VOLUME 33, ISSUE 2

Summer 2018

THE SAN DIEGO PSYCHOLOGIST

The Official Newsletter of the San Diego Psychological Association

In this issue

President's Corner

by Cynthia A. Cotter, Ph.D.

Welcome to the second issue of The San Diego Psychologist for 2018!

This issue includes articles featuring the presentations from our 2018 SDPA Spring Workshop held this past May 19 entitled Preparing for the Unthinkable: Mental Health Provider Roles in Disaster Recovery. This was the inaugural event of this title produced by the SDPA Disaster Psychology Committee co-chaired by Deborah Hopper, Ph.D. and Robert McGlenn, Ph.D.; it included remarkable national and local experts in disaster response and was hugely successful. The Committee is currently marketing the event to other organizations and is offering assistance to organizations so that more events of this type might be produced. If you are interested in these efforts, please contact the Disaster Psychology co-chairs. Special thanks to Mary Mulvihill, Ph.D. for being the guest editor of this important issue of The San Diego Psychologist.

We have recently launched our SDPA Fall Conference for this year, which will take place on October 27th, 2018; earlybird registration extends to September 30, so REGISTER NOW.! The event entitled, Encountering Substance Use in Clinical Practice: Emerging Issues and Divergent Perspectives focuses on the very timely topic of problematic substance use. There has been a rapid increase in the use of prescription and non-prescription opioid drugs in the U.S. over the last two decades. Drug overdoses have become the leading cause of death of Americans under the age of 50, with two-thirds of those deaths from opioids. Behaviors related to alcohol abuse and alcoholism in the U.S. have also become much more serious. The speaker list for this year's conference is sterling: Our keynote is George F. Koob, Ph.D., Director of the National Institute on Alcohol Abuse and Alcoholism. Beth D.

Darnall, Ph.D., Clinical Professor, Department of Anesthesiology, Stanford University Medical School will present on the dual crises of pain and prescription opioids. We are excited to have investigative journalist Sam Quinones, author of Dreamland: The True Tale of America's Opiate Epidemic speak on the sociocultural roots of the current opiate crisis. Other topics presented at the conference include marijuana post-legalization, addiction and personality, working with people of color in substance use treatment, support for families of substance users, and understanding relapse. Divergent perspectives on intervention/treatment are presented. There will also bespecial musical presentations. Please join us for our most exciting SDPA Fall Conference to date.

SDPA is pleased to announce that it will be a Platinum Sponsor for the 2018 NLPA (National Latina/o Psychological Association) Conference (attach link) to be held from October 18th-21st 2018 at the Hyatt Regency La Jolla at Aventine. We are fortunate that this conference is local this year; please don't miss the opportunity to attend this amazing national event.

If you are already an SDPA member, we are so happy for your participation. If you are not, there is no better time to become a member. Members receive many benefits and discounts, including lower registration fees to the 2018 SDPA Fall Conference. Join SDPA NOW! We hope to see you soon.

Editor's Note

by Gauri Savla, Ph.D. (*Guest Editor*)

The San Diego Psychologist is grateful to Dr. Mary Mulvihill of the SDPA for guest editing this important issue based on the SDPA Spring Workshop entitled, *"Preparing for the Unthinkable: Mental Health Provider Roles in Disaster Recovery."* She was responsible for curating the content, gathering and writing the transcripts, and doing the initial edits for this issue. She has written the Editorial for this issue.

The featured articles in this issue are not verbatim transcriptions of the authors' presentations. The transcriptions have been edited for content, length, copy, and grammar for the purposes of this publication.

As always, thank you for reading.

Editorial

by Mary Mulvihill, Ph.D. (*Guest Editor*)

Dear Readers,

The San Diego community is on the leading edge of disaster response. In 1984, a McDonald's restaurant in San Ysidro, a border town in San Diego was the scene of one of the earliest mass shooting incidents in our country's recent history. Twenty-three people, including many children, were killed by an active shooter. This incident caught the Disaster Response community completely off guard, since mass shootings were rare at the time. After careful study of the emergency response to the event, ways to minimize casualties in similar events were devised in order to increase readiness. Some of the changes instituted included having SWAT teams carry their weapons with them in their vehicles for faster response, and developing robots to retrieve the wounded from the disaster site when unsafe for medics to do so. These "lessons learned" were applied nationwide to different extents, but particularly here in San Diego, where a shocked and saddened community took the need for improved disaster response seriously. Every disaster, although unwelcome and terrible, is an opportunity to study potential challenges and find ways to anticipate and solve them when the next disaster occurs.

The lessons learned from this and other incidents that followed have informed the "best practices" in the field of mental health disaster response field. The current issue of the San Diego Psychologist highlights the program from the SDPA 2018 Spring Workshop, Preparing for the Unthinkable: Mental Health Provider Roles in Disaster Recovery. The goal of the workshop (and this issue of The San Diego Psychologist) is to help you understand how the local San Diego County disaster response system works, where you fit in, and how you can help as mental health professionals.

The workshop was carefully planned and executed over 18 months by the Chair of the invaluable SDPA Disaster Psychology Committee, Dr. Deb Hopper and her team, which included SDPA members, Dr. Bob McGlenn, Dr. Glenn Lipson, Dr. Wendy Tayer, and Mr. Bo Robertson. Based on their knowledge of the field, they determined the agenda and assembled a first-rate team of speakers. They were also integral to the preparation of this issue of The San Diego Psychologist.

The conference, held on May 19th, 2018 at West Auditorium at Scripps Mercy Hospital was a tremendous success, attended by 90 mental health professionals and graduate students. The dynamic speakers, all experts in the field of Disaster Response, were led by keynote speakers,

Drs. Chip Schreiber and Melissa Brymer. All speakers had extensive, first-hand experience on the front lines of many recent local and national disasters.

Dr. Schreiber is one of the nation's leading "second responders," i.e., the mental health professionals participating in the recovery efforts on site. Dr. Brymer was the lead mental health professional in the 5-year post-Sandy Hook school shooting recovery effort, as well as many other school and workplace shootings across the country. She also worked with Dr. McGlenn as a second responder after the shooting at Santana High School in Santee, in 2001.

From our local resources, Ms. Crawford, head of San Diego County's Emergency Response Command Center, is the one who takes command instantly when local disasters strike. She is capable and knowledgeable, and we were fortunate to hear her speak at the workshop. Dr. Lipson has extensive experience in our local Red Cross shelters and shared many tips about what to expect and what is most helpful in the immediate days after an event. Dr. Tayer applies the CBT model to explain why people do what they do when challenged by a disaster and the pitfalls of stress-induced, maladaptive thinking that one must be aware of. Dr. Hopper shared excellent, pragmatic tips on how to prepare for a disaster and cope when the "unthinkable" happens, both at home and work, including with our clients.

If you were not able to attend the event or if you just want to review some of the informative training provided, this issue of The San Diego Psychologist is for you. Through this issue, the experts in the mental health disaster preparedness field, will answer many of your questions about how you can prepare yourself, your family and your practice for the "unthinkable".

We hope that you will be inspired to take a leadership role in your own community to help prepare and if needed, respond, when your mental health skills and expertise are called for.

Please refer to the list of Resources, compiled by the SDPA Disaster Psychology Committee for additional, up-to-date disaster preparation and response information and the list of local mental health-related disaster response organizations, should you be inspired to consider the volunteering options available to mental health professionals. Both are available online at the bottom of the two Disaster Preparedness 101 articles.

Mental health professionals play a vital role Disaster Preparedness, Response and Recovery – be part of the solution!

County of San Diego Emergency Operations & Information Access Plan: What You Need to Know as a Mental Health Provider.

by Holly Crawford

Ms. Crawford, San Diego County Disaster Manager, explained her critical role of coordination and communication when disaster strikes, a complex effort often overlooked by the public. Two critical components of her job are (1) to provide accurate, consistent

information to the public about what is happening/what to do, and (2) to conduct the planning & management of the evolving needs during a disaster. This includes such practical considerations as how many shelters are needed and where, whether facilities for large animals are required, etc. This crisis leadership requires good situational awareness, necessary to make and act on decisions even if information is limited, as it often is during a developing emergency. Ms. Crawford is an experienced County employee, with an incisive mind, the ability to think on her feet and a "can do" attitude, which give her excellent credibility in taking command of an emerging disaster situation.

Fires comprise our number one local disaster risk. San Diego County is rather advanced with respect to disaster preparation, thanks in part to the terrible Cedar Fire in 2003. A silver lining to this event was that needed changes to local disaster response were identified, based on the problems encountered. Some of the same issues that San Diego faced during the Cedar Fire were faced by Sonoma/Napa during their recent fires, since they had not experienced a large scale fire for a long time. These disaster system management changes included having all ER personnel use the same radio frequency, development of the "reverse 911" notification system for evacuations, increased fire-fighting air assets, and training of County employees to immediately staff shelters. An emergency chaplaincy program is now run out of Rock Church, to provide spiritual support. Also, more effort is now directed to individuals with special access and functional needs, such as those with disabilities. San Diego is also now the site of the Regional Terrorism Threat Center.

The challenge in past disasters has been primarily how to get information to and from the public during the event. However, with social media being the primary source of information these days, the challenge has to do with how we can sift through a massive amount of information of varying accuracy efficiently. Since San Diego has minimal notable weather events, most of us do not follow the weather channels commonly used in other cities to keep the community informed. During disasters, the 911 system typically gets overwhelmed mainly by "missing person" inquiries, so there is an effort underway to shift this function to the 211 system. Simply by employing an "out of state" and a "local" central contact for your family, you may be able to avoid contributing to this traffic jam by having your own points of contact to reconvene your loved ones in a disaster.

For personal notification, the Wireless Emergency Alert system is built into your phone's chip, so you will get automatic bulletins from extreme weather and other emergency alerts in your area (National Weather Service), AMBER alerts (in cases of child abduction, sent by the National Center for Missing and Exploited Children), and Presidential alerts in a national emergency. For specific local Information, the SD Emergency App can be downloaded to your phone to provide guidance for disaster preparation, response, and convenient, pop-up disaster notifications.

http://www.readysandiego.org/alertsandiego

http://www.calalerts.org

It is also critical to register your mobile phone with the County for emergency notifications (reverse 911). Your residential landline is automatically enrolled, if you still have one, but no mobile phones unless you request it. Register your mobile phone for the SD County Emergency notification system by going to the Alert San Diego website online. This is important, as you never know where you will be when disaster strikes. Finally, make sure you have a phone which does not require electrical power or cell phone towers, (which may go down during a disaster), to operate. Everyone needs to own one phone which plugs directly into the phone cable socket, which can be obtained at Goodwill for a few dollars.

Lessons from the Field: Toward the Way Forward in Mental Health Disaster Response

by Merritt "Chip" Schreiber, Ph.D.

Dr. Schreiber, a child psychologist and expert on disaster response, discussed current issues in disaster response from a national perspective, based on his work as the CPA Disaster Response Network Coordinator (DRN) and a Red Cross volunteer, and his vast experience deploying to major national disasters for many years. The CPA DRN is based on the local jurisdiction of the 57 counties in California. He drew attention to the DRN member from San Diego, Dr. Deborah Hopper, who is the current Chair of the SDPA Disaster Psychology Committee.

Dr. Schreiber noted a number of concerns for the direction of the disaster response field related to mental health (second responders). Often, disaster response operations tend to be "one size fits all," when in reality, individuals vary in their needs, based on many factors. It is still not completely clear where mental health professionals fit in with disaster response, per se. The focus remains on acute response, rather than prevention or the aftermath.

Dr. Schreiber pointed out that as clinicians, we tend to focus on individuals rather than populations. Disaster work is optimized by a clear understanding of population groups in the ways in which people respond to disasters. Certain subgroups of the population tend to respond differently to disasters than others, e.g., those who have faced disasters in the past. 30-40% of disaster victims can develop new mental health disorders after experiencing such an event. Yet, many people are resilient and able to return to their baseline functioning after enduring "transitory distress." Symptoms may resemble post-traumatic stress disorder, but much of the symptomatology is sub-clinical. People tend to fear disaster recurrence, which may trigger symptoms again, but this fear tends to fade over time.

When disaster strikes, a large number of mental health providers and volunteers of varying motive and skill simply show up, and they need to be coordinated. There are increasing efforts to automate this process online. The response to the recent Hurricane Harvey was so large, that it crashed the online mental health volunteer system. Over 5,000 volunteers deployed to this event, even though the site was quickly taken down when capacity was reached. Dr. Schreiber, due to his experience, is often responsible for the assessment and

coordination of mental health volunteers on site. It is necessary to appropriately "vet" these individuals before sending them into the field to manage the affected public. Once selected, volunteers may need guidance or targeted training. Much of what has been learned about disaster response and its aftermath comes from a 12-year follow up study after 9/11, conducted by the National Institute for Occupational Safety and Health (NIOSH) within the Centers for Disease Control and Prevention.

There are two main pathways after a disaster: (1) the Acute Disaster Response and (2) the Later Response, both significant to recovery. The severity of the disaster is also important. Extreme, widespread disasters are a great equalizer since most people are greatly challenged simply due to local conditions. In a more moderate intensity disaster, individuals with prior trauma, depression, mental health issues or recent stress may be particularly at risk.

Following the disaster, anyone exposed to an event is now considered vulnerable in future disasters, since experiencing the event will comprise a new mental health risk factor. He noted that most mental health providers are trained to "chase tears" during a disaster, but the most helpful effort may actually be to identify those survivors who are at highest risk and steer them toward the appropriate services. He labeled this phenomenon "triage vs. secondary assessment." The interventions for these high risk individuals may vary greatly, depending on their needs. Generally, only 25% of those affected receive timely care, a statistic that can be improved with targeted training.

Dr. Schreiber noted that American disaster response teams have not learned from their international colleagues who seem to do a better job connecting victims with appropriate resources. He perceives a huge gap in the US between provider capability and awareness that further mental health intervention is available and may be helpful post-disaster. With low awareness and few referrals for follow-up services, mental health care services for many people after disasters is inadequate. He emphasized the need for systematic secondary screening of victims and the "alignment of intervention intensity" to relative risk and resilience among population groups, thereby countering the "one size fits all" approach. He called for the development of strategies to treat population groups for the identified reactive pathways after a disaster to further extend secondary prevention efforts.

Another important element is to protect volunteers (and first responders) from undue exposure to traumatic scenes. Repetitive, sensational media coverage is a hazard for disaster workers as it may detract from efficacy on the job. Dr. Schreiber stated that he avoids consuming any disaster-related media while deployed, in order to preserve his energy and focus for what he must do at the scene. Obviously, one will invariably be exposed to incidental trauma while on site, but the policy of limiting one's media consumption will serve to minimize the emotional repercussions of this work. Although the majority of first responders are resilient during/after the disaster, approximately 10% may develop adverse mental health sequelae. Some of them may have had predisposing risk factors, such as recent emotional stress or depression.

As Dr. Schreiber summarized, recovery intervention efforts do work and are worth undertaking. After 9/11, there was a $100 million effort to conduct crisis counseling, which was unprecedented. From a Public Health perspective, even if individuals are only slightly impaired, and their work, only mildly affected, when this impact is multiplied across the population affected by a large scale disaster, the economic loss and human suffering is substantial and significant. Unfortunately, no matter how much care is taken, we are bound to miss many people after a disaster who need and might benefit from intervention. Identifying and reaching everyone who needs assistance after a disaster is one of the biggest challenges going forward.

Responding to the Needs of Children and Families After Mass Violence and Disasters

by Melissa Brymer, Ph.D., Psy.D.

Dr. Brymer is the head of the National Child Traumatic Stress Network, which promotes best practices for pediatric trauma recovery. The nationwide network comprises 87 sites, including Rady Children's Hospital in San Diego. Between natural disasters, violence and terrorism, there have been many such events in recent years which have exposed children to extreme events, including mass violence. The technical definition of mass violence is "an intentional violent crime which causes physical and psychological injury with at least four casualties, which increase the burden of victim assistance and compensation." School shootings and mass casualty events may not necessarily be the same thing (although colloquially, they are often conflated as such). Dr. Brymer pointed out that only eight of the last 22 school shootings met the full definition of a mass casualty event. For example, there are many school shootings where, thankfully, no one is injured.

Dr. Brymer discussed some recent mass casualty events to illustrate how each event is unique and presents different challenges for recovery. Each event has the potential to change perceptions and beliefs of professionals involved in the disaster field as well. For example, after Sandy Hook, it was realized that elementary schools are not necessarily safer or immune to violent events. After Parkland, we now appreciate that students exposed to a school shooting can be fierce and effective advocates for better safety, and that this may help them heal. It is necessary for the mental health responder to know something about the community history, the unique features of each event, and relevant cultural traditions/rituals, to be able to identify those individuals at highest risk, and interventions which might be effective.

The first example discussed was the shooting at Sandy Hook Elementary School, where the perpetrator was an ex-student, during what appeared to be the most positive part of his life adjustment. He returned to where he felt comfortable to enact his violence. The doors were securely locked, but he shot off the lock. Although no one knows how this happened, since no one realized the school even had an intercom system that could even be used, this system was

accidentally turned on at the start of the attack. This exposed all the children to the horrific sounds of the violent attack, extending the trauma well beyond the affected classrooms.

In this event, the tragic loss of the Sandy Hook principal, vice principal, and school psychologist, wiped out the administrative "brain" of the school, so survivors had to cope with the loss of people they loved and with the loss of their institutional memory which helped the school function smoothly. Since children/teachers were relocated to another town while the school site was investigated, then razed to the ground and rebuilt, the school community members were "refugees," in that they could not follow their usual, convenient routine for four years. Familiar routines are helpful to children's coping with a trauma. For example, the UN supplies a "School in a Box" to refugee sites, so disaster responders can get children in shelters and refugee camps into positive, structured educational routines as soon as possible.

Another example discussed was the *Festival 91 Harvest Concert* in Las Vegas, which was unique since its impact was not confined to Las Vegas, where the attack took place. In fact, 62% of ticketholders were from California, and quickly scattered after the event, without access to organized intervention. The sheer size of this event (59 killed and 527 injured) was unprecedented. There are still so many questions unanswered about the perpetrator, which is unusual. No motive has been put forth to explain his actions, posing a challenge for assembling a coherent narrative, essential for healing. Many "first responders" in this event turned out to be taxi drivers or random passersby who were not formally trained EMTs, thus putting them at risk. Dr. Brymer noted that it is important to remember that first responders and providers have their own grief after the event, not just victims' families and survivors. Memorials and community support provide valuable support to all individuals affected in the community.

To illustrate a different type of event, the San Bernadino workplace shooting incident was also discussed. This incident occurred at a holiday party/meeting of the County Public Health Department. One of the victims' co-workers and his wife were the perpetrators; one the perpetrators being someone they had worked alongside for five years and thought they knew compounded the confusion and grief caused by the incident. The victims' County EMT co-workers were the first responders, called upon to help their colleagues. The Public Health Department's work unit moved to a temporary location while their former office was remodeled so that the perpetrator's familiar cubicle was not part of their environment as before. This physical disruption adds to the coping burden for survivors.

Dr. Brymer then presented the Five Steps for Mental Health Disaster Recovery, according to the current National Child Traumatic Stress Network (NCTSN) model, developed out their extensive experience with traumatic events.

In this model, the general approach to disaster response always starts with **Re-establishing Safety**. Besides the direct risk from the violent event, there may be new safety risks or severe adversities after the event (for example, in shelters or getting to them). Both victim/survivor

specific and community-wide safety measures are often needed. Extra law enforcement brought on to the scene must be encouraged to approach the survivors with sensitivity, as their presence may feel intrusive to some vulnerable groups. For example, after Sandy Hook, implementing a large police presence on a daily basis among elementary school age children involved thinking through how not to frighten them further. As it happened, someone donated hundreds of small rubber ducks, so these were handed out by law enforcement on site for comfort, as part of their routine function to make them less scary.

Once people are safe, **Calming Efforts** are needed. Many individuals may be shocked or acutely bereaved. Parents and teachers need information about how to help children cope. Resources and information on post-traumatic grief are often helpful. Posters and signs from "kindred spirits" who have gone through similar tragic events are often very meaningful to current survivors. This helps them feel they are not alone and there is another community which understands some of what they are going through. The Sandy Hook Community received over 500,000 letters of support, which showed them how much people cared. However, managing this logistically and respectfully was a challenge in itself. In the end, the letters were organized into a "digital library" with open access. The actual letters were then burned in a ritual, and the remains compressed into bricks, which formed the foundation of their new school.

Survivors need opportunities and interventions that help them **Build their Self-efficacy,** which may have been damaged during a sudden harmful event that left them feeling helpless. Providing resources and information so that people can make good decisions is a basic step in this process. Allowing survivors to give their input into decisions that need to be made is also important. Community town hall meetings, mourning rituals, and religious services can provide opportunities for meaningful decisions to be made by the community. These efforts also provide community recognition and validation of the seriousness of the tragedy and its aftermath. This collective healing can be very empowering, thus enhancing recovery.

Facilitating **Helpful Connections** is the next step in the recovery process. People do not heal after a traumatic event in isolation. Identifying those individuals with low social support, who may be isolated, or have special needs is critical. Being with people they love and connecting meaningfully with those who understand is the most healing environment for recovery. Social media can be helpful, but care must be taken; a strange and distressing modern phenomenon is the "truther" movement, that is, after an event, there are people communicating online who claim the event did not happen or was staged by actors, which is potentially harmful and invalidating. Survivors and their families are also usually targeted by trolls with aggressive and frightening threats. The members of the notorious Westboro Baptist Church may show up, for example to the school's graduation, to heckle survivors with hate speech. This is a new and troubling phenomenon, for which awareness and prevention may help in advising survivors and in organizing post disaster events to prevent survivors from further harm.

Finally, **Fostering Hope** is important. With acceptance that their lives are forever changed, survivors and their families must find a way to go on with the new reality. In this way forward, they benefit from memorializing their loved ones in creative ways, which add meaning to their lives and the lives of others. For example, after Sandy Hook, many parents created non-profit organizations which aim to contribute potential solutions to or prevention of school-based violence in their child's memory. *Safe and Sound Schools* is an organization devoted to safe school environmental designs run by two Sandy Hook mothers. *Dylan's Wings of Change* is dedicated to supporting children with autism, and *The Avielle Foundation* is run by two neuroscientist parents to find new information about the brain and violent behavior; both organizations are named after children who were murdered at Sandy Hook. *Love Wins: An Ana Grace Project, Jesse Lewis: Choose Love Movement* and *Sandy Hook Promise* are other organizations created in the aftermath, which augment healing for those involved and contributing, strengthening the community.

With the lessons learned from each event, the NTCSN has been working on modernizing disaster mental health response. Particularly problematic for healing post-disaster is the tendency for a "let's move on" attitude, which undermines how long grief and trauma recovery take. It is difficult to have the necessary patience in our "hurry up" culture. Profound grief and anger are difficult to sit with. Even clinicians may avoid contact with this, and seek to move on. It takes significant effort to create a cohesive, stable community over time, in which survivors can take the time they need to fully recover. Survivors must also be protected from intrusive media interviews, where they are urged to recount the event over and over again.

Many challenges remain. For mental health providers, shielding oneself from media coverage about the event is widely understood now to be essential in order to have the energy to effectively treat the survivors, but increasingly hard to do with the proliferation of media into many aspects of our life. A particular challenge is how to include the injured and/or hospitalized survivors in the community support events and grief rituals, such as memorials, when they cannot physically participate. When they recover from their injuries, they may find that the community has already moved on. A recent investigation showed that six years after the incident, the majority of the injured children never went back to school, thus missing out on the organized longer term "postvention"/recovery efforts and may be lost to follow-up. More research is needed to develop interventions which fit their needs.

A lesson learned from the school shooting in Chardon, Ohio in 2012 was that many first responders never get to learn the outcome of those they helped during the acute emergency, which can create an information gap that is hard to heal with. Sometimes rescuer/survivor reunions can be very helpful and healing. Other groups in disaster response often overlooked for trauma recovery intervention include law enforcement, members of the media, local funeral directors and any community organization which has been involved in the response in any way. NAMI has a good program available for law enforcement, *Preparing for the Unimaginable*.

The ABCs of second responder self-care during and after a disaster are
- **A**wareness (that one has been affected and how)
- **B**alance (restoring energy, rest, play and joy)
- **C**onnection (seeking out support resources and community)

Care must always be taken to restore oneself as needed when participating in disaster response.

There are a number of free online resources which can help MH providers become more informed and prepared to offer post-disaster support. The NCTSN website, NCTSN.org, is the starting place for many resources. At https://learn.nctsn.org/, there is a course and an app for Psychological First Aid, courses in Trauma Focused CBT, Psychological Recovery Skills, Traumatic Grief, and links to many other web-based resources. Some of these online courses are CE approved.

For parents, UCLA has created *Helping Kids Cope*, a parent's app which covers 8 different types of disasters and how to help kids through them. It is important to remember that notable events such as sudden evacuations, parental panic or periods of time without any power can be frightening for children, although these may be taken in stride by adults. To address this, graphically appealing children's stories about some unlucky mice who cope with various disasters have been developed. These are posted online at the NCTSN center website in various languages, including English.

Mental Health Response to the Immediate Impact of a Community Disaster: Common Challenges in Emergency Shelters

by Glenn Lipson Ph.D.

Dr. Lipson has been involved with disaster response deployment via the Red Cross in San Diego for a number of years. He discussed his extensive experience with local Red Cross Disaster shelters, which tend to be the primary sites of psychological first aid.

The work of a mental health provider in such settings is challenging; the work conditions are often harsh, uncomfortable for all, and focus on general, basic needs, rather than preferences or individual needs. Survivors in shelters may be wet, dirty, hungry, thirsty, and sleep deprived. The most basic comforts, such as being able to take a shower or maintain cleanliness are a challenge. Meeting these, however, may make a huge difference to the survivors. Simple acts of kindness that let people know that they are being helped by good people they can depend on are vital to the recovery process. A major initial focus for many survivors is to try to assemble a coherent narrative of what happened, which requires filing in information gaps and understanding the sequence of events. Very often, responders and volunteers don't yet have this information either, which can provoke a lot of frustration among survivors.

One of the biggest (and often unexpected) challenges is coping with and helping survivors cope with a high level of anger directed toward the first and second responders. This is especially true when the disaster is "manmade" rather than a natural disaster. Many mental health providers do not have experience dealing with such high levels of anger. The extreme situation can stir up complex issues that cannot be easily or quickly handled. Dr. Lipson stressed how important it can be to acknowledge that as a mental health provider, he may not have the information the survivors are seeking about the situation or the immediate solution for their needs. Mental health providers are often not briefed in the acute phase, so that first responders can focus on those directly in harm's way. Dr. Lipson reminds us that letting survivors know proactively that those on scene don't have this information, and explaining the complexity of the situation may help mitigate anger directed at second responders.

Given the high levels of confusion and uncertainty, survivors are often looking to place blame for the incident or lack of adequate/immediate resolution, which can lead to further challenges. Certain sub-groups (e.g., immigrants, Muslims) may be scapegoated as "causing" the disaster, which can then fester over the years among individuals and across communities. When an individual becomes stuck in the anger, he or she cannot move forward through recovery. Dr. Lipson referred to the work of the Buddhist monk, Thích Nhất Hạnh, in which he counseled the application of mindfulness, acceptance, and mindful processing of anger to generate calm. The reality at hand can then be investigated and good decisions made to respond effectively to the current situation. Personal or sub-group blame must be shifted to "situational" blame to promote healthy recovery.

This kind of emergency shelter work can be very meaningful and gratifying for the provider, albeit unpredictable and sometimes intense. For mental health providers, fostering compassion and promoting self-soothing, while appreciating that past trauma may be activated, is helpful.

Dr. Lipson shared the helpful acronym, *HEAL*, which stands for **H**ear (listen, validate), **E**ngage (be present in the moment), **A**ccept (no platitudes, sorrow, anger is ok), and **L**augh.

Many absurd and ridiculous situations arise in shelters, so imparting and encouraging humor and laughter can help ease tensions. Simple kindnesses and comforts, including listening to music or using art to express one's losses can also be helpful coping strategies. Dr. Lipson recounted one of his experiences working in a shelter, wherein the environment became soothing with the arrival of a musical group and the resulting respite felt by the survivors.

Dr. Lipson recommends taking courses on Psychological First Aid to gain the specific skills useful in supporting recent disaster victims. One example of a good reference for this protocol can be found in the *Field Operations Guide* developed by the VA. https://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp

There are several apps that one can download on their mobile device that can help with psychological first aid (list compiled by Wendy Tayer, Ph.D.). The following are a few examples:

1. Virtual Hope Box
2. Stress Less Cards
3. Breathe 2 Relax
4. Insight Timer
5. Help Kids Cope by the National Child Traumatic Stress Network
6. Psychological First Aid (PFA Mobile)

Extreme circumstances and traumatic loss often compel application of a spiritual perspective. Dr. Robert Jay Lifton, a psychiatrist famous for his research on the psychological causes and effects of war and political violence has coined the term, "death imprint," to describe the phenomenon of coming so close to near-fatality that the experience leaves a deep mark on the psyche. The "death imprint" may affect not only direct victims of the disaster, but also their loved ones, and the first and second responders involved in recovery. Personal meaning may vary, but there is a general sense of a changed sense of self and relationships with self and other. Grief may be a big part of this shift, since loved ones, homes, pets, and essential personal items may have been lost. Through kindness and the creation of a safe "holding environment" in which to process the event, a person must come to terms with why they experienced the traumatizing event via cognitive, emotional, and sometimes spiritual processes.

Consider, for example, a carpenter, who has lost his tools that enable him to work, ones which took a lifetime to accumulate and are not fully replaceable. The meaning of these lost tools is not just "stuff"; the impact of any loss is unique to each individual, depending on the significance, and should not be prejudged by the mental health provider involved in the recovery process. Values clarification, resulting in a change of priorities, may be a part of the "post traumatic growth" after a disaster; this process benefits the survivor over time, and can help him or her become stronger and more resilient than they were before the event.

Vicarious trauma is a real risk for secondary responders in disaster recovery, given their exposure to people's raw anger, shock, fear, and horror, as they are encountered in shelters and on scene, further amplified by the survivors' repeated recounting of their stories as they process their experiences. This risk may be further exacerbated by sleep deprivation in both survivors and responders. If responders do not process their own disaster-related trauma, they are at risk for a delayed post-traumatic emotional response and maladaptive coping behaviors such as substance use as a form of self-medication. Dr. Lipson led the audience through a guided imagery exercise, of victims in a shelter imagining gentle rain washing away the

imprint of their trauma, i.e., the sights, sounds, smells, loss. This can also be a soothing self-care activity for providers, and can be shared with other survivors.

Overall, disaster recovery work is not for the faint of heart, but can be very rewarding and meaningful. Each mental health provider has to determine his or her comfort level with traumatic exposure, assess their own recent emotional challenges, consider their own health and hardiness, the time they have to devote, and whether they can manage being away from family, pets, work, and clients, both on short notice and for varying lengths of time. It is imperative that clients of mental health providers who expect to deploy from time to time in local or national disasters be advised in their informed consent that their regular therapy may be interrupted on short notice should their providers be summoned in the wake of a disaster. As difficult as it is, the rewards of being able to make a positive impact after a disaster, and to use one's professional skills and expertise to make a significant difference in a survivor's outcome are incredibly gratifying.

Disaster Preparedness 101 (Part 1): Practical and Psychological Issues in Response Readiness for Mental Health Professionals

by Wendy Tayer, Ph.D.

Why are you interested in reading this article on Disaster Preparation? Are you simply curious? Have you had a crisis or been in a disaster which has spurred you to become better prepared? Were you inspired by watching recent media accounts of disasters in the news? Are you no longer in denial about the necessity for preparation? Whatever your reason, I thank you for taking the time to read this article and becoming more informed.

If you are not as ready as you would like to be, know that you are not alone. Data from FEMA shows that 60% of people have not practiced how to respond in a disaster at home or work in the past year. Just 39% of families have a disaster/escape plan in place. These numbers have not changed since 2007, even though 80% of people live in areas that experience extreme weather events. Why don't more people prepare for disasters?

Research data suggest that 25% of survey respondents under-prepare or do not prepare at all because of poverty and lack of information. It is hard to think far ahead if you do not understand what could happen or are just trying to survive on a day-to-day basis. Others report a belief that terrorism, disease outbreaks and hazardous materials, (commonly, HAZMAT) incidents are unlikely to occur, so no preparation is necessary. As with many other behavioral domains, self-efficacy is predictive of preparation for most types of disaster. For natural disasters, self-efficacy and a belief that *preparation will help one survive* the most severe disasters are predictors of preparation. Individuals who engage in planning and training for disaster preparation at work and school are more likely to prepare, whereas caregivers as a group are the most likely to prepare household disaster plans. People aged 18-34 years and older than 75 years, and those living in poverty are the least likely to prepare.

Besides simply not having sufficient resources or not knowing what to do exactly, the disaster preparation and planning process is fraught with thinking errors. Our minds often misfire into maladaptive thinking, especially under pressure. Some examples of common disaster-related thinking errors are:

- Normalcy Bias: "Everything will be fine."
- Magical Thinking: "I'll jinx it if I prep."
- External Locus of Control: "The government will rescue us."
- Perception of Inadequate Resources: "I don't have enough money or space to prepare."
- Inaccurate predictions of the future: "It won't happen here."
- Short Memories: "Let's build condos here (landfill where Katrina hit)."
- Misconceptions about disasters: "Water is the greatest danger in a hurricane."
- Differences in perceptions of natural vs. manmade disasters: "I can't control nature, so I'll accept whatever the weather does." (Paul Slovic, *et. al*)

Overall, denial is our most powerful defense, and this thinking error is the biggest hindrance to adequate disaster preparedness.

There is also a conflict between facts and intuition in coping with the inevitability of a disaster. Social-Cognitive scientists have studied population norms and determined several factors which may be at play. Thinking biases (arising from our tendency to commune with like-minded people) can affect group norms and behavior, working in both positive and negative directions for disaster preparation, depending on what our close associates are doing (Meyer). Individuals vary in their risk perception, in terms of how much threat they perceive in the future vs. the present, which determines behavioral choices including how much we prioritize preparation (Repeik).

In research on denial (Gorman), the role of "confirmation bias" is notable, which means that testimonials and stories we hear or read about disasters may be compelling in confirming danger and the value of preparation measures. This is necessary to counteract the false belief that risk is nonexistent or minimal. Unfortunately, much of the population does not understand probability very well, a phenomenon referred to as "temporal parochialism" (Schulz), and this hampers disaster preparedness motivation.

Understanding these cognitive barriers can guide intervention efforts to counteract them and motivate better disaster preparation. For example, PSAs to increase public awareness and basic education provided by the Red Cross and FEMA increase readiness. Community institutions such as schools, worksites, public facilities, and organizations may offer more in-depth disaster response training. The United States federal government offers annual Prepare-a-Thons to coordinate community efforts across the nation. More informally, the sharing of stories among people is another way to raise awareness and impart information.
The best time to conduct disaster preparedness training is when people are open to novelty, and not too tired or anxious, which may interfere with learning. Individuals may elect to write

about different points of view, such as why to prepare or why not to prepare, in order to explore their beliefs and expectations.

In San Diego, potential natural disasters include earthquake, fire, flash food, mudslides, tsunami, terrorist attack, gun violence, and chemical toxicity or even chemical warfare. To summarize, obtaining the facts and figures regarding local types of common disasters and what to do to prepare and respond is the first step toward preparedness. Earthquake and fire drills help familiarize people to the procedures and processes involved and to troubleshoot potential barriers. These drills also help determine escape routes in case of an emergency so that one can act quickly when the need arises. When anxiety and panic increase, it is very difficult to make good decisions and to think through everything that may be needed. Having a written or well-rehearsed plan, and following that plan can increase the odds of a good outcome.

Other practical steps for disaster readiness include preparing basic and necessary supplies, always keeping a full tank of gas in your car, a water bottle handy, and extra cash in your wallet. (These steps are detailed below.) Maintain safety measures in your vehicle, including flashlights, hazard markers, and first aid kit. Driving apps, such as *Gas Buddy* (that lets you know where the nearest station is) and *Waze* (that has the most current, GPS based road information, including alternate routes) may be useful to have loaded on your mobile phone. At home, it is important to regularly check your home appliances and smoke alarms, and maintain safety measures. Once you are well informed, then reach out and educate others in the family and workplace about good disaster preparedness strategies.

Please refer to the educational and coping Resources for Disaster Preparedness compiled by the SDPA Disaster Psychology Committee for further information.

Disaster Preparedness 101 (Part 2): How to Get Ready at Home and in Your Practice in Four Simple Steps

Interview with Deborah Hopper, Ph.D., *Chair, SDPA Disaster Psychology Committee*

Let's say you are convinced that it is a good idea to do some disaster preparedness in order to promote a good outcome and prevent undue trauma in the event of an unexpected disaster. You still need to know the specific steps you can take to prepare adequately.

We interviewed one of our local experts, Dr. Deborah Hopper, SDPA Disaster Psychology Committee Chair, to learn what she recommends.

Q: Dr. Hopper, WHO should prepare for a possible disaster?

A: *All of us*. Below is FEMA's model of the *National Emergency Management system*. At the bottom tier of the pyramid is *all* of us. We each have a responsibility to know what to do *before, during and after* a disaster event.

The Emergency Pyramid

We learned from the hurricanes and local wildfires from Fall 2017 that each of us needs to plan for our own welfare; we cannot solely rely public resources in the event of a large-scale disaster. As FEMA warns us, we know that the next emergency is coming. We just don't know *when* or *what kind* it will be**.** But we *can and must* prepare now for the next emergency. Our family, friends and community depend on it. For mental health professionals, there are particular considerations unique to being a psychotherapist as far as planning for safe evacuation, communication, boundary clarification, and advance planning for special populations, so that client's needs and treatment considerations can be addressed during the disaster, which we can discuss at the end of the interview.

Q: WHY should we prepare for an unexpected disaster?
A: The most personal reason to prepare is in line with how disaster mental health responders are trained. The first principle is: Each of us MUST make it a priority to practice taking adequate care of ourselves and our families, first. This is akin to putting the oxygen mask first on yourself in the event of a loss of cabin pressure when flying. We do that so if we choose to help others who are impacted, we aren't *risking our own well-being*. This is a basic principle of self-care.

***Q:* Are there real outcome benefits to being prepared for a disaster in advance?**
A: Being prepared reduces fear and anxiety, and increases the odds of a better outcome. In contrast, if we don't plan ahead, and *practice* our plans, when a disaster happens, it is more likely that our *"Fight-Flight-Freeze"* instincts will be calling the shots. For example, in fires, which are unusual events, people tend to get overwhelmed by the fire with its smoke, heat, and destruction, and often respond with panic. Panic can impair judgment and cognitive flexibility, which can result in the failure to problem-solve or make good decisions. This is an unfortunate but common reaction that can increase the probability of getting injured.

According to FEMA, "With advance preparation, i.e., plans and drills, individuals, families and communities will fare better. They will know what to do before and during an earthquake, where to seek shelter during a fire, or how to get to higher ground if there's a tsunami. They will be ready to evacuate their homes and take refuge in public shelters and

know how to care for their own basic medical needs. People can even avoid danger completely".

Being able to avoid danger is the ideal solution to minimize injury and trauma and cannot be left to chance. As Dr. Tayer discussed in her article, understanding our cognitive limitations in emergency situations, i.e., how hard it is to calmly and effectively problem solve when the body's "emergency reaction" is triggered, helps us to make better plans and appreciate that we do need to actually *use* our plans. In an emergency, we may not be thinking clearly or we may unexpectedly freeze, so a familiar plan, well thought out in advance and practiced, can provide the template for strategic action to attain safety as quickly as possible. This advance planning is well worth the time and effort.

***Q:* If the need to prepare for a disaster is real and beneficial, how are we doing in motivating community members to do so?**

A: People are starting to appreciate the importance of Disaster Preparation. Preparedness is actually on the rise: 90% of people have taken *at least one* action, the most common being to stock supplies. 46% have taken three actions, like also attending a community meeting and participating in a drill. 75% of survey households had supplies, and 50% had emergency plans. It is up to each and every one of us to join them if we haven't done so already.

***Q:* What are the basic steps to preparing for a disaster in the home setting?**

A: There are four basic steps to your disaster emergency plan: (1) be informed, (2) make your plan, (3) build a kit, and (4) get involved in the community. For overall information, the Ready.gov website has FEMA's resources: lists, plans by type of disaster, and more that can help you create and enhance your emergency plan.

Step 1: BE INFORMED

Before any disaster happens, you need to know *how you'll receive advance warning*. Please refer to the list of Resources compiled by the SDPA Disaster Psychology Committee for a list of disaster apps and websites.

For myself, I set up the FEMA app to receive any alerts for San Diego County on my cell phone to stay informed. You can use local San Diego radio stations, KOGO AM 600 and KSON FM 103.7 for emergency warnings. I have a portable crank radio at home that does not require electrical or battery power, so can be long lasting when information updates are needed. In the "go-bag" in my car, I have a hand-held version of this radio. This way I can stay informed as the disaster evolves. I will be able to know what is happening and to have the information I need to take the best actions to keep myself and my family safe. I will also know where help may be needed from me so I can play a positive community role in the disaster.

Step 2: MAKE A PLAN: Develop a household emergency plan and discuss it with household members.

Assess your personal/family's needs. *Having a personal plan is important.* There are many components to the personal plan, so I will briefly mention each one: (1) family communication, (2) escape routes, (3) evacuation, (4) special needs preparation, (5) animal needs, and (6) vital documents and records. For more information, you may wish to consult www.ready.gov, where you can find worksheets that can help you address all the necessary details for your own circumstances in each of these areas. You also may want to consider making some "up-front" decisions, such as deciding whether you need earthquake or flood insurance or adequate home/rental insurance coverage.

Here are the basics of each Personal Emergency Plan component:

(1) FAMILY AND WORK COMMUNICATIONS:
This is an *essential* component of your personal and family disaster plan. I recommend using FEMA's version, which is a worksheet to complete with your family. This guides you through the many aspects of emergency family communication which must be considered and may not be obvious. This "before, during, and after" disaster communications map will be invaluable to you and your family members, since the biggest concern during a disaster is to locate and ascertain the safety of one's family members, many of whom will be separated when the disaster occurs. For example, since local communication infrastructure may be lacking in a disaster, the family communication plan typically includes designated out of state contact persons who can serve as a family clearinghouse for messages.

(2) ESCAPE ROUTES:
Part of your plan should include escape routes *within* your home and office. You also need to consider escape routes for each member of your family based on their routines, and regularly practice drills using them. Depending on your work setting, you must be familiar with emergency exits, etc., so that you can safely evacuate staff and patients. Point out the safety exits to patients as part of the preparation process. Consider whether you need to do practice drills with your staff or patients. One important reason to drill: every time I have participated in a simulated drill, I have learned at least one important new thing to apply going forward.

(3) EVACUATION PLAN:
In addition to exiting from your home or workplace, plan *evacuation routes* for when you need to leave the immediate area and beyond. Know routes and alternate routes away from danger. It is important to have paper maps as back-ups in the event cell towers fail.

In case of evacuation from your office, would you want to have asked your patients to be prepared in advance if a disaster happens while they're with you? If a patient takes public transportation to their appointment with you, will you evacuate them with you if needed?

(4) PREPARING FOR SPECIAL NEEDS:
Research tells us those with special needs are especially impacted by disaster; fortunately, caregivers are one of the groups that typically prepares in advance. As part of your personal disaster plan, you will need to include supplies, transportation, medical equipment, etc., tailored to you and your family member's individual needs.

In your office setting, does the population you treat warrant additional consideration of issues (transportation, medications, electrical power generation etc.) related to staying safe in a disaster?

(5) CARING FOR ANIMALS:
Many of us couldn't leave our pets to fend for themselves in a disaster, and we ourselves might not evacuate as a result. Thus, we need to take necessary steps to have the supplies and arrangements they need ready in advance depending on the size and type of household pet, including horses and birds. We can further ensure our pet's safety plan if we have a copy of their medical records with us.

(6) VITAL RECORDS AND DOCUMENTS:
This includes health insurance cards, medical records, legal documents – where are they stored? Where are they backed-up? Are copies or a thumb drive ready to grab and take with you? FEMA's survey indicated on average 65% of us tend to safeguard our documents, which is a good start. After the wildfires last Fall, I heard a radio call-in show where one woman explained it took her two years to deal with insurance companies, etc. after losing her home in a wildfire and trying to rebuild. Having access to the necessary documents may speed this process up.

Step 3: CREATE A DISASTER SUPPLY KIT

Basic Home Disaster Supplies Kits: When preparing for an emergency situation, it is best to think first about the basics of survival: fresh water, food, clean air, and warmth. In addition, this may mean providing for your own shelter, first aid, and sanitation. You should be ready to be self-sufficient for at least three days. YouTube has many public service videos that educate you on what to pack for a disaster. A great example of one of these can be found at https://www.youtube.com/watch?v=lkr93WBEiaM. The basic disaster supplies kit is your first building block – it can be duplicated for each family member, and kept in several or all the appropriate locations, such as home, work, car, or school. Don't forget to include kits for your pets.

The Disaster "Go-Bag": You cannot predict where you will be when disaster occurs. The "go bag" includes the "basic" supplies kit, plus other essential items that your family may need such as prescription medicine, medical supplies, diapers, or spare contact lenses. You also want some cash in small bills.

Other Useful Items: Consider additional items necessary for immediate safety— an accessible flashlight, shoes by your bedside in case you need to evacuate during an earthquake to protect your feet from broken glass, and in your car, and sturdy walking shoes, in case you have to evacuate quickly while traveling.

Your Disaster Storage System: After the building blocks of your BASIC three-day disaster kit and "go-bag," the storage system is a larger kit which adds essential comfort items, such as bedding, additional clothing, toiletries, towels, fuel and light, can opener, dishpan, dishes, etc. You can find lists for these contents at www.READY.gov. Note that several smaller containers (instead of one large one) can be more portable in the event of an evacuation.
If you don't have time to assemble your own kits, and you have the money, you can buy ready-made kits online. In addition to the Red Cross store, there are many vendors, e.g., Costco, Walmart, Amazon, and "Prepper" sites that sell supplies that can last for longer periods of time. Disaster kits, whether homemade or commercial make great gifts for family members and friends.

Step 4: GET MORE INVOLVED IN THE COMMUNITY

As we have discussed, the first step for disaster preparation is completing your own personal preparedness plans at home and work, so that you can take care of yourself, your family, and your clients as appropriate. After addressing your own needs, consider becoming a volunteer. The community needs more trained and prepared volunteers to assist promptly during disasters. Consider this article as a "Call to Action" to get involved in making a difference in your community! Remember that clinicians cannot "self-deploy" to disaster responses, so if you'd like to be able to, consider volunteering with one of the agencies today.

If your time is limited, know that without needing to become an official disaster mental health volunteer, you can take basic life support classes from the American Red Cross or attend CERT community classes to learn important safety steps. You can also watch online videos put out by FEMA and other disaster preparedness resources on YouTube to educate yourself.

Please refer to the document entitled *Choice Points for Disaster Mental Health Volunteering* put together by the SDPA Disaster Psychology Committee to learn about local agencies that have various volunteer roles and training opportunities for mental health professionals. This resource list compares the various organizations so that you can choose one that fits your skills and time availability**.**

***Q:* Dr. Hopper, are there additional, specialized office/work setting considerations when thinking through one's Disaster Plan which practicing mental health professionals need to consider?**

A: Yes, if your personal plans are ready and you have basic supplies for up to 72 hours for yourself and your family, what about your offices? Do you have any office staff? Do you discuss preparedness with them? Will you plan for contingencies if they resulted in any patient(s) who might be "trapped" with you? How extensive will your plan be? This must all be thought through.

It is important to think about communication issues you may expect in regard to your work context. Important considerations for mental professionals include: How will you contact patients during a disaster event? After the event, will you continue "business as usual" as much as possible? Go on hiatus as needed? Will you discuss with patients what steps you or they will take to reconnect after a disaster? Do you have a patient list for yourself, or someone else, e.g., your biller, a colleague, etc., to contact your patients if you aren't able to?

Besides having back-up virtual storage of your professional records (there are encrypted records storage options that are HIPPA compliant, such as Carbonite) how will you plan for the physical security of your patient's records in your office, for example, in an earthquake, if the building is damaged? Can you? For further information, the Red Cross holds an annual Business Continuity course here in San Diego.

Q: **Is it our job as mental health professionals to teach disaster preparation to our clients as part of risk reduction for post disaster injury, hardship, and trauma?**

A: Each of us needs to come up with our own answer to this, depending on the nature of our practices or work setting. I suggest taking some time to consider the issue, and decide how you personally prefer to handle it. Thus, you've at least given the matter some thought, considered the ramifications, and would have some comfort with your decision.

The American Psychological Association began a Resilience Campaign after 9/11, and asked psychologists to take resilience training into their communities. So there's some precedence *in the community setting* for this. But that isn't private practice, which is why we need to weigh this for ourselves, since circumstances and appropriate actions will vary.

If you work with a special population, such as patients with a history of heart disease or stroke, you may want to make sure that your clients are well informed and prepared to cope with a disaster since their survival may depend on it. Also to consider, is a thorough assessment of patients' anxiety, given its propensity to hinder the effective advance preparation for a potential disaster.

Based on your preferred approach, you can assemble the appropriate educational or other materials you think you might need. The list of educational and coping RESOURCES compiled by the SDPA Disaster Psychology Committee mentions two APA websites, where you can retrieve handouts for specific types of disasters, both natural and man-made, and in

some cases grouped by school age, for work with individuals and families. The mobile apps listed are particularly useful, on-the-go resources that utilize different coping strategies for disaster recovery.

Q: **What are the psychotherapeutic implications of including disaster preparation as part of your usual practice as a psychologist?**

A: Again, I think this is to be determined by each of us on a personal basis. Dr. Tayer and I recommend several possible approaches: psychoeducation, modeling, demonstrating a "go bag," discussions about the benefits of preparedness versus consequences of failing to prepare, or recounting disaster preparedness anecdotes, depending on the population you work with and your therapeutic approach.

The key is to mull over the subject of disaster preparedness *in advance of* a disaster, where you can consider the ramifications for each of your clients and your practice as a whole, and reflect upon what course of action you feel would be for your patients.

Q: **What do you suggest for people like me who are busy professionals with many responsibilities and limited time? Where should I start and how I can keep from letting anxiety and overwhelm stop me from taking needed action steps?**

A: Give yourself the gift of time; plan to develop your own preparedness plan over several months. Prioritize what you need to do first. A simple first step is going to www.Ready.gov and getting a premade list of what to buy so you have three days' supply of essentials. Set aside one day or half-day a month to take that step, and additional days over time for subsequent steps (your family preparedness plan and its separate components as described above; assembling a "go bag" for yourself in your car, and so forth. Do what we suggest to our patients, i.e., "chunk," thus breaking down the larger goal into smaller, doable parts. Acknowledge the progress made, and if there's a setback (a missed opportunity to do a piece), reschedule it and keep going. You'll hopefully feel a sense of accomplishment that will be reassuring as you make progress. If you need motivation, find a FEMA or other video to watch that reminds you why what you're doing is important. In addition, if social interaction motivates you, consider joining CERT in your area. You'll learn the basics quickly and meet neighbors who are interested in helping neighbors. If you want to go above the personal level, stay with CERT as a volunteer or consider the Red Cross. You'll be reminded of the necessity of preparation by engaging with them.