International Terrorism and Human-Made Disasters

The ecological, contextual model of crisis intervention, based on ecosystem theory that has emerged on the international scene, is characterized by continuously accelerating events in dynamically changing cultures and environments (Conyne et al., 2003; James, Cogdal, & Gilliland, 2003; James & Gilliland, 2003, pp. 341–342; Myer & Moore, 2006; Norris et al., 2006). Foremost among these events in the United States has been the September 11, 2001, hijackings and terrorist attacks and destruction of the World Trade Center towers in New York City, the attack on the Pentagon, and the crashed airliner in Pennsylvania. These tragedies caused untold grief, loss of property, loss of life, economic damage, and a

change in the attitudes of most Americans regarding safety and security (Bass & Yep, 2002; Pyszczynski, Solomon, & Greenberg, 2002). The actions following 9/11 also set in motion other unprecedented events, such as the passage of the Homeland Security Act by the U.S. Congress and the invasions of Afghanistan and Iraq, and placed security in the United States at wartime levels. Practically every American had the feeling of having been individually attacked (Brainerd, 2002) and that we were, indeed, at war.

Add to 9/11 other terrifying events—the bombing of the Murrah Federal Building in Oklahoma City, the attacks on students in high schools from Littleton, Colorado, to Springfield, Oregon, to college students at Virginia Tech University and Northern Illinois University—and there is good reason for most Americans to think the United States is no longer a sanctuary but a battleground. Across the world, events such as the taking of hostages by Chechens and their resulting deaths in a rescue attempt in a Moscow theater and a southern Russian school, Palestinian suicide bombings in the streets of Israel, Muslim radicals' bombing of a nightclub and hotel in Bali and Jakarta and trains in Madrid, the Charlie Hebdo magazine attack in Paris, the assassination of armed services recruiters in Chattoonga, Tennessee, drug gang wars in Mexico that approach total war, embassies and nightclubs blown up in Africa and Asia by al Qaida, and the postwar chaos in Iraq and Afghanistan all send clear messages that the world is an unsafe place and that terror may strike unannounced anywhere and at any time. As a result, the hypervigilance of being constantly on guard, the economic loss because of these attacks, and the social and financial expenses of guarding against them cause a variety of previously unknown stressors to appear that impact and crosscut entire nations, cultures, and ecosystems.

Disaster in the form of terrorism has its own special brand of traumatic wake for survivors and has the potential to have metastasizing effects across large systems (Huddy & Feldman, 2011; Morgan, Wisneski, & Skitka, 2011; Ursano & Friedman, 2006). This is true because of the unpredictability of the when, where, and to whom it will happen. Further, the seeming randomness creates fear and anxiety because there is no assurance it will not happen again, and where is anybody's guess. The use of insidious means such as poison gas, germ warfare, or nuclear arms causes horror and incredulity at their seemingly immoral use in the business of mass murder. Information is often inaccurate or highly controlled by the government, which creates uncertainty and anxiety. Increased, constant hypervigilance creates constant and heightened anxiety, which causes both immediate and long-term physical health problems.

Media coverage enhances the horror of gruesome death and injuries. Constant viewing of scenes of death and destruction increases trauma risk. Further compounding the trauma is the aftermath of the terrorist attack with ruinous financial loss and frustration and anxiety at the government's inability to act or bring the perpetrators to justice—particularly when they are outside the country's borders. Finally, there is the added difficulty of finding victim services and mental health professionals who have the know-how to deal with the unique issues that terrorist victims bring with them (Dziegielewski & Sumner, 2005; Myers & Wee, 2005, pp. 247–248). Pastel and Ritchie (2006) aptly call these weapons of mass *disruption* because of the profound psychological ripple effects they cause.

The Israelis are no strangers to terror. Practically all Israeli children carry cell phones so that they can immediately contact their parents and let them know they are safe after bombing or rocket attacks. It is somewhat chilling that one of the favorite children's costumes during the Israeli Purim holiday (somewhat equivalent to Halloween in the United States) among ultraorthodox Jews was a replica of the "Zaka" uniform. Zaka is an ultraorthodox volunteer organization dedicated to ensuring proper burial according to Jewish rituals. In the immediate aftermath of a terrorist attack, they search for body parts to bring as much of the body as possible to burial (Galai-Gat, 2004). After Galai-Gat delivered the paper just cited at the Annual Convening of Crisis Intervention Personnel, she related how amazed she was that people could come and go so freely from the downtown Chicago hotel where the convention was being held. Thus in a changing world, the question arises, "As go the Israelis, shall the rest of the world go also, and does our mental health system go with it?"

Terrorism brings unique challenges to mental health professionals when weapons of mass destruction are used. The ratio of physical dead and wounded to psychologically afflicted is astounding. Obhu and associates (1997) found that in the Tokyo subway gas attack 11 people died but up to 9,000 people sought medical care because they *thought* they had been gassed. There is also the potential for organic mental disorders along with standard stress reactions given the type of weapon used. Medical isolation and

quarantine can create additional stress in individuals who may not be able to receive support from their social systems and in fact may be seen as lepers to be avoided (Flynn, 1998).

The worldview of individuals subjected to terrorist-generated disasters may be very different from others'. There is a good deal of evidence to indicate that these individuals experience PTSD, panic and anxiety disorders, and depression at a far greater and more intense rate than others who are subject to "natural" disasters (U.S. Department of Justice, 2000). While there has been progress, with the counseling field becoming more trauma aware (Shallcross, 2011) and the Red Cross making concerted efforts to provide crisis intervention training to wider segments of first responders, there is as yet little unified training for the sheer number of mental health providers needed in *any* large-scale disaster or megadisaster. This issue is even more pressing with the lack of expertise to deal specifically with terrorist acts (Myers & Wee, 2005, p. 251; Roberts, 2005).

Lastly, the mental health infrastructure itself may be destroyed or disabled by human-made or natural disasters or simply be overwhelmed by the staggering volume of people it will be expected to service. In her pictorial representation of early interventions with survivors of terrorist attacks, Galai-Gat (2004) showed a Gary Larson cartoon of a crisis center going over a waterfall while on fire—a good analogy for the worldwide state of crisis intervention and what kinds of chaos ecosystemic crises can bring to local agencies, as witnessed by New Orleans mental health facilities attempting to get back into operation after being completely shut down by hurricane Katrina (Shraberg, 2006).

Planning for Disasters. There are two types of disasters, those that have prior warning time and those that do not. As a result, local EMAs have various disaster plans that are implemented in stages. Although there might be very little warning in the case of a tornado or a chemical spill from a derailed train, hurricanes and forest fires generally do have lead time for preparation. Nassau County has a very complex and lengthy hurricane plan that is divided into 10 stages. A brief description of those stages follows to give you an idea of just how involved this business is (Nassau County Emergency Management Department, 2003). For each stage, a particular action is noted and the responsible section is designated to implement it. Those sections are emergency operation center (EOC) command, planning, logistics, operations, administration, recovery task force, and elected policy makers.

Awareness stage. 72–60 hours Estimated Land Fall (ELF) of hurricane. Activate emergency command center. Establish liaison with the National Weather Service, state department of emergency management, surrounding counties, media, utility services, law enforcement, and fire agencies. Conduct vulnerability analysis. Activate alert phone system. Prepare primary evacuation routes. Notify all gas and diesel wholesalers

to restock retail outlets within 12–24 hours. Test EOC communications equipment.

Standby stage. 60–48 hours ELF. Activate emergency broadcast system. Notify amateur radio group to go on standby. Use local media and National Weather Service bulletins to advise boat owners, home owners, drawbridge operators, and motel and hotel managers, and detail causeway and bridge closings and evacuation routes. Coordinate establishment of emergency worker shelters. Secure EMS ambulances, transport vehicles, oil spill trailers, and heavy equipment.

Decision stage. 48–45 ELF. Activate traffic control plan and emergency transport plan. Declare state of emergency and activate county emergency plan. Recommend/ order evacuation. Designate nonessential businesses to close. Coordinate decision-making actions and link all municipalities, law enforcement agencies, fire districts, utility companies, hospitals, and medical care facilities with State Division of Emergency Management and the National Hurricane Center.

Preparation stage. 45–36 ELF. Begin implementing evacuation plan for "at risk" populations such as mobile homes, people with special needs, tourists, campers, people without transportation, and low-lying areas. Activate all EOC communication systems. Announce public closings. Implement 24-hour operation of fleet management garage and fueling resources. Activate emergency transportation plan. Prepare shelters for opening.

Evacuation stage. 36–4 ELF. Issue evacuation orders. Identify areas at risk. Announce shelter openings and transportation pickup points. Request National Weather Service to broadcast information on road closures. Activate/coordinate shutdown of electric power services. Maintain communications with public shelters, emergency worker family shelters, special care centers, emergency transportation, area hospitals, animal emergency care facilities, power, water, sewage, utilities, fire districts, law enforcement, and public works. Begin preplanning poststorm activities.

Storm/emergency stage. Monitor storm/emergency characteristics. Continue preplanning poststorm activities. Continue communications with other agencies.

Immediate emergency stage. Commence local emergency response activities. Determine long-term human service needs, including mental health care counseling. Determine information and referral services. Assess temporary housing needs. Distribute resources: food, water, clothing, and cleanup kits. Activate recovery task force and review damage reports. Recommend implementation of appropriate moratoriums and adoption of emergency resolutions and ordinances. Determine if curfew is needed. Activate Damage Assessment Teams. Monitor public health conditions.

Evaluation stage. Determine if primary threat still exists. Conduct/coordinate initial impact assessment effort. Reaffirm and/or reestablish communications with all shelters, hospitals, towns, state emergency operations, law enforcement, public works, fire districts, and surrounding counties. Enact emergency resolutions. Determine initial mutual aid requirements and request assistance from state EOC. Discuss emergency ordinances to be enacted. Issue news media releases. Establish times for briefings/planning meetings. Report accidents to date and update status. Assess damage to areas with existing or potential hazardous materials. Summarize current operational activities underway. Discuss current strategy. Review human resource needs. Determine additional resources needed. Implement rest and rotation policies for emergency workers. Assess logistics of transportation routes opened, distribution sites, feeding procedures, and available sleeping facilities.

Reconstruction stage. Perform long-term activities or projects focused on improving or strengthening community's economy. Complete restoration of services. Dispose of debris and allocate resources to cleanup chores. Focus on community recovery planning, building and construction issues, and environmental/ecological issues. Continue/complete human services delivery assistance of information and referral, resource distribution, health care delivery, mental health care counseling, and transportation assistance. Complete activities for presidential disaster declaration. Perform hazard mitigation projects to reduce community's susceptibility and vulnerability to hurricanes. Repair, replace, modify, or relocate public facilities in hazard-prone areas.

Restoration stage. Perform assessment of community needs and economic damage. Address the following restoration issues: economic and job base assessment, community recovery planning, building and construction issues, public information and citizen

outreach, and environmental issues and ecological concerns. Provide health care delivery for both pre- and postdisaster needs, including home health care management and case referral. Put mental health care counseling into operation. Determine victims' counseling needs by triage assessment. Determine training needs for mental health professions on disaster-related issues. Place mental health professions/CISD team members on community assessment teams. Determine where counseling services will operate. Determine transportation needs to public feeding sites, shelters, and disaster service sites. Reestablish and implement public transportation service. Chore service needs assessment for cleanup. Determine needs and coordinate with volunteer groups for debris cleanup, interior home cleanup, window repair, etc. Coordinate with FEMA to set up Disaster Field Office and Disaster Application Centers. Assist in establishing temporary housing sites. Establish a federal public assistance office to coordinate all disaster relief efforts to clients. Participate in interagency hazard mitigation team and hazard mitigation survey activities. Complete after-evacuation report and county incident report. Critique the management of the storm emergency.

Throughout the unfolding stages of the disaster, constant needs assessment should occur. A community mental health needs assessment formula (Flynn, 2003, p. 23) that constantly updates the dead, hospitalized, nonhospitalized injured, homes destroyed, homes with major and minor damage, unemployed due to job loss, and other losses will give a good indication of the potential numbers of people in need of crisis counseling services. The same community-wide assessment should continuously occur in regard to mental health (Katz, 2011). Nancy Freeman was asked when she would know that the crisis is over. She stated, tongue in cheek, that she'd know because no one had called and everyone had found his or her dog and Aunt Nellie. In reality, the immediate crisis is considered passed when everyone's safety is assured from any effects of the disaster, public works are back in operation, and services are returning to normal. That's when the EOC can get a doughnut and some sleep!

The foregoing plan for hurricanes can be adapted to any kind of disaster, whether natural or human-made. While timelines may be very compressed or in some instances operations may start at the emergency stage, the format is replicable with just about any kind of community-wide crisis. Although local EMAs have very little preparation time for other types of disasters, they do not stand idly by waiting for something to happen. Continuous interagency tabletop exercises give them practice in responding to a variety of potential disasters. Assessment of particularly vital and vulnerable public sites, ranging from water treatment plants to nursing homes, is made to determine what needs and weak points there may be. Jerry Lane spends a fair amount of time working with individual agencies to develop their own internal disaster plans to fit with the overall one that the local EMA has.

Mental Health Components of Local EMAs

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Any local mental health clinic should have a prototype disaster response plan (Lane, 2003). While each community will have variations due to its own particular regional and state systems of mental health delivery, geographic locale, and population differences, they should generally follow along with what Hartsough (1982) has outlined for mental health agencies' typical response to a disaster.

The following points are abstracted from Hartsough (1982) and Lane (2003). First of all, the centers must have a plan that assumes that they may be victims themselves and have breakdowns in communications; loss of or inability to find staff; loss of equipment, supplies, and records; inability of staff to cope with loss; and problems recognizing their functional limits. The mental health center must be prepared to provide services in two situations—a localized but traumatic event and a large-scale disaster. A localized event can be responded to without affecting operations to any great degree. A disaster will most likely disrupt operations to some degree, while drastically increasing the demand for services. A clear chain of command with redundancy features is mandatory. There should be an assessment of population groups in the area with regard to high-risk groups such as children, non-English-speaking, elderly, and low socioeconomic groups. Interagency cooperative agreements should be made. A specific mental health liaison person should be named to the local EOC.

Predisaster training encompasses development of outreach programs that target "normal people acting normally in an abnormal situation." Training specifically targets practitioners who have not had formal training in outreach or who historically perform poorly when they have to rely on their formal training. Consideration should be given to sending local clinicians to Red Cross training. Drills and tabletop exercises should be developed and conducted in coordination with the local EOC.