and if you’re too democratic, there may not be time to accomplish goals that are extremely pressing. Be flexible and adjust your leadership style according to circumstances.

**AUTHENTIC LEADERSHIP TRAITS:**
The following describe a set of traits and abilities that are commonly mentioned when describing effective leaders.

- Effective leaders lead by example.
- They tend to be confident, hopeful, optimistic, resilient, transparent, moral, ethical, and future oriented.
- They’re aware of the circumstances and contexts of the situation.
- They give priority to developing staff to become leaders themselves.
- They’re self-confident, genuine, reliable, and trustworthy, and they have a primary focus on building followers’ strengths, broadening their thinking, and creating a positive and engaging work environment.
- Because people trust them, they’re able to motivate others to high levels of performance.
- Rather than letting the expectations of other people guide them, they’re prepared to act based on their own core beliefs.
- They engender trust and develop genuine connections with others and they are more concerned about serving others than they are about their own success or recognition.

While it’s unlikely that you’ve mastered all of these traits, consider how you can work to develop them under normal conditions so you’re best prepared to lead well during a crisis.

**Effective Leadership through Emotional Intelligence**

Emotions play a significant role in the workplace, but never more so than in times of crisis. Emotions are catching. When leaders are optimistic or resilient in the face of challenges, staff will be motivated. When leaders are distraught or worried, staff will experience similar feelings.

Your staff will take cues from your facial expression. When leaders smile, staff will follow suit. This has been referred to as “emotional contagion.” Leaders who convey that somehow they will get through difficult or crisis situations and remain hopeful during the most traumatic events can transmit this emotion to their staff, thereby fostering staff resilience. Bear in mind, however, that overconfidence and bravado are not helpful. In fact, leaders who display humility have a positive impact on staff.

Effective leaders have the ability to recognize, express, understand, and evaluate their own emotions and the emotions of their staff. In order to accomplish this, leaders need to regulate their own emotions. Regulating emotions can involve displaying positive facial expressions (e.g., smiling) and masking negative ones (e.g., disgust), calming yourself down, or refraining from argumentative behavior. It can also involve relieving stress by healthy coping (discussed in other tipsheets). If you can regulate your own emotions you will have the capacity to demonstrate positive emotions and control negative ones such as disappointment, uncertainty, and annoyance. This creates a supportive and positive organizational climate. Effective leaders instill optimism, confidence, and faith in their staff by suggesting that they work together for a better future, although they may face challenges...
Effective Leadership

There is one caveat here: Faking positive emotions, feigning enthusiasm, interest, and calm is not helpful.

One aspect of emotional intelligence which should not be underestimated is empathy. In order to understand and respond effectively to the emotions of those you supervise, you must know what they are thinking and feeling through empathy. You can practice and work at being more empathic by attending to your staff members’ reactions, thoughts, and emotions. Studies have shown that leaders who can empathize and read emotional expressions of their staff are rated as more effective, and workers were more satisfied with such managers.

Coping with Stress

When a leader is unable to cope with stress and demonstrates negative emotions, staff will be distressed and the leader will be viewed as less competent. In highly stressful situations it is more important than ever to empathize with your staff members’ emotional reactions. This can lead to lower stress levels, increased job satisfaction, and better work performance. Paying attention to your own emotions and the emotions of your staff, regulating your emotions, and empathizing with your staff does not only have an impact on emotional outcomes, such as distress and burnout. It also leads to better task performance, particularly on creative tasks. Your emotional competence in stressful situations is a key predictor of the success of your staff and the goals of the organization.

Making Effective Decisions and Judgments in Crisis Situations

A disaster is defined in part by its ambiguity and urgency. In such circumstances it can be very difficult for managers to assess information and make decisions effectively. In addition, because leaders in crisis situations are under severe time pressure, they often have less time to acquire and process information. Self-efficacy, an individual’s beliefs about his or her abilities to accomplish a specific task in a specific context, is one good predictor of competent leadership in a crisis. What may be most helpful in these circumstances is for you to have the confident belief that you have the knowledge, skill, and ability to lead others effectively. What is helpful in increasing this self-efficacy as you prepare to address the needs of the situation and your staff?

• Try to be more open-minded, exploratory, and adaptive when responding to difficult decisions.

• Think about your successful previous experiences in challenging circumstances. This can create a greater level of confidence.

• Recognize what you can and cannot control and try to not become frustrated or angry about conditions or problems that are beyond your control.

• Your ability to think divergently – the ability to generate multiple alternative solutions to problems – can help you to be more creative in dealing with ambiguous and challenging crisis and decisions.

• If possible try to get the formal authority you require to lead others in the crisis situation. Clarifying your role as an authority can increase confidence in your efficacy to do so.

• Get as much experience as you can both in leadership and dealing with crisis situations. Leaders with experience feel more confident.

• If you lack the experience or even if you have considerable experience, it is extremely helpful to practice crisis scenarios. The degree to which you’ve practiced and rehearsed crisis response protocols such as tabletop or actual live drills can increase your sense of self-efficacy.
Self-efficacy can be changed through practice and training. Consider the following set of statements that can allow you to consider and prepare for a public health emergency. If you feel prepared you’re more likely to be confident, assess information, and make decisions effectively as you deal with both the situation and your staff.

- I know who to call if I receive a report of an occurring or impending crisis.
- I am sure what my role and responsibilities would be in a crisis.
- I frequently review the crisis response plans that my unit has in place.
- I have adequately practiced my unit’s crisis response plan.
- I keep others at work up to date on the best way to reach me in a crisis.
- I believe my unit’s response plan is the best it can possibly be.

**Important Considerations for Effective Leadership in Crisis Situations**

- You have considerable impact on those you lead. Think about your responsibility to and compassion for your staff.
- Keep your staff informed and be sure they know that your door is open and that you’re available for them.
- When disaster strikes, speak to your staff, ask for their support, and let them know your plans and intentions.
- Get as much information and advice as you can from as many sources as you can.
- Try to get as many staff members as possible involved in assisting with the crisis.
- Create a positive and supportive work climate.
- Be open to viewing your staff and the crisis situation with new perspectives and flexibility.
- Be sure there is someone working for you who you trust enough to lead if you need a break or are away or on vacation.
- Be fair and impartial to your personnel.
- Lead by example. If you participate in menial tasks, staff members are more likely to take on whatever needs to be done.
- Give every staff member something challenging and important to do. Everyone wants and needs to feel both valuable and appreciated for their contribution.
- Regular meetings can build teamwork and contribute to a positive atmosphere.
- Set reasonable expectations and be tolerant even and perhaps especially in crisis situations.
- Don’t point out weaknesses in staff members in front of others.
- Empower and show confidence in those you give responsibility to.
- Don’t be afraid to change course or change your mind if your approach to staff members or the crisis is not working.
- Never forget to congratulate yourself and your staff for a job well done.

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This publication was supported under a cooperative agreement from the Centers for Disease Control and Prevention (CDC)—grant number 5U90TP000404-02 to the Research Foundation of the State University of New York, Albany. The contents do not necessarily represent the official views of the CDC, or the host institutions.
The Public Health Worker’s Role in Response: Orienting Staff New to Emergency Preparedness

We are aware that in many localities, staff turnover in positions related to Emergency Preparedness creates a burden in orienting and training newly hired or re-assigned personnel. This final, special-purpose tipsheet tries to assist with that issue by providing “the big picture,” conceptual overview of their new role, coming at the topic from a mental health perspective, as do the eight core tipsheets. It is not intended as a comprehensive training program.

As a public health professional, you can serve an important role in building resilience among personnel and community members in advance of disasters, and you can do a great deal to mitigate stress reactions once an emergency occurs. However, you may be called upon to do so while managing the logistical response to the event, trying to maintain continuity of operations, keeping your supervisors informed about the situation, complying with personnel policies, completing paperwork and record-keeping, and so on – not an easy task! You might also be called on to ensure that stress management activities are delivered per the agency plan; and that the activities are both culturally appropriate and perceived as helpful, rather than as yet another source of stress.

This tipsheet is intended to help you understand how you can contribute to your organization’s efforts to address psychosocial needs before, during, and after crises in order to support recovery.
Public Health and Disaster Response:

The public health field’s general emphasis on prevention certainly applies to disaster preparedness, which can reduce both physical harm and psychological reactions. You should become familiar with the Department of Homeland Security’s National Response Framework, which attempts to standardize emergency preparedness and response plans so agencies can efficiently coordinate their efforts following a disaster. The public health role is detailed in Emergency Support Function (ESF) #8: Public Health and Medical. A 30 minute online course detailing the function is available on the FEMA website:

http://training.fema.gov/EMIWeb/IS/is808.asp

FEMA specifies that ESF #8 encompasses responsibility for behavioral health care, including assessing mental health needs and providing Psychological First Aid to survivors, as well as providing disaster mental health training materials to workers. Of necessity, attention to those psychosocial needs may be secondary to more urgent medical, environmental, and food safety demands immediately after a large-scale emergency. Nevertheless, their official inclusion in the function confirms that they’re an essential element in disaster preparedness and response.

The need for competence in preparedness applies at the personal level for you and your staff as well as at the organizational level: Anyone whose professional role means they’re likely to become involved in the response to a crisis should be sure to have a family plan in place, including a strategy for contacting or reuniting with other family members, provisions for child and pet care, and plans for handling any other relevant demands you’ll face if the disaster occurs in your community. Knowing your home and family are taken care of will enable you to focus on work demands, which will likely be intense following a large-scale disaster. Going through the process of preparing your own plan will also help you understand logistical barriers or psychological sources of resistance that may stop your staff or community members from doing so themselves, which may give you insight into framing public messaging to encourage these actions.

Your Role Across the Disaster Management Cycle:

It’s important to note that the following section describes your role throughout the disaster cycle in general terms, outlining the types of activities you may be involved in. During a declared emergency, your agency will most certainly operate using the Incident Command System (ICS); meaning that the scope of your actions will be circumscribed more narrowly and your responsibilities defined very specifically in the Job Action Sheet you will be issued.

A basic premise of disaster management is that the response always begins at the local level and is scaled up as necessary to meet needs that exceed capacity, and then scaled down again once demands are locally manageable. Additionally, it’s useful to think of disaster

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1 Additional federal trainings that may be helpful for public health workers include:
   - IS-100.b – Introduction to Incident Command System
   - IS-700.a – National Incident Management System: An Introduction
Both can be found at http://training.fema.gov/IS/NIMS.asp
management as a cycle. In fact, the response itself is only one phase (though an intense one) which should be preceded by extensive preparation, and followed by careful assessment to determine how to improve plans for the next event. Of course, it’s impossible to predict and plan for every type of emergency, with multiple contingencies; so planners often use an “all-hazards” approach that could be applied to any kind of disaster rather than focusing on narrowly defined events. Still, lessons can and should be learned each time a plan is activated, and used to improve preparedness for the future.

Since public health professionals are likely to be very familiar with the communities they work in as well as the specific health needs that may arise post-disaster, they can contribute in important ways to each phase of the cycle.

1. Planning and Preparedness:
In this stage likely hazards are identified for your community (see Tipsheet #1, which discusses the following examples and others—seasonal weather events, sites at elevated risk of industrial or transportation accidents, and identified potential targets of terrorism). Local response capacity and infrastructure are assessed. Plans are created, working within the National Response Framework, to determine specific roles and responsibilities for those involved in the immediate and longer term responses.

Public health professionals can contribute by identifying vulnerable populations within the community who may need additional assistance during and after disasters (for example, aid with evacuating, and/or special assistance in emergency shelters). You can also help to identify the range of demand for medical and environmental each possible event might cause—for example, the need to establish and supply staff for points-of-dispensing medical countermeasures (e.g., vaccines or antibiotics) or mass decontamination facilities, or “simply” to provide clean drinking water throughout a region after a massive flood. Establishing a working relationship with local media members and preparing informational materials about likely health and mental health consequences of foreseeable events will expedite your ability to disseminate information—and generally having plans in place in advance to meet disaster-related demands will increase the speed of response should it be needed.

2. Mitigation:
Of course it’s always better to avoid harm than merely to react to it, however efficiently, so this phase focuses on prevention or reduction of the threats identified in the first phase. This could involve the implementation of stronger safety codes (such as strengthening building standards in an area with significant seismic risk), the relocation of at-risk populations (such as those living in flood plains), or the improvement of individual preparedness (such as developing a campaign to encourage residents to create family emergency plans).

This is also an opportune time to confirm that stocks of supplies needed are current and adequate for the unfolding emergency. Virtually every necessary consumable from modern antibiotics to packaged drinking water has an expiration date. Unless that is tracked carefully there’s a risk of having less availability than you believe at the time it is needed most. Some needs may be very specific to your community. For example, the availability of sufficient doses of Potassium Chloride (KI) for residents living in the proximity of a nuclear plant is critical there, but not in more distant areas. Since natural emergencies do not recognize political boundaries, frequent communications with other local health departments should review resource availability in general; in particular, check assumptions about the availability of resources that they planned would be shared.
Especially when it comes to improving individual readiness, public health professionals who have experience developing health promotion campaigns can help structure messages to improve compliance. Training staff and community members in Psychological First Aid can also be seen as a kind of mitigation as it will increase capacity to deliver this early intervention as quickly as possible.

3. Response:
During the response phase, the emergency plans are implemented in reaction to an expected or ongoing event. The focus now is on containing physical damage (such as putting out fires or stabilizing structures), saving lives and treating the injured, ensuring that survivors’ basic needs for shelter and sustenance are met, and restoring essential services like power and communications.

If an event was expected, public health professionals may be present during the response phase, for example, to provide Psychological First Aid and early assessment as displaced residents arrive at shelters. You also may provide mental health support to emergency responders and managers to help maintain workforce resilience in a time of great stress. If the need for medical care overwhelms local hospitals, public health nurses and others with medical training may be called on to provide direct care. However, anyone who is not a trained first responder should take care not to put themselves in harm's way, or to get in the way of trained responders, until on-scene conditions are safe.

4. Recovery:
Efforts in the recovery phase focus on returning the community to its pre-event condition if the event was fairly small, or on creating a “new normal” since changes from a large scale event are often permanent. (Note that in the case of an emergency without a clear end-point, like a lengthy disease outbreak, recovery activities may begin while the response is still underway.) While this work generally occurs at the local level, many outside organizations may be involved, providing technical assistance and financial and material resources as well as services such as feeding and sheltering.

Public health professionals play an essential role during this phase. Specific demands obviously will depend on the nature of the disaster, but you may be involved in a variety of tasks (perhaps simultaneously) including disease monitoring, working to ensure the safety of food and water, organizing points-of-dispensing for mass prophylaxis or medications, restoring needed medications and assistive devices to shelter residents, establishing policies for quarantine and social distancing, educating the public about cleaning up after a flood, and so on. Mental health reactions are likely to be most evident during this stage as community members come to terms with their losses, and as response professionals absorb the suffering they’ve been exposed to.

5. Evaluation:
Finally, a careful evaluation of the entire event should be conducted, with the involvement of public health managers as well as representatives of all relevant responder organizations. Were the plans thorough and appropriate or did gaps become apparent? Can additional targets for mitigation be identified in hopes of preventing or reducing harm from a repeat event? Were the response and recovery efforts carried out as intended, or were there lapses in communication or other problems of implementation? Every aspect should be considered
thoughtfully – and the conclusions should then be incorporated into updated plans, completing the cycle.

Not surprisingly, this is the phase that’s most likely to be overlooked. People may be so consumed by the event for such an extended period that the last thing they want to do is revisit it when it’s finally over. Even more problematic, many people aren’t comfortable having their actions closely examined, so personal defensiveness may get in the way of maximizing future preparedness. Public health professionals may be able to advocate for the community by reminding those involved that this is not a critical assessment of individual or agency performance (unless, of course, that’s warranted by some actual failure) but an opportunity to improve and protect the public better in the future.

Finally, throughout the disaster management cycle, public health professionals designated by your agency can play an important role in communicating with and educating the media as well as community members. Helping ensure that everyone involved accurately understands the risk of harm as it impacts them and their community, be it from radiological exposure, a communicable disease, or any other threat, can obviously help to reduce distress and anxiety. It also may provide a tangible benefit by reducing the surge of people with medically unexplained physical symptoms that is likely to tax emergency departments. On the other side of the risk communication coin, receiving information from a trusted health expert may convince people to follow a recommendation to evacuate, get vaccinated, or take some other protective action they might otherwise avoid due to denial or underestimation of the seriousness of the threat.

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