Psychological Intervention with the Virginia Tech Mass Casualty:
Lessons Learned in the Hospital Setting

Report to Virginia Tech Review Panel
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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. Approximately 30 professionals of varied backgrounds, drawn from local and national organizations, were involved in the delivery of psychological counseling services at MRH.

Process for Development of the Document
Once the team had completed its interventions in response to the acute phase of the crisis, a process was initiated to consolidate lessons learned and to prepare a formal report. This process began with the creation of a broadly based document which included a "timeline of events" along with personally compelling moments, and professionally relevant experiences. This initial working document was developed by the lead author (who served as coordinator of the Crisis Counseling Team) to reflect the collective experience of the treatment team.

Those treatment team members who were extensively involved in service delivery, were invited to a post event review. Their comments were recorded by the lead author and assembled into a first draft of a document focused specifically on "lessons learned ". (Those who elected to participate in this review are noted above as contributing authors.)

A summary of the first draft was presented as part of a Continuing Medical Education program, and the full draft document distributed for review and comments. The current draft 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. Additional review and revision is planned.

The goal of the process is to create a consensus document that reflects the collective reflections and insights of the mental health providers who responded to in the hospital setting.

Document Format

Items of content is listed as discrete units of information (in contrast to paragraph style) to facilitate comment and revision. The items are organized into themes, which are identified as "lessons."

***The document is a "work in progress" and in that sense is incomplete. It is provided in its current form in respect to the urgency of the timeline under which the Virginia Tech Review Panel is operating. The authors apologize for the unfinished nature of the writing, and will work to promptly clarify or elaborate on any of the specific comments or general themes that are in the report.*

LESSONS LEARNED

Introduction

The most compelling and most important lessons learned pertain to 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 appeared to blend pragmatism with general principles from the psychological sciences.

In contrast, the delivery of designated crisis intervention counseling services, 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 as psychotherapist; and, as psychologically sophisticated observer of human behavior.

Lesson 1: Hospital as Sanctuary/Safe Haven

Regaining emotional equilibrium begins with a safe place to be

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 VT) 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 needs 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 provide a "place to be" for students and loved ones within the hospital provided a sanctuary. MRH provided a comfortable place for loved ones of the those wounded (or feared wounded) within a segregated section of the hospital with access to comfort facilities, food etc. It also provided information about loved ones and expedited opportunities for timely visitation.
This fits the broader mission of a health care facility in regard to 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 intervention to address and mange trauma will likely diminish its long term impact on these indirect victims.
However, 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 to those with only 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 is often denied (canceling elective interventions and discharging non-critical patients from the hospital).
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 renders the hospital an ideal place to provide support and guidance.
Information is essential to providing support and guidance. See Lesson 2: Information as Aid & Comfort.

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 met an objective set of standards or regulation.

Lesson 2: Information as Aid & 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 facilitates coping with trauma.

Analysis
The need for information 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 relative to the status of loved ones
Accurate information will short circuit generalized "worst case scenario fears" (eg, there are still gunmen on the loose) 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, there is appreciation for a careful and patient explanation of why information is not available (vs. withheld) along with indication of what is being done to get information. This seems to carry a metamessage that the needs of loved ones are being recognized, and that effort is being made to meet these needs (which 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 be inaccurate, and delivered in a way that is insensitive, countertherapeutic or even traumatizing.
As a health care provider, not providing known information feels counter therapeutic. This feeling is accentuated by awareness that rumor and media will fill the information void with less attention to accuracy and will deliver information in a way that is more likely to be disruptive.

Comment on Information Networking
"Texting" – At MRH groups of students were engaged in cell phone texting and simultaneous face-to-face sharing of information creating a unique information network (alternate to "official network" and "media")
Texting was continuous through periods when cell phone networks were overloaded.
The benefits of this network are that it is trust-driven, well intentioned, and delivers specific information directly to those most immediately in need – with the disadvantage being the potential to drive rumor.
The presence of this alternate information network further reinforced the importance of providing accurate information to those most personally influenced.

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 significant others, a list was developed that included all hospital patients admitted in relation to the casualty to MRH. 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 (that is, the absence of a central information authority) about those killed and injured; and, with respect to the emotional urgency of loved ones (of those known, suspected or feared to be killed or injured) - this list was extended to include those know to be hospitalized at other hospital facilities
Providing information to loved ones enabled them to expedite contact with those injured by identifying their location.
Doubts about the appropriateness of release of information was balanced by the realization that expediting contact with loved ones might provide an opportunity for a death bed visit that might otherwise be lost.
As hours passed, many that were feared or suspected lost were found to be safe; and, 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 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.
In the face of great need for info: Are HIPAA laws an obstacle to management of crises?

Lesson 3: Media as Obstacle

Many people seemed far more angry at the media than the killer

Impression
Media presence was a conspicuous and pervasive element of the casualty, that was seldom helpful, often counterproductive, and sometimes inflammatory. As such, the impact of the media demands scrutiny, and a set of management strategies to diminish its potential negative impact.

Comments in this section focus specifically on the national media. Local media were less problematic.

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 & indirect)
Efforts by media to circumvent restrictions diverted resources from service delivery
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 the media as transparently self-serving, insensitive and shameless.
There was a widely voiced hope that media behavior was so extremely disruptive and counterproductive, that the media itself would respond with constructive self-scrutiny aimed at finding a better way to respond to similar crises. This hope was apparently naïve.
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 (eg., watching television programming) interactions merit consideration.
Mental health providers need to be prepared to address: 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.
A working media behavior prototype serves as a basis both: for directing personal behavior with the media; and, for counseling victims regarding their interactions with the media
The collective impression of mental health professionals (assimilating subjective experience and professional analysis) yields the following rather decidedly uncomplimentary profile
Media Behavior Prototype: Narcissistic entitlement regarding readiness to violate rules established by crisis responders, reluctance to cooperate when caught in rule violating behaviors, comfort with deceptive practices, apparent lack of concern of the impact of their behavior on victims, and, desire for access to and control of information to the exclusion of colleagues in the field.

Media Related Intervention Strategies

General Considerations
Key question: What is the potential benefit of the interaction?
Providing aid and support is not a media role
Providing entertainment is a media role
Providing information is a media role, though there is not a pervasive rigorous standard
for accuracy
The interviewee lacks control over the "skew" or "slant" of the presentation of the
interview
Media presentation of an event whether accurate or not, well intentioned or not, may have
a potentially counterproductive or even inflammatory effect.

Guidelines for Targeted Interventions
About granting a TV interview:
This may come up as a question from victims
Goal is to facilitate decision making regarding whether to grant an interview
Offer information from "general considerations" above
Ask questions: "What do you hope to accomplish by granting an interview?" "Do you
trust that you will be treated fairly?"

About TV/ Media Viewing:
Media has a potent impact.
Understanding and managing this potent impact is prudent
Intervention is more at coaching – and may be initiated by counselor

Concern regarding Milieu Violation
Media intrusion is a systems problem to which all should be alert
Examples of milieu violations include: attempts to physically cross security lines,
unsolicited contacts with victims, family and providers under false pretense
Generating a specific list of "Media Milieu Violation Strategies" would help raise
vigilance and facilitate efforts at limiting disruptive impact

Lesson 4: Visual Image as Theraputic Agent

The visual image is a "psychological scalpel" that can heal or destroy

Impression
Therapeutic assessment of trauma related imagery and memory offers insight into
psychological status and provides an opportunity for intervention that is timely and
naturalistic

Analysis

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

The intrusive recollection, often dominated by the visual image, is a hallmark of traumatic stress disorders

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

Negative images can "freeze" the person at the moment in time when fear & 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 victims, as well as, responders.

To be witness to 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.

Visit 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 appeared to be mutually beneficial (to survivors & 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 Media Imagery
TV airing of the Killers video was akin to mass marketing of traumatic imagery. As a consequence, the airing of the Killer's video was likely retraumatizing for victims and their loved ones.

Lesson 5: Grasping Therapeutic Role and Function

Effective intervention rests on flexibility and spontaneity

Impression
Mental health providers have a unique and critical role in crisis intervention. The effectiveness of psychological intervention is linked to broad based thinking about human behavior, a readiness to reach beyond the customs and practices of psychotherapy, and a willingness to forge partnerships with other providers.

Analysis
Identifying Role
"Think Broadly" regarding role - as in provide support and relief from stress and suffering

Think Broadly" regarding scope of service – as in provide relief from stress and suffering for patients & families & friends & staff &…

"Begin with the Basics" - as in use psychological knowledge and skills to observe and assess as a means of determining role and scope

"Be flexible & spontaneous" - as in letting go of implicit elements of structure in psychotherapy (scheduling, session length, record keeping, controlled environment)

Implicit in above items is the need to NOT be bounded by conventional customs and practices of psychotherapy

Implicit in above items is importance of contributing to a pervasive therapeutic milieu

Nursing role & function offers an effective model for integrating intensive psychological services into a hospital environment

Examples of nursing-analog mental health functions include: Routine check-ins to see if need for counseling; brief staffing of patient status at changing shifts; patient continuity in staff assignments

Spontaneity
There is a need for readiness to provide interventions that address unique pragmatic aspects of mass casualty – for example:

Media related psychological interventions (see Media as Obstacle-above)

Questions about the motives and state of mind of the killer (see Making Sense of Cho-below)

Feelings of awkwardness with being the object of curiosity

Timeline
A shifting of roles came as the recovery and treatment process evolved

Day 1 was more focused on managing people, logistics and information (than counseling per se) against a background of uncertainty. Day 2 brought a transition to more of a counseling role. Day 4 saw peak need for intervention with staff. Hospital function and overall crisis service delivery tapered to baseline by Day 7.

Scope: Circles of Trauma - defines potential scope of service

Direct victims – those killed and injured

Direct trauma - loved ones of those killed and injured

Secondary trauma (by direct association with casualties) to medical, rescue and public safety personnel – eg., VaTech Health Services; MRH staff

Remote trauma to members of the community (from an existential sense of "violation") and to those who feel some degree of shared identity with the victims

Thinking about Long Term Impact
Need to consider both acute and post traumatic response

Post traumatic response is more difficult to identify and manage

Post traumatic responses are outliers, happening in relatively unpredictable time and circumstances

Potential Concerns:

Survivor guilt

Overcompensation by men who escaped and left women behind

Backlash to Asian ethnic groups & perceived loners

Partnerships
Forging partnership is essential to effective service delivery
Partnerships need to be developed 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*
Partners: Human Resource staff, Chaplains, Police
Coordinated efforts among natural partners is essential to optimal function in a mass casualty situation
This can be complicated by the need for a large number of providers to function in concert.

HR & Psychology:
HR staff function as practical facilitators for psychological service delivery because of familiarity with the people and setting, the ability to effect logistics (eg., access, facilities),and the organizational abilities and "psychological mindedness" of HR

Chaplaincy & Psychology:
There is a strong common ground especially in times of great loss
At MRH, chaplains and psychologists were able to work effectively under same umbrella
This coordinated effort maximized synergy of service and minimized potential problems with overlapping roles

Police & 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
Police help insure safety; and, can readily access other public safety resources

Comments on Professional Roles
"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 practitioner

Lesson 6: Ownership & Partnerships

Ownership and Partnerships are central elements in community response to trauma

Impression
Ownership is a foundation 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, to recover from the trauma (community=insiders)
In a mass casualty the community will need the assistance of those outside the community (ie, Outsiders) to meet its needs
These needs include: 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
Not all efforts to help are wanted or beneficial; that is, helpers do not necessarily become partners
The importance of ownership by the community was well recognized by sophisticated outsiders (eg., Trauma Relief, Billy Graham Crusade, HCA Hospital Chaplaincy)
Recognition of the need for ownership by the community, along with the insight and understanding it conveys lead "outsiders" to be more readily be accepted as partners

Partnerships
Defined as: *Who is doing, more or less, what you are doing; or ,Who is needed for you to do what you need to do*
See Partnership related comments in "Grasping Therapeutic Role and Function" - above

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

Lesson 7: Making Sense of 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. However, it is beyond the scope of this inquiry

Analysis
The following observations and questions have been noted during the lessons learned exercise
"Is Cho a victim too?"

Should Cho have a spot in the memorial on the VT Drillfield? – There are 32 spots named for the victim and 1 that is 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 service a bell was rung 33 times – which is the right number?

Providers are aware backlash toward Asian ethnic groups, as well as, fear of backlash (and shame) from within Asian ethnic groups

There has been some use of the phrase: "Cho qualities." Is this dangerous in its overinclusiveness and intrusiveness? Does it stigmatize loners? Does it further disenfranchise the disenfranchised?

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

Lesson 8: Being a Caregiver & 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 providers after trauma is emerging as a standard practice
The efficacy of CISD, in general, and the Mitchell Model, in particular, have recently come into question
While a full critique is beyond the scope of this paper, our assumption is that the Mitchell Model is beneficial when well implemented (and is significant in historic context)
However, the limitations of the model render it neither necessary nor sufficient for the full range of interventions appropriate for trauma responders.
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: 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 factors lead 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.

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.

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