

“All the DRT”

**The Newsletter of the Child & Family Disaster Research
Training & Education Initiative**

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“All the DRT” on Interventions for Children and Adolescents

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All the DRT is the newsletter of the Child and Family Disaster Research Training (DRT) & Education Initiative, one of three disaster research training grants funded by the NIMH, NINR, and SAMHSA. The goal of the project is to enhance the nation’s capacity for conducting rapid, post-event, disaster mental health studies.

The goal of *All the DRT* is to provide you with current information about the DRT project and inform you about research conducted in the area of disaster mental health. We hope you enjoy reading our newsletter and continue to support this important area of research.

RESEARCH on Interventions for Children and Adolescence

An Interview with *Judith Cohen, PhD*

Judith A. Cohen is a Board Certified Child & Adolescent Psychiatrist and Medical Director of the Center for Traumatic Stress in Children & Adolescents at Allegheny General Hospital in Pittsburgh, PA. With her colleagues, Dr. Cohen has developed and tested Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for traumatized children, described in the book *Treating Trauma and Traumatic Grief in Children and Adolescents*. Dr. Cohen has served on the Board of Directors for the American Professional Society on the Abuse of Children and the International Society for Traumatic Stress Studies (ISTSS). She is Associate Editor of ISTSS's *Journal of Traumatic Stress* and co-editor of its forthcoming published guidelines for treating PTSD. Dr. Cohen is principal author of *Practice Parameters on Posttraumatic Stress Disorder*, published by the American Academy of Child & Adolescent Psychiatry, which awarded her its 2004 Rieger Award for Scientific Achievement. Dr. Cohen publishes trains, consults, teaches extensively, and sees clinical cases related to the assessment and treatment of childhood trauma. She and her colleagues have recently revised TF-CBT for Childhood Traumatic Grief (CTG) and they have conducted three pilot studies supporting the efficacy of this treatment approach for traumatically bereaved children and their parents. *All the DRT (ATD)* interviewed Dr. Cohen in September.

ATD: Dr. Cohen, tell us how you became involved with the field of child trauma?

JC: *My interest in child abuse began as an undergraduate, when I did my honor's thesis on the psychobiology of contraception and learned about the high rate of child sexual abuse. This interest was reinforced during post-graduate training in pediatrics and then child psychiatry, when I worked with Dr. Ellen Frank on a research grant treating adults and older adolescents who had experienced rape. Dr. Frank encouraged me to develop and test interventions for children and younger adolescents who had experienced sexual abuse, because nothing was known about effective treatments for this population. Around this time, I also started working with Tony Mannarino, who was seeing many children as part of his work with Child Protective Services. We started to systematically evaluate psychological symptoms in children who had experienced sexual abuse, and that was the start of our ongoing collaboration into how to effectively treat traumatized children.*

ATD: What are the major interventions in the field of trauma and children?

JC: *Simply put, the major interventions for traumatized children include the following: individual therapy (primarily cognitive behavioral, client centered, attachment/psychodynamic, and other), family, group (school-based and other), and pharmacologic.*

The treatments that have the most evidence of efficacy for traumatized children are cognitive behavioral, such as TF-CBT (Trauma-Focused Cognitive Behavioral Therapy) and CBITS (Cognitive Behavioral Intervention for Trauma in Schools), and dyadic attachment therapy for young children (Child Parent Psychotherapy). These treatments have more things in common than that differ from each other. Good therapy is good therapy, and I suspect that this will be true for most types of effective treatments: they will share or overlap in many of their effective components, even if they have some unique components as well. It is important to recognize that many treatments have not yet been tested, so we can't say whether or not they are effective. However, to the extent that they are similar or different from interventions that have been tested, we can draw some inferences.

One of the things research seems to suggest is that directive treatments in which traumatized children are encouraged to talk in some way about their traumatic experiences—rather than continuing to avoid the feared reminders—and where children learn coping skills are superior to non-directive treatments where children direct the pace and content of treatment (and are therefore able to continue to use avoidant strategies). With this said, when good, empathic therapists provide child-centered therapy to children and parents, these children also improve significantly—just not as much and not as quickly as children who receive more directive treatment.

ATD: What are the major components of TF-CBT?

JC: *The components of TF-CBT are summarized by the acronym PRACTICE: Psychoeducation, Parenting skills, Relaxation skills, Affective modulation skills, Cognitive coping, Trauma narration and cognitive processing, In vivo mastery of trauma reminders, Conjoint child-parent sessions, and Enhancing safety and developmental trajectory. These components are described in detail at <http://www.musc.edu/tfcbt>.*

ATD: You and your colleagues are well known for your groundbreaking interventions in the field of child abuse. What are the differences between working with abused children and working with children traumatized by disaster?

JC: *I've found many parallels in working with children who have experienced abuse and children exposed to disasters. In the acute aftermath, there is uncertainty and fear; families' and communities' resources are challenged to meet the child's needs; and most families are highly distressed. Over time, resilience is the rule, but many children have ongoing mental health problems. Barriers often prevent children from having access to high quality care in both situations.*

Research has shown that children who are most affected by either disasters or child abuse are often those who have experienced multiple previous traumatic events. So contrary to expectations, many—if not most—children identified after community disasters don't identify the disaster as their worst or only traumatic event. We saw this after 9-11 and Hurricane Katrina. Many of the

highly affected children had experienced previous traumas for which they had never received treatment. Disasters, thus, provide a window of opportunity for identifying and treating traumatized children who otherwise would not receive services. This is not to say that disasters are not in themselves traumatic, but the most vulnerable children may be those previously traumatized children who never received prior interventions.

This raises the issue of "siloining" types of traumatized children and treatments, which I believe is a disservice to our field and to traumatized children.

ATD: Could you explain what you meaning by “siloining” and speak more to that?

JC: *By siloining, I mean dividing treatments and treatment studies according to a specific type of trauma that children have experienced. So for example, children who have experienced sexual abuse are evaluated under a "sexual abuse" study; children who have experienced community violence are evaluated under a "community violence" study; and children who have experienced domestic violence are evaluated under a "domestic violence" study, and so forth.*

The research suggests that this is probably a false division, since most of the children we are seeing have experienced multiple traumas. Additionally, there is no evidence to suggest that, if children have developed PTSD symptoms, these symptoms differ according to the type of trauma the child has experienced (e.g., Saunders, 2003). So a treatment model that is effective in treating children's PTSD symptoms for one type of trauma should theoretically be effective for children's PTSD symptoms for another type of trauma, and we should not have to keep testing it repeatedly for every imaginable type of trauma that children could be exposed to.

For example, CBITS has been tested in school settings for children exposed to community violence and for children exposed to disasters. But those were just the traumas that the studies focused on. We know that many of these children also experienced other types of traumas, and that these children experienced improvement. Do we really have to test CBITS for every other type of trauma before we can say that it works for children's PTSD symptoms in school settings, period?

The same is true for Child Parent Psychotherapy for young children. So far, it has been tested for children exposed to domestic violence. Similar interventions have been used for very young children and infants exposed to early loss of parents, neglect, and so forth. Most of these children experienced multiple traumatic events. Do we really believe that these children or their parents didn't experience improvement in their PTSD symptoms related to these other events? Of course they did. Why do we have to test CPP for every other traumatic event? Doesn't it make sense to assume that CPP will work for preschool children's PTSD symptoms, period? Why waste time testing it over and over again for every different type of trauma, when it is PTSD symptoms that we are concerned about, not different types of traumas? Once you have developed the same symptoms,

similar interventions (with some modifications to address the specific trauma type) should work.

This is what we have found with TF-CBT so far (e.g., sexual abuse, multiple traumas, disaster) and this is what we expect to continue to find both with TF-CBT and with other types of child trauma treatment. It doesn't make sense to keep testing each treatment for every imaginable type of trauma. This "silo" approach is not the best use of our limited resources.

ATD: In your article *Interventions for Children and Adolescents*, you talk about the protective factors that parents can provide. Would you speak more to that?

JC: *Parents can contribute to children's positive outcomes in a variety of ways. First, higher levels of parental support significantly predict more positive outcomes. Second, parental support is not static; it can be enhanced (for example, through CBT interventions), and such enhancement leads to more positive outcomes. Third, parental PTSD is correlated with PTSD in children, which suggests that successful treatment of parental PTSD and other psychopathology will contribute to more positive child outcomes. Fourth, parental emotional distress significantly predicts poor child outcomes. Resolving parental distress (for example, through CBT interventions) will lead to more positive child outcomes. Finally, parents who receive CBT interventions learn positive parenting skills that lead to less behavioral problems in traumatized children.*

ATD: What is the current thinking on debriefing as an intervention for use with children?

JC: *The current research on psychological debriefing is limited. One well-controlled and well-conducted study did not show significant benefits (or harm) for children who received debriefing. However, we need more research with regard to brief, acute interventions since brief interventions of some type may be important options to offer some children, especially in large scale community traumas.*

ATD: What are the challenges of researching the effectiveness of interventions in this area?

JC: *The main challenges of researching acute interventions—those provided immediately after child traumas—are that many children don't seek treatment in the acute aftermath of trauma and that we don't know which children will benefit from acute treatment and which children don't need it.*

There is controversy over whether it is beneficial to provide treatment to children in the immediate aftermath of trauma exposure. We know that some proportion of children will recover spontaneously. We also know that some proportion of children will go on to develop significant lasting PTSD symptoms.

If we knew which children were which, we would provide acute treatment to those in the second group and provide watchful waiting to all others. The challenge of conducting a study of acute treatment is that we know we will be

getting a biased sample. Even with that said, it is extremely challenging to conduct such a study with any population other than medically injured (for example burn victims or motor vehicular accident victims), because arranging for IRB approval for informed consent requires anticipating the scenario leading to the acute trauma before it occurs. This is virtually impossible to do. One exception is the current NIMH disaster grant, although the approved research focuses on adults, not children. Thus, it is again unlikely that any acute treatment outcome research (other than perhaps for Psychological First Aid, which is not treatment) will be conducted in the acute aftermath of any trauma other than medical, such as a motor vehicle accident.

ATD: In your article, *Interventions for Children and Adolescents*, you say, "...There is still much to be learned in order to ensure that all children receive the best possible care in these tragic situations." Please describe what areas need to be researched and what needs to be done to ensure that all children receive the best care.

JC: *In order to conduct acute child treatment outcome research in the area of disasters, it will be necessary to design studies pro-actively (i.e., to obtain IRB approval before the disaster occurs). So far that hasn't happened, and as a result, child treatment studies after disasters have started months rather than weeks after the disaster. These studies have yielded important information, but so far, none about acute interventions.*

ATD: Thank you, Dr. Cohen, for your time and for your continued work on behalf of children and adolescents.

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PROJECT UPDATE:

Child & Family Disaster Research Training & Education Initiative

The Child and Family Disaster Research Training and Education Project (DRT) is in its fifth and final year. The goal of the DRT project is to enhance the nation's capacity for conducting rapid post-event disaster mental health studies, drawing on the extensive experience of the nation's leaders in child trauma. To meet this goal, ten Research Teams

(RTs) have been established and taught the skills necessary to design and conduct studies in the aftermath of a disaster or terrorist incident.

Research Team (RT) training and updates:

The University of Virginia School of Medicine RT, under the leadership of Ed Kantor, MD, received its final training on June 27, 2008. Led by Brian Houston, PhD, the training—entitled “Designing and Conceptualizing a Child and Family Disaster Mental Health Research Project”—involved RT members working together to identify and operationalize a disaster mental health research project. Virginia RT members will finalize and implement their research project in the coming months. The University of Virginia School of Medicine RT was the final research team to complete their DRT training.

In this final year, several RTs will be completing projects developed during their participation in the DRT program. The Melissa Institute for Violence Prevention and Treatment RT in Miami, Florida has collected over 800 disaster preparedness needs assessments completed by teachers, administrators, and staff in the Miami Dade County Public School District. The Melissa Institute RT will analyze the needs assessment data over the coming months and will work with Miami school district personnel to locate training for school teachers and staff that addresses the needs identified in this assessment. The Northwest Center for Public Health RT, led by Randy Beaton, PhD, is finalizing a public health manuscript that describes and discusses the roles and responsibilities of public health systems in addressing disaster mental health outcomes in children and families.

Curriculum Update:

Brian Houston, PhD, has developed a new module for the DRT curriculum, “Designing and Conceptualizing a Child and Family Disaster Mental Health Research Project,” on how to develop and conduct a disaster mental health research project. Through group-based experiential work, the module helps participants identify a disaster mental health research topic, develop an appropriate research method and protocol, create appropriate disaster mental health research instruments, and establish a plan for implementation of the research project.

Curriculum Advancements:

The Yale University School of Medicine RT, led by Steven Marans, PhD, Steven Berkowitz, MD, and Hilary Hahn, EdM, MPH, finalized an adaptation of the DRT curriculum focused on the importance of, and approaches to, disaster mental health research that can benefit first responders and their families. The Oklahoma State Agency RT, led by Steven Davis, PhD, David Wright, PhD, and Tracy Leeper, MA, is adapting the DRT curriculum for training state department of mental health administrators, clinicians, and evaluators and will focus on the importance of disaster mental health issues for state mental health agency personnel. The curriculum will provide instruction on how to use data to inform and evaluate the delivery of disaster mental health services.

If you are interested in more information or have questions about the DRT curriculum or trainings, please e-mail us at tdc@ouhsc.edu.

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PROJECT HIGHLIGHT:

Yale University Child Study Center Research Team Develops DRT Curriculum Adaptation for First Responders and their Families

In March of this year, under the leadership of Steven Marans, PhD, Steven Berkowitz, MD, and Hilary Hahn, EdM, MPH, the Yale University Child Study Center Research Team (RT) conducted a two-day curriculum development meeting in New Haven, Connecticut. The meeting of representatives from the first responder and mental health research communities was held to determine how best to adapt the DRT curriculum to address research involving first responders and their families.

Contributions to the first responder curriculum came from attendees Linda Degutis, DrPH, Director of the Yale Center for Public Health Preparedness and Associate Professor of the Yale Department of Surgery and Emergency Medicine and School of Public Health; Dean Esserman, Colonel of the Providence Police Department; Richard Gist, Principal Assistant to the Director of the Kansas City Missouri Fire Department; Christina Hoven, DrPH, Assistant Professor at the Columbia University Mailman School of Public Health; James Mosley, Director of Public Safety City of Wilmington, Delaware; and Francisco Ortiz, Chief of Police (retired), New Haven, Connecticut Department of Police Services.

The curriculum adaptation that emerged from this meeting has been completed by Steven Marans, PhD, Steven Berkowitz, MD, and Hilary Hahn, EdM, MPH, of the Yale Child Study Center RT. Entitled “First Responders and their Families: Partners in Research on Disaster and Terrorism,” the curriculum addresses the importance of involving first responders and their families in the process of disaster mental health research and how such research can be structured. The Yale Child Study Center RT is developing a plan for implementing the first responder curriculum in the coming months.

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DISASTERS IN HISTORY: The Halifax Explosion of 1917

On December 6, 1917, as the workday began and as children were on their way to school, a munitions ship in Halifax Harbor, Nova Scotia collided with a relief vessel, resulting in the largest manmade explosion until Hiroshima.

The explosion occurred during World War I, when Halifax was Canada's major eastern port. Ships supplied with food, ammunition, and troops convened in Bedford Basin, and then linked up with heavily armed escort warships for the trip across the Atlantic. The roads, railways, and waterways teemed with traffic: troops garrisoned in Halifax, families visiting their sons before they headed off to war, and young men seeking the readily available jobs. The waterfront was bustling with activity day and night.

The cargo ship, the *SS Mont Blanc*, chartered by the French government, had arrived from New York City loaded with explosives and volatile material. Although precautions had been taken, such as lining the holds with wood and using non-sparking copper nails, there were over 2500 tons of various explosive materials on board.

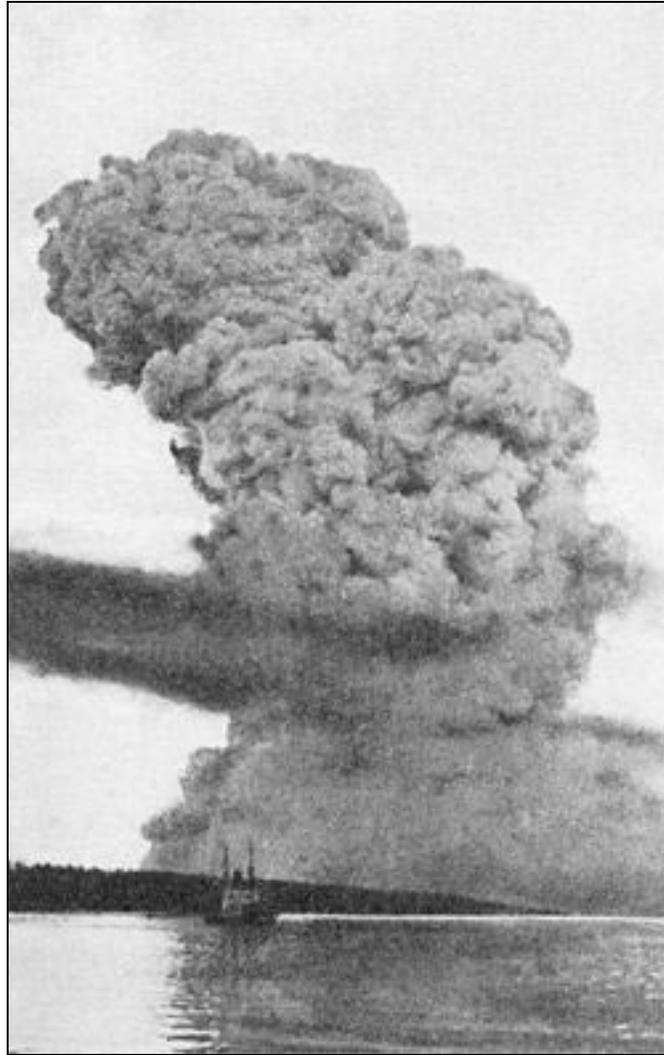
The Norwegian *SS Imo* had been chartered by the Commission for Relief in Belgium. Her cargo holds were empty, as she was on the way to New York to load up on relief supplies. "Belgium Relief" was painted on her sides to communicate neutrality.

The *Mont Blanc* had been due into the harbor the night before, but she arrived too late to be let through the anti-submarine nets and had to wait until the next morning. That was when the *SS Imo* weighed anchor and, behind schedule, headed for sea at a brisk pace. It has been suggested that since her cargo holds were empty she may have been traveling at a much faster speed than normal.

At 8:40 a.m., in the area of the harbor called The Narrows, the two ships collided. Benzol drums on the *Mont Blanc* broke loose, spilling fuel on the deck. Ten minutes later the *Mont Blanc* was on fire. It drifted, finally coming to rest against Pier 6 in the industrial district called Richmond. The captain and the crew, thinking they had hit a mine and acutely aware of the volatile cargo, launched lifeboats and fled to the opposite shore. Workingmen and children on their way to school joined the crowd gathering along the shore to watch the burning ship.

At 9:04, the *Mont Blanc* exploded, knocking down houses, spewing shrapnel and searing debris, and blinding and wounding or killing most of the bystanders. The ship was

completely decimated. The explosion actually sucked some people into the air and deposited them a quarter mile away. The *SS Imo* captain and crew, along with the crews of many other vessels, perished in the explosion.



The “mushroom cloud” over Halifax.

An area of 325 acres of Halifax was flattened by the explosion’s pressure blast. Fragments were carried for kilometers. Most windows in the city were blown out, trees were snapped, iron rails were bent, and all structures along the adjacent shore were obliterated. The explosion created a tsunami in the harbor and waves crashed along the shoreline, tearing ships from their moorings, throwing some ships on land, and sinking smaller boats. The tsunami surged north to Tufts Cove wiping away an entire encampment of the indigenous Mikmaq tribe. As if the explosion and tsunami had not done enough damage, fires broke out as overturned stoves ignited the newly collapsed houses. Over 2,000 men, women, and children died, and over 9,000 people were injured.

Much of the infrastructure of Halifax was gone; the Richmond railway yards, the naval college, the Protestant Orphanage, the Richmond Printing Company, the Arcadia Sugar Factor, the Hills and Sons Foundry, the two largest general stores, two churches, two schools, three piers, shipyards, Oland's brewery, and the Dartmouth city rink were decimated. And above it all, hung a huge mushroom cloud, first black with debris, and then white. Rumors spread that the Germans had bombed Halifax.



Ruins of Hillis & Sons Foundry, where 41 people died

The early relief efforts were not coordinated. Like many cities of the time, Halifax was not prepared for a large disaster. There were too few hospitals for the wounded and too few morgues for the dead. Firemen worked half-time; the police force numbered 47. There were few social services and no public safety committee. The dead and injured were carried to the hospital in wagons, cars, fish trucks—in whatever vehicle could be driven, by whoever could drive. Civil servants—police, fire, and soldiers—arrived on the scene and worked to put out fires, pull survivors and the dead from collapsed buildings, and nurse the wounded. Identification of bodies was difficult. Babies and children separated from families could not be identified; people died before their families could find them. The wounded and the survivors walked stunned through the streets, heading to Point Pleasant Park, to Citadel Hill, or to other fields or parks. Many were not dressed for the cold. The Red Cross, The Salvation Army, and St. John's Ambulance Brigade went through the streets giving first aid and handing out clothing. Canadians from the outskirts of Halifax and nearby areas poured into the city to help.

The city set up the Halifax Relief Committee, with subcommittees for transportation, emergency, food, and finance. Thousands of people who only had what they had been wearing that morning, needed clothing. By the end of the day, all the homeless had found shelter in theatres, meeting halls, boxcars, church basements, and schools. Even prisons were emptied to give beds to the homeless. And it was not a moment too soon: the next

day a blizzard blanketed the city of Halifax with 16 inches of snow, impeding relief, rescue, and recovery efforts.

Luckily, national and international relief was on its way. Supplies—clothing, food, building materials, and skilled workers—began arriving from other parts of Canada by train within 48 hours. U.S. volunteers, mostly from Massachusetts, came and remained for months. Relief donations are estimated to have been over \$23 million.

Most people in the United States are unaware of the Halifax Explosion of 1917, but important lessons have been learned and applied to maritime standards and emergency planning nationally and internationally as a result of this disaster. Policies now include stricter regulations on dangerous cargoes, reporting standards, and traffic management, and Halifax's response to the explosion informed the evolution of Canada's Emergency Measures Organizations (EMOs).

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BOOK REVIEW: Disaster Books

All the Dirt staff has utilized many books for the Disasters in History series. Below is a list of several of those books for your convenience.

Barry, John M., *Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America*. Simon & Schuster. New York. 1997.

John Barry's books are not for the faint of heart. Not only does he cover epic topics, but Barry also covers them in extraordinary depth, as witnessed by this volume's 465 pages of narrative, 53 pages of notes, and a 15 page bibliography. Barry's book on the Mississippi river flood and its impact on US society reads like a novel. He transforms his research—detailed minutes of public meetings, transcripts, letters, newspaper accounts, and memoranda from the era, along with interviews of 125 people—into a riveting, fast-paced narrative with actual conversations from 80 years ago. Barry is able to convey clearly complex scientific and political issues. Reading *Rising Tide*, one is awed the power of the vast and implacable Mississippi, saddened at the desperation of those who suffered in its wake, and made aware of the long-lasting significance of the flood of 1927. As Wil Haygood of the *Boston Globe* describes in his review:

The river inundated the homes of nearly one million people, helped elect Huey Long governor and made Herbert Hoover president, drove hundreds of thousands of blacks north, and transformed American society and politics forever.

Kitz, Janet F., *Shattered City: The Halifax Explosion and the Road to Recovery*. Nimbus Publishing Limited. Halifax, Nova Scotia. 1989.

Janet Kitz became interested in the Halifax explosion through her husband's mother and sister who were survivors of the 1917 disaster. Initially researching for an anthropology paper, Kitz began interviewing survivors, collecting materials, reading old newspapers, and exploring the Public Archives of Nova Scotia (PANS). In 1981, she was invited by the curator of history at the Nova Scotia Museum to examine, and subsequently to catalogue, hundreds of unclaimed effects from dusty boxes and 187 cloth bags that had been untouched for 64 years. Kitz' account, while first person in its voice and perspective, is a comprehensive one, covering the facts and the human stories behind the events leading to the explosion, the rescue efforts, the relief efforts, the recovery, and—in an epilogue—the building of the memorial bell tower and the burial of a time capsule to be opened on the hundredth anniversary of the explosion on December 6, 2017.

Laskin, David. *The Children's Blizzard*. Harper Perennial. 2005

David Laskin tells the story of what has been called the School Children's Blizzard, where between 250 and 500 people—many children—perished in the snow and ice before they could find adequate shelter. The morning of January 12 had been rather mild across the plains of Minnesota, Nebraska, and the Dakota Territories. Then a storm came up without warning; a blinding sheet of whirling snow swept across the plains and the temperature plummeted to 25 degrees below zero. Because it had been so mild, farmers had taken their wagons into town, men were in the fields, and others were out on horseback or walking. As the storm approached, some children remained at school, while others were sent running home only to be caught by the freezing blizzard. Laskin writes a moving drama of the plight of the homesteader families and the hundreds who lost their lives, but also explains the rudimentary meteorology of the times, the politics of the Army Signal Corps, the science of hypothermia, the impact of the storm on westward migration, and the controversy that arose in the newspapers in the days following the blizzard. Laskin chronicles five pioneer families, from the stories of their immigration to their experience of the worst storm in memory. Laskin writes with poignancy, recounting both the fateful decisions that resulted in tragic death and the numerous acts of heroism.

Steinberg, Ted. *Acts of God: The Unnatural History of Natural Disaster in America*. Oxford University Press. 2006

Ted Steinberg has written a well-documented, highly researched history of natural disaster in America, but he is far more interested in the role that humans play in disaster than in the role of nature. Beginning with chapters on the disaster histories of Hannibal, Missouri; Charleston, South Carolina; San Francisco, California; and the state of Florida; Steinberg details how U.S. government officials' and business leaders' responses to disaster have contributed to a "continuing cycle of death and destruction." Citing examples of the plight of the

poor, minority, immigrant, and other underserved communities, Steinberg supports his premise that “the traditional response to natural disaster does not benefit everyone equally.” Steinberg, a Case Western Reserve University professor and environmental historian, points out the increasing numbers of people killed in disasters in the last half of the 19th and first half of the 20th centuries during a time in which more and more development occurred by building on landfill, on water, and seismic-prone areas. In a post-Katrina preface to the second edition, Steinberg indicts the administrations of Bill Clinton and George Bush and their policies of deregulation, privatization, out of control development, and cutbacks in social programs for the tragic results of the 2005 hurricanes in the Gulf Coast.

Barry, John M. *The Great Influenza: The Epic Story of the Deadliest Plague in History*. Viking Penguin. 2005.

Readers who enjoyed Barry’s *Rising Tide* will not be disappointed by *The Great Influenza*, the story of the 1918 pandemic that killed 100 million people worldwide. Barry originally planned to take three years to write about the influenza plague, detailing its presumed origin in Kansas to its toxic migration throughout the world (save Australia), and introducing the reader to the scientists who tried to battle the pandemic and the political leaders who tried to respond to it. Seven years later, Barry has completed a powerful narrative, exploring in depth the nature of American medicine: the development of Johns Hopkins Medical School under William Welch, the establishment of public health and its role in epidemiology and prevention, the breakthroughs in understanding the war between virus and the immune system, the search to find a vaccine to prevent and a serum to cure influenza, the progress of scientists from doing informed guesswork to good science. Barry has researched the material exhaustively, yet his powerful narrative reads like an epic novel. He has captured the terror of the times, the “fear, not the disease” that “threatened to break society apart,” and the stories of those who tried to control the uncontrollable.

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REVIEW of RECENT ARTICLES & REPORTS:

- [Chapter: Children and Debriefing: Theory, Interventions, and Outcomes](#)
- [Article: Developmental Considerations in the Use of Cognitive Therapy for Posttraumatic Stress Disorder](#)
- [Chapter: Interventions for Children and Adolescents](#)

CHAPTER SUMMARY - WRAITH

Children and debriefing: Theory, interventions and outcomes. – Ruth Wraith. In *Psychological Debriefing: Theory, Practice and Evidence*. Raphael & Wilson, (Editors). Cambridge University Press. 2000.

This chapter describes the concept, process, and technique of debriefing for children affected by critical incidents and attempts to clarify some of the definitional confusion surrounding the practice. When adapting debriefing practices for children, the author stresses that failing to pay attention to developmental issues may put children at risk for higher levels of stress and distress, as well as for secondary traumatization when debriefing is conducted in a group setting.

A critical first step in debriefing, according to Wraith, is reestablishing a sense of safety before engaging in debriefing practices with children. Drawing upon conceptual and theoretical guidance, the author carefully examines the pro and cons of individual versus group debriefing practices for children.

Only cursory attention is paid to issue of when debriefing should take place. While it is mentioned that debriefing for adults is usually conducted “in the time between the emergence from the state of shock and numbing” and before a “consolidation” of the stressful event can take place, no further information is provided to substantiate how this timeframe may best be pinpointed.

The author mentions that on the conceptual level, debriefing “provides the opportunity” for an “accurate cognitive framework of the experience, the recognition and validation of incident-related experiences and feelings, reassurance of the appropriateness of these and information about their management.” However, Wraith goes on to state that whether or not this may be obtained through debriefing continues to be an empirical question. Thus, the following sections of the chapter are couched within a conditional acceptance of the appropriateness of debriefing for children.

Wraith suggests that debriefing follows psychological first aid strategies. Specifically, the author outlines how, for children, psychological first aid may be useful in the immediate disaster aftermath before debriefing takes place. It remains unclear when debriefing becomes appropriate and whether or not a psychological first aid/debriefing combination may, in effect, comprise a wholly different approach to addressing stress and distress in children after critical incidents.

The author cautions that delivery of psychological first aid and debriefing should only be done by individuals who meet certain criteria: someone who is known and trusted by the child; someone who knows each child developmentally and functionally; and someone who understands child development, childhood trauma reactions, childhood

psychopathology, and family and group practices. However, it is doubtful that such qualifications will be present in the wide range of potential psychological first aid/debriefing providers, as such in reality providers may be teachers, scout leaders, and others.

Not surprisingly, the unanswered questions raised in the latter part of the chapter have served as important guidelines to the field when developing early response strategies for children subjected to stressful events. Should children be subjected to debriefing? Should they be mandated to participate? Can harm befall children who participate in debriefing groups? In other words, what is the evidence that debriefing, whether preceded by psychological first aid or not, is safe for children?

As noted in the editorial comments to this chapter, given high clinical skill, debriefing may be safe and useful. However, can potential safety ever suffice when dealing with children?

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ARTICLE SUMMARY – VERNBERG

Developmental Considerations in the Use of Cognitive Therapy for Posttraumatic Stress Disorder. – Eric M. Vernberg and Craig Johnston. <i>Journal of Cognitive Psychotherapy: An International Quarterly</i> . Volume/Issue 15, 223-237, 2001.
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This article adds substantial dimension to the discussion of trauma-related treatment in children and adolescents by paying careful attention to developmental sequela and factors. The authors outline how the symptomatic presentation of PTSD may be affected by child development and discuss developmental differences in arousal tolerance and the use of avoidance as a coping strategy.

To increase coping in trauma-affected youth, the authors stress the importance of designing CBT-based interventions in age and developmentally appropriate forms. As an example of such an approach, the “*Coping Cat*” protocol¹ is mentioned. Further, the benefits of relaxation training, thought-stopping, and restructuring techniques are

¹ *Coping Cat Workbook, Second Edition*, by Philip Kendall and Kristina A. Hedtke. Child Therapy Workbooks Series (2006).

discussed. The use of exposure—gradual exposure as well as flooding—as a therapeutic technique for reducing PTSD is outlined.

Vernberg and Johnston argue that receiving education and accurate information about the stressor is useful in helping children discuss a traumatic experience in more rational and pragmatic ways. In so doing, youth can regain a sense of control and calm over their physiological and emotional reactions.

The authors further stress the importance of considering contextual factors in the treatment of PTSD in youth, specifically, the link between parents' behavior and their ability to provide support to traumatized children and adolescents. Also important is the need to address issues pertaining to continued disruptions and trauma exposure, as well as comorbidity with other related disorders. Thus, the authors call for treatment approaches that not only are symptom-specific, but also are developmentally- and contextually-sensitive to therapeutically address the entire spectrum of the trauma exposed youth's functioning.

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CHAPTER SUMMARY - COHEN

Interventions for Children and Adolescents Following Disasters. – Judith A. Cohen, Anthony P. Mannarino, Laura E. Gibson, Stephen J. Cozza, Melissa J. Brymer, & Laura Murray. In *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice*. Ritchie, Watson, & Friedman (Editors) Guilford Press. 2005.

The chapter (1) presents a review of empirical treatment studies of studies of children following disasters and mass violence and children traumatized by interpersonal violence; (2) discusses benefits and challenges of conducting widespread early screening of children following disasters, and (3) offers a synthesis of which children to treat, how to treat them, when treatments should be offered, and how to optimally train community therapists to provide these treatments.

The authors present a literature review of treatment for children following disaster and mass violence, limited to well defined treatment inventions and those reporting changes on pre- to post-treatment assessment instruments. As one of the most consistent risk factors for developing mental health problems after trauma exposure is a history of past

trauma, the authors also review the child treatment literature regarding interpersonal trauma.

The literature offers the strongest support for TF-CBT (Trauma-Focused Cognitive Behavioral Therapy) and CBITS (Cognitive Behavioral Intervention for Trauma in Schools) approaches; these have similar components: psychoeducation, affective modulation skills, stress management skills, information about the cognitive tripartite model, systematic exposure and contextualizing intervention techniques, cognitive processing of the traumatic experience, and parental skills training. Additionally, there are interventions for children who suffer from traumatic grief including psychoeducation about grief in the context of the child's culture, acknowledging what has been lost, addressing unfinished business and ambivalent feelings, preserving positive memories, recommitting to present and future relationships with the living, and making meaning of the traumatic loss. The authors point out that there are potential advantages to conducting treatments in group settings, particularly in situations of community trauma.

While there is less empirical data to guide decisions about optimal timing of treatment or about early trauma response, the authors offer several recommendations based upon clinical considerations, specifically early use of psychological first aid (PFA), which includes providing basic necessities, optimizing parental adjustment, providing social support and reassurance, and giving age-appropriate information.

Although there are many barriers, the authors recommend the widespread screening of children for significant mental health difficulties and referral of identified children for in-depth evaluation in the acute aftermath of a community trauma. Additionally, they stress that therapists be trained and provided ongoing supervision in evidence-based practices (EBPs) and that these EBPs be used in a manner that is relevant to children's religion, ethnicity, race, language, and cultural community.

The authors continue the chapter with a discussion of military and emergency service professionals, practice considerations in the event of disaster and mass violence, precautionary and reactive strategies for children of the military, and a summary of immediate, short-term, and ongoing response recommendations for families, schools, and communities following community violence. Following a clinical vignette, the authors conclude the treatment review recommending research to (1) accurately identify children at greatest risk, (2) evaluate the efficacy of early childhood and adolescent interventions, (3) determine the optimal timing, dosage, and critical ingredients of TF-CBT for different developmental levels, (4) assess the efficacy and cost effectiveness of pharmacological intervention in the early hours or days after trauma exposure, (5) evaluate treatments other than CBT, and (6) determine the best dissemination strategies.

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~ ASK THE ETHICIST ~**

Editors of *All the DRT* received the following text message from Dr. Ethequel DiLemma, who is in Galveston, Texas. A team from Oblivia University in Alaska is undertaking a research project in the hurricane-affected area that has raised the concern of our ethicist.

Kind Readers of All the DRT:

Please identify the problems in the following research design and suggest how the Oblivians should adjust their design in order to be able to proceed.

With gratitude,

Ethequel DiLemma

This study of school-age children in Galveston, Texas who were affected by Hurricane Ike seeks to generate evidence about the best treatment protocol for children experiencing a major hurricane. In this protocol, children who meet criteria for PTSD, determined by color changes in a mood ring when presented with pictures of the hurricane, will be randomly assigned to one of three experimental conditions: Cognitive-Behavioral Treatment, Mood Ring Homeostasis Therapy, and Daily Aqua-therapy. The study involves paying the children \$500 each to complete the study and calls for excluding potential subjects who are African American or Hispanic. The interventions are proposed to last approximately one year, with no payment to the study subjects who discontinue treatment. Subjects for the study will be recruited from patients of the investigators. Only parental consent will be required for children 8 years of age and older. Evaluation of intervention outcome will be based on clinician judgment as to whether a child improved. Study subjects who show signs of major disturbance over the course of the study will be dropped. At the end of the study, the therapist who has the greatest number of improved children will receive a special prize. Publications reporting on this research project will include the name of each child along with the accompanying outcome data.

We will publish the best response to Dr. Dilemma's dilemma in the next issue of *All the DRT*.

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A Little More DRT on the DRT

The Child & Family Disaster Research Training & Education (DRT) grant draws on the extensive experience of the nation's leaders in child trauma. DRT is led by Betty Pfefferbaum, MD, JD, Director of the Terrorism and Disaster Center at the University of Oklahoma Health Sciences Center and a member of the National Child Traumatic Stress Network, and Alan M. Steinberg, PhD, Robert S. Pynoos, MD, and John Fairbank, MD, of the UCLA/Duke National Center for Child Traumatic Stress.

All the DRT has been put together for your enjoyment by:
Cynthia Whitham, LCSW, with assistance from
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For more information:

<http://tdc.ouhsc.edu>

<http://www.nctsnet.org>

<http://www.disasterresearch.org>

<http://www.redmh.org>

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