Psychiatry and Terrorism:  
The Profession's Role in Disaster Response Planning

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ABSTRACT: While America wages the “war” on terrorism and endeavors to protect the physical safety of its citizens, it is imperative to plan for the population’s mental health needs in future terrorist/disaster scenarios. The importance of psychiatry’s potential role in preparing the community for the psychological impact of terrorism is underscored against the historical backdrop of the field being “carved out” from the organization, delivery, and financing of health services in our society. A practical framework is offered for designing an organization’s mental health disaster plan, including recommendations for strategic infrastructure and tactical response capabilities. Finally, the unique features of clinical practice with disaster victims are noted, including intra-clinician conflicts between professional/community interests and personal/family obligations during acute disaster events. [International Journal of Emergency Medical Health, 2004 6(4),197-204.]

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That terrorist acts can have profound physical, social, political, and economic effects on the citizens of the United States is indisputable; however, it is the psychological impact of such incidents that could become one of the country’s greatest challenges of the 21st century. It is estimated that two to ten mental health casualties occur for every physical casualty of terrorism, such as the scud attacks in Israel in 1991 and the Sarin gas attack in the Tokyo subways in 1995 (Holloway, Norwood, Fullerton, Engel, & Ursano, 1997). Domestic terrorist experiences in both Oklahoma City and Manhattan demonstrated high psychological casualty rates—50%
in Oklahoma City (North & Pfefferbaum, 2002) and 18% in New York City of those exposed (Schlenker et al., 2002); the latter study noted a doubling of base rates of post-traumatic stress disorder (PTSD) and major depression. The point has been made that terror possesses an infectious characteristic as potentially virulent as the most contagious of the physical pathogens that may be incorporated into weapons of mass destruction (Saathoff & Everly, 2002).

Given that the functioning of society is arguably more endangered by psychological injury than by physical injury or even loss of life, some have proposed that protecting the public’s mental health from the effects of terrorism should be a formally addressed element of national defense policy (Susser, Herman & Aaron, 2002). A recent report from the Institute of Medicine (IOM) notes, “Much of the nation’s attention since September 2001 has focused on the ‘war on terrorism’ and on ensuring the safety of the nation... overlooked, however, is the need to prepare the country for one of the primary objectives of terrorism—psychological injury” (Institute of Medicine, 2003). The IOM report concludes that the country’s mental health systems are not able to meet the psychological needs that result from terrorism and recommends that Federal, state, and local disaster planners specifically integrate the psychological consequences of terrorism into their overall preparedness planning process. For readers who might have an opportunity to contribute to such planning, several questions should be addressed, viz.,

What does history teach us about (the barriers to) integrating psychiatry into health plans? What strategic and tactical capabilities should be incorporated into such plans? What are the core competencies required when providing face-to-face clinical services to disaster victims? And, what unique professional and personal challenges should be anticipated when providing psychiatric services in a disaster field?

Disaster Psychiatry: Carved Out Again?

Despite terrorism representing a major assault upon the individual’s sense of well being and upon the psychosocial fabric that undergirds American society, psychiatry and mental health disciplines typically are excluded from disaster preparedness planning. This vulnerability to the “carve out” has been observed in health policy and planning decisions at local, state, and federal agency levels—indeed, even in hospital disaster plans. For example, an article (Berman & Lazar, 2003) on hospital emergency preparedness after September 11 described many “lessons learned” but failed to include any of those related to mental health. Moreover, of 21 disaster plans (prior to September 11) developed at a major national academic medical center, The Johns Hopkins Health System, none included provisions to address the mental health needs of faculty, staff, or students, and none incorporated psychiatric membership on key crisis and disaster steering or operations committees. That these are not isolated oversights in planning for the psychological and psychiatric implications of terrorism is confirmed by an exhaustive survey of 90 courses cited in The Compendium of Weapons of Mass Destruction Courses Sponsored by the Federal Government (FEMA, 2000). This review found that only four (4.4%) courses mentioned psychological topics in their disaster training and preparedness curricula, course agenda, or objectives (Myers, 2001).

Public law 107-269 (USHSA, 2002) established the U.S. Department of Homeland Security but made no reference to disaster-specific mental health needs or services. In the government reorganization mandated by that statute, many agencies were brought under the purview of the new department Secretary, including those involving physical health responses to disasters, e.g., the Office of Emergency Preparedness (OEP) and the US Public Health Service (PHS). The Emergency Services and Disaster Branch of the Substance Abuse and Mental Health Services Administration (SAMHSA) was excluded. Finally, of the $11 million designated for the PHS and for local departments of public health for disaster and terrorism preparedness, no funds were allocated for mental health disaster response (U.S. Home Security Website, 2004).

Disaster mental health is hardly the first example of psychiatry’s being overlooked and underfunded in healthcare planning; indeed, carving out psychiatry is a long-standing American tradition. Two examples of neglecting the country’s psychiatric needs are the state hospital reform movement of the 19th century and the managed care movement of the 20th; in neither instance were the needs of the American public served. The state hospitals were not integrated with academic medicine’s emergence and ultimately became warehouses for psychiatry’s most needy. More recently, under the impetus of escalating costs, managed care appeared as a general societal phenomenon in the 1980s and ‘90s. Managed care carved out mental health, which became policed by psychiatrist-reviewers and physician-advisors. Psychiatrists became the instruments of cost-containment, largely because behavioral health was a field lacking in consensus and replete with unvalidated therapies like EST, crystal healing treat-
ment, Rolffing, and orthomolecular and mega-vitamin therapies. The results were the reinforcement of stigma and the separation of psychiatrists from primary care, where 5-20% of general medical patients present with psychiatric disorders (Goldberg, 1999).

The prevailing view is that non-psychiatric physicians and policy makers carve out psychiatry because of unique issues of confidentiality, stigma, and misunderstanding of the field, an explanation that casts psychiatry as a passive victim of external influences. Perhaps a more accurate view is that psychiatrists and mental health professionals, through inaction, carve themselves out. In the case of the state hospitals, Silas Weir Mitchell's criticisms of the entrench positions of the state hospital superintendents in the late 19th century foreshadowed by 80 years the admission of the mistake that organized psychiatry had initially perpetuated (Mitchell, 1894). In the case of managed care, Bennett (1993) has noted that numerous developments have attested to the plasticity of demand and the need to control supply and apportionment rationally. They include scandals in the proprietary hospital business, the excessive use of hospitalization for substance abuse in adolescent patients, and the tendency toward "psychiatrization" of problems with social, legal, moral, or economic roots.

Similarly, in the field of disaster mental health, the carve out of psychiatry may be due to internal as much as external factors. Intra-profession factors include organized psychiatry's inability to win the uniform respect of non-psychiatric physicians and the discipline's rivalry with non-psychiatric mental health professionals. Moreover, despite the inherent logic that the vulnerabilities of some people in acute crises may occasion the need for therapeutic aid, the issue of whether disaster-related anxiety states may be an example of over-medicalization may have undermined the credibility of mental health in disaster situations.

Certainly, the debate over "debriefing" (Arendt & Elklit, 2001; Dyregrov, 1998; Rose, Bisson & Wessely, 2003) has not enhanced the profession's image. Disaster-specific controversies are emerging in a profession that is already rife with criticism, including challenges to its fundamental approach (DSM-IV) to categorizing and understanding disorders (McHugh & Slavec, 1998).

To prevent the field of disaster preparedness from being one more instance in which psychiatry and behavioral health services are not considered core elements of public health planning, each community, organization, and institution should have a disaster/terrorism response plan that includes mental health. Moreover, when psychiatry has an opportunity to contribute to such planning, knowing how to approach the planning task is important.

The Mental Health Disaster Plan

Developing the mental health component of disaster plans involves two convergent processes: (a) building the strategic infrastructure and (b) planning the tactical response.

Strategic Infrastructure

The minimal strategic infrastructure consists of three components:

1. The Emergency Operations Center (EOC): The EOC serves as the decision/response nucleus during crises and disasters. It houses the jurisdictional chief executive, the designated director of emergency operations, and any key organizational department heads or their equivalents. The EOC serves as the command and control headquarters. As the conduit for command and control data, the EOC should be staffed with the chief health officers in addition to other department heads. Because of the critical role that psychological factors play in terrorism and other mass disasters, both the chief physical health officer and the chief mental health officer should be stationed at the EOC. Historically this has not been the case.

2. The Field Incident Command System (FICS): The FICS represents the operational field extension of the EOC and is responsible for seeing that the directives of the EOC are enacted and that rapid and reliable information reaches the EOC. Once again, because acts of terrorism are attacks on the human psyche, mental health officers should be an integral part of the FICS, serving in consultative and direct service-outreach capacities.

3. The Communications System: Communications is the third and final strategic component and usually consists of a primary system with one or two alternative or back-up systems. Field communication systems need redundancy to be operationally reliable. However, "communications" entails more than operational data exchange; effective risk and incident management communications are also essential in terrorism and mass disasters. When appropriately structured, timed, and disseminated, information prepared by mental health specialists can play a significant role in informing and empowering the affected populace and government authorities.
Tactical Response Planning

Complementing the strategic infrastructure is the tactical response plan, which is developed through a seven-step process:

1) **Threat designation.** This step entails the identification of the specific threats most likely to be encountered by the community, organization, and institution.

2) For each threat, the target, or constituent group to be protected or served, is designated and carefully defined.

3) The third step in formulating the tactical response plan entails the stipulation of what **types of interventions** are to be used for each target group. This is sometimes referred to as designation of the **core tactical competencies**.

4) The **timing** of implementing interventions is essential. Disasters evolve in somewhat predictable stages, and interventions are most likely to be successful when they are applied at a point in the evolution of the disaster when they are most likely to exert their greatest effect. Similarly, applying interventions at inappropriate temporal points could easily neutralize any potential benefit and even intensify distress.

5) Having completed steps 1-4, an **inventory of resources** is necessary to plan the tactical response.

6) The **assessment of tactical competency and capability** as represented by the identified resources is the next step in the plan formulation.

7) Finally, if areas of deficiency are identified, **tactical training** is required to meet the core tactical competencies as identified above. Furthermore, conducting training updates and periodic simulations and table-top exercises is an essential aspect of effective training.

**Toward Best Practices**

Individuals' desire to assist disaster victims is practically universal, and well-intentioned medical and paramedical professionals often flock to disaster sites to offer assistance to others. Limited resources can be wasted, however, in attempts to coordinate the efforts of would-be helpers. Currently, there is little consensus about which mental health interventions are most beneficial to whom and at what times during and following a disaster. There is a dearth of randomized controlled trials (RCTs) in the literature of disaster mental health (Deahl, 2000; Deahl, Srinivasan, Jones, Nesblett & Jolley, 2001; Everly, Boyle & Lating, 1999; NIMH, 2002; Rose, Bisson & Wessely, 2003; van Emmerik, Kamphuis, Hulsbosch & Emmelkamp, 2002), and there is confusion about appropriate early intervention throughout the field. The NIMH consensus report (2002) of experts in the field of disaster psychiatry not only acknowledged the limited number of RCTs conducted in the area of disaster response but also underscored the problem of the lexicon used for interventions within the field of disaster mental health. The majority of contributors specifically suggested abandoning the term **debriefing**—a term that has become semantically meaningless because of the variety of interventions, conditions, and settings that has characterized its use.

The scientifically immature status of disaster mental health leaves prospective responders faced with a challenging clinical and ethical dilemma, viz., the choice between providing services that are without rigorous validation but yet could be of benefit or providing no services. Under these circumstances an imperfect but rational approach, it would seem, is to acknowledge the weaknesses in the field and to develop a repertoire of interventions based on evidence from non-randomized investigations, case studies, expert panels, and field experience. Where threads of empirical and experiential conclusions converge in such resources (e.g., Arendt & Elklit, 2001; British Psychological Society, 1990; Deahl, 2000; EAPA Disaster Task Force, 2002; Everly et al, 1999; IOM, 2003; National Voluntary Organizations Active in Disaste, 2002; NIMH, 2002; Professional Practice Board Working Party, 2002), they might be considered evidence upon which to construct working hypotheses for field testing. Ten examples of such research and/or consensus based findings that can guide planning and interventions are

1. A significant level of acute demand for psychological services following disasters should be expected (up to 45% in the case of terrorist events).
2. Specialized training in emergency mental health is imperative.
3. Ability to meet basic physical needs is a priority, followed by assessment of the need for other interventions.
4. Emergent disaster mental health intervention is but one point on a total continuum of care that includes pre-incident planning, acute psychological assessment and first aid, sub-acute disaster response, and chronic phase therapeutic and rehabilitative interventions.
5. A phase-sensitive, multi-component intervention system is recommended.

6. When considering the aforementioned recommendations from the perspective of core tactical competencies, at least five emerge and may serve as a framework for education and training:
   - the ability to differentiate benign from pathological symptoms,
   - skill in one-on-one crisis intervention,
   - skill in small group crisis intervention,
   - skill in large group crisis intervention, and
   - the ability to plan and implement an integrated, phased, multi-component emergency mental health initiative.

7. Normal recovery for affected individuals is the norm, and participation in early intervention services should be voluntary.

8. An acute disaster mental health intervention is not therapy nor a substitute for therapy.

9. Skill in core tactical competencies/interventions is more important than the specific therapeutic "models" or theoretical orientations in disaster work.

10. The mitigation of acute symptoms of distress with on-site screening/triage is a more likely outcome than the prevention of subsequent PTSD.

*Phase-Specific Services*

Integrating broad principles from consensus findings with direct experience gained from two decades of crisis- and disaster-intervention work, the authors have designed a disaster response protocol that consists of four phases: pre-incident, acute, sub-acute, and chronic. The actions implemented during each phase vary both with the temporal proximity to the disaster event and the populations served.

The Pre-incident Phase is primarily focused upon recruiting and training mental health liaisons and responders, establishing early relationships with the various departments of the institution, and providing psychoeducation (e.g., resiliency training, psychological inoculation, and education about potential psychological sequelae of disasters).

The Acute Phase entails assembling the command and control centers (see above); conducting a multi-perspective assessment; providing psychological first aid, triage, support, and pastoral care; identifying and ameliorating ongoing and modifiable environmental exposures; and facilitating communications and dissemination of appropriate information to combat confusion and contagion of hysteria.

The Sub-Acute Phase consists of identifying, triaging, and reaching out to high-risk individuals; offering facilitated, but participant-directed, group interventions to naturally-occurring cohorts of voluntary individuals; and maintaining on-going communication and dissemination of information and education.

The Chronic Phase focuses on reestablishing contact and communication between departments and their mental health liaisons, following up with individuals who received intervention during previous phases, providing individualized psychiatric services via an extended network of clinicians, and promoting and supporting community cohesion with on-going communication and dissemination of information.

*On The Disaster Scene*

Providing psychiatric services at disaster sites involves unique professional and personal challenges.

*Clinical Challenges*

The necessity of a careful mental status exam in a disaster context, particularly following a terrorist incident, is critical. Sometimes this effort is complicated by the variety of ways that exposure to biological or chemical agents can produce changes in the mental state (Crimando, 2004; DiGiovanni, 1999; Horowitz, 2001). Beyond the rage and helplessness felt, and whether or not they have actually been exposed to toxins, victims of such terrorist acts will face primal fears of exposure and contamination (Horowitz, 2001) and are likely to exhibit signs of central nervous system arousal (Holloway et al., 1997). In 1995 when terrorists released Sarin in the Tokyo subway system, 5,510 individuals sought emergency help; however, 4,000 had minimal injuries or no injuries (Norwood, 2002). Because proper treatment can be delayed, for example when patients with chemical or biological exposures are inappropriately triaged to psychiatry, great care must be taken with the assessment process. While this report is not meant to be a clinical guide, several observations are worth sharing. Nerve agents, through their central nervous system actions, cause a confused mental state, impaired concentration, and psychomotor changes, as well as slowing of speech, anxiety, irritability, constricted pupils, mood changes, as well as intellectual impairment (DiGiovanni, 1999). Biological agents can produce malaise, mood changes, and delirium (and the waxing and waning of consciousness can make them difficult to detect). It is well established that anxi-
ety disorders and depression accompany terrorist attacks and that there are significant physiological responses to disasters. Hyperarousal signs to be anticipated include tachycardia, hyperventilation, muscle tension, and other physiological signs of stress. These reactions can be adaptive or can be prodromal symptoms of a psychiatric disorder (Shalev, 2002). As mentioned earlier, there is some question whether labeling these reactions as symptoms may de-emphasize how normal they are (Norwood, 2002). As a result, the responder is faced with the difficult task of determining which symptoms should be of concern and which should be considered “normal” (American Psychiatric Association, 2002; Galea et al., 2002; Honig, Grace, Lindy, Newman & Tichner, 1999).

Some information is accumulating on the predictors and correlates of post-disaster psychiatric problems. At higher risk for PTSD and depression are rescue workers and those individuals who were (a) physically close to the incident, (b) suffered personal losses, (c) incurred stresses in the year preceding the disaster, (d) had relatives who were disaster survivors, (e) lost jobs, (f) had theirs lives disrupted, and (g) experienced panic after the disaster (Classen, Koopman, Hales, & Spiegel, 1998; Galea et al., 2002; Schlinger et al., 2002).

Personal Issues

Notwithstanding the unique clinical issues involved in disaster work, perhaps the greatest challenge is the demand to diverge from—some would say, transcend—one’s traditional professional role. While studying what is known about best assessment/intervention practices in the disaster field, the would-be responder needs to anticipate the profound differences between a psychiatrist’s practice in a traditional clinical setting and that in a disaster context. The differences can surface the moment an incident occurs and may involve ambivalence about whether to even go to the disaster scene. There may be concern for personal safety, including fear of contamination by a biological, chemical or nuclear agent, as well as worries about the safety of one’s family (DiGiovanni, Reynolds, Harwell, Stonecipher, & Burkle, 2003). This conflict-of-loyalty between personal responsibilities and professional obligations can be partially mitigated if responders have made concrete plans in the event of terrorist-instigated or other mass disaster incidents.

Psychiatric responders will be facing the same fears, terrors, and trauma as the people they are treating (Galea et al., 2002; Schlinger et al., 2002; Ursano, Fullerton, Vance, & Kao, 1999) and, as victims and helpers emerge in a disaster field, their roles and experiences often become interwoven so that the distinction between victims and responders becomes blurred. Prior training, planning, and sensitivity to self-protection may help combat practitioner fears and uncertainties. Comfort can also be taken in the knowledge that as a responder the practitioner is promoting community cohesion and organization and thus actively fighting terrorism.

The psychiatrist typically operates as part of a team at a disaster site (North & Pfefferbaum, 2002). Ideally, all team members are familiar with their respective responsibilities; for example, the psychiatrist may perform mental status exams, emergency triage, and pharmacological treatment, while other team members carry out their non-medical professional roles. Cohesive functioning within the team will likely be enhanced if the psychiatrist adopts an attitude toward other team members of “different but equal.” Occasionally, psychiatrists may not only find themselves in the unfamiliar position of being on a team but playing out a role fundamentally different than their usual one. After the mental status exam and triage, rather than applying traditional psychological theories or psychiatric interventions to help people, the psychiatrist might sit down and simply talk to primary or secondary victims such as firemen or emergency medical personnel. The nature of these conversations might entail helping people locate food or shelter, communicating information about relatives or social services, walking around casually comforting dazed people, and letting survivors tell their stories at their own pace. A critically important service can be referral to a clergy member.

One psychiatrist has noted, “Regarding the role of a psychoanalyst in this time of tragedy, the most important thing I can say is that I was first and foremost not a psychoanalyst” (Stimmel, 2002, p. 276; see also Adams-Silver, 2002). Responders at the scene of September 11 reported that the firemen took great efforts to hide their pain. They had to be approached at a slow pace, and seemingly innocuous conversations led to the sharing of horrifying memories and emotions. The seemingly simple but actually complex task of “just listening,” while facing one’s own feelings of panic, vulnerability, horror, anger, and helplessness, has been noted to be “truly a most active therapeutic tool” (Stimmel, 2002). Essentially, there is not one perfect way to experience or work through a disaster. In such unique and trying circumstances, it is important to emphasize the unique humanity of each individual as a kind of antidote to the dehumanization inherent in terrorism. The responding psychiatrist may find that
what is most healing in post-disaster settings is what has been poignantly referred to as a “ministry of presence” (North, Weaver & Hong, 2001, p. 537).

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