SERVING DIFFERENT POPULATIONS

Assessing the potential mental health needs of different groups following a terrorist event includes a review of the three elements listed below. High levels of any of these indicate a need for monitoring and possible intervention.

- **Nature and severity of the event.** This can be assessed several ways. One obvious way is by looking at the number of casualties and the amount of property damage that result from the event. However, the level of terror and fear spread among communities and individuals may not necessarily coincide with casualties or property damage.
- **Level of exposure/proximity to the event.** Terrorism affects the entire community, but it most severely affects those who experience the event directly or those who have previously been traumatized by a terrorist-related event.
- **Group-specific vulnerabilities that could be aggravated by the event.**

The disaster mental health worker should keep in mind that, during a terrorist event, the populations often categorized as “at risk” populations may not necessarily be those most in need of mental health services. That need will largely be determined by the specifics of the terrorist event. However, the following factors may be used as considerations when attempting to identify specific populations within a community that may be adversely affected.

- Race/ethnicity
- Refugee and immigrant status
- Age
- Gender
- Religion
- Attitudes (including mental health stigmas)
- Lifestyles and customs
- Interests
- Values
- Beliefs
- Physical disability status
- Mental/emotional disability status
- Family frameworks (e.g., single-parent, blended-family, or multiple-family households)
- Income levels
- Professions and unemployment rate
- Languages and dialects
- Education and literacy levels

Providing Services to Children and Older Adults

Interventions and services need to designed and adapted to "fit" special populations. Recognizing, for example, that parents and caretakers are primary contributors to a child's recovery from trauma and bereavements, disaster mental health workers should incorporate interventions with these significant adults into a plan for children. Similarly, those intervening with elderly survivors should modify the content and format of psychoeducational materials as well as the delivery strategy for services. Disaster mental health workers should be knowledgeable about developmental differences in cognitive and emotional processing and in the daily routines that need to be reestablished.[13]

The following charts provide practical suggestions for providing services to children and older adults.

Table 4. Children's Reactions to Trauma and Suggestions for Intervention[14]

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
1–5	• Clinging to parents or familiar adults • Helplessness and passive behavior • Resumption of bed-wetting or thumb sucking • Fear of the dark • Avoidance of sleeping alone • Increased crying	• Loss of appetite • Stomach aches • Nausea • Sleep problems, nightmares • Speech difficulties	• Anxiety • Generalized fear • Irritability • Angry outbursts • Sadness • Withdrawal	• Give verbal reassurance and physical comfort • Provide comforting bedtime routines • Help with labels for emotions • Avoid unnecessary separations • Permit child to sleep in parents' room temporarily • Demystify reminders • Encourage expression regarding losses (deaths, pets, toys) • Monitor media exposure • Encourage expression through play activities

[13] DeWolfe, D.J. (Draft, April 2002). Mental health interventions following major disasters: A guide for administrators, policymakers, planners, and providers. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[14] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
6–11	• Decline in school performance • School avoidance • Aggressive behavior at home or school • Hyperactive or silly behavior • Whining, clinging, acting like a younger child • Increased competition with younger siblings for parents' attention • Traumatic play and reenactments	• Change in appetite • Headaches • Stomach aches • Sleep disturbances, nightmares • Somatic complaints	• Fear of feelings • Withdrawal from friends, familiar activities • Reminders trigger fears • Angry outbursts • Preoccupation with crime, criminals, safety, and death • Self-blame • Guilt	• Give additional attention and consideration • Relax expectations of performance at home and at school temporarily • Set gentle but firm limits for acting out behavior • Provide structured but undemanding home chores and rehabilitation activities • Encourage verbal and play expression of thoughts and feelings • Listen to child's repeated retelling of traumatic event • Clarify child's distortions and misconceptions • Identify and assist with reminders • Develop school program for peer support, expressive activities, education on trauma and crime, preparedness planning, and identifying at-risk children

Ages	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
12–18	• Decline in academic performance • Rebellion at home or school • Decline in previous responsible behavior • Agitation or decrease in energy level, apathy • Delinquent behavior • Risk-taking behavior • Social withdrawal • Abrupt shifts in relationships	• Appetite changes • Headaches • Gastrointestinal problems • Skin eruptions • Complaints of vague aches and pains • Sleep disorder	• Loss of interest in peer social activities, hobbies, recreation • Sadness or depression • Anxiety and fearfulness about safety • Resistance to authority • Feelings of inadequacy and helplessness • Guilt, self-blame, shame, and self consciousness • Desire for revenge	• Give additional attention and consideration • Relax expectations of performance at home and school temporarily • Encourage discussion of experience of trauma with peers, significant adults • Avoid insistence on discussion of feeling with parents • Address impulse to recklessness • Link behavior and feelings to event • Encourage resumption of social activities, athletics, clubs, etc. • Encourage participation in community activities and school events • Develop support programs for peer support and debriefing, at-risk student support groups, telephone hotlines, drop-in centers, and identification of at-risk teens

Table 5. Reactions to Trauma and Suggestions for Interventions with Older Adults[15]

Behavioral Symptoms	Physical Symptoms	Emotional Symptoms	Intervention Options
• Withdrawal and isolation • Reluctance to leave home • Mobility limitations • Relocation adjustment problems	• Worsening of chronic illnesses • Sleep disorders • Memory problems • Somatic symptoms • More susceptible to hypo- and hyperthermia • Physical and sensory limitations (sight, hearing) interfere with recovery	• Overwhelmed and shutting down • Depression • Despair about losses • Apathy • Confusion, disorientation • Suspicion • Agitation, anger • Fears of institutionalization • Anxiety with unfamiliar surroundings • Embarrassment about receiving "handouts"	• Provide strong and persistent verbal reassurance • Provide orienting information • Ensure that physical needs are addressed (water, food, warmth) • Use multiple assessment methods, as problems may be underreported • Assist with reconnecting with family and support systems • Assist in obtaining medical and financial assistance • Encourage discussion of traumatic experience, losses, and expression of emotions

Approaches for Stress Prevention and Management for First Responders

Emergency workers—police, rescue squads, firefighters—are often the first ones on the scene and the last ones out. Long hours, harsh working conditions, and a close-up view of death and destruction leave them vulnerable to intense trauma reactions.

Table 6. Approaches for Stress Prevention and Management for First Responders[16]

Dimension	Immediate Response	Longer Term Response
Management of workload	• Clarifying with immediate on-site supervisor regarding task priority levels and work plan • Recognizing that "not having enough to do" or "waiting" is an expected part of crisis mental health response • Delegating existing "regular" workload so that workers are not attempting disaster response and their usual job	• Planning, time management, and avoidance of work overload (e.g., "work smarter, not harder") • Conducting periodic review of program goals and activities to meet stated goals • Conducting periodic review to determine feasibility of program scope with the human resources available

[15] Ibid.
[16] Ibid.

Dimension	Immediate Response	Longer Term Response
Balanced lifestyle	• Ensuring nutritional eating and hydration; avoiding excessive junk food, caffeine, alcohol, or tobacco • Getting adequate sleep and rest, especially on longer assignments • Engaging in physical exercise and gentle muscle stretching when possible • Maintaining contact and connection with primary social support	• Maintaining family and social connections away from program • Maintaining (or beginning) exercise, recreational activities, hobbies, or spiritual pursuits • Pursuing healthy nutritional habits • Discouraging overinvestment in work
Stress reduction strategies	• Reducing physical tension by using familiar personal strategies (e.g., taking deep breaths, washing face and hands, meditation, relaxation techniques) • Using time off to "decompress" and "recharge batteries" (e.g., getting a good meal, watching TV, shooting pool, reading a novel, listening to music, taking a bath, talking to family) • Talking about emotions and reactions with coworkers during appropriate times	• Using cognitive strategies (e.g., constructive self-talk, restructuring distortions) • Exploring relaxation techniques (e.g., yoga, meditation, guided imagery) • Pacing self between low- and high-stress activities, and between providing services alone and with support • Talking with coworkers, friends, family, pastor, or counselor about emotions and reactions
Self-Awareness	• Recognizing and heeding early warning signs for stress reactions • Accepting that one may not be able to self-assess problematic stress reactions • Over-identifying with or feeling overwhelmed by survivors' and families' grief and trauma may result in avoiding discussing painful subjects • Trauma overload and prolonged empathic engagement may result in vicarious traumatization or compassion fatigue (Figley, 2001, 1995; Pearlman, 1995)	• Exploring motivations for helping (e.g., personal gratification, feeling needed, personal history with victimization or trauma) • Understanding when "helping" is not being helpful • Understanding differences between professional helping relationships and friendships • Examining personal prejudices and cultural stereotypes • Recognizing discomfort with despair, hopelessness, rage, blame, guilt, and excessive anxiety, which interferes with the capacity to "be" with clients • Recognizing over-identification with survivors' frustration, anger, anguish, and hopelessness, resulting in loss of perspective and role • Recognizing when own disaster experience or personal history interferes with effectiveness • Being involved in opportunities for self-exploration, and addressing emotions evoked by disaster work