Acute Crisis Intervention with Pediatric Victims and Their Families During a Mass Casualty Event

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by Peter Sternberg, L.C.S.W. 2/15/2005, updated and revised 5/30/2011

Introduction

Preparation for mass casualty/bioterrorist situations occupies a considerable amount of time and attention of emergency planners, government organizations, first responders and hospital personnel. A mass casualty disaster will strain the resources of EMS, HEICS, the hospital staff. Chaos and fear will affect victims, families and care providers alike. This paper, combined with its companion paper entitled "Practical Considerations for Management of Pediatric Victims during Hazmat Decontamination" proposes a comprehensive approach to caring for children and their families who are in the midst of a disaster (18). A review of the literature, pertinent web sites and interviews with planners reveals that there has been little discussion and virtually no protocols established for crisis intervention with pediatric victims *during* the mass casualty situation. There is every reason to believe that with support, training and practice, care providers can reduce the level and intensity of damaging psychological sequelae and nosocomial trauma of a mass casualty event through effective crisis intervention. This paper is an attempt to examine the emotional needs of pediatric victims, family members and hospital staff *during* a mass casualty situation and proposes protocols and interventions.

Assumptions

It is not the intent of this proposal to define terms and situations that have been explored elsewhere. A mass casualty event, whether man made or naturally occurring is an event where many people are, or believe themselves to be victims and consequently, become patients. The focus of this proposal is to look at the experience of the pediatric victim and the family from the moment of the victimizing event through the discharge from the hospital. As a part of this focus, attention will be paid to preparation and training for professionals. What is not explored here

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because it has been the subject of much research and training, is dealing with the *post-traumatic* experience including critical incident debriefing.

Obviously in any disaster, physical first aid is the priority. An unfortunate byproduct of appropriate and necessary first aid and treatment can be "nosocomial trauma." We see this when pediatric patients must be separated from their parents, when they must endure painful examination or tests and when they are waiting. The driving assumption and focus of this proposal is that the child victim's experience can be made more or less: painful, traumatic or harmful based on how he is dealt with during care and while awaiting care. This paper will look at *emotional* first aid while the pediatric patient goes through triage, tests, wait time and treatment. (Please note: some of the considerations proposed here may have applicability to adults and have applicability to situations other than mass casualty.)

A mass casualty event, particularly a bioterrorist event that affects children, is one of the most horrifying situations to contemplate. It is an utter assault on our emotions, imaginations, our bodies, our organizing views of the world and our spirits. Realistic visions of mass pediatric casualties overwhelm our every sense and overwhelm us *in* every sense. This is true regardless of one's role: healthcare provider, parent, teacher, EMS, government planner, etc.

Most of us correctly shield ourselves from unlikely horrifying situations by relying on the "unlikeliness" of the event taken with the notion that the thinking and planning we have already done will be sufficient if "the moment of truth" ever arrives. Bolstering our sense of "unlikeliness," is our shared experience of already having our tangible, financial, mental, physical and emotional resources near exhaustion. Most of us who would be expected to respond to a pediatric mass casualty disaster are already at capacity with the demands of our everyday professional lives.

This "shielding" we do is a paradox: on the one hand it impairs our vision and preparedness – on the other hand it is a *necessity*. As Ernest Becker eloquently argues in his landmark work *The Denial of Death*, without a denial of death (and associated horrors) we humans would simply be too overwhelmed to function in everyday life (3). Without denial, a constant awareness of our fragility would intrude into our thinking, planning and capacity to have meaningful relationships. Simply put, Becker asserts, our anxiety level would be too high.

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From that perspective, our efforts to shield ourselves are both natural and healthy. This ubiquitous "shielding" coupled with our belief that we "are ready" plus the very reasonable thought that "mass casualty events are highly uncommon," permit and encourage us to not fully contemplate the horrific.

A contention of this paper is that natural and healthy shielding permits and encourages us to avoid fully planning and preparing for the horrific – and this is most notable when the horrific involves children. One wonders if the paucity of information noted in the Literature Review below is a reflection of this notion. This paper contains a further discussion of the phenomena of "shielding" along with protocols for, and suggestions of, specific crisis intervention language. Attention and planning in these areas can help professionals: effectively and efficiently render physical first aid, minimize emotional traumatic sequelae for their patients and more effectively handle personally traumatizing affect in horrific circumstances.

Literature Review

In an effort to fully explore the literature, my colleagues and I looked beyond mass casualty preparation to the topic of responding to children during an acute crisis. Some of the government agency web sites we explored were: Substance Abuse and Mental Health Services Administration, Center for Disease Control, American Academy of Pediatrics, National Institute of Mental Health, National Center for Children Exposed to Violence. Local fire departments, hospitals and schools were contacted and interviewed to ascertain what others were doing. The State of Illinois Emergency Response Team for Pediatrics was consulted, as were private hazmat training professionals.

One might start with the question: "*Why would acute crisis intervention be a useful tool for increasing efficiency in rendering first aid to mass casualty pediatric victims?*" This question is the subject of "Practical Considerations for Management of Pediatric Victims during Hazmat Decontamination" (18). Briefly summarized: any planning, organization and practice coordinated among all of agencies and responders would minimize the level of chaos, misunderstanding and miscommunication that is endemic in such an event. Chaos, misunderstanding and miscommunication will delay pediatric victims (even more than their

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adult counterparts) from getting treatment - thereby increasing the severity and number of casualties.

The next question might be: "*Why would we think acute crisis intervention is a useful or meaningful tool for minimizing the psychological harm of a mass casualty event?*" Jessica Hamblen, PhD, wrote "A National Center for PTSD Fact Sheet" regarding PTSD in Children and Adolescents for the National Center for PTSD, Department of Veterans Affairs (8). She explores the risk factors for PTSD and says: "there are three factors which have been shown to increase the likelihood that children will develop PTSD… the severity of the trauma, the parental reaction to the trauma and the physical proximity to the traumatic event." An inadequate or chaotic response on the part of treating personnel to an influx of pediatric victims and their families certainly involves those three factors. *The severity of the trauma* is at once out of the hands of the responders yet very much affected by what the responders do after the initial event. The victim's *perception* of the event, her level of fear, her capacity to cooperate with treatment and her experience of comfort and care are very much subject to the how responders treat her. Secondly, *the parental reaction to the trauma* is quite effected by the way responders deal with both parents and pediatric victims. How quickly information is available, how skillfully bereft parents are calmed, directed, educated and comforted can greatly mitigate what the parent and the child ultimately experience. The parent's internal state (the one we can mitigate) then becomes the second factor for how the child reacts and adjusts to the event. Finally, *physical proximity to the event* is relevant to us as responders as our preparedness and practice answers the question: "*Has the victim been brought from the traumatic scene to a place of safety and care or has the victim been brought to a place where his trauma continues?*" (To appreciate this point, consider the scenarios of decontamination described later in this paper.) I think the answer to the question is, yes, acute crisis intervention can be useful and meaningful in minimizing the likelihood of PTSD in children and adolescents by virtue of understanding the risk factors Dr. Hamblen describes. We can go further and think about **trauma on top of trauma or "nosocomial trauma," if the reactions of the responders are inadequate or chaotic and actually increase the physical and emotional devastation of the original event**.

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Psychological interventions with children in a mass casualty situation have been addressed in the literature under a number of different headings. Many esteemed professionals have written articles dealing with Terrorism, Bioterrorism, Crisis, Disasters and Mass Casualties, e.g.: “Trauma and disaster” by Ursano, Fullerton and McCaughey (19), “Disaster Psychiatry: Principles and Practice” by Norwood, Ursano and Fullerton (12), “Facing war, terrorism and disaster: toward a child-oriented comprehensive emergency care system” by Laor, Wolmer, Spirman, and Wiener (9) and “Psychosocial Consequences of Disasters – Prevention and Management” by the World Health Organization (20) to name just a few. Some offer excellent guidance for physical intervention with children, e.g.: “Bioterrorism” by Cieslak and Henretig in Pediatric Annals, March 2003 who explore under the heading “Are Certain of the Problems Unique to Pediatrics?” the fact that children have “unique anatomical, physiological, immunological and developmental considerations that potentially affect their vulnerability to biological agents” (5).

The American Academy of Pediatrics in the March 2000 Clinical Report “Chemical-Biological Terrorism and Its Impact on Children: A Subject Review” under the heading of “Special Vulnerabilities in Children” looks closely at the issues of how children might experience certain agents, how they might experience the HAZMAT situation, and how those who will be responding and caring for them need to prepare (1). An example of the preparation is: “Because children spend the majority of their day in school, community preparation for the chemical-biological threat should include the local education system. Schools may also become a necessary site for triage and treatment of pediatric casualties, requiring community planning include this possibility” (1). Again the post-incident situation is addressed, e.g.: “Pediatricians have an essential role in responding to psychosocial sequelae of a chemical-biological incident” (1). Missing from the “Recommendations” section are comments about psychosocial intervention with children during the crisis. The AAP’s monograph on it’s web site titled: “The Youngest Victims: Disaster Preparedness to Meet Children’s Needs” also overlooks this need (2).

Dr. Daniel Schonfeld writing in the Pediatric Annals of March 2003 addresses “Supporting Children after Terrorist Events – Potential Roles for Pediatricians” 14). He makes

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the case for addressing the emotional impact of terror events and that pediatricians are well positioned to identify reactions and to educate patients and parents. Dr. Schonfeld believes the pediatrician is able to make interventions and referrals when needed. He goes into the signs and symptoms of children's reactions: fears, sleep problems, regression, physical complaints, depression, pessimism and the PTSD constellation (re-experiencing, numbing, decreased interest, avoidance, increased arousal, hypervigilance, decreased concentration, irritability and anger). Dr. Schonfeld further identifies the grief/ bereavement issues facing survivors including the loss of the "assumptive world" (14).

A discussion of how victims might experience various agents is addressed by Dr. Cleto DiGiovanni, Jr. in "Domestic Terrorism with Chemical or Biological Agents: Psychiatric Aspects" (6). Dr. DiGiovanni discusses the need for psychiatric triage to differentiate "anxiety, fear, panic, somatization and grief from agent-induced alterations." He catalogues the effects of chemical and biological agents on mental status including changes in response to common drugs used for treatment. Dr. DiGiovanni urges psychiatrists to become involved in their hospital's disaster response plan to "ensure that the mental health component is more than token." He believes that psychiatrists will need to function as consultants and should be familiar with the effects of and the treatment for the chemical and biological agents that may be used in a terror incident (6). Dr. DiGiovanni does not address agents and treatments affecting children differently than adults. Most notably: there is less information available on treatment dosing for children and children are more susceptible to damage from lower dosages/exposure to toxins due to smaller bodies.

Most of the clinical, academic and governmental agency literature address the considerable psychological damage victims – specifically children, can experience going through a disaster. A very useful component of this focus is alerting clinicians, parents and educators on how children are different than adults in their presentation of signs and symptoms of post traumatic syndrome, and offering practical suggestions for intervention, e.g.: "After a Disaster: A Guide for Parents and Teachers" from SAMHSA's National Mental Health Information Center 18). On *The Child Advocate* web disaster page is a monograph titled "Disaster help for parents and children" which begins to address how to intervene with children *during* the crisis (4). The

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heading: "Listen to the Children Interview" identifies seven "where, what, when and how" questions to ask the child victim. In the heading "Dealing with Children's Reactions" direction is given about providing comfort. In the section titled "Trauma Intervention" the following four points are made: 1) "protect children from the excitement of onlookers (media), 2) reunite children with parents immediately, 3) coordinate with other caregivers, 4) support parents in dealing with events." There is a potentially very useful section on "Pain and Fear Management" for professionals to use covering: "distraction, guided imagery, suggestion, thought stopping, self-instruction and relaxation" (4).

What seems to be missing from the literature, hospitals' disaster planning, and hazmat training is a frank rendering of the demands of pediatric mass casualty for: effective crisis intervention with children, crisis intervention with their families and crisis intervention with "emotionally flooded" staff.

What Might a Mass Casualty Situation Involving Children Look Like?

To understand the emotional needs of pediatric victims and their families in a mass casualty event we need to consider some of the ways the event could involve children. Here are some views of mass casualty situations:

- an influx of obviously physically injured patients
- an influx of patients suffering the effects of exposure to chemical agent or radiation
- an influx of patients suffering the effects of exposure to a non-infectious biological agent
- an influx of patients suffering the effects of exposure to an infectious biological agent
- an influx of patients that taxes and overwhelms hospitals and resources in a region.

Here are some factors that exacerbate the situation:

- the victims are primarily children (children and adolescents)
- the victims were exposed to a hazardous material requiring decontamination either because the victims are not being brought to the hospital by first responders or, because the hospital can not trust that each and every victim they are receiving has been adequately decontaminated in the field
- the pediatric victims are not with their parents at the time of exposure/assault

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- the hospital must be on lock-down to prevent being breeched with contaminants
- the hospital must control the access that the pediatric victims have to their families or other adults they know (teachers)
- holding and then decontaminating children in rain, snow, dark or cold
- not all the patients from the disaster have gone to the same hospital.

Having now "set the stage," the next sections of the paper address ways of doing Acute Traumatic Crisis Intervention.

Helping a Frightened Child Who is Separated From His Parent

What does the child (or adult) patient need to see and hear while awaiting treatment or waiting for HAZMAT processing into the hospital? There are two situations to address: in the first, the event is clear and physical injuries are present (bomb blast, nerve agent, etc). In the second, the child is not experiencing physical pain or symptoms. The child is frightened and knows something is quite wrong, but has a limited understanding of her situation. In my role of *Psychological Services and Mental Health Unit Leader* in the *Human Services Arm* of HEICS while at Rush North Shore Medical Center in Skokie, IL, I participated in disaster drills. I was able to experience and observe first hand what happens to professionals when they are exposed to chaos, adrenaline, inadequate or incomplete communication, and overwhelming demands. Staff became overwhelmed, fearful, defensive, narrow in focus and angry – and this was a drill!

In an actual mass casualty event, as a staff, we will be dealing with victims who are terribly frightened, quite possibly in pain or ill, confused, overwhelmed and probably feeling desperate. Our child patients may be going through this without their primary support system and will have the further destabilizing influence of group hysteria. *It is vital that the pediatric patient immediately experience an adult who:*

- *is in charge,*
- *is informed,*
- *is reassuring,*
- *is caring,*

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- *is able to explain why the patient is having this experience,*
- *is able to explain the process they will be experiencing and*
- *is able to explain when their world will be upright again.*

Communicating With a Child or Adult Who Requires Decontamination

Consider how demanding the decontamination process is when *everything goes this unrealistically smoothly*: two adults, who speak English, are waiting patiently for their turn to take instruction from someone wearing frightening garb, who cannot hear them very well and who cannot speak to them clearly. They are waiting to take their turn to strip down, let go of clothing, wallets and jewelry, scrub in front of, or be scrubbed by other people dressed in frightening garb. Only then are they let into the hospital where they encounter "regular" hospital staff.

Now consider the following scenario: a HAZMAT event is taking place that affects a community including a school. The hospitals in the region are put on notice. They are on lockdown to prevent being breeched by contaminated patients and hysterical family members. Since the hospital cannot assume that all of the patients they are receiving have been adequately decontaminated in the field and they know for a fact that some patients have not been brought in by EMS, they must do their own decontamination. The victim group is made up of children and adults. Not everyone speaks English. The police (who must remain a safe distance from everyone) have set up a perimeter. Parents arrive and see their children in the group awaiting decontamination. The police have been trained to keep the decontaminated victims sequestered until they can be processed. Hospital staff in HAZMAT gear are unable to adequately hear or speak to anyone. As the chaos grows, hospital decon staff become increasingly stressed, decreasing their effectiveness and the amount of time they can remain suited. Non-decon staff are also under pressure to respond to increasing chaos as the hospital is besieged with overwrought family members.

Without going further into the scene, the breakdown is obvious. I refer the reader to the companion paper to this one entitled "Practical Considerations for Management of Pediatric Victims during Hazmat Decontamination" for a discussion of the victim management issues in

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the scenario (18). Clearly, in order to avoid a chaotic and potentially tragic breakdown in a HAZMAT situation involving children, a victim management plan and crisis intervention must be available. All patients, but particularly pediatric patients, need to encounter an adult who is in charge, who can communicate effectively, who manages the environment and addresses the child's total experience – *especially if the child's cooperation is needed* while they are waiting to be decontaminated.

What follows is a discussion of emotional, mental and behavioral stability *during* a traumatic event. This is a cross-disciplinary piece relevant for any health care provider or responder.

As care providers, our purpose is to help restore the patient's emotional/ mental/ behavioral stability while they are in the midst of a crisis. ("Patient" in this case refers not only to the pediatric victim but his family as well.) We cannot undo the damage the patient is experiencing, but we can attempt to ameliorate it and not contribute to it. Therefore, in a crisis, a realistic objective of intervention is not for the patient to be "fine" but rather for the patient to: a) better withstand the *extreme demands* of the situation and b) minimize ongoing psychological damage. The components of this type of intervention are now discussed.

Emotional Presence

First and foremost, emotional presence is the foundation of any other intervention and attempt to elicit cooperation, comfort and minimize harm. Emotional presence can be thought of as the clinician's willingness to sense, intuit, feel and know what the other person is experiencing because the clinician's senses, feelings and knowledge are focused upon and open to the person at that moment.

> The following excerpted material illustrates emotional presence. In Advanced Techniques of Hypnosis and Therapy - the Selected Papers of Milton Erickson, M.D., Dr. Erickson describes a pediatric intervention on his own son who had just sustained a serious facial injury (7). In the paper "Pediatric Hypnotherapy", Dr. Erickson illustrates the importance *of "joining with the patient" by confirming their experience* (7). Dr. Erickson writes about coming upon his injured son: "'…that hurts awful

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> Robert, that hurts terrible.' Right then and there, without any doubt, my son knew that I knew what I was talking about. He could agree with me and he knew that I was agreeing completely with him. Therefore he could listen respectfully to me, because I had demonstrated that I understood the situation fully. … [T]here is no more important problem than so speaking to the patient that he can agree with you and respect your intelligent grasp of the situation as judged by him in terms of his own understandings. …Then I told Robert, 'And it will keep right on hurting.' In this simple statement, I named his own fear …as he took another breath (I said), 'And you really wish it would stop hurting.'…this was *his* wish…with the situation so defined, I could offer a suggestion with some certainty of its acceptance… 'Maybe it will stop hurting in a little while, in just a minute or two'" (7).

How are we to integrate Dr. Erickson's approach? The context we are working within is that the patient is in the midst of a crisis and we likely have many patients requiring help. Any of our encounters with a pediatric patient or her family offers an opportunity to "join with the patient" whether we are trying to manage a crowd of victims awaiting decontamination, guiding a victim through decontamination, doing triage and first aid or meeting and guiding family members trying to find their loved ones. As Dr. Erickson demonstrates, this is not an approach that requires much time, rather it has to do with the sensitivity and focus the clinician uses as they proceed with treatment. If hospital staff are trained to *confirm the patient's experience*, they needn't find it a distraction from their "appointed rounds," but rather a tool to be more efficient with any clinical goal they are pursuing.

There is a downside. When staff emotionally connect with their patients, they are subjected to the emotional toll of feeling *with* and *for* those patients. Since the emotional toll of caring and connecting in healthcare is well discussed in the professional literature under headings like; emotional stress of healthcare workers, burnout in caregivers and secondary traumatic stress disorder, I will not explore it here. For the purposes of this paper, the emotional toll of connecting with victims of a mass casualty event has to do with being subjected to and asked to respond to: very out of the ordinary injury, very out of the ordinary numbers and the personal and collective experience of terror (fear for one's own safety and

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the safety of loved ones).

What is required for caregivers to be emotionally present in the midst of a mass casualty event? **They require the support of other's emotional presence for them!** At minimum, this means that thought is given to the staff's circumstances and efforts are made to perceive and respond to their needs.

Prior to ever experiencing a horrific event, support comes in the form of adequate training. Adequate training may resemble "Stress Inoculation Training" developed by Donald Meichenbaum, PhD. that has the components of Education, Rehearsal and Implementation (12). In the "education" phase, the clinician would participate with a trainer to develop a view of the stressors along with a view of how the clinician tends to experience stress. The "rehearsal" phase is the development and enhancement of coping skills. The last phase is "implementation" in which the clinician gets to practice stress reduction and management in simulated stressful situations (another benefit of drills). The anticipated result of a program like this is, the clinician is better prepared to face and function in a horrific event and suffers fewer and more treatable signs and symptoms of Traumatic Stress themselves. Another benefit is: doing this training as a group promotes teambuilding – a potentially very useful support tool noted below.

During the mass casualty event support comes in the form of three types of backup: a) having adequate numbers of staff to rotate in and out of action and b) a fully trained and operational Staff Support Services section of the Human Services Arm of HEICS who will be able to assess staff and provide emotional and physical support as needed (14). The third type of backup is teambuilding - an outgrowth of staff going through training and drills as a group. Clinicians who feel a part of a team will likely feel less isolated. A sense of "sharing the event" can help to disperse the stress of answering highly unusual professional demands. To reiterate the point, asking hospital staff to respond to a mass casualty event – particularly one that involves children, without planning, practice, "stress inoculation", teambuilding and adequate backup will likely produce frustration, misdirection, misunderstanding, mistakes and chaos. This constitutes "nosocomial harm" to the hospital staff.

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Information and Reassurance

Pediatric victims and their families need information. Children need to be told something of what has happened to them and what will be happening. If they are not with their parents, they need to be told that their parents are being contacted. Parents may come to a hospital but be kept from their children. Those parents need to be informed of their child's status and the process the child is going through including when they can be reunited. The parent may come to a facility and not be able to find their child – this being more problematic when victims of an event are taken to more than one hospital. Intra and inter-hospital communication will be vital in order to provide the information that will help quell the hysteria of parents who cannot find their children.

Children need reassurance. Keep in mind that there is great variation for reassurance depending on: the age of the child, the circumstances of their victimization, the presence of family or the presence of another known and trusted adult. What follows are some approaches to providing reassurance:

a) Since children are highly influenced by the emotional state of their caregivers – it is important to convey calm and security.
b) For caregivers who are familiar with using:
    - distraction, e.g.: "do you have brothers and sisters?" "what are your interests?"
    - guided imagery, e.g.: "you know that activity you were just telling me about (sports, dance, music, etc) – what's it like when you are: on the field, in the dance studio, playing your instrument, etc."
    - suggestion, e.g.: "you'll probably feel tired as soon as you feel less scared. It's OK to rest."
    - thought interruption, e.g.: "let's focus on "x" (mention something related to what is happening that is different than what the patient is on) right now."
    - relaxation through deeper breathing and progressive tensing and releasing of muscles,

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These techniques can be very helpful with children and adults. Please note that none of these techniques is suggested to replace taking the time and effort to *attune* to the patient.

c) if the child experienced a specific “event” reassure the child that the “event” is now over
d) repeat to the child that he is with caring, helpful people at a local hospital
e) tell the child what you are doing and help other caregivers do the same
f) periodically reassure the child that she is safe and will be well cared for
g) encourage talking: listen to the child tell you his rendition of the events that got them to the hospital, encourage the child to tell you about herself, e.g.: siblings, interests, pets, etc
h) normalize the child’s experience: “you are experiencing and feeling what anyone would”
i) be mindful of “magical thinking” in younger children where they develop a fantasy that the event was somehow caused by their actions, thoughts or feelings
j) if the child is upset, periodically reassure the child that it is OK for him to be upset and offer your comforting presence
k) be aware of the “quiet child” who has withdrawn or is in psychological shock and requires your steady emotional support. Be aware that support is not necessarily a verbal experience
l) be aware of the child’s need for spiritual comfort and know how to obtain the resources of a chaplain (accessing a chaplain is addressed in HEICS through the Human Services Division (14)).

Logistics

a) Obtain pertinent information, e.g.: names of family and how to make contact, medications they are taking, etc.
b) Provide nutrition.
c) Give information in a language the child can understand about: what happened, the length of time it takes for tests and treatment, and when updates are expected.

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d) Protect children from undo excitement and stimulation, e.g.: onlookers, media.

e) Reunite children with parents as soon as possible, or with another familiar adult available such as a teacher or caregiver.

f) Until there is an adequate support system available to the child try to avoid exposing the child to any news of trauma or loss of any friend or relative.

g) If possible, try to keep the children from hearing other children's rendition of what happened.

Obtaining Cooperation

a) Warn children about painful procedures when they must occur – reassure them that they are doing a good job of cooperating.

b) Explain and re-explain expected procedures and the staff attending them.

c) After telling the child what to expect from tests and procedures, give the child the task of noting any changes in their condition to be reported to you later.

d) When necessary, give the child **firm direction** to get her cooperation. When cooperation is vital, **do not ask the child**, rather say: "We need to do x, y and z, so, I need for you to do a, b and c. I will be right here with you, you will be OK." Asking implies that the person has a choice in the matter. The child could feel fooled or deceived when asked to make a choice where there is none.

Support

Emotional first-aid can continue once the staff person has "joined with the patient." Supportive statements like: "you look scared", "this must be confusing to you", "you look very upset", "have you ever gone through anything like this before?" gives the caregiver an opportunity to **allow the person to vent**. "Allow the person to vent" means that they speak, cry, wail, sob, yell, etc and the staff person listens and then says or does something to indicate that they comprehend what was just expressed. Staff will need to intervene if the patient is doing anything physically damaging to herself, others or objects. However, physical expressions of affect like hitting a

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pillow are *not* physically damaging. Here are examples of indicating one's understanding of another's distress: "I see how angry you are," "You look terrified," "SILENCE," eye contact or a touch on the arm.

"Nosocomial Harm" Other Than From Inadequate Preparation

The following is *not* emotional first-aid and can produce long-term harmful effects:

a) do not tell the child to "be brave" (it is fine to encourage their strength to make it through something difficult)
b) do not criticize, devalue or shame the child, e.g.: "that's silly", "you shouldn't feel that way", "you're being a baby", or use body language that conveys disapproval
c) do not compare the child to other patients who are not giving you a problem
d) do not threaten the child, e.g.: "If you are not good, the nurse will give you a shot."
e) do not bring up: "Spirituality, God, Right and Wrong, Deserving or Religion" to explain the child's circumstances or cajole their cooperation
f) do not make a promise you can not or will not keep.

Be alert to other caregivers who may be speaking to a child with one of these approaches. When things are happening quickly and there is the immediacy of medical need, misstatements may occur with no time or opportunity to appropriately intervene. However, when there is an opportunity for intervention one might verbalize something like this to a colleague who misspoke; "I think the child you were just speaking with could respond to an approach like this (insert your correcting comments)" or, "This child looks difficult to work with, how about I try to get his cooperation (help him calm down, get these questions answered, etc)" or, "if this child is asking questions about God, I'll ask the chaplain to come over."

What Parents Need

There are two distinct experiences parents can have with a mass casualty situation: they

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can be with their child, know roughly what happened and have some sense of the child's condition, or they can be separated from their child and not know: where their child is, what occurred and their child's current condition.

When Parents Are Present

Acute emotional first aid *for parents* might look like:

a) getting updated information about their child's condition
b) *attunement* to better cope with the trauma *they* are now experiencing
c) support, reassurance and opportunities to appropriately vent feelings
d) education about the child's medical situation and ongoing treatment needs
e) information and education about the emotional sequelae from trauma for their child and themselves (handouts should be available)
f) guidance and direction about what steps will be needed after discharge for medical and psychological concerns (handouts should be available)
g) help in addressing any spiritual issues they may currently be experiencing or may experience in the immediate aftermath (know how to access a chaplain through HEICS – Human Services Division (14))
h) physical support: nutrition, a blanket, etc.

Emotional first aid *to the parents* **is** *for the child's benefit* in that:

a) Support for parents provides an opportunity for them to safely vent feelings – *not* in the presence of the child. Remember, the affective state of the parent has **everything** to do with the emotional experience the child is currently having and has much to do with how the trauma registers in the child's psyche (read: vulnerability to PTSD), in the hours, days, weeks and months following the trauma.
b) Parents will need guidance as to how the child might process the experience so they can be empathic, accepting and supportive.
c) Parents will need to be taught to recognize indicators that the child is struggling with the experience and is in need of help.

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d) Parents will need direction to alert other adults in the child's life (pediatrician, relatives, school personnel, clergy, etc) that they may see reactions from the child indicating difficulties with the integration process (handouts to parents should be available).

e) Parents will need guidance about responding to the child's spiritual questions, needs and concerns following the traumatic event (handouts should be available).

f) Parents need to be protected from the media.

All of the above is made more complex in situations where one parent is out of town or the parents are divorced or there are multiple children from one family involved in an incident (this is particularly so if the children are at different facilities).

When Parents Are Not Present

Parents may or may not know:

- the child's location
- what happened to their child
- the child's condition
- how to get important information *about* their child *to* the treating hospital.

It may be a sitter or nanny who is in the situation with the child and there may be lag time before the parent is informed. Acute emotional first aid is vital *for the parent* in that, after hearing that their child is involved in a mass casualty event ***and*** being separated from their child, the parents are likely to immediately be at some level of crisis. When staff encounter parents on the phone, at the trauma scene or at the hospital they should anticipate the parent would demonstrate some or all of the following (listed in increasing order of intensity):

- *adrenalized* state, which does not support rational thinking
- *highly emotional*: crying, loud and pressured speech or difficulty speaking, still redirectable, showing some signs of shock

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- *frantic*: running, wild eyed, rapid and pressured speech, demanding, difficult to redirect, in psychological shock
- *hysterical*: crying/sobbing, yelling or screaming, demanding, incoherent speech, very difficult to redirect, possibly belligerent, in a state of psychological shock

Staff must be ready to intervene with parents who are in a state of crisis and shock. Those staff will need the following:

a) a room designated for families in crisis where staff can meet in relative privacy with the family they are helping
b) access to the latest information about where the victims are (keep in mind that staff may be working with a family whose loved one is at another facility)
c) a supply of tissues, pillows (for comfort, screaming into and hitting)
d) backup, in the event a family member becomes a patient in need of psychiatric or other triage.

The emphasis of the intervention revolves around conveying to the parent:

1) staff know where their child is or are taking these steps to find the child
2) telling the parent about the child's condition ASAP
3) escorting the parent to the child if that is feasible
4) if the child is at another facility, helping the parent determine how they will safely get there and where to go once they arrive at that facility
5) if the parent can not see the child immediately, telling the parent about the process the child is likely to be experiencing, e.g., decontamination
6) telling the parents when they will likely be able to see their children
7) giving the parents information timely updates
8) encouraging the parents to express their emotional reactions while the crisis worker maintains a stance of calm, strength and acceptance
9) offering the services of a chaplain
10) helping the parents link with people in their personal support network
11) help plan for other family members who require care e.g., other children who are at home.

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Note: parents who are separated from their children *because the children are being decontaminated* will likely be going through some, if not all of the experiences described above and may need some, if not all of the interventions described above. Discharge preparation and education for the parents is the same as discussed earlier.

A Reminder: The scenes just described contain raw and powerful emotion. Witnessing this emotion or giving care to someone going through these emotions can be very taxing for staff. **It is understandable that staff are affected by these experiences and need a chance to debrief and reconstitute**. This is exactly the situation where the Staff Support Section of the Human Services Arm of HEICS must be prepared, present and active.

Integration of Community Resources

The American Association of Pediatricians specifically calls for the involvement of community professionals, agencies and government in preparation for a mass casualty (1) (2). Pediatricians need to work with schools anticipating the various situations that can develop. The disaster may be at a school or school premises may be needed for off-site care of less critically injured victims.

Our research has uncovered a paucity of such planning. In fact the schools we called had no conception of what a decontamination situation would look like, let alone the demands on the children and the school staff. Schools are uniquely positioned to introduce and prepare children to the demands and processes of a mass casualty situation in a manner that is age appropriate and sensitive. This education could be provided through a “disaster safety” (in the model of fire-safety) presentation done either live or through video. In the section entitled “Priority Recommendations” the National Center For Disaster Preparedness states in it’s Executive Summary dated 2003, of the Pediatric Preparedness for Disasters and Terrorism - A National Consensus Conference offers this guideline: “Conduct pediatric disaster drills in every school, every year, in partnership with school organizations, local response agencies, appropriate governmental authorities and, where appropriate, supervised youth groups” (10).

Clearly the time to involve the community is not during the crisis with frantic phone calls

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searching for resources, backup and cooperation. Community hospitals with no pediatric unit, would, in a large scale mass casualty situation, be forced to care for pediatric cases without the option of transfer. For these facilities, not having the usual and customary resources of a hospital with a pediatric unit, it is even more important to line up community support before the fact.

What Do Hospitals Need?

- precredentialing pediatricians from the community, to facilitate availability without wading through the obstacles of credentialing during the disaster (this may include lining up the services of a child psychiatrist)
- precredentialing community mental health professionals, to augment, backup and support the efforts of the Human Services Division of HEICS without encountering credentialing obstacles
- precredential trained clergy to augment, backup and support Pastoral Care Services within the Human Services Division of HEICS
- develop a line of communication with local school personnel for coordinating logistics and care issues
- develop standardized forms among regional hospitals and aid agencies for identifying victims, missing persons, etc.
- have publicized telephone lines dedicated for the incoming calls associated with a disaster, keeping the hospital's phone system functional.

What Does the Hospital Need to Offer?

- a forum for fire and police responders, school personnel, local community mental health agency staff, pediatricians, State and Local Emergency Response Agencies, American Red Cross, Pastoral Care Clergy and HEICS representatives from area hospitals to meet and identify issues specifically related to caring for pediatric disaster victims

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- acute traumatic emotional first aid training to those groups and agencies who will be interacting with pediatric victims
- coordinating with these agencies innovative ways of sharing a database for victim identification, e.g.: digital photos with accompanying demographic information
- adequate opportunities for multiagency practice of the management, triage, treatment, and acute emotional first aid for children and parents

Summary

What Hospitals Can Do Now

By openly addressing the human phenomenon of "shielding" from horrific visions and possibilities, disaster planners can move beyond the sense of "unlikeliness" that impedes adequate planning for pediatric disaster victims. Then, dealing with horrific scenarios can be broken down into manageable segments. The emotional burden of this planning is best shared by a team and done with adequate staff support.

Here is a list of steps for moving beyond "unlikeliness":

- Train personnel about pediatric emotional first-aid and preventing nosocomial trauma during a disaster.
- Develop a training program to educate staff how to "join with" pediatric (and adult) patients and to anticipate the emotional demands of caring for pediatric disaster victims.
- Develop quick reference emotional first-aid materials for use in a disaster. These materials can be differentially "tuned" by discipline and department.
- **Train and support staff in the Human Services Arm of HEICS** in learning and practicing crisis intervention with children and parents using a variety of disaster scenarios.
- Identify staff with needed skills such as background or training in working with children, parents and families. They are a resource for training other hospital staff,

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participating in drills and providing specialized care in a disaster.

- **Line up outside resources** prior to needing them, as previously discussed. **Practice Communication with Other Facilities** for the purpose of standardizing forms and methods to share information.
- Practice responding to different scenarios using HEICS tabletop drills. Each sub-area within HEICS can also similarly drill themselves.
- **Do multiagency, realistic drills that present a variety of situations that could bring an influx of pediatric victims.**

(For a discussion of Logistical Considerations and Victim Management and Processing, see: the safety of loved ones in "Practical Considerations for Management of Pediatric Victims during Hazmat Decontamination" (18)).

In a mass casualty situation the demands on the HEIC System and the resources of the hospital will be great at the same time *chaos* and *fear* will be injected into the mix. The demands are greater when the victims of the event are children. Any organizing, training and practice in the area of acute traumatic crisis intervention with children and parents experiencing a disaster will likely: a) increase patient cooperation with treatment, b) reduce chaos, c) reduce staff stress and exhaustion, and d) reduce damaging psychological sequelae and "nosocomial trauma" for victims and caregivers alike.

Further Research

Fortunately, there are few events we can research. Obviously the ethics of providing care limit the design of any research on human subjects and the unpredictability of the time and the nature of the event is another research limitation. However, there are agencies that are likely to be involved in a hazmat event wherever they occur such as the American Red Cross, the CDC, etc, and are uniquely positioned to record the process and gather data for later analysis.

I propose that the professional community develop lines of inquiry that would refine

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what has been proposed in this paper. Data collection tools can be tested and refined. Collaboration between researchers and the agencies likely to be involved in a mass casualty event could result in the agencies having these tools on hand. Information from an unfortunate event could inform our emerging best practice.

An Area for Further Development: Psychological and Moral Wounding to Care Providers

Ethical Concerns

What are the ethics of asking someone to expose themselves to known harm as part of the performance of their work duties in a disaster response without:

- informing them of the risks to their physical health and wellbeing,
- informing them of the risks to their *psychological* health and well-being,
- and adequately preparing them for the experience to mitigate the magnitude and duration of the damage they may experience?

When someone is asked to perform duties that are outside of the scope of her job, or that she is ill-prepared to perform adequately, or that exposes her to harm, she may well feel betrayed by her superiors. She may feel unsupported by "administration" and invisible to the authorities except to the extent that the authorities can make use of her. She will likely be vulnerable to greater psychological damage and consequently, greater sequelae (PTSD). In his compelling and insightful books, *Achilles In Vietnam*, and *Odysseus in America,* Dr. Jonathan Shay (16, 17) describes "moral wounding:" the condition in which an actor feels betrayed by the authority directing his actions and who claims responsibility for the actors' best interests. Dr. Shay describes the effects of traumatic experiences in combination with moral wounding as *causing damage to the individual's character* (italics mine) perhaps exemplified by the loss of faith in the system or leaders that *broke faith* (italics mine). This material is discussed in depth in a separate paper by this author titled *Traumatic Stress in Care-Providers Responding to a Pediatric Mass Casualty Event: The Ethics and Practicalities of Inadequate Training and Preparation in Psychological/Moral Wounding.*

Additionally, there is reason to believe that as systems breakdown either by being utterly

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overwhelmed or by inadequate preparation, rescuers and treaters will be witness to increased morbidity and mortality among pediatric victims. We have already seen data from mental health trauma literature indicating that helplessness and/or a sense of incompetence heightens traumatic impact and increases psychological harm to the care provider. This will exacerbate the problem.

To avert the largely hidden devastation Shay speaks of, and to be in compliance with OSHA requirements of informing workers of job related risks, *and to be respectful of the moral covenant that directs our societal relationships*, it is necessary for all of the agencies involved in rescue and response to fully inform their employees of what may be asked of them under the extreme conditions of a mass casualty event. Those agencies, including mental health centers and schools which may become secondarily involved, must help employees prepare for what they are likely to experience.

Practical Concerns

From a coldhearted, purely pragmatic point of view, is it *practical* to engage in a practice that can potentially decimate the rescue and response workforce in the aftermath of responding to the disaster? Can we really afford to lose a significant number of our fire, EMT, police and health care personnel because they have sustained physical and psychological damage? The data Dr. Robert Maunder from Mt. Sinai Hospital in Toronto presented June 15, 2007 at the Chicago Metropolitan Healthcare Council Seminar on *Pandemic Flu: Psychosocial Planning*, from his study of the 2003 SARS outbreak that affected that hospital is that in the aftermath of that outbreak: "34% of all participants (healthcare providers) reported planned or actual decrease healthcare work." (11). And this data is derived from events that had largely *adult* victim populations. It is common knowledge that emergency workers and care-providers are more affected by child victims than their adult counterparts.

Conclusion

We live our daily lives largely dismissing the possibility of mass casualty disasters – let

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alone disasters that have numerous pediatric victims. And we live our daily lives expecting and assuming that our rescue and healthcare systems will respond adequately to whatever befalls us. Here is an alternate vision:

> In addition to education, (*excluding* "just-in-time education" which informs the individual of risks to their wellbeing *just prior* to their deployment) it is through periodic drills that that the moral and practical obligation of preparation is fulfilled.
>
> The drills ***must present realistic scenarios***, meaning staff are faced with:
>
> - realistic numbers of victims in approximating true levels of distress,
> - realistic time lines,
> - realistic sounds,
> - realistic pressure,
> - realistic actors,
> - and a realistic amount of time for the drill to unfold.

There is little reason to believe that the system will function without this level of preparation. There is little reason to think there will not be devastating sequelae at all levels from the failure to prepare.

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