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Interview with George Doherty, author of "Proceedings of the 6th Rocky Mountain Region Disaster Mental Health Conference."

Today, Tyler R. Tichelaar of Reader Views is pleased to be joined by George Doherty, who is here to talk about his new book "Proceedings of the 6th Rocky Mountain Region Disaster Mental Health Conference."

George Doherty has held positions as counselor/therapist, Masters Level psychologist, consultant, educator, and disaster mental health specialist and is a former U.S. Air Force Officer. Currently, he serves as President of O`Dochartaigh Associates, a position he has held since 1985. He is also President and CEO of the Rocky Mountain Region Disaster Mental Health Institute. He has served as an Adjunct Faculty member of the University of Wyoming, a Psychologist for Rural Clinics Community Counseling Center (State of Nevada) in Ely, NV, and an Adjunct Instructor for Northern Nevada Community College, and is currently an Adjunct Faculty member of Kennedy-Western University. He has been an Associate Member of American Psychological Association and is a Life Member of the Air Force Association and a Life Member of the Penn State Alumni Association. He has authored numerous publications on subjects within his fields of specialty. He has also been honored by the following professional societies: Arnold Air Society, 1962; John Henry Cardinal Newman National Honor Society, 1964; Psi Chi, 1971; Commemorative Medal of Honor 1985, 1993 (ABI). He has served as a Research Advisor and Research Fellow at the American Biographical Institute.

Tyler: Welcome, George. I'm excited to talk to you today about the mental health conference and the book that was generated from it. To begin will you tell us a little bit about the Rocky Mountain Region Disaster Mental Health Conference. Why was it begun and what is its purpose?

George: The Rocky Mountain Region Disaster Mental Health Institute is an independent, nonprofit, 501 (c) (3) organization whose mission is to promote the development and application of practice, research, and training in disaster mental health, critical incident stress management, traumatology, and other emergency response interventions and the promotion of community awareness, resilience and recovery. This includes hazards vulnerability and mitigation research, planning and training for first responders, mental health professionals, chaplains and related personnel.

The purpose of the Institute Conference is to provide a forum for presentation of research results, education, training and consultation in Disaster Mental Health Services (DMHS) and Critical Incident Stress Management (CISM), advances in delivery of DMHS and CISM, discussion and sharing of information, ideas and plans, development of a DMHS and CISM research and service delivery network, presentation of Continuing Education training for mental health professionals, first responders and chaplains, training for newly recruited DMHS and CISM volunteers and first responders, and publication of program proceedings and papers as appropriate for dissemination to DMHS and CISM professionals and first responders locally, regionally and nationally.

The Conference was begun in 1999 to provide opportunities for first responders and disaster mental health professionals to present and learn from each other, share ideas and experiences, and to network with each other. An effort is made each year to bring together people from the Rocky Mountain Region, other states across the US and selected other countries where significant events have taken place and/or researchers and practitioners in the field have contributions to make.

Tyler: Why specifically did you decide to turn the Proceedings of the 6th conference into a book?

George: We have published the Proceedings of each of our conferences in one form or another since 1999. The papers presented the first few years were published as special editions of the journal "Traumatology" by Green Cross. We published the Proceedings of the Estes Park conference ourselves and have published the more recent ones through Loving Healing Press.

It is part of the mission of the Institute to disseminate information about the research and practice of Disaster Mental Health and critical incident stress management and related areas. In order to accomplish this and help ensure that we reach many people in the field, we decided to publish through Loving Healing Press in order to reach as many responders and mental health professionals as possible. Through the conference and our publication, we hope to reach anyone in the fields of emergency medical services and trauma units, crisis intervention, mental health, traumatic stress, emergency services, disaster mental health, military, National Guard and Reserves, schools, law enforcement, firefighters, chaplains and other first responders.

Tyler: I understand the conference focuses largely on the mental well being of those deployed to help during a disaster. What are some of the ways to help the families of those whose loved ones must be away from them to go overseas to help others?

George: In order to understand the effects of disasters on mental health professionals who intervene, it is helpful to look at two of the key concepts of disaster mental health.

First of all, no one who sees a disaster is untouched by it. This includes the workers. The intensity of the emotional climate of the disaster demands that the worker continually confronts and manages all kinds of painful expressions of emotion.

Disaster workers are normal persons who generally function quite well under the responsibilities and stresses of their jobs. However, exposure to traumatic stimuli and the demands of disaster work can cause workers to show signs of emotional and psychological strain. These reactions are normal under the extraordinary and abnormal situation of the disaster. Disaster stress and grief reactions among workers are usually transitory in nature. Relief from the stressors and the passage of time usually lead to the re-establishment of equilibrium. Education of workers about normal stress reactions and the importance of stress management on the job can help workers to anticipate and manage their own reactions to the disaster.

It is important for responders who are deployed to any incident or disaster to make arrangements for family support while deployed. This is especially true for those who will be gone for extended periods and/or responding overseas (e.g. the tsunami in Asia). For prolonged periods, arrangements need to be made to make sure families have information, support services, and an understanding of how their loved one will be responding. Spouses and children will be affected. It is important for families in some cases to go through a debriefing about the incident as well. A crucial period is when the spouse returns home. There is a re-adjustment period that may last for a variable period. A good example is one involving military deployment. One of the presentations at the conference was entitled "Reunion and Re-integration with the Family after Deployment." It discusses family support and family concerns addressed by the Department of Defense (DOD) Family Assistance Centers for families of deployed military personnel. While the role of those deployed to various disasters are different, and usually shorter in duration, support for families and responders during and following deployment is critical. Keeping our responders able to function effectively and do their jobs and to keep families intact is important to all. We need to provide information about how to increase controllability of acute stress reactions, shape coping behaviors, foster help-seeking when appropriate, provide social interventions to build team/unit cohesion and bolster social support networks, and interventions to prepare family members for stressors introduced by their relative's deployment. In order to accomplish this, a variety of intervention techniques or tactics for increasing high-risk responders' resilience during short-term, intermediate and long-term adjustment periods are needed.

Tyler: What kind of mental health issues might a person have who assists in the recovery and cleanup after a disaster, and how best can those issues be treated?

George: Psychological effects are universally present to at least some degree in responders involved in disaster situations. Teams of responders on the spot of a disaster or following one have psychological reactions very similar to those of the victims. Their reactions vary with the magnitude of the event and the number of casualties. For example, consider the differences in affect between reactions of responders to a traffic accident versus an incident like the Oklahoma City bombing or Columbine High School or the Virginia Tech shooting. There are a number of

factors that affect the severity of responders' reactions to disasters and critical incidents. Some of these factors include: the nature of the traumatic event; the proximity of the responder to the event; the nature of the responder's role; the responder's prior experience; the responder's current life situation; the behavior of others at the incident; psychological preparedness for the incident; etc. There are also factors of occupational stress and cumulative stress that need to be considered. Generally, responders function well despite the responsibilities, dangers and stress factors which are inherent in their work. However, sometimes it happens that the intense stress of the event overwhelms their previously used defenses.

Verbalization or debriefing sessions following a disaster, critical incident or tragedy are needed following an event to help responders deal with their personal reactions. These are used to help prevent development of delayed or lasting reactions. It is also important to recognize that some responders may listen and discuss more openly with peers than with mental health professionals. Some of the tactical interventions that trained peers use include individual crisis intervention, defusing and debriefing. These are three of the elements of Critical Incident Stress Management (CISM).

The longer workers are assigned to an acutely stressful situation, the more likely they are to develop some of the following problems: Physical signs of acute stress (e.g., exhaustion, headaches, gastrointestinal distress, loss of energy, etc.); Emotional signs (e.g., depression, irritability, anxiety, etc.); Cognitive signs (e.g., mental slowness or confusion, inability to make decisions, loss of ability to conceptualize thoughts or prioritize tasks, decreased memory and attention span, etc.); Behavioral signs (e.g., hyperactivity, excessive fatigue, inability to express self verbally or in writing, etc.).

Workers may experience post-traumatic stress days or weeks after the incident, or at the time of a similar incident. It is important to note that the majority of responders and victims will have only temporary problems associated with the stress they experience. They are normal people having normal reactions to an abnormal situation. These are understandable, warranted, and necessary feelings to recover. It is also important to stress this to victims and responders who may otherwise see themselves as sick.

Everyone has experienced stress at one time or another. Professionals in every field learn how to take advantage of their stress response. They use it to bring their performance to a peak (consider athletes in competitive sports). These people also learn how to lower their stress response. Whether they learn this through trial and error or through training, such a pattern of behavior minimizes stress responses and results in feeling more in control.

Psychological first aid is emerging as the crisis intervention of choice in the wake of critical incidents involving trauma and mass disaster. It is similar to the concept of physical first aid. Just as physical first aid is used for injuries ranging from minor scratches to serious wounds, psychological first aid is used to provide psychological support for experiences ranging from minor stressors in daily life to traumatic events. Psychological first aid teaches providers when and how to make referrals for professional mental health care.

The role of mental health clinicians in the aftermath of disaster and terrorism is growing in importance. Assessment and treatment of acute responses to traumatic stress has received much attention since the World Trade Center incident on September 11, 2001. Those events underscore the value of having a trained and ready mental health workforce.

Various cognitive-behavioral approaches have varying degrees of reported success in alleviating post-traumatic stress. At present there does not seem to be any one technique that is effective in all situations. A distinction needs to be emphasized that there is a difference between post-traumatic stress and post-traumatic stress disorder (PTSD). When making referrals, it is important to make sure that an adequate assessment be made by a mental health professional. It is also important to identify adequate and appropriate referral resources prior to an incident. An inappropriate referral has potential for doing more harm than good.

My book "Crisis Intervention Training for Disaster Workers: An Introduction" (Loving Healing Press) deals more in-depth with these areas as well as others that responders and mental health professionals should be aware of.

Tyler: George, will you explain to us what that distinction is between post-traumatic stress and post-traumatic stress disorder?

George: Acute stress reactions and PTSD itself usually fade without treatment. Following the World Trade Center attack in September 2001, trauma counselors were dispatched to New York City. Many of them found that they had

little work. In October and November 2001, researchers reported that 7.5% of adults living in Manhattan below 110th St had PTSD. By February of 2002 the number was down to 1.7%.

Most people have suffered or will suffer a traumatic experience at some time in their lives. However, few ever develop PTSD. Stress responses after a personal or community disaster are normal. Most people cope with disaster as they cope with grief. Attempting to make a diagnosis and intervene soon after a trauma could lead to mistaking a transient reaction for a more serious disorder. Even dissociation can serve as a protective mechanism, especially if it occurs during the trauma and doesn't persist. People are not necessarily in denial if they do not seek professional help.

Posttraumatic Stress Disorder (PTSD) is a diagnosis made by meeting certain criteria outlined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. In order to meet these criteria,

- The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone (e.g., serious threat to one's life or physical integrity; sudden destruction of one's home or community; seeing another person seriously injured or killed as a result of an accident or physical violence; etc.)
- The traumatic event is persistently re-experienced in at least one of the following: recurrent and intrusive distressing recollections of the event; recurrent distressing dreams of the event; sudden acting or feeling as if the traumatic event were recurring; intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event.
- Persistent avoidance of stimuli associated with trauma or numbing of general responsiveness (not present prior to the trauma).
- Persistent symptoms of increased arousal (not present prior to the trauma).
- Duration of the disturbance of at least one month.

The duration criteria is an important differential between PTSD and Posttraumatic Stress. The latter is a normal response to an abnormal situation and, if it dissipates and/or is dealt with, is not generally a problem. If the symptoms persist for more than 30 days, treatment with a therapist is indicated. An additional concern would be inclusion of depressive and/or anxiety symptoms that persist. When in doubt, consider referral and seek advice from a mental health professional.

Tyler: George, you said there does not seem to be any one technique that is effective in all situations, and I appreciate your explaining all the factors that need to be considered in how a person would react to the stress of a disaster. But can you give us a specific example of a case where a responder needed mental health treatment following a stressful situation. For example, in 9/11 concerning a fireman who responded to the disaster, or any other situation you want to use as an example. Where would the mental health professional start in helping the individual?

George: In the aftermath of the Pacific Southwest Airlines Flight 182 disaster, many disaster assistance, public safety, and emergency workers developed a variety of psychological problems and emotional or behavioral symptoms when returning to work or their families following the intensive week-long clean up effort. Acute crisis reaction, intense stress, and job related impairment were found to be quite common.

Disasters are complex human, bureaucratic and political events. A behavioral health disaster plan is essential for coordination of behavioral health emergency response efforts with other emergency response organizations during and following disasters. Each state department of behavioral health should have a behavioral health disaster plan that is a component of the state emergency management plan.

Interventions by mental health professionals appropriate for the first few weeks after the initial phases of disasters or critical incidents should focus on immediate physical and psychological needs. Brief, present-focused interventions, such as psychological first aid, information giving, and trauma interviews or debriefings should figure prominently in this phase. Difficulties persisting months or even years after the impact phase has ended will require more in-depth counseling and/or therapy. Critical Incident Stress Management (CISM) is an approach that has gained widespread use over the past two decades. The mission of CISM with first responders is the advancement of educational and direct support programs focused on critical incident stress management for first

responders. It is basically a strategic approach that coordinates a number of tactical interventions. The following types of interventions, managed and/or provided by qualified volunteers, are examples of tactical interventions:

- Critical Incident Stress Debriefing (CISD)
- Defusing
- Demobilization
- On-scene Support
- Crisis Management Briefings (CMB)
- Individual Services (One-on-One) peer support
- Family Services
- Pastoral Care

Using a strategic planning approach, mental health professionals and trained peers identify potential threats, target populations and groups, and determine at what point in time to intervene with what types of tactical interventions and what resources are needed to respond effectively. Such planning is at the heart of intervention. It requires a focus on intervention in circumstances involving acute distress. It is critical initially to assess the nature and severity of the crisis reaction. The next step involves stabilizing the situation. The third step focuses on reducing the distress that is associated with an acute stress response. The goals of these interventions are:

- Mitigating the impact of the event;
- Facilitating normal recovery processes in normal people who are experiencing normal reactions to an abnormal situation; and
- Returning those affected to adaptive functioning.

The role of mental health professionals in responding to critical incidents and disasters during and immediately following the event is to provide psychological first aid, triage and CISM. None of these include therapy. If more intense treatment is indicated, the person is referred for further assistance.

Some methods found to be effective therapies with different individuals include cognitive and cognitive-behavioral therapies, Traumatic Incident Reduction (TIR) and EMDR.

Tyler: George, to what extent are people trained before the disaster happens to be mentally ready for the emotional difficulties of dealing with a trauma?

George: Mental and psychological preparedness for responding to disasters and critical incidents should be a part of the training and preparation that all responders receive. Training in CISM and what to expect emotionally can assist workers in dealing with their own and co-workers' responses and help them support each other. Trained peers should be members of every team that responds. Mental health professionals are not immune to emotional responses because of their profession. They need to involve themselves in the trainings and exercises along with peer responders. This serves a number of purposes. They become known by the other responders and they also learn first-hand what the responders do and are faced with. Their presence at trainings and practice exercises helps build team cohesiveness, trust and understanding.

Tyler: George, how did you personally become involved in the conference?

George: As president of the Rocky Mountain Region Disaster Mental Health Institute, I have been involved in the planning, development, and running of the conferences since 1999. As a disaster mental health specialist and having been deployed to disasters in that capacity in the past, I saw that the emerging field had few training and conference activities at that time. Together with a number of others, I started the conferences. The largest conference thus far was the first one in 1999 and took place at the University of Wyoming with an attendance of around 250 delegates and presenters from 21 states and five foreign countries. We have continued on an annual basis and the 7th conference will take place in November, 2008.

Tyler: George, you are really the editor of the book. Will you tell us about how the book is organized and what information is presented in it?

George: The current volume documents the conference presentations and related activities. Presenters have placed their presentations into articles that are included in order for others to be able to update their knowledge and information on the topics presented. The theme of this conference was "FROM CRISIS TO RECOVERY: Resilience and Strategic Planning for the Future." Each day concluded with a number of roundtable discussions addressing related issues and topics. The conference had two major goals: (1) to learn from research, field experiences and networking; and (2) to provide a safe, fun, relaxing time to enjoy away from regular responder activities.

Information was presented on traumatic stress in the workplace (police suicides, behavioral health in emergency preparedness); planning disaster responses (resilience, response and strategic planning; response of Civil Air Patrol in mass disasters; how to develop statewide disaster behavioral health plans); Ethics in providing disaster mental health services; Cultural issues in disaster responses and trauma recovery; Special populations and trauma response (experiences of WW II fliers; forgotten trauma victims—elderly; Tourists—terrorism and disaster); Demobilization support—reunion and reintegration with families following military deployment. Two workshops were offered on the Incident Command System (ICS) and National Incident Management System (NIMS) and the role of behavioral health professionals. A two-day workshop on Strategic Crisis Intervention Planning was also provided pre-conference.

Tyler: George, what would you say was the greatest lesson or benefit that came about as a result of the 6th Rocky Mountain Region Disaster Mental Health Conference?

George: Networking, sharing information formally and informally. The importance of planning and pre-event resilience training and education.

Tyler: I understand a 7th conference is planned. Can you tell us how readers who are interested can find out more about it?

George: The dates will be November 6-9. The specific information will be posted on the Institute web pages at: http://www.rmrinstitute.org They can mail us at Rocky Mountain Disaster Mental Health Institute, Box 786, Laramie, WY 82073-0786 or phone: 307-399-4818. Email Address is: rockymountain@mail2emergency.com. A Call For Papers will go out and be posted on the web page with information for submissions in April with a deadline in mid-July.

Tyler: George, you've written and published several books and articles in the past. Will you tell us more about some of your other writings?

George: A number of these are listed on the web page http://www.rmrinstitute.org The Institute Newsletter listed at that site has articles archived that are from 1999—2007. Additional articles are listed in the column on the left of the opening page. Some of the published articles are also listed at: http://www.rmrinstitute.org/articles.html Two of the conference proceeding articles were published in 1999 and 2004. Those articles are in Special editions of the Green Cross journal Traumatology. I was Guest Editor for them. The 1999 issue included two issues. A major article "Cross Cultural Counseling in Disaster Settings" http://www.massey.ac.nz/~trauma/issues/1999-2/doherty.htm was published in the Australasian Journal of Disaster and Trauma Studies. Books can be accessed through Loving Healing Press or you can go to Amazon.com and placing George W. Doherty in the search engine. Books on the Amazon.com site have reviews and opportunities to view short passages. At least one of the books is also listed in and available in the Amazon.com Kindle where you can purchase them for your Kindle hand-held device electronically. They have an explanation of the Kindle on their site. Of the books listed with Amazon.com, the 5th year Proceedings and the 6th year Proceedings are listed. The book which was published last Fall, "Crisis Intervention Training for Disaster Workers: An Introduction" is also available. It is a book also designed to be used for college courses, continuing education, and reference work. It includes a scenario of an incident which can be adapted for use in team trainings.

Tyler: Tell me more about "Crisis Intervention Training for Disaster Workers: An Introduction." What kind of training steps are taken to train disaster workers?

George: The book is set up so that it can be used in a college course, a training workshop or self-study. It starts by discussing the fundamentals of disaster response and critical incidents. Sections deal with children, special risk

groups, cultural aspects, rural crises, interventions, stress management, coping and resiliency, war, terrorism and terrorists. The book ends with a test that can be taken and used to evaluate the training in order to receive a certificate of completion and used for continuing education credit. Finally, the book includes a step-by-step response to a disaster/critical incident scenario that can be used by a group for a table-top exercise or by individuals who can send their responses for comments. The content of the book includes general theory and models of disaster mental health, CISM, crisis intervention techniques commonly used in these situations, supportive research, and practice of approaches used in responding to the victims, workers and communities affected by disasters, critical incidents and terrorism threats and events.

Tyler: What was different for you about writing “Proceedings of the 6th Rocky Mountain Region Disaster Mental Health Conference” compared to your previous writing?

George: While I did contribute myself by writing an article, my major role in this publication was to be the editor. This meant that most of my work was involved in collating, editing and formatting the contributed articles.

Tyler: Will you tell us more about the previous Proceedings of the conference that Loving Healing Press published and what the focus was for each of those conferences?

George: The initial conference was published in the journal “Traumatology” in 1999 in two special editions and was a cross-section of the current research in the advancing specialty of disaster mental health. The next conference was also published as a special issue of “Traumatology” two years later and focused on Crises in Rural America. I served as guest editor for both. The Institute self-published the Proceedings of the Estes Park, Colorado conference in 2005. It is available through the Institute. This conference focused on the effects of the Tsunami in the Indian Ocean and related topics including implications of global warming, women's mental health post-disaster, stress debriefing, Traumatic Incident Reduction (TIR), children and disasters and trauma treatment, cross-cultural techniques, etc. The 5th conference in Casper, WY (published by Loving Healing Press) dealt with the theme: TAKING CHARGE IN TROUBLED TIMES: Response, Resilience, Recovery and Follow-up. It included reports on Katrina, Abu Ghraib, and a nightclub bombing in Israel.

Tyler: As I mentioned above, you also work as a mental health counselor. Will you tell us a little about the type of counseling you do?

George: I have a private counseling practice. I also volunteer each month at a free medical clinic. Most of my current work is involved in crisis response. I am the Clinical Coordinator for the Snowy Range CISM Team. I also respond when called by the National Crisis Care Network. I have been deployed in the past for a number of national and regional disasters as a disaster mental health specialist with the Red Cross.

My experience over the years has primarily been in rural areas of the west (including rural eastern Nevada; rural southern Colorado and Wyoming). When working for the state of Nevada, I also worked with Viet Nam Veterans in rural Nevada through a special contract with the Veterans Administration.

My experience over the years in rural areas was initially in mental health centers and included a bit of almost everything and a good deal of crisis work and cross-cultural work.

Tyler: What are your biggest frustrations as a counselor and overall in the field of mental health?

George: Convincing mental health professionals of the importance of getting actively involved with disaster responders, getting training to be available to respond as mental health professionals, recognizing the fact that they must get training (especially in Incident Command) in order to respond (they cannot expect just to show up when an incident occurs). As a counselor, especially in rural areas, my biggest frustrations over the years have been lack of resources, including the electronic and computer acceptance—use and availability. An additional early frustration was lack of continuing education opportunities, availability and costs.

Tyler: And what do you feel are your greatest rewards or satisfactions?

George: Being able to work in rural environments. Seeing people adapt and adjust to situations. Being able to work with and train first responders and others in small rural communities and to be able to deploy to national disasters.

Tyler: Thank you, George, for talking with me today. Before we go, will you tell our readers about your website and what additional information can be found there about "Proceedings of the 6th Rocky Mountain Region Disaster Mental Health Conference"?

George: The website is http://www.rmrinstitute.org. It contains links to our newsletter archive with articles on disaster mental health from 1999—2007. It also contains information and links about trainings and our next conference. There are links to book sites as well as various journal articles.

Thank you, Tyler, for the opportunity to discuss this all with you.

Tyler: Thank you, George. I hope the Mental Health Conference and the publications resulting from it continue to be a successful source of education in carrying on the important work of helping disaster responders.

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