Supporting Communities and Victims in the Wake of Terrorism and Mass Casualty Attacks

April Naturale, PhD
ICF International
Victim Support Europe
May 13-15, 2015
Lisbon, Portugal

What is Disaster Behavioural Health

A set of actions used to monitor, identify, screen, assess, intervene and treat stress, emotional distress, mental health and substance abuse concerns that result in the aftermath of a disaster.

Disaster Behavioural Health Principles

- No one who sees a disaster is untouched by it (direct/indirect survivors; individuals and whole communities)
- Mental health concerns exist in most aspects of preparedness, response and recovery
- Most people pull together but their effectiveness is diminished
- Most people do not see themselves in need of mental health services even in the face of disaster

What to Expect

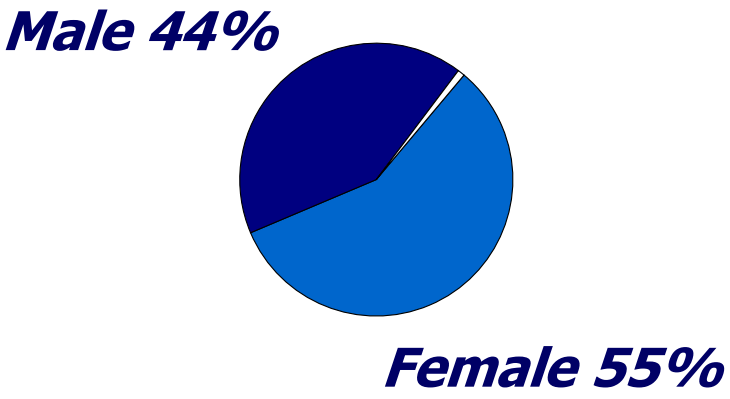
After a natural, human caused accident, or technological disaster, most humans will experience *short term* emotional, physical, cognitive, behavioural and spiritual distress reactions of varying degrees and most will improve on their own if they have good social supports and coping skills. A small number (generally 5-10%) will develop a diagnosable mental health disorder. In a large scale or scope event, this number is relative.

In terrorism and mass violence events that result in mass casualties, the recovery trajectory is impeded and thus may be much longer.

Common Complaints

Post 9/11 statistics; similarities with large scale natural events such as Hurricane Katrina

- Sadness (27%)
- Anxiety, fear (24%)
- Difficulty sleeping (22%)
- Difficulty concentrating (17%)
- Extreme change in energy level (15%)
- Intrusive thoughts (14%)
- Distressing dreams (13%)



Sleep problems of all kinds, nightmares and/or flashbacks, changes in eating habits and gastrointestinal problems, fatigue, sadness, short tempered, increased startle response, avoidance, lack of joy, questioning beliefs.

Early and Mid-Term Intervention Principles

- Promote a sense of safety
- Promote and teach calming techniques
- Self and community efficacy
- Connectedness
- Instill a sense of hope

(Hobfall et al., 2007)

Marathon Bombings 2013

Manhunt/ Shoot-out

Why Intervene 1-2 Years Later?

- Terrorism and mass violence **disrupt the recovery** trajectory.
- **Basic needs remain unmet**-*Safety*: protecting self and family in an unsafe place, e.g. a warzone; *Food* - having to go out of town to find supplies; *Shelter*-fixing a damaged home; and *other practical needs* - obtaining medical care, finding a new/different job- thus attending to emotional needs is considered a luxury.
- **Many "feel numb"** for an extended period, do not realise they are in need of assistance and don't connect needs to the disaster
- Many are so overwhelmed by the aftermath they have become **isolated** from their social circles and the outside world (i.e., reduced contact with others, relocation to another area, etc.).
- Many will seek help only when they experience a crisis.

Marathon Bombing Multiple Risk Factors

- Complex injuries (many unseen) e.g. disabling, disfiguring injuries that inhibit or restrict independent functioning; Traumatic Brain Injury, Hearing loss and Tinnitus, Vision loss
- Economic impacts re: inability to work, loss of income, loss of function
- Loss of familiarity, routine and social supports
- Loss of health, mental health and substance abuse services/care
- Loss of sense of safety in their world; Difficulty making meaning of the event
- Media attention and trial of perpetrator/sentencing issue

Target Population-Survivors

- Physical injuries (shrapnel, amputations, disfigurement)
- Chronic pain
- Hearing loss and vision loss
- Traumatic brain injury
- Residents of the Watertown area who were in lockdown as the police searched for the perpetrator and shooting was widespread
- Directly and indirectly exposed school-aged children
- Survivors expressing suicidal ideation/intent
- Survivors who have been victims of previous incidents of crime, bombing events and/or terrorist attacks

Target Populations-Responders

- Survivors who acted as responders on the scene of the crime in the immediate aftermath
- Responders (EMT, ambulance, law enforcement, fire) who attended to the injured on the scene, answered calls
- Responders who picked up or cleaned up body parts
- Medical staff in ambulances, emergency rooms, and treatment centers who attended to the injured
- Responders who participated in the lock down and shoot out in Watertown

Screening and Referral; Evaluation and Training

- Use of assessment form, the SPRINT-E
- Referral to Community Based Disaster Interventions
- Data Collection (who are we helping)
- Programme Evaluation (were we effective)
- Training private practitioners (increasing competence)
- Training public sector providers (increasing capacity)
- Training trainers (provide sustainability)

Disaster Specific Interventions

- CBT for Post Disaster Distress
- Trauma Focused Cognitive Behavioural Therapy (TF-CBT)
- Group-Based Interventions for Post-Disaster Survivors
- Eye Movement Desensitization and Reprocessing (EMDR)
- Narrative Therapy

And for Both Survivors and Responders:

- Mindfulness-based Stress Reduction as an Adjunct
- Stress Management and Self Care

Disaster Specific Interventions for Children and Schools

- Trauma Focused-Cognitive Behavioural Therapy (TF-CBT for Children and Parents)
- Healing After Trauma Skills (HATS)
- The Classroom-Based Intervention (CBI)

QUESTIONS?

For more information, contact:
April.Naturale@icfi.com

The Marathon Bombing Behavioral Health Program is supported the Massachusetts Office for Victim Assistance (MOVA) with an Antiterrorism and Emergency Assistance Program Grant awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this exhibition are those of the authors and do not necessarily reflect those of the Department of Justice.