Psychological Intervention with the Virginia Tech Shootings: Lessons Learned and Recommendations

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From: Dr. John Heil

Letter to Readers and Reviewers

The response to the mass shootings on April 16, 2007 at Virginia Tech challenged all community public health and public safety resources, including mental health services.

There were two primary centers of mental health service delivery in response to the shootings: Virginia Tech University and Montgomery Regional Hospital (MRH). MRH was the primary site of medical care provided in response to the shootings. In the immediate aftermath of the incident, the hospital also became a gathering place for the loved ones of those known (or feared) to be killed or injured. In so doing the hospital filled a critical void that existed from the time of the shootings, till the university based support and information center became operational.

The focus of mental health services at MRH included those wounded, the families and loved ones of the victims of the shootings, and hospital staff. Although there is a growing base of theory and practice to guide response to mass casualties, our retrospective evaluation has revealed significant gaps in this knowledge base, and has identified useful lessons learned in the process of responding to the tragedy.

As a consequence, those involved in service delivery have elected to undertake a "lessons learned" exercise in the hope that should a similar event unfortunately take place, mental health providers would be better prepared to respond, and as a consequence the quality of services provided would be maximized. We are following the "lessons learned" model, cited in Gheytanci, A. et al. (2007), which identifies 5 inter-related processes:

1. Collection of the lesson

2. Validating or verifying the accuracy of the lesson

3. Storing the lesson

4. Disseminating the lesson

5. Reusing the lesson

Through a sequence of meetings and presentations (which are detailed in the report), we have begun to move forward simultaneously on the five components of the model. At this juncture, we have elected to request external review and comment. In selecting reviewers from diverse backgrounds, we hope that the final report will broad in its scope and presented in a way that is relevant to a wide audience. The document provided for review is the report submitted to the Virginia Tech Review Panel established by executive order of Governor Kaine. While not in finished form, the urgency of the timeline of the Review Panel did not allow for a more detailed and polished document. However, we do feel that the "broad strokes" of the lessons learned are accurately articulated.

Currently, the impressions and conclusions are stored as discrete units of information (vs. paragraph style), and organized within lessons learned categories, to facilitate comment and revision. Implicit in our approach is the intent to develop a consensus perspective, which is true to the collective experience of those involved in service delivery. The experience of the shootings and their aftermath is an emotionally provocative one for service providers. Because the emotions evoked by the event are important and a valid source of inquiry, the lessons learned process began with a reporting of events and the "thoughts and feelings" that these events evoked. While we have worked to present a fair and accurate impression, we have not attempted to sanitize the report emotionally.

The goal of the review is to clarify, validate and expand the lessons learned document. In reviewing and critiquing the document **please feel free to comment on any or all of the following:**

Clarity, logical integrity and persuasiveness of the impressions presented

Perception of the report as fair and balanced, or alternately, biased or incomplete

Any suggestions regarding the "lessons learned" process as it relates to collecting, validating, storing, disseminating and reusing the lesson

Executive Summary

The response by mental health counselors to the April 16, 2007 shootings at Virginia Tech is worth reviewing by those who study similar mass crises or may face them, especially in college communities. The authors provided services at Montgomery Regional Hospital to victims and their loved ones and to hospital staff and affiliates. Subsequently, they initiated a lessons-learned analysis.

Sanctuary: Emotional restoration began with finding a safe haven

Administrators at Montgomery Regional Hospital set apart a section of their institution for the use of victims' displaced friends and loved ones. This provided multiple benefits.

Information: Prompt, accurate information was precious

Information allayed fears and enabled coping. The report describes communications providing aid and comfort to victims and their loved ones. Rumors and broadcasts filled voids with ready answers, sometimes insensitive, other times countertherapeutic or even traumatizing. While laws and policies have good reasons to limit official networks' release of information, this was problematic in the mass-trauma setting.

Boundaries: Some media behavior was inappropriate

The public relies on the mass media. However, some non-local broadcast media representatives interfered with hospital staff, serving their news organizations by adversarial, aggressive intrusion requiring vigilant resistance. This sapped energies needed elsewhere. Media behavior angered many in the community.

Imagery: Most commonly visual, this had potent effects both in trauma and in therapy

Intrusive recollection characterizes traumatic stress disorders. Visiting the survivors - an innovative solution - allayed first responders' and medical providers' traumatizing images of damaged victims. Contrariwise, exposure to the perpetrator's recorded communications, aired by the media, further traumatized some.

Alliances: Mental health providers benefited from partnerships with other professionals

Quickly formed partnerships were needed to direct the response, flexibly and without territoriality. Both opportunistic and well-meaning partners appeared, needing to be vetted for optimal assistance.

Caretaker Needs: Some helpers needed help afterwards

The hospital staff's mindset included the expectation that crisis counseling generally would be sought as needed, with participation encouraged, but with individual choice respected.

Resolution: Framing what happened

Ultimate coping required coming to terms with the doer and the deed, with the burden of having borne witness to the event, and with the impact of the event on the sense of community.

Introduction

In response to the Virginia Tech shootings, a psychological crisis counseling team was assembled at Montgomery Regional Hospital (MRH), the primary site for medical service delivery to the victims of the shootings. This team provided services to victims of the shootings, their families and loved ones, and hospital staff and affiliates. Approximately 30 professionals of varied backgrounds, drawn from local and national organizations, were involved in the delivery of psychological counseling services at MRH.

Following the incident, members of the response team gathered to conduct an after-action review of events and debriefing. The comments recorded during the review and debriefing, in conjunction with documentation of events during the crisis by the lead author, served as a starting point for the development of this lessons-learned project. Subsequently, the document was developed further through a cyclical process of review and revision. A Report was presented to the Governors Panel reviewing the Virginia Tech Shootings. Subsequently, the process of review and revision continued blending comments from participating providers and external reviewers, also incorporating information from the psychological literature and commentary garnered through a series of seminar presentations to professional audiences. This has resulted in a two-part report: Part 1 is a statement of lessons learned (an updated and revised version of that submitted to the VT Panel); Part 2 focuses on intervention strategies.

This project is modeled after the Lessons Learned Systems approach of Gheytanci et al. (2007), which is drawn from the work of Weber, Aha, & Becerra-Fernandez (2001). It includes five components: (1) Collection of the lesson; (2) Validating or verifying the accuracy of the lesson; (3) Storing the lesson; (4) Disseminating the lesson; and (5) Reusing the lesson.

Gheytanci et al. (2007) note that substantial effort has been put into addressing the initial steps of the lessons-learned process (i.e., collecting, validating/verifying and storing the lesson) but problems in dissemination and reuse of lessons learned are significant, and undermine the opportunity to benefit from the knowledge gained.

In keeping with this caution, a dissemination plan is being developed in tandem with this report.

Method

This report is an assessment based on the facts, reflecting the collective impression of professionals whose judgment is informed by direct exposure to the event, by formal training in psychological concepts and methods, and by professional experience in psychological intervention. The report has been developed through a repeating cycle of information assimilation, review and revision.

Document Development

Following completion of its response to the acute phase of the crisis, the intervention team conducted a post-event review and debriefing. At this time, the team elected to consolidate lessons learned and prepare a formal report. Those team members who elected to participate are listed above as authors.

The development of the report began with the creation of a timeline of events, highlighted by personally compelling moments and professionally relevant experiences. An initial working document was developed by the lead author, who

served as coordinator of the intervention team. The document blends the collective experience of the treatment team, incorporating contemporaneous documentation of events by the lead author as the response to the crisis unfolded.

A summary of the first draft was presented as part of a Continuing Medical Education (CME) program, and the full draft document was distributed for review and comments. A revised document was created that incorporates comments from the contributing authors, as well as the participants in the CME program – most of whom provided crisis counseling in some setting in response to the tragedy. In addition, two VT students who were affiliated with the lead author's clinical practice, Psychological Health Roanoke, participated in the seminar and provided comments.

Following additional review by the authors, a report was provided to the Virginia Tech Review Panel (VTRP), *Psychological Intervention with the Virginia Tech Mass Casualty: Lessons Learned in the Hospital Setting*. That is considered a preliminary document, provided in unfinished form in response to the exigency of the timeline under which the VTRP was operating.

The report submitted to the Review Panel was subsequently distributed to a set of external reviewers for additional critique and comment. The reviewers are a diverse group of psychologically minded professionals representing a broad base of knowledge and experience.

In service of the goal of disseminating the lessons learned, a series of training seminars have been presented to professionals. This elicited additional comment and critique,

which has also been incorporated into the final report.

In summary, the final document is the product of a cycle of review, comment and revision. It includes input from professionals within and outside of the mental health field, as well as those with and without direct personal association with the event. This process has been useful in identifying, clarifying and validating lessons learned, as well as conceptualizing and integrating these lessons into a meaningful framework.

Document Format
The report is organized into two parts: Part 1 lists lessons learned, in keeping with the format of the report submitted to the VTRP. Part 2 offers recommendations for intervention in cases of mass casualty, expanding and reconfiguring the information presented to the VTRP.

In Part 1, content is organized into themes, which are identified as lessons. Specific comments are listed as discrete units of information (in contrast to paragraph style) to facilitate additional comment. Part 2 is an extension of the lessons learned, incorporating action elements; it is intended as an intervention manual.

Part 1: Lessons Learned
Those that we learned (and those that we learned we needed to know more about)

Introduction
The most compelling and most important lessons learned pertain to the earliest phase of the crisis, that is, to the events of the first few hours and decisions made in response to these events. The absence of an established set of professional guidelines for intervention in the earliest moments of the crisis, in conjunction with the urgency of the moment, presented a formidable challenge

to the first psychological responders on the scene. In retrospect, the effective decisions appear to have blended pragmatism with fundamental principles from the science and practice of psychology.

In contrast, the delivery of crisis intervention counseling services after the first day, albeit challenging, was both more straightforward and more congruent with established knowledge and methods in mental health practice.

The lessons identified draw on the expertise of the mental health professional both as psychotherapist and as psychologically sophisticated observer of human behavior.

Lesson 1: Hospital as Sanctuary/Safe Haven
Regaining emotional equilibrium begins with finding a safe place

Impression
MRH was in the ideal position to provide aid and comfort to the victims (direct and indirect) of the casualty, and was wise to do so – creating a sense of sanctuary at a time when it was sorely needed.

Analysis
In the immediate aftermath of the shootings, the VT campus was closed down and the information center (Inn at Virginia Tech) not yet operational.

Students were temporarily displaced from familiar places and people, and from the VT campus and its leaders – and in this sense, were to an extent, psychologically homeless. The students and loved ones of those killed and injured (or those feared killed or injured) were distraught and in search of support and guidance.

There was a strong need for sanctuary – that is, a place to be that offered security, as well as access to loved ones and information about them.

The strategic choice by MRH to offer a place to be for students and loved ones within the hospital provided a sanctuary. MRH provided a comfortable place for loved ones of those killed and injured (or feared killed and injured) within a segregated section of the hospital with access to comfort facilities, food, et cetera. It also provided information about loved ones and expedited timely visitation.

The role of sanctuary fits the broader mission of a health care facility: providing aid and comfort to those in medical need. While those killed and injured are the direct victims of trauma, their loved ones are indirect victims – and at high risk for immediate and subsequent health problems. Timely supportive intervention in response to trauma is likely to diminish its long-term impact on these indirect victims.

It would have been reasonable, and much simpler, to operate with the more typical and more narrowly defined mission of a hospital – to provide services only to those with bona fide and relatively urgent medical needs.

Mass casualty scenarios typically call for a narrowing of the hospital medical mission, in the sense that less-urgent medical care often is denied (e.g., canceling elective interventions and discharging non-critical patients from the hospital). Thus providing sanctuary runs contrary to this well-established principle of response to mass casualty.

Still, from a pragmatic perspective, the hospital is in an ideal position to provide sanctuary in that it provides access to loved

ones and information about them. In addition, hospital staff are health care professionals whose duties implicitly entail providing aid and comfort to the sick.

In the immediate aftermath of the casualty there is a convergence of law enforcement and other support services providing a nexus of information and human resources. This access to information renders the hospital an ideal setting to provide support and guidance.

Comment on the Role of the Hospital

The confidence of a community in its institutions contributes to the perceived quality of life of a community. Institutions will define themselves in times of crisis.

A hospital will define itself in a time of medical crisis by meeting the perceived needs of the community – independent of whether it meets an objective set of standards or regulations.

The hospital's response to the casualty served the community well.

Lesson 2: Information as Aid and Comfort

In times of chaos, information is precious

Impression

The desire for and apparent need for information in times of crisis is profound. To provide information in a sensible way is to provide support and guidance, and thus facilitate coping with trauma.

Analysis

In times of community crisis, information is sought after by different constituent groups (e.g., public safety, medical, media, loved ones of victims) for different, and sometimes conflicting purposes.

For each of these constituent groups, information is empowering.

The need for information about loved ones in a time of crisis is profound.

The information-seeking behavior of those who suspect or fear that loved ones are dead or injured is characterized by intensity, urgency, and sometimes desperation.

Accurate information brings order out of chaos, and allows those involved to move forward--to do what needs to be done next, as determined by the status of loved ones.

Accurate information will short-circuit generalized worst-case scenario fears (e.g., "there are still gunmen on the loose"; "a loved one is injured," et cetera.) and help restore a sense of order.

Accurate information will bring relief to those whose loved ones are in good hands.

Accurate information allows the loved ones of those that have died to begin the grieving process.

In the absence of information, a careful and patient explanation of why information is not available is useful. This appears to convey a meta-message that the needs of loved ones are being recognized, and that effort is being made to meet these needs. This contributes to a sense of sanctuary.

Loved ones seek information in detail beyond that which has apparent logistic value, as if the details of "How, What, When and Where" provide some sense of connection to those otherwise feeling a sense of separation.

In the absence of legitimate information, other information will fill the void, most likely via rumor or the media.

Other information available (either by media or rumor), is far more likely to be inaccurate, and delivered in a way that is insensitive, countertherapeutic or even traumatizing.

Lessons from Hurricane Katrina
Lessons learned from the response to Hurricane Katrina indicate the importance of effective information management. Of the "twelve key failures" (Gheytanci et al., 2007), two were clearly information related – "lack of efficient communication" and "rumor and chaos."

The report on Katrina reinforced our recognition of the potentially destructive nature of rumor and misinformation, noting *"The possibility for unnecessary, deeply disruptive secondary chaos is a real threat in catastrophic disasters"* (p. 124).

Information as Dilemma
In this crisis, three distinct information networks were operating: the official information network managed by public safety and medical responders; the media; and an informal network largely composed of loved ones of those feared killed and injured - a "family and friend" network. The "family and friend" network assimilated the limited information available from the official network, the copious information available through the media, and piecemeal information gathered from personal networks (largely via person-to-person contacts within established "family and friend" networks).

The media and the "family and friend" network are both susceptible to rumor, and hence to the spread of inaccurate information, and suffer varied problems as a consequence.

The "family and friend" network is the first line of support and coping. It is trust-driven and well intentioned, and delivers specific information directly to those most immediately in need. As such it is a legitimate network, in need of and benefiting from timely, accurate information. The relative balance of information, from official sources and from the media, influences both the accuracy and the efficacy of the "family and friend" network.

The more information received from the official network relative to that from the media, the better the network. Official networks have better access to and a vested interest in presenting information accurately and in a way that considers the wellbeing of the citizenry.

However, varied laws and policies, in addition to other practical constraints (e.g., related criminal investigations, the need to operate by a high standard of accuracy) limit the ability of the official network to release information – even as a void in official information creates susceptibility to rumor and chaos. Restrictions on the release of information are a detriment to the relief effort in some ways and thus inadvertently contribute to suffering.

A health care provider with access to critical information regarding patient status (e.g., knowledge of the death of a loved one) faces a dilemma. Not providing this information feels unethical and countertherapeutic, while providing such information may be in conflict with privacy laws.

This dilemma is accentuated by awareness that rumor and media will fill the void with

information that is likely to be less accurate, and less likely to be delivered in a way that is sensitive to the needs of those experiencing significant personal loss.

The Patient Manifest List
The following describes actions taken to provide information to loved ones in the spirit of aid and comfort

In response to the need to notify family and friends, a list was developed that included all hospital patients admitted to MRH in relation to the casualty. This information was distributed in accord with hospital policy (hospital privacy practices, first right of parental/next of kin notification, etc.).

It became apparent that MRH was at the center of the network of medical service delivery, and thus the single agency with the best access to information about those (killed and injured) who had reached medical facilities.

In recognition of the void in information about those killed and injured (that is, the absence of a central information authority), and out of respect for the emotionally urgent need for information experienced by loved ones of those known, suspected or feared to be killed or injured, this list was extended to include those known to be triaged to other hospital facilities.

Providing information to loved ones enabled them to expedite contact with those injured by identifying their locations. Doubt about the appropriateness of the release of information was balanced by the realization that expediting contact with loved ones might provide an opportunity for a deathbed visit; an opportunity that might otherwise be lost. As hours passed, many that were feared or suspected lost were found to be safe and progressively fewer remained unidentified.

By late afternoon, the patient manifest list, and the varied (formal and informal) information networks converged in an unanticipated way–it became apparent that those few whose whereabouts remained unknown and who were not on the patient manifest list were likely to be among the deceased.

Comment on Information Disclosure
Various policies and guidelines that govern the release of information by health care providers are problematically restrictive for the mass trauma setting.

We pose the question: In the face of great need for information, are HIPAA laws an obstacle to the management of crises, in general, and to effective psychological intervention, in particular?

Commentary on the Role of Information
Commentary on the Role of Information as Aid and Comfort: Matthews

From: *Matthews, J. R. (2007). A Louisiana psychologist's experience with Hurricanes Katrina and Rita. Psychological Services, 4(4), 323-328.*

Emphasizes the value of informal, personally constructed information networks – typically via phone and Internet – in providing information as aid and comfort in a uniquely useful (i.e., person-specific) way, in contrast to formal media networks which focused on urban centers or otherwise provided more broad-brush coverage.

> *When we were evacuated, we used our cell phones to make regular calls to our neighbors who had left shortly before we did. We shared information about the storm, hotels,*

gas stations with short lines, and generally provided a level of human contact during the stress of heavy traffic and concern about the storm. Most of the media coverage seemed to center on the French Quarter and center of the city. Those of us who lived in other areas found it quite difficult to get any sense of what might have happened to our homes. (p. 324)

Commentary on the Role of Information – Need and Challenges: VT Panel Report

From: *Virginia Tech Review Panel (2007, August). Mass Shootings at Virginia Tech: April 16, 2007. Report of the Review Panel presented to Governor Kaine, Commonwealth of Virginia.*

Throughout the report reference is made to the importance of timely and accurate information presented in a sensitive manner – and to the varied complex issues that render this task so challenging.

Parents, spouses, faculty, students, and staff scrambled for information that would confirm their loved ones were safe. They attempted to contact the university, hospitals, local police departments and media outlets, in an attempt to obtain the latest information. Chaos and confusion reigned throughout the campus in the immediate aftermath. (p.136)

Mass fatality events, especially where a crime is involved, present enormous challenges with regard to public information, victim assistance, and medical examiner's office operations. Time is critical in putting an effective response into

motion. Discussions with the family members of the deceased victims and the survivors and their family members revealed how critical it is to address the needs of those most closely related to victims with rapid and effective victim services and an organized family assistance center with carefully controlled information management. Family members of homicide victims struggle with two distinct processes: the grief associated with the loss of a loved one and the wounding of the spirit created by the trauma. Together they impose the tremendous burden of a complicated grieving process. (pp. 145-146)

Commentary on Privacy Laws: VT Panel Report

From: *Virginia Tech Review Panel (2007, August). Mass Shootings at Virginia Tech: April 16, 2007. Report of the Review Panel presented to Governor Kaine, Commonwealth of Virginia.*

Substantial attention is directed to privacy laws, highlighting their complexity and opacity. Chapter V of the original report is devoted exclusively to privacy laws with extensive additional information presented in Appendixes G and I.

Information privacy laws governing mental health, law enforcement, and educational records and information revealed widespread lack of understanding, conflicting practice, and laws that were poorly designed to accomplish their goals. (p. 63)

The Panel also offered the following formal recommendation:
"V-2 Privacy Laws should be revised to include 'safe harbor' provisions."

The provisions should insulate a person or organization from liability (or loss of funding) for making a disclosure with a good faith belief that disclosure was necessary to protect the health, safety, or welfare of the persons involved or members of the general public. (p. 68)

Lesson 3: Ownership and Partnerships
Ownership and partnerships are central elements in the community response to trauma

Impression
Ownership is a foundational element of community response to trauma. In mass casualties, outside assistance is essential. By forming partnerships with community responders, outsiders enhance the effectiveness of the community's response. Professional rivalries (which may undermine trauma response) are remedied by partnerships.

Analysis
The community needs to own the trauma response, to manage the trauma, and to recover from the trauma.

In a mass casualty, the community will need the assistance of those outside the community (outsiders) to meet its needs.

These needs include three elements: people power (substantial numbers of specialists to meet expanded needs); special expertise, where this is lacking; and support for caregivers.

The need for assistance gives rise to the need for partnerships.

Partnerships are defined as alliances among those who function in a similar role (e.g., counselors and ministers), or those whose roles are interlocking or overlapping (e.g., public safety responders, hospital medical staff and HR administrators).

Not all efforts to help are wanted or beneficial; that is, helpers do not necessarily become partners.

Those outsiders who recognized the need for ownership by the community were more readily accepted as partners, and in turn better served the community.

The importance of ownership by the community was well recognized by sophisticated outsiders (e.g., HCA Hospital Chaplaincy, Trauma Relief, Billy Graham Crusade).

Lessons from Hurricane Katrina
Lessons learned from response to Hurricane Katrina bear heavily on issues of partnership and ownership. Of the "twelve key failures" (Gheytanci et al., 2007), five relate to ownership and partnership: "poor coordination plans"; "ambiguous authority relationships"; "who should be in charge?"; "ambiguous training standards"; and "personal and community preparedness."

Territoriality
Professional and personal rivalries are found in day-to-day practice settings and in mass casualty settings. The emotional intensity of the mass casualty environment may accentuate these rivalries.

Partnership is the remedy to rivalry.

The need for leadership (and the possibility of a void in leadership) in the mass casualty environment may also accentuate these rivalries.

Effective leadership respects the ownership of the community, forges partnerships, and circumvents rivalries.

Opportunism

Professionals in the mental health fields and the clergy have training and ethical codes that guide their behavior, and place priority on the wellbeing of clients. The absence of professional training not only raises the possibility of ineffective intervention, but also of ethical violations that could be detrimental to victims.

There is concern that organizations or individuals may use critical incidents in an opportunistic way to foster pre-established agendas, essentially prioritizing their agenda ahead of the well-being of the victims – for example, consider the possibility that media would hire people defined in some way as counselors simply to gain access to incidents and to gain an advantage over their media competitors.

Comments on Professional Role and Function

Because of the time urgency of crisis intervention and the need to blend responders from varied settings into teams, it is essential that professional titles clearly convey a defined professional role.

Access by mental health providers/counselors to the facility should be limited to verifiably credentialed individuals. This function probably should be overseen by a health care professional.

While resources consisting of outside support and assistance may be available and needed, utilizing such resources efficiently is a substantial challenge logistically.

For practical and logistical reasons, there is an optimal number of service providers to compose an intervention team. It is possible that there are more providers available than are needed, or if needed, more providers available than can be effectively integrated into the response team.

Lack of understanding of an individual's skill set clearly is an obstacle to efficient utilization of resources.

"Chaplain" is a broadly defined but poorly understood term. Many assume inaccurately that it is synonymous with ordained clergy.

There is a similar concern with the term "counselor"– which may or may not imply a professionally trained and licensed mental health practitioner.

Commentary on the Role and Function of Chaplains: Hargrave

Rickey Hargrave of the International Conference of Police Chaplains was solicited as a reviewer and offers the following commentary:

> *The International Conference of Police Chaplains (ICPC) is writing a definition for Chaplain that does NOT include what the Chaplain does but specifies WHO the Chaplain is. Following the bombing of the Murrah Building in Oklahoma City, where Chaplains were used in many areas and received a lot of high-profile publicity, groups sprang up using the term "Chaplain" to gain access to incident scenes. As part of the incident credentialing processes we would mandate questions be asked about actual clergy status on*

the part of Chaplains. Qualifications should include, among other things, ordination/ commissioning, ecclesiastical endorsement, and specific theological training. Inquiry as to past involvement in similar critical incidents should be made and evaluated. While it is true there are "lay" Chaplains serving in various capacities, in critical incidents the higher standard must be maintained.

Commentary on Optimal Utilization of Psychological Resources: Sellars

Dr Bruce Sellars, VT alumnus and Roanoke-based Clinical Psychologist, was one of many who offered professional help that went unutilized.

As a psychologist who participated in the emergency response effort during the recent Virginia Tech tragedy, the immediate reaction observed in mental health professionals (and likely the citizens at large) is one of wanting to help in some way. As such, a contingent of mental health professionals went to the Tech campus from Roanoke upon hearing from two other psychologists on site that additional help was needed. We were directed to the Red Cross headquarters where we were politely informed no additional assistance was needed. We were not trained ARC volunteers but it seemed that part of future disaster plans should try to account for the willing outpouring of the citizenry to provide immediate assistance. A disaster in a community also affects those living in the community and glued to televisions or Internet sites. It seems hard to believe that certain individuals with specific training

should be sent packing. While it is appreciated that the disaster site needs to be made secure and controlled, provisions for local volunteers with certain skill sets need to be included in future disaster plans.

Commentary on Optimal Utilization of Psychological Resources: Matthews
From: *Matthews, J. R. (2007). A Louisiana psychologist's experience with Hurricanes Katrina and Rita. Psychological Services, 4(4), 323-328.*

Our profession needs to have better immediate access to victims…the process I saw in which licensed psychologists were required to go to the capital and complete a range of forms before being allowed to work in disaster centers not only slowed the provision of services, but also may have deterred some from volunteering. Such delays just compound the sense of abandonment felt by many victims. (p.327)

Commentary on the Need for Screening of Mental Health Volunteers: VT Panel Report

From: *Virginia Tech Review Panel (2007, August). Mass Shootings at Virginia Tech: April 16, 2007. Report of the Review Panel presented to Governor Kaine, Commonwealth of Virginia.*

As occurs during many disasters, some special interest groups with less than altruistic intentions arrived in numbers and simply took advantage of the situation to promote their particular cause. One group wore T-shirts to give the impression they were bona fide counselors when their main goal was

to proselytize. Others wanted to make a statement for or against a particular political position. Legitimate resources can be a great asset if they can be identified and directed appropriately. (p.145)

Lesson 4: Visual Image as Therapeutic Agent
The visual image is like a psychological scalpel, cutting deeply, with the power to wound or to heal

Impression
Imagery is a potent element in the experience of trauma, influencing the initiation and maintenance of symptoms, and also serving a critical role in therapeutic intervention.

Imagery can be positive or negative, therapeutic or countertherapeutic.

Analysis
A brief overview of the role of imagery in trauma follows, one that is generally consistent with established professional knowledge and practice.

Therapeutic assessment of trauma-related imagery and memory offers insight into psychological status.

The intrusive recollection, often dominated by aversive visual imagery, is a hallmark of traumatic stress disorders.

The intrusive negative image is a gateway to the visceral component of traumatic emotions.

Negative images can freeze the person at the moment in time when fear and anxiety are at a peak – and as such are past-centered.

The best countermeasure to traumatic imagery is positive imagery.

Positive, present-centered images reinforce the safety and the reality of the moment.

It was hypothesized that specific positive images of recovery would mitigate the negative imagery associated with exposure to the trauma – for victims as well as for medical and public safety responders.

Witnessing the survivors' recovery and return to health was hypothesized to be a countermeasure to the traumatic imagery and memories experienced by first responders and medical providers.

Visits to hospitalized survivors were offered to medical providers and first responders based on the hypothesis that this would reinforce the positive outcome of the medical and rescue work, and serve as a countermeasure to traumatic reactions.

The visits by ER, OR, Rescue and Police to hospital survivors were clearly mutually beneficial (to survivors and to providers/rescuers) by all measures of self-report and observation.

At its best, the impact of the visit was transformative for providers/rescuers.

It appears that the positive image of the survivors recovering and doing well provided a potent, present-centered countermeasure to the past-centered image of trauma.

Though this intervention appears to be counter to standard hospital practice, it should be considered in future mass casualty situations.

Comment on the Airing of the Killer's Video

Exposure to negative, countertherapeutic imagery is typically a direct and unavoidable consequence of being present at traumatic events.

Exposure to traumatic imagery after the fact is discretionary, and may either facilitate recovery or exacerbate the impact of the trauma on victims.

The management of imagery exposure according to a therapeutic plan is an inherent element in psychotherapy for trauma.

Unwanted or unanticipated exposure to traumatic imagery by victims, such as that provided by the media, can be countertherapeutic and worsen the impact of trauma.

The airing of the killer's video raises a series of compelling questions:

> -Did airing of the killer's video worsen the impact of the trauma on its victims?
>
> -Was airing of the killer's video a collaboration with the killer? That is, did this foster the killer's agenda by continuing to inflict pain and suffering even after his death, and by providing him the notoriety that was a part of his motivation for killing?
>
> -Did airing of the video encourage future mass murderers with a similar agenda?

Lesson 5: Media as Obstacle
Many seemed far angrier with some of the media than at the killer

Impression
Media presence was a conspicuous and per-vasive element of the casualty; one that was all too often counterproductive and sometimes inflammatory. As such, the impact of the media demands scrutiny, and calls for development of a set of management strategies to optimize the beneficial aspects of media coverage and to diminish the potential negative impact.

The intensity, persistence and resourcefulness with which the media seek information suggest that they recognize that information is power.

The commentary that follows focuses primarily on problems encountered with the media and how such problems may be avoided. The behavior of the national and international broadcast media was seen as most problematic, with the local media far less so.

Analysis
Restricting access of media to the hospital setting is well advised.

The primary focus of available resources should be on the victims of trauma (direct and indirect). The combination of the sheer volume of tasks necessary to respond to casualty, in conjunction with time urgency and emotional intensity, places a maximal load on staff time and resources.

Efforts by media to circumvent restrictions on access to the hospital diverted resources from service delivery.

In response to casualty, extra hands are needed with staff functioning outside of customary roles. Those who were needed to prevent inappropriate media access were diverted from other potential helping roles.

Presence of media in the hospital setting creates a high potential for contact that is

unwanted, troublingly intrusive and countertherapeutic – which would potentially undermine the sense of hospital as sanctuary.

There was a shared perception of some in the media as transparently self-serving, insensitive and shameless. There was a widely voiced hope that media behavior was so extremely disruptive and counterproductive at this event that it would trigger constructive self-scrutiny aimed at finding a better way to respond to similar crises.

Although not widely publicized, the coverage did trigger commentary within media circles on ethical management of psychological crises, with specific reference to the VT shootings. For example, see commentary from the Poynter Institute in St Petersburg, Florida (www.poynter.org).

Because of the pervasive and influential impact of media presence, mental health providers need a set of media-related intervention strategies, specific to mass casualty situations, to complement established crisis intervention methods.

Both active (e.g., giving an interview) and passive (e.g., watching television programming) interactions merit consideration as part of media coping interventions.

Mental health providers need to be prepared to address several issues: their own personal behavior with the media; the varying desire of the victims to either interact with or avoid interactions with the media; and milieu-violating behaviors on the part of the media. Simultaneously, local responders should be sensitive to the need created by psychological crisis to educate the general public about psychological issues, and the potential long-term benefits this may provide.

Because of the potentially negative impact of media involvement, the unfamiliarity of many mental health providers with media interaction and the vulnerability of the victims, a relatively cautious and protective strategy is suggested.

Specifically counselors should be to alert to media behavior characterized by insensitivity, entitlement and manipulation.

Critique of Media Commentary
Sam Singer of the Sam Singer Group, solicited as a reviewer of the report to VT Panel, offers the following commentary on media role and function.

> *The media analysis included in the Report to Virginia Tech Review Panel illustrates the critical need for psychological crisis counseling professionals to abide by a comprehensive media policy during a mass casualty event. The analysis, while essentially accurate, fails to fully grasp the complexity of the media landscape, even as it acknowledges that the local press behaved differently than the so-called national media.*

> *It is important to understand the motivations of reporters and editors during times of extreme crisis. More often than not, the information available immediately following a mass causality event is sparse and sketchy. Because of the competitive dynamics engendered by the 24-hour cable networks and the Internet news sites, this information, sparse or inaccurate as it may be, is repeated and speculated upon ad nauseam. The pressure to report new information grows ever more intense for reporters on the ground.*

Typically, most reporters from national outlets are unfamiliar with the community in which the crime/disaster has occurred. While local reporters are able to work their existing sources and information networks, out-of-town media personnel are, at least at first, almost totally reliant on official spokespeople from hospitals, law enforcement, schools, government, et cetera. These spokespeople represent organizations that are trying to protect the public, including primary and secondary victims, and are therefore almost immediately in conflict with reporters struggling to unearth new details.

The hyper-competitive nature of the 24-hour media, the lack of good information following a major crime/disaster and the understandable reluctance on the part of official spokespeople to divulge too many details too soon, results in reporters searching for any avenue of information they can find. These avenues often include eyewitnesses, victims and victims' families and friends, and sources who are not authorized by their organizations to speak to the media.

While this search for information is often aggressive, insensitive, unsettling, frenzied and problematic, it is not the result of reporters' sense of "narcissistic entitlement." It is an understandable, if extremely troubling, result of a combination of factors that often surround a mass casualty event. Understanding these factors better will help us better craft policies and guidelines to protect

victims and their friends and families.

Lesson 6: Making Sense of the Shooter, Cho
How many victims…32 or 33?

Impression
Making sense of Cho is a central question to coping with this tragedy and avoiding future tragedies.

While a detailed treatment of the topic is beyond the scope of this report, observations and comments that arose during the lessons-learned exercise are detailed below.

Analysis
"Is Cho a victim too?"

On the impromptu VT Drill Field Memorial, there were 33 spots--32 named for the victims; and 1 that was unnamed with the message – "We are still praying for you."

At the VT memorial service, a bell was rung 32 times for the victims; At the MRH hospital memorial service, a bell was rung 33 times– which is the right number?

There were ample local anecdotal reports of backlash toward Asian ethnic groups, as well as shame (and fear of backlash) from within Asian ethnic groups.

Similarly, use of the phrase, "Cho qualities," has been noted. Is this dangerous in its over-inclusiveness and intrusiveness? Does it stigmatize those who choose to remain to themselves? Does it further disenfranchise the disenfranchised?

Scapegoating and racial stereotyping would seem to extend the impact of trauma.

Treatment providers should be sensitive to the impact of this effect on clients presenting in therapy, and should work to counter this effect in the community.

Is there a lesson from the Amish (following the mass casualty in Pennsylvania) that forgiveness will help bring peace to the grieving?

Lesson 7: Being a Caregiver and Caring for the Caregivers
With great need comes the opportunity to do great good – and to simultaneously experience great sadness and great satisfaction – and great conflict about this awkward mix of sadness and satisfaction

Impression
A culture of acceptance of psychological intervention, and of psychological distress in response to trauma, in conjunction with readiness to utilize mental health services will facilitate long-term recovery.

Analysis
The long-term impact of trauma on medical, rescue and police is well documented.

Psychological intervention with public safety responders after trauma is emerging as a standard practice.

The efficacy of CISD (Critical Incident Stress Debriefing) in general and the Mitchell Model in particular have recently come into question, seemingly because the limitations of the model render it neither necessary nor sufficient for the full range of interventions appropriate for trauma responders.

However, the importance of some form of critical incident stress management, as a complement to tactical debriefings, is recognized. Alternatives to the pioneering Mitchell Model are available. For example, Psychological First Aid (Brymer et al, 2006) is an approach advocated by both the National Child Traumatic Stress Network (www.nctsn.org) and the National Center for PTSD (www.ncptsd.va.gov).

Implicit in the above commentary is a question as to the best way to implement crisis-counseling services for hospital staff in the immediate-post-trauma time period.

At MRH, a prevailing attitude regarding crisis intervention arose that was characterized by these elements: general acceptance (and the absence of stigma for those participating); readiness to adjust work schedules to accommodate those requesting services; encouragement for participation from peers and supervisors (with occasional mandated intervention at the discretion of supervisors); and an environment of peer support.

This approach led to a sensible balance between the expectation that counseling would be sought when needed, and respect for individual choice.

Interventions with hospital staff peaked on Day 4 in keeping with Mitchell Model predictions of a peak in need at 72 hours post-incident.

Hospital staff, like many others, felt that their sense of community as a safe haven had been shattered. During debriefings, staff described changes in behavior that reflected fear, uncertainty, and the need to take protective measures (e.g., more-ready access to firearms; development of protective strategies in case of being accosted). When such conspicuous changes are apparent it is likely that the same underlying behavior will be manifested in other more subtle ways.

For all the stressors associated with mass casualty work, it is also a potential time of fulfillment and validation as a professional.

However, caregiver guilt is a potential issue of concern among those who were unable to provide services or who were not satisfied with their performance during the casualty.

Part 2: Psychological Intervention In Mass Casualty:
Recommendations From Lessons Learned

Introduction
Effective intervention rests on flexibility and spontaneity

Impression
Mental health providers have a unique and critical role in crisis intervention. The form, style and purpose of intervention varies according to the time lapsed since the critical incident. There are 3 distinct time frames for service delivery: the first hours, the first days, and the first years. The effectiveness of psychological intervention is linked to broad-based thinking about human behavior, readiness to reach beyond the customs and practices of psychotherapy, sensitivity to the broad reach of trauma in a mass casualty, and willingness to forge partnerships with other providers.

The intervention recommendations presented are specifically focused on the VT Mass Casualty, but are intended to apply to other mass casualty scenarios, in particular those that occur in a college community.

Because the academic calendar of a university has a distinctive rhythm, marked by the comings and goings of students, the timing of any casualty is likely to influence the nature of the impact and the manner of response. Because April 16 is in the latter part of the semester calendar, the intervention needed to address both the reasonable readiness to take exams and the anticipated student exodus at the end of the semester.

Commentary on the Role of Psychology in Disasters: Gheytanci et. al.

From: *Gheytanci et al. (2000)* on lessons leaned from Hurricane Katrina:

> *Unfortunately, psychology as a discipline continues to view its role in disasters as narrowly focused on the final phase of these events, with much of the research, policy, and practice emphasis placed on treating trauma, rather than its prevention. Instead, a comprehensive approach aimed at embedding psychological science throughout the five phases of disasters – planning, crisis communication, response, relief, and recovery – is needed. Such a stance would view psychology as a core component of a broad, interdisciplinary effort to mitigate disasters within a public health framework. (p. 127)*

Comments on Role and Scope

Identifying Role
Recommendations to mental health providers for identifying an effective role follow:

-Think broadly regarding role – provide support and relief from stress and suffering.

-Think broadly regarding scope of service – provide relief from stress and suffering for patients and families and friends and staff and others deemed appropriate.

-Begin with the basics – use psychological knowledge and skills to observe and assess as a means of determining role and scope.

-Be flexible and spontaneous – let go of implicit elements of structure in psychotherapy (scheduling, session length, record-keeping, controlled environment).

-Implicit in these suggestions is the need to NOT be bounded by conventional customs and practices of psychotherapy.

-Implicit in these suggestions is the importance of contributing to a pervasive therapeutic milieu.

Partnerships
Forging partnership is essential to effective service delivery.

Partnerships need to be developed both with those who do, more or less, what mental health providers do and those whose help is needed for mental health providers to do what they need to do.

Mental health providers accustomed to functioning in a general medical environment will naturally develop partnerships with medical staff.

In a public safety emergency, such as a mass casualty, other partners (albeit less familiar ones) are essential to optimal functioning, including human resource (HR) staff, chaplains, and police.

Coordinated efforts among natural partners are essential to optimal functioning in a mass casualty situation.

This can be complicated by the need for a large number of providers to function in concert.

HR and Psychology
HR staff function as practical facilitators for psychological service delivery because of familiarity with the people and the setting,

and the ability to effect logistics (e.g., access, facilities). HR staff optimally blend organizational abilities and psychological mindedness.

Chaplaincy and Psychology
There is a strong common ground, especially in times of great loss.

At MRH, chaplains and psychologists were able to work effectively under the same umbrella.

This coordinated effort maximized synergy of service and minimized potential problems with overlapping roles.

Police and Psychology
The less controlled a scene, the greater the likelihood police will be needed and (hopefully) present.

Police are trained in the assessment and management of human behavior under duress, and have evolved into first responders for those suffering psychological crises.

Police help to ensure safety, and can provide ready access to other public safety resources.

Circles of Trauma
The impact of mass trauma is far-reaching.

"Circles of trauma" defines both the scope of impact and the scope of service.

While the greatest impact is likely to be felt by those most directly affected, the effects of trauma ripple outward through the community to include those killed and injured, their loved ones, public safety and medical responders, and in a collective sense, the community as a whole.

While the primary focus is by necessity on those most directly affected, the reach of trauma is deep, and those in need of service may be easily overlooked.

For example, a student electing to return home after the casualty died in a motor vehicle accident. Should this student be included in the casualty count and memorialized as the others have been?

The counselors from the community providing services are themselves part of the circle of trauma. As a consequence, they should be alert to their personal reactions and emotions, and take care to prevent these from taking priority over those of the client, or otherwise having a countertherapeutic effect.

Strategies for Intervention
The manner and style of psychological intervention is a direct function of the time lapsed since the triggering event.

Strategies for intervention are thus organized according to time frame.

Three time frames are identified: The first hours; the first days; and the first years.

Most mental health interventions in response to trauma come after the fact – that is, at some point beyond the first days – and often months, years or even decades later. The protracted effects of exposure to trauma are well detailed in the psychological literature, as are methods for psychological intervention. Because this time frame is outside the scope of acute response, it will not be dealt with in detail in this report.

Intervention during the "first days" time frame is increasingly well understood but not yet a part of mainstream training for mental health professionals. It is in this period that the prototypical public safety-oriented crisis intervention takes place. Although clearly in a developmental stage, there are a relatively well-established set of expectations, strategies and practices for intervention in this time frame. Many of the lessons learned in the hospital are most immediately and directly relevant to intervention provided in the first days.

The role of psychological intervention during the "first hours" time frame is not well explored, not well understood, and seldom even considered as a component of initial response. The key question is: "What, if any, is the role for the mental health professional in this setting?" Offering analysis and recommendations regarding the role of psychologists is the focus of the section on the first hours.

Discussion of the time frames proceeds in reverse order, from the most familiar and best understood to the least well understood.

Two topics – managing the media and the impact of visual imagery – are treated in detail, and appear after the discussion of intervention that is oriented around time frame.

Intervention by Time Frame

Timeline
As the crisis unfolded, the role of the mental health provider changed. The initial hours were a time of uncertainty, with Day 1 primarily focused on managing people in a general sense (rather than providing counseling per se) - with attention to logistics and information sharing, reacting to the media, and dealing with the shock of the event. By Day 2, much of the information about the tragedy was known, bringing a shift to more of a crisis counseling role. By Day 4, those affected were beginning to return to some

semblance of a normal routine. This coincided with a peak in apparent distress in medical staff, and saw the greatest amount of CISM type intervention. Hospital function and overall crisis service delivery tapered to near baseline by Day 7.

Intervention Compared and Contrasted in Relation to Time Frame
From an operational or logistics perspective, interventions provided during each of the time frames have a distinct look and feel.

As psychological intervention moves from the traditional office setting to the public safety setting, the practice of psychotherapy is progressively deconstructed.

There are certain customs and practices that are implicit in the everyday function of psychotherapy, and that create its distinct look and feel. Intervention is typically for diagnosable mental disorders, appointments are scheduled in advance, personal information is verified and substantial amounts of medically and legally mandated paperwork are completed, clients are staged in a waiting room that is typically quiet and sedate, intervention is on a time clock and is conducted behind closed doors to maximize privacy, encounters are carefully documented and billing records are generated.

Interventions in the public safety setting are distinctively different, as the familiar therapeutic environment is deconstructed. Intervention is less likely to treat a diagnosable disorder than to prevent one. Standards of documentation and privacy are distinctively different, as are the strategies underlying the use of this information. The setting and timing of service delivery are variable and a reflection of the immediate circumstances.

Intervention in the public safety setting calls upon mental health providers to step outside the familiar, into a setting that may be outside their comfort zone, and that demands flexibility and resourcefulness to adapt effectively.

The First Years – Long-term Impact
"The First Years" refers to the long-term impact of trauma. The long-term impact of trauma, including delayed onset of psychological disorders, has long been receiving significant attention.

Acute stress disorder refers to symptoms that are contiguous with the event but that extend beyond the first days. Post-traumatic stress disorder refers to delayed onset of symptoms or to continuous disruptive symptom extending beyond the first months of trauma.

Attention to stress disorders is historically driven by concerns for veterans returning from combat (reaching back to the Vietnam era).

More recently, the long-term impact of critical incident stress has received attention in the public safety setting, driven by awareness of the negative impact of exposure to trauma on public safety responders as demonstrated in performance, as well as retention.

However, methods for managing the long-term consequences – and specifically for preventing post-traumatic disorders or subclinical traumatic responses – are not well understood.

Rendering effective treatment is further complicated by the possibility of delayed onset of symptoms and because the link between trauma and symptoms may not be apparent.

Addressing long-term impact should incorporate a direct approach to management of acute stress disorder, and a preventive approach to post-traumatic response. Potential long-term issues specific to this casualty include:

-survivor guilt;

-over-compensation by men who escaped and left women behind; and,

-backlash toward Asian ethnic groups and perceived loners, whether direct and conspicuous or subtle.

The First Days – Crisis Intervention and CISM
The "first days" time frame begins when the event is controlled (and no longer an active emergency) – metaphorically, when the dust has settled. Once the sense of imminent danger has passed, psychological intervention can proceed without elevated concern for the safety of those involved in service delivery, or concern that the presence of mental health providers will complicate the delivery of other public safety services.

Responders may use established models of service delivery: crisis intervention for victims (direct and indirect), and critical incident stress management for responders.

Crisis Intervention is the general model for intervention with the victims and loved ones. Because this is considered a clinical intervention, its form and style are similar to psychotherapy (mental health service delivery to those with diagnosable disorders). The specific focus is on stabilization of psychological status. Time urgency marks it as distinct among psychotherapeutic interventions.

Critical Incident Stress Management (CISM) is a general model for intervention with public safety professionals. This generally demands special training that is not routinely provided as part of graduate programs in mental health. While it bears many similarities with crisis intervention, it is not considered psychotherapy, is not usually billed to insurance carriers, and is not usually documented according to prevailing clinical standards. It is considered preventive.

While crisis intervention should be in the repertoire of all mental health providers, critical incident stress management may be unfamiliar. However, increasing numbers of mental health and public safety professionals are trained in approaches to critical incident stress management.

Special considerations regarding service delivery in response to mass casualty follow:

A Model of Psychological Dynamics
A simple Loss-Threat model of psychological dynamics does not assume pathology, but does define a potential continuum of response from normal crisis reaction to pathology. The experience of loss is associated with the prototypical depressive response (e.g., sadness, grieving); threat, with the prototypical "anxious" response (e.g., restlessness, worry, fear).

A Public and Shared Experience (see Circles of Trauma, above).
Mass casualty is a community experience. The unique elements of psychological intervention with mass casualty follow from the public nature of the event and a sense of shared experience by community. In contrast, traditional psychotherapy is a distinctively private experience. The grief response reaches broadly and deeply into the community.

There are many in great need of psychological support, both from mental health professionals and from personal support networks.

While counseling interventions may directly address clients' presenting needs, counselors should also be educating those involved in the tragedy to recognize less-obvious signs of the impact of trauma. In this way, the effectiveness of natural support networks may be enhanced.

Members of the community without any direct personal loss or direct exposure to trauma may convey a collective sense of personal violation – as if the community itself had been wounded.

Issues of Responsibility and Accountability

Questions of responsibility and accountability are multifaceted. These may be personal and related to particular individuals' loss, or be more general in nature - reflecting both pragmatic and existential questions regarding public safety.

The public nature of the trauma leads to public witness of the grief response of the victims' loved ones. In some cases, loved ones may seek accountability or look to assign blame. This in turn may trigger public commentary on the issues of accountability and blame, as well as the reasonableness of the response of the loved ones' responses. Because the trauma calls attention to issues of public safety, community debate may follow in relation to pragmatic issues regarding community safety and the effectiveness of public safety agencies.

Existential questions may also arise around the question: "Why and how does such a thing come to happen?" Mental health providers are encouraged to remain within their professional roles and withhold opinions about accountability for a variety of reasons, including limited knowledge and police and public safety policies and procedures.

High-Profile Media

Even the presence of media personnel and the abundance of national reporting about a casualty will present challenges and evoke reactions from those affected by the tragedy. Thus media related concerns are likely to arise in counseling interventions. (See Media as Obstacle, above; and Managing Media Impact, below.)

Issues may range across a broad spectrum from awkwardness with being the object of curiosity to frustration with media coverage and the commentary of pundits.

While mental health professionals are well schooled in protecting the privacy of individuals, they should be cautious in any and all interactions with the media, so they do not inadvertently violate privacy or create the perception that they may have done so.

A Collaborative Intervention Milieu

The distinct manner in which psychological services are provided is a reflection of the time urgency of the event and the need to operate within the structure of a broad-based public safety response. This meant adapting to a hospital environment and integrating efforts with other response service providers.

Adapting to the Hospital Setting

Nursing role and function offers an effective model for integrating intensive psychological services into a hospital environment. Examples include:

-routine check-ins to see if there is a need for counseling;

-staff briefing of patient status at changing shifts; and

-patient continuity in staff assignments.

Coordinating Activities with other Service Providers

There is a need to work within a complex but ambiguous organizational structure and function as a team. This requires forging partnerships and managing issues of rivalry within and across professions.

The First Hours – What is the Role for Psychology?

Psychological responders typically are not operational in the first hours.

However, it does appear that important decisions need to be made that draw on psychological principles and that have a psychological impact. That is, there are psychological interventions made in the first hours. Consequently, there is a role for psychologists in this time frame - through direct involvement, through training of other public safety responders, or both.

The Virginia Tech Panel Report identifies actions taken in the first hours that are psychologically significant, including but not limited to death notifications, and emphasizes the importance of psychologically minded actions in response to trauma.

The experience of mental health responders in the hospital setting reinforced the value of psychologically minded actions in the immediate response to the crisis.

The role for psychology in this time frame is not defined. However, there does appear to be an opportunity to expand the scope and effectiveness of public safety response to crises by bringing psychology into this arena. In recent historic context, there is clearly an expanding role for psychology in public safety including these contributions:

-pre-employment psychological screenings

-post critical incident interventions

-threat assessment

-profiling of offenders

-hostage negotiations; and

-crisis intervention training for officers.

These developments are, in turn, a reflection of an emerging sense of accountability and responsibility in the public safety setting for the psychological wellbeing of citizens.

If there is a role for mental health in the first hours then it is likely to be a natural extension of these services.

If psychological interventions are an important element in mass casualty and other community-wide trauma, then timeliness of response merits careful consideration. By way of analogy, consider the importance of timeliness of medical response to an arterial bleed or a stroke. The sooner care is provided, the better the outcome. The longer the delay between trauma and service delivery, the more significant the problem becomes, and the more complex the intervention becomes.

Timely psychological intervention is the driving concept behind CISM and the related use of debriefings and defusings. Defusings typically take place in the latter part of the first hours, as the dust is beginning to settle.

These are much less common than debriefings, which typically occur during the first days – perhaps in part because psychological responders are less readily available.

Potential Roles for Psychologists

There are varied roles the psychologist may potentially fill in guiding intervention in the first hours. The following suggestions are broadly inclusive, and meant to elicit more detailed inquiry.

Direct interventions: defusings with public safety personnel; crisis intervention with victims and their loved ones.

Consultation: indirect intervention such as providing consultation to other professionals regarding procedural decisions which have a psychologically significant impact (e.g., setting and manner of death notices), or in assessing psychological status of responders by observational methods.

Training: guidance for medical and public safety responders in the management of the psychological status of victims and their loved ones.

The physical presence of the psychologist in this setting is essential to gain understanding of psychologically relevant issues and of the operational constraints of the context in which interventions are to be delivered.

The First Hours at MRH

In the hospital environment in the first hours, multiple functions were unfolding simultaneously: providing urgent medical care; criminal investigation; and implementing the role of the hospital as sanctuary.

In this chaotic environment, medical staff and administrative personnel were compelled to make decisions in response to events driven by exigency of time and circumstance, and the absence of a clear command structure to which to defer decisions.

Psychological guidance did help inform some of these decisions. Of particular importance was balancing the emotional needs of those presenting to the hospital, with the necessity of preventing this support function from interfering with other hospital functions.

The overarching theme of psychological intervention in the first hours was creating a sense of sanctuary. In addition to initiating a formal crisis counseling service, other functions performed included:

-Providing information directly to loved ones;

-Facilitating access to information for loved ones, from varied sources (e.g., police, hospital administrators, university officials, et cetera);

-Management of staging area (e.g., structuring space to accommodate needs, providing food) while minimizing impact on other hospital functions;

-Coordinating services with Virginia Tech Counseling Center;

-Supporting University officials present at the hospital;

-Organizing of ministerial volunteers spontaneously presenting to provide aid (e.g., integrate in crisis counseling services, arranging for chaplain-directed prayer meeting);

-Discussion of media coverage and means for managing this.

The Role of Psychology in Disaster Response and Planning

Commentary on Integrating Psychology in Disaster Response and Planning: VT Panel Report

From: *Virginia Tech Review Panel (2007, August). Mass Shootings at Virginia Tech: April 16, 2007. Report of the Review Panel presented to Governor Kaine, Commonwealth of Virginia.*

The report frequently alludes to the value of a psychologically minded approach to intervention with victims and their loved ones beginning in the first hours. Specific recommendations offered by the report reinforce the participation of mental health professionals in disaster planning and response.

Recommendations

X-4 Training should be developed for FAC, law enforcement, OCME, medical and mental health professionals, and others regarding the impact of crime and appropriate intervention for victim survivors. (pp. 132-133)

X-11 The Commonwealth should amend its Emergency Operations

Plan to include an emergency support function for mass fatality operations and family assistance. The new ESF should address roles and responsibilities of the state agencies. The topics of family assistance and notification are not adequately addressed in the National Response Plan (NRP) for the federal government and the state plan that mirrors the NRP also mirrors this weakness. Virginia has an opportunity to be a national leader by reforming their EOP to this effect. (p.133)

XI-1 Emergency management plans should include a section on victim services that addresses the significant impact of homicide and other disaster-caused deaths on survivors and the role of victim service providers in the overall plan. Victim service professionals should be included in the planning, training, and execution of crisis response plans. Better guidelines need to be developed for federal and state response and support to local governments during mass fatality events. (p.146)

Commentary on the Role of Psychological Practice: Miller

From: *Miller, T. W. (2007, November). Trauma, change and psychological health in the 21st century. American Psychologist, 62(8), 887-898.*

In the American Psychological Association 2007 Award Address for "Distinguished Professional Contributions to Practice in the Public Sector," Miller suggests directions for change in the practice of psychology relevant to crisis intervention services, including modifications in health care delivery paradigms with attention to shifts in clinical populations and points of intervention.

Special Topics
The Impact of the Visual Imagery of Trauma
Visual and other imagery associated with trauma is a point of focus in assessment and intervention in each of the time frames.

Trauma and the imagery associated with it, as typically presented in clinical practice, is private. However, the public nature of the imagery associated with mass casualty adds an additional dimension of complexity, and needs to be considered in providing psychological intervention.

Managing and perhaps limiting exposure to imagery has a potential therapeutic benefit.

The potential for interventions focused specifically on management of visual imagery and traumatic recollections are discussed.

First Days
Assessment of trauma-related imagery in the first days offers a window into the psychological experience of the individual, and provides an opportunity for intervention that is timely and naturalistic.

Visit to Survivors as Intervention
In the course of conducting formal and informal assessments with medical and public safety responders during the first days, the potency of disturbing images was apparent.

An Emergency Department staff member mentioned in an informal encounter that it would be helpful to see the survivors alive, alert and recovering – but assumed this would not be possible, as it ran counter to customary hospital practices. This custom was set aside to allow the visit, which produced a positive result for the staff member and was well received by the survivors.

A member of the hospital clerical staff, who had been called upon to assist with logistics in the Emergency Department treatment areas, presented for consultation with acute distress disorder, marked by vivid disturbing dreams recalling the trauma. This staff member was also provided an opportunity to visit with the survivors, with notably positive benefit, and a rapid and significant decline in disturbing dreams.

Subsequently, a CISM style debriefing was conducted with the first medical responders to the scene, who by all standards had performed extraordinarily well, but whose memories were laden with disturbing im-

ages. A visit was arranged for them with several of the victims. The impact of this visit on the first responders (each of whom were VT students) was remarkable.

Subsequently, visit opportunities were offered to other public safety personnel, with notable benefit for them. These continued to be well received by the survivors.

Analysis of Survivor Visits as Intervention
An analysis of the benefit of this intervention follows, in colloquial terms:

The visual image can be a sticking point in recovering from trauma.

The intrusive negative image is a gateway to the visceral component of traumatic emotions.

Negative images can freeze the person at that moment in time when fear and anxiety are at a peak – and as such are past-centered.

The best countermeasure to traumatic imagery is positive imagery.

Positive images reinforce safety and the reality of the moment – and as such are present-centered.

It was hypothesized that specific positive images of recovery would mitigate the negative imagery associated with exposure to the trauma for responders. That is, to be witness to the survivors' recovery and return to health would function as a countermeasure to the traumatic imagery experienced by first responders and medical providers. Though this intervention appears to be counter to standard hospital practice, it should be considered in future mass casualty situations.

First Hours

During the first hours there is opportunity to restrict access to disturbing scenes, limiting the exposure to particularly aversive images, and thus managing the memory of the event.

This relates to direct exposure to incidents, and indirect exposure via the media.

Varied formal and informal practices are in place in pubic safety settings to limit access to crime scenes for a variety of reasons. It appears prudent to consider likewise limiting access to the imagery of trauma, through the media and otherwise.

Considering the Broadcast of the Killer's Video

The airing of the killer's video raises compelling questions relative to its impact on victims and loved ones:

-Did the timing and the content of the killer's video worsen the traumatic impact of the event?

-If the video did worsen trauma for victims, was its airing balanced by some other benefit?

-Was the TV airing of the killer's video akin to mass marketing of traumatic imagery?

Commentary on Broadcast of the Killer's Video: Capus and Ross

From: *"Decision Examined: Poynter Discussion of NBC's Use of the Killer's Video"*

(http://www.poynter.org/column.asp?id=10 1&aid=121760)

The contrasting views of NBC News (by president Steve Capus) and its local affiliate,

WSLS TV Roanoke, (by Jessica A. Ross) touch on ethical questions, while simultaneously illuminating the differing perspective of the national and local broadcast media.

> *I want to take a moment to explain our decision. I assure you it was not taken lightly. It was only done after careful consideration and with great sensitivity to the families and friends of the victims and the entire community of Virginia -Tech. Steve Capus, NBC News*

> *After a serious editorial discussion, the Newschannel 10 management team has decided to no longer air any audio from Cho Seung-Hui's ranting death tape. We will also no longer show any images of him pointing weapons at the camera. We realize that would only further cause pain to the Virginia Tech community.*

> *-Jessica A. Ross, WSLS TV Roanoke*

Managing Media Impact

The media operate by a code of behavior that is poorly understood by outsiders (including mental health professionals), making effective interaction with the media challenging.

Media training, that is, training in skills and methods for interacting effectively with the media, is increasingly common among those anticipating media contact.

Mental health providers responding to mass casualty need a media plan to address issues including the following: their own personal behavior with the media; the varying desire of the victims (and others) to either interact with or avoid the media; and milieu-violating behaviors on the part of the media.

A media-intervention strategy should recognize and respect the important role media play in bringing news of significant events to the public.

Dynamics of Media Interaction
The manner by which a media interview is sought and conducted is unfamiliar to most mental health professionals.

The experience of the Virginia Tech shootings suggests that media contacts should be approached with caution.

Specifically, counselors are cautioned to anticipate insensitivity, entitlement and deception.

Experiences that serve as the basis for this caution are elaborated below:
The apparent assumption of a right to have access to restricted settings, active resistance to leaving secure areas when asked to do so, and attempting to negotiate based on sense of entitlement – "Do you know who I am?"

Readiness to use deceptive practices to gain access to secure areas.

Apparent lack of concern for the impact of their behavior on victims (e.g., rush to display grieving without asking permission; violation of typical personal space boundaries; disrespect for a stated wish for privacy).

Attempts at access to and control of information to the exclusion of colleagues in the field.

Media-Related Intervention Strategies
General Considerations
Media presentation of an event, whether accurate or not, well intentioned or not, may have a potentially counterproductive or even inflammatory effect.

Providing information is a media role, though there is a lack of any pervasive, rigorous standard for accuracy.

Providing aid and support is not a media role.

Providing entertainment may be a media role.

The interviewee lacks control over the skew or slant of the presentation of the interview.

Counselors Personally Interacting with the Media
   Questions to consider:
-What is the benefit of speaking with the media?

-What are the potential costs of media contact? Examples include the possibility of unintended privacy violations; failure on the part of the interviewee to effectively present the intended point of view; and misrepresentation of one's personal view even when effectively presented.

-If there is a need to communicate with the media, who might best fill that role?

-Be aware of the seductive nature of the media interview. The request to provide an interview can be flattering and cultivate a false sense of importance.

Media-Related Counseling Interventions
About Granting a Media Interview
A question or concern about granting a media interview may arise from victims, their loved ones, medical and public safety responders, or others who are formally or informally consulting with a mental health professional. The goal is to facilitate decision-making regarding whether or not to grant an interview.

The counselor may offer information from general considerations noted above.

The counselor may also ask cautionary questions, such as: "What do you hope to accomplish by granting an interview?" and "Do you trust that you will be treated fairly?"

About TV/ Media Viewing

Media viewing, in particular vivid visual presentation of events, can have a potent impact. This may be informative or illuminating; alternately, it may be distressing or disruptive.

A systematic attempt to give careful consideration to the pros and cons of media viewing is likely to be of value, particularly for those who are intimately associated with an event.

Maintaining a Therapeutic Milieu

Media intrusion is a systems problem to which all should be alert.

In response to acute crisis, mental health providers need to cultivate a sense of sanctuary for victims, and thus also to be vigilant to unwanted media intrusion.

Examples of milieu violations include the following:

-Direct attempts to physically cross security lines;

-Attempts to enter through restricted access points (e.g., staff entries) as staff exit;

-Bait and switch tactics, such as asking for access to a bathroom then proceeding to secure locations;

-Misrepresenting identity in order to gain access, including use of disguises;

-Unsolicited contacts with victims and family via contact information acquired from various information databases (e.g., using vehicle license numbers as a means to obtain personal information);

-Contact with hospital staff under false pretenses, (e.g., posing as representatives of insurance companies seeking access to patient information); and

-Unsolicited and deceptive contacts with staff (e.g., posing as members of organizations with whom staff are affiliated).

Concluding Comments

It is tempting to think of the media as a single entity, when in fact it is a truly diverse enterprise. A particularly important distinction seems to be between those media outlets that are exclusively news-oriented and those whose mission is skewed toward entertainment. In general, the offensive behavior noted in this report was more typical of the national broadcast media than of local media, and of broadcast media than of print media.

The interests of the mental health professions and the media converge where issues bearing on mental health are newsworthy, as in the Virginia Tech Shootings. Given this potential common ground, in conjunction with the right, need and expectation of the public to be informed of important events, the media are among the groups with whom mental health providers should seek to form partnerships. How mental health professionals could best embark on this task is outside the scope of this report.

However, the relatively favorable feelings toward local media are noteworthy. Perhaps this is because as members of the community, the local media have a true sense of ownership, and are more inclined to form

partnerships. The deep and intensely offensive feelings evoked by some in the national broadcast media may be related to their projection of a false sense of ownership that is perceived as entitlement.

If mental health-media partnerships are to be realized, proactive planning for interaction in times of crisis is necessary. Given the emotionally compelling nature of the task faced by mental health crisis responders and their potential lack of media intervention skills, this particular group is likely not well positioned to respond to the media. A more pragmatic course may be for professional mental health organizations, with access to experts and existing media plans, to implement the media partnership, involving local providers in those ways deemed most reasonable.

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