MSSNY

Medical Society of the State of New York

PSYCHOLOGICAL IMPACT OF DISASTER AND TERRORISM

TENDING TO THE HIDDEN WOUNDS

Dear Physician:

The events of September 11th changed our state and our country in ways we still can't fully understand. One of the most devastating and pervasive results of this tragic day was the impact it had on mental health. Those who were directly affected, such as families who lost loved ones and survivors of the tragedy, suffered substantially increased rates of mental disorders including, most frequently, depression, anxiety and post traumatic stress disorder. But the sheer maganitude of the event shattered the sense of safety and security which had previously characterized the lives of the vast majority of us. Resultant psychological disorders have been extensive. It is now evident, beyond argument, that providing care following a major disaster requires that serious attention be given to mental disorders as well as physical injuries.

The State Department of Health has worked with the Medical Society of the State of New York to create a program to train physicians to treat patients who are suffering mental health problems resulting from a disaster. At the Medical Society, we recognize that people turn to their physician when they are encountering either physical or mental problems. We know, therefore, that this training program is essential to treat New York State's population adequately in the event of a public health disaster or terrorist attack.

The training program created by MSSNY is entitled, "The Psychological Impact of Disaster and Terrorism: Tending to the Hidden Wounds". It consists of four separate training modules accredited with continuing medical education credits. Physicians can take this training program online. Information on both the online and live programs is available at www.mssny.org.

This particular reference card draws some of the key information from the training program in a format that can be quickly accessed. Additionally, there are different modules on biological, chemical and nuclear agents which a physician may also take online or by attending one of MSSNY's live bioterrorist seminars. We encourage each of you to take these free continuing medical education accredited courses on the biological components and the psychological consequences of living in a world when the use of weapons of mass destruction is no longer a threat, but a reality.

In the years to come after 9/11, it is so very important that we care for our patients fully and that we treat all their "wounds". As a New York State physician organization, MSSNY is proud of how physicians responded to 9/11. We are equally proud today, in how we are continuing to respond to the changes which confront us in the new age in which we now live.

RESOURCES

Medical Society of the State of New York (MSSNY)
www.mssny.org
Phone: 518-465-8085 (Albany)
Phone: 516-488-6100 (Westbury)

Disaster Psychiatry Outreach
www.disasterpsych.org
Phone: 646-867-3514
E-mail: info@disasterpsych.org

New York State Office of Mental Health
www.omh.state.ny.us
Phone: 518-474-4403
Fax: 518-474-2149

New York State Department of Health (NYS-DOH)
www.health.state.ny.us/home.html
After hours NYSDOH Duty Officer: 518-465-9720
After hours State Emergency Management Office (SEMO) State Warning Point: 518-457-2200

New York City Department of Health (NYC-DOH)
www.nyc.gov/html/doh/home.html

TABLE OF CONTENTS

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MANAGING ACUTE PHASE
IN THE FIELD

PSYCHOLOGICAL FIRST AID

What it is: Simple psychological interventions that enlist survivor's innate coping strategies and facilitate the healing process.

Why it is needed: Disasters can worsen pre-existing psychiatric illness or activate maladaptive coping strategies; simple and thoughtful interventions can contain and reverse the psychiatric symptoms.

Key concepts:

- Provide for basic needs
- Protect from further harm
- Contain agitation & arousal
- Support those in most distress
- Keep families together and provide social support
- Be aware of impact on entire family
- Provide information, educate and foster communication
- Orient survivor to available services

WHEN WORKING AT DISASTER SITE

- *When On-Site* - Be willing to help with any needs that are within your capacity, from provision of medical care to setting up site for providing care to handing out blankets.
- You may need to assist in establishing a safe and effective site for providing care.

Survivors are more likely to seek medical rather than psychological care in the field.
Utilize medical encounters as opportunities to provide psychological support.

1
Engage the Survivor

ENGAGING THE SURVIVOR

Use informal conversation progressing to general inquiries about survivor's well-being.

Ask questions that assess survivor's needs:

- Are you hurt?
- Have you eaten?
- Have you slept?
- Have you washed?
- Have you made contact with your loved ones?
- How are you getting by?
- With everything that's happened, what is on your mind?

Engaging survivors is difficult. Be flexible, but use a directed approach that is informed by physical and emotional proximity to the disaster.

2
Address Physical Safety & Basic Needs

PHYSICAL SAFETY & BASIC NEEDS

Survivor's basic needs critical for survival must first be addressed:

- Medical care
- Pain relief
- Food and drink

Provide physical shelter from:

- Ongoing disaster
- The elements
- Onlookers

3
Assess Psychological Safety

PSYCHOLOGICAL SAFETY

- Provide a calm physical space.
- Use a reassuring manner that reduces agitation and arousal.

Unless the survivor wishes to discuss the event, avoid "debriefing" of the survivor's experience during the disaster as this may prolong the trauma experience or may lead to re-traumatization.

MANAGING ACUTE PHASE
FROM THE FIELD TO OFFICE

ACUTE PHASE DEFINITION

The acute phase encompasses the trauma's immediate impact occurring minutes, hours, or days following the event. In the acute phase, most reactions are adaptive and will resolve before becoming symptomatic.

Social connectedness is critical

- Keep family and friends together.
- Help survivors reconnect with loved ones.
- Foster communication, in particular among survivors.

Help survivors assert their ability to help themselves

- Provide information about the event and orient the survivor to services available.
- Educate about expected reactions, coping strategies, and self care.

EXPOSURE ASSESSMENT

Amount or dose of exposure correlates to risk of developing psychological symptoms. Use the following questions to assess exposure:

- Are you hurt?
- Has anyone close to you been hurt?
- Have you suffered any losses? (home, job, other property, etc.)
- Have you seen others hurt?
- What did you see?

TREATING CHILDREN IN THE ACUTE PHASE

- Attending to parents' needs can help their children, who take their cues from their parents during stressful times.
- Helping adults will also benefit children as they react to their parents' reactions.
- Employ an age appropriate approach to children (e.g., permit younger children to join the parent in their bed for comfort while sleeping).
- Encourage parents to talk to their children about their experience of the disaster in an age appropriate manner.
- Encourage parents to restore child's daily routine as soon as possible.
- Involve children in family's recovery from the disaster - a sense of empowerment is important for children.

PSYCHOPHARMACOLOGY IN THE ACUTE PHASE

Using medications to manage psychiatric symptoms in the acute setting is effective and appropriate. Limit prescription to a few days supply and make sure to arrange a follow-up appointment.

Anxiety and insomnia

- Short course of benzodiazepines and hypnotics (lorazepam, clonazapan, zolpidem, zaleplon, diphenhydramine)

Anti-psychotics

- Use only for extreme agitation and disorginazation in the acute settings.
- Victims with emerging or exacerbation of pre-existing psychosis should be referred to emergency rooms.

Antidepressants

- Depression is difficult to diagnose in acute setting, therefore initiating treatment with antidepressant medication is usually not appropriate in the acute phase.
- *SSRI warning for adolescents* - Although a matter of debate, studies suggest increased suicide risk amongst adolescents taking SSRI's.

POST-ACUTE PHASE

The post-acute phase begins once the immediate threat is removed and encompasses trauma's long-term sequelae in the days,weeks or even months following the trauma. In post-acute phase a transition to "everyday life" is seen.

POST TRAUMATIC STRESS DISORDER

POST TRAUMATIC STRESS DISORDER - OVERVIEW

PTSD - A pathological stress response syndrome that can be defined as the maladaptive persistence (at least one month) of disabling symptoms long after the resolution of a trauma.

Symptoms fall under four chief domains:

- Intrusive
- Avoidance
- Negative Cognitions/Moods
- Hyper-arousal

PHYSICIAN ADMINISTERED SCREENING TOOL FOR PTSD*

The following is a useful screening instrument which is administered by a physician. A patient is instructed to respond with **YES / NO** answers.

- Do you avoid being reminded of this experience by staying away from certain places, people or activities?
- Have you lost interest in activities that were once important or enjoyable?
- Have you felt more isolated or distant from other people? - In the last month?
- Have you found it hard to have love or affection for other people? - In the last month?
- Have you felt that there was no point in planning for the future? - In the last month?
- After this experience, were you having more trouble than usual falling asleep or staying asleep?
- Do you become jumpy or get easily startled by ordinary noises or movements?

Four or more positive responses is strongly associated with PTSD and is an indication of further assessment. The clinician should also probe for other symptoms of PTSD and explore their daily impact on the patient's life.

If less than 4 postive responses, watch for sub-syndromal or PTSD which can also be profoundly disabling and treatment should be considered.

PTSD's severity can range from sub-syndromal to profoundly disabling.

** Based on DSM IV Criteria, DSM V brief screenings still being researched.*

PTSD - RISK FACTORS

There are a number of factors that can predispose the victim to clinical PTSD:

- ***Pre-Trauma Factors***
  - Past history of trauma
  - Family history
  - Medical history
  - Past psychiatric history
  - Individual resilience
- ***Traumatic Event***
  - Dose of exposure
  - Experience of trauma
- ***Post-Trauma Factors***
  - Social supports

TREATMENT OPTIONS

Medications

- Long-term pharmacotherapy with antidepressants: SSRIs are effective medications for the long term treatment of PTSD.
- Treatment with SSRI's result in better outcomes when used in combination with specialized psychotherapies and social interventions.
  - Go to page 3 for adolescent use warning.

Encourage self-care and use of relaxation techniques

- Basic self-care—meals, walking, etc.
- Regular sleep/wake schedule
- Regular relaxing evening routine
- Routine deep breathing exercises

Grounding techniques are useful for relief of dissociation and flashback symptoms.

- Instruct patients to focus on immediate surroundings.
- Unstructured relaxation can exacerbate dissociation.

MAJOR DEPRESSIVE DISORDER

DEPRESSIVE DISORDER OVERVIEW

Primary Symptoms must include (for at least two weeks)

- Depressed mood most of the day every day, *or*
- Diminished interest or pleasure in nearly all activities

Related disorders:

- **Persistent Depressive Disorder (Dysthymia)** - Depressed mood and associated symptoms below the threshold for Major Depression that are experienced more days than not for at least two years.
- **Adjustment Disorders** - Significant emotional or behavioral symptoms causing distress within 3 months of exposure to an identifiable stressor.

SCREENING TOOL BASED ON DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION

Begin by asking:

- Have you been feeling down, depressed, or hopeless?
- Do you have little interest or pleasure in doing things?

If *yes* to either question, continue with SAD-A-FACES questions. If *no* and still suspect depression, go through to screen for sub-clinical depression.

SAD-A-FACES - For a diagnosis of major depression, presence of five or more within two-week period is required.

Sleep	insomnia/hypersomnia
Appetite	increase/decrease/weight change
Dysphoria	sadness/irritability
Anhedonia	lack of interest/pleasure/sex drive
Fatigue	decreased energy
Agitation	psychomotor agitation/slowing
Concentration	reduced ability to focus
Esteem	decreased self-esteem/guilt
Suicide	passive: life not worth living/active: plan, means

TREATMENT APPROACH

- Educate patients regarding symptoms of depression.
- Reassure that treatment is effective.
- Explain that symptoms can be a product of one's biology, life experience.
- Provide support: listen, highlight patient's strengths, lend permission to cry.
- Medication: SSRI's are a safe and effective first line agent, although there are many other options. In the short term, add symptomatic medication to target insomnia or anxiety.

SUICIDE RISK

Individuals struggling with depression are at a high risk for suicide.

Always ask a depressed person about suicide - you will not precipitate an attempt by asking.

Profile of repeat suicide attemptors: Young female, borderline personality, impulsivity, disrupted intimate relationship, prior attempts.

Profile of suicide completors: Older white male, lives alone, recent loss, chronic health problems, substance abuse, prior attempts.

SUBSTANCE USE DISORDERS

OVERVIEW

- Increase in use of alcohol and other substances after exposure to traumatic event is common.
- Men more likely to cope with traumatic event through substance abuse.
- Substance users more likely to experience traumatic event because of activities related to obtaining substances and impairment while intoxicated.
- Abuse and dependence defined as pattern of substance use leading to clinically significant impairment or distress.

CRITERIA FOR SUBSTANCE USE DISORDER

At least two of the following:

- Taking the substance in larger amounts or for longer than you meant to
- Wanting to cut down or stop using the substance but not managing to
- Spending a lot of time getting, using, or recovering from use of the substance
- Cravings and urges to use the substance
- Not managing to do what you should at work, home or school, because of substance use
- Continuing to use, even when it causes problems in relationships
- Giving up important social, occupational or recreational activities because of substance use
- Using substances again and again, even when it puts you in danger
- Continuing to use, even when the you know you have a physical or psychological problem that could have been caused or made worse by the substance
- Needing more of the substance to get the effect you want (tolerance)
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

RAPID SCREEN FOR ALCOHOL ABUSE/DEPENDENCE

CAGE Questionairre - "*Have you ever?*"

Cut down - Have you ever thought about cutting down on your drinking?
Annoyed - Have you ever been annoyed by criticism of your drinking?
Guilt - Have you ever felt guilty about your drinking?
Eye opener - Do you ever have a drink in the morning?

More than one positive response should alert you that individual might be having a problem with alcohol.

ACUTE STRESS DISORDER

OVERVIEW

ASD is characterized by the development of dissociative, anxiety, hyper-arousal, avoidance, and re-experiencing symptoms within one month of traumatic stressor and lasting between two and four weeks.

- Key difference from PTSD is duration and presence of dissociative symptoms in ASD.
- ASD and PTSD may represent individual's inability to recover from a normal array of adaptive reactions to trauma in the short and long term.
- ASD often becomes PTSD when the symptoms do not remit within a month.

DIAGNOSTIC CRITERIA

In response to the same possible traumatic exposure that can cause PTSD, a survivor experiences nine or more symptoms from among any of the five categories:

- Intrusive
- Avoidance
- Negative Mood
- Hyper-arousal
- Dissociative

The symptoms last at least three days. If they last more than a month, consider diagnosing PTSD.

OTHER ANXIETY DISORDERS

Following a traumatic event, individuals may develop anxiety disorders other than ASD or PTSD.

- **Panic Attack** - Individual experiences a time-limited period of extreme anxiety with a host of concomitant somatic symptoms.
- **Panic Disorder** - Anxiety disorder in which an individual experiences recurrent panic attacks, and changes his or her behavior and thinking as a result.
- **Generalized Anxiety Disorder** - Worries and anxiety are global and debilitating.