Utility of Fear Severity and Individual Resilience Scoring as a Surge Capacity, Triage Management Tool during Large-Scale, Bio-event Disasters

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Abstract
Threats of bioterrorism and emerging infectious disease pandemics may result in fear-related consequences. Fear-based signs and symptoms, if left undetected and untreated, may be extremely debilitating and lead to chronic problems with risk of permanent damage to the brain’s locus coeruleus and stress response circuits. The triage management of susceptible, exposed, and infectious victims seeking care must be sensitive and specific enough to identify individuals with excessive levels of fear in order to address the nuances of fear-based symptoms at the initial point of contact. These acute conditions, which include hyper-vigilant fear, are managed best by timely and effective information, rapid evaluation, and possibly medication that uniquely address the locus-coeruleus-driven noradrenalin over-activation. This article recommends that a fear and resilience (FR) checklist be included as an essential triage tool to identify those most at risk. This checklist has the utility of rapid usage and capacity to respond to limitations brought about by surge capacity requirements. Whereas the utility of such a checklist is evident, predictive validity studies will be required in the future. It is important to note that a unique feature of the FR Checklist is that, in addition to identifying individuals who are emotionally, medically, and socially hypo-resilient, it simultaneously identifies individuals who are hyper-resilient and can be asked to volunteer, and thus rapidly expand the surge capacity.


Introduction
During the 2003 severe acute respiratory syndrome (SARS) pandemic, fear frequently was cited as a psychological consequence;1–9 fear itself was referred to as a “central pathogen” in the early epidemic process and was believed to be “spreading faster than the disease itself.”10 In Hong Kong, fear about the SARS outbreak was considered “stronger and more widespread” than the fear of any comparable, life-threatening illness.11 The SARS pandemic is but one example of modern day bio-events, which are defined as large-scale disasters secondary to biological agents that are either naturally occurring (e.g., Influenza A, potential H5N1 outbreak) or deliberate (e.g., small pox, inhalational plague, anthrax) in nature.12 Bio-events, like other ‘silent disasters’ (chemical, radiation), provoke uncertainty through fear of exposure to an unseen bio-agent for an indeterminate time with the propensity to cause states of extreme fear/panic, helplessness, and horror within the population. Until recently, fear, its consequences (such as potential post-traumatic stress disorder (PTSD)), and their prevention, research, and management options have received little attention. Advances in the neurochemistry of fear have provided both mental health workers and disaster planners new opportunities to identify and mitigate the suffering of individuals debilitated by consequences of fear. Whereas such opportunities often are overlooked in the greater scheme of disaster management protocols, the authors argue that the
science of fear must be understood better and integrated into victim triage-management at the initial point of contact in any large-scale disaster event, especially those of a ‘silent’ nature, such as pandemics.

The Fear Response in Disasters: A 2006 Update

Fear, in contrast to anxiety, is the emotion that occurs when there is a clear and obvious source of danger that would be regarded as real by most people. Individual fear, and even population panic, involve the activation of both the central and peripheral sympathetic nervous system, allowing one to respond quickly when faced with an imminent threat to survival. Previously, this was termed the “fight-or-flight” response. In a series of recent articles reviewing the biological literature on the hardwired human response to extreme fear, one of the authors has pointed out that the above 1929 catchphrase is incorrect and that the correct sequence of the initial responses to extreme fear is actually freeze-flight-fight-fright. This especially is evident in silent disasters during which the “fight” segment of the fear response sequence is not applicable.

Excessive fear, recognized as a hyper-vigilant fear response, may be seen in the susceptible, exposed, and infectious population seeking care. It is caused by the over-activation of noradrenergic neurons and manifests as signs and symptoms of hyper-arousal; its persistent symptoms being recognized as the biological basis for acute and chronic PTSD.

Disasters due to natural hazards commonly are accepted the world over as the ‘will of God or nature’. Although some level of emotional distress is common, the distress rarely reaches diagnosable levels and the duration of distress is self-limiting. The main exception is seen in persons who are less resilient because they have experienced prior psychological symptoms. They are at increased risk for developing elevated levels of anxiety, depression, and somatic symptoms. The same probably is true for persons who are less resilient because of financial or multiple medical problems.

The incidence of post-disaster [AU ???] PTSD often is used as the standard by which psychological severity of a disaster’s impact on a population is measured. Current diagnostic criteria for PTSD require that a person experience, witness, or be confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and that a person’s response involves intense fear, helplessness, or horror. Using measures specifically developed to assess PTSD, researchers have found low rates of PTSD following floods, volcanoes, mudslides, and tornadoes where property damage was substantial, but other dimensions of trauma thought to contribute to PTSD, such as direct threat to one’s survival or the presence of dead bodies, were not present. However, the relationship of PTSD with fear-based events, such as exposure to lethal, inter-group violence (combat, war zone exposure, or intentionally caused disasters that result from terrorism) produce PTSD rates that usually are several times higher, and, as such require reinvestigation the potential that they can be prevented and/or mitigated.

Shalev et al conducted a landmark, prospective study of the onset, overlap, and course of PTSD and major depression in 211 subjects presenting to a general hospital’s emergency department following traumatic events. These authors found that major depression and PTSD occurred early on after trauma. The authors found that “63 survivors (29.9%) met criteria for PTSD at one month, and 37 (17.5%) had PTSD at four months. Forty subjects (19.0%) met criteria for major depression at one month, and 30 (14.2%) had major depression at four months. Comorbid depression occurred in 44.5% of PTSD patients at one month and in 43.2% at four months.” Shalev et al concluded that “major depression and PTSD are independent sequelae of traumatic events, have similar prognoses, and interact to increase distress and dysfunction. Both should be targeted by early treatment interventions and by neurobiological research.”

Humans Are Not Hardwired to React Adaptively to Pandemics

Evolution’s role in altering species-specific risk for virulence of the disease during pandemics is well known; however, only recently has psychiatry and psychology begun to explore the evolutionary underpinnings of common psychiatric symptoms related to the limbic fear-circuits in humans. These background concepts have been reviewed by Bracha. Building on concepts pioneered by Nesse, Bracha has argued that neuro-evolutionary time-depth principles also are useful in predicting human behaviors during the early stages of pandemics. Intensive animal husbandry practices that facilitate re-assortment-triggered genomic shifts and pandemics only appeared following the emergence of high-population-density societies (circa 2000 BC). During the evolution of the human fear-circuits (early Pleistocene), population densities were too low for pandemics to occur.

Fear-circuitry evolution primarily was driven by disasters caused by natural hazards, predatory animals, and eventually, war. Therefore, humans evolved and became ‘hardwired’ to flee and seek safety in numbers. Whereas self-preservation often is assumed to be the natural response to physical danger, the greater stressor appears to be separation from attachment figures such as familiar persons and places. Therefore, it is not surprising that disaster organizations, such as the Red Cross, historically have developed post-disaster, shelter care expertise. However, mass shelters in bio-events increase density-related risks, and become not only irrelevant and impractical, but actually contraindicated. Moreover, the post-disaster psychiatric expertise developed by disaster organizations also now have been shown to actually be detrimental (Cochrane Database of Systematic Reviews).

Bio-Events and Fear-Based Concerns

The modern world has seen increasing population densities, more crowded bio-event-disaster-prone, urban centers, and emerging diseases often resulting from encroachment of humans into formerly animal dominated environments (e.g., Hanta virus, Ebola, and HIV). The goal of triage-management in any pandemic is to prevent secondary
infections by reducing the transmission rate of disease. Epidemic control is based on the fact that if the reproductive rate (Ro) of the disease (measured as average number of individuals directly infected by a primary case) can be held below 1, the disease eventually will disappear. The SARS epidemic data indicates that during the first weeks of a pandemic, many individuals may have mistaken symptoms for infection-caused (cytokine-driven) symptoms or panic symptoms for infection-caused (cytokine-driven) symptoms. Therefore, susceptible, but unexposed individuals may have ignored public announcements to shelter themselves in-place and instead flocked to hospitals, emergency departments, and clinics. Such actions actually increased the density and disease transmission by mixing uninfected persons with those already infectious. In the initial days of the SARS outbreak in Toronto, the health system was ‘inundated’ with susceptible individuals seeking care for the disease they did not yet have. In countries and cities hit by SARS, reports indicate that non-compliance of the population was considered the main factor for the delay in controlling the disease.

Triage–Management of Fear

Fear is said to have three components: (1) cognitive; (2) physiological; and (3) behavioral. Psychological stress will be ubiquitous among the outbreak-affected population, but for the most part, will not represent psychiatric illness. Fear is essential. It is the recognition of what is a threat to personal survival, and therefore, must address fundamental issues of safety. The susceptible population represents the largest population subgroup requiring immediate intervention, often provoked out of fear. If not attended to in a timely and accurate manner, this population may disrupt resource-limited services at healthcare facilities. Effective information should mitigate the sense of danger and fear and lead the population to accept their home as a safe ‘shelter-in-place’ environment. A secondary goal is to narrow the susceptible population to a manageable number of those who will require additional professional assessment, evaluation, and monitoring.

If effective, risk management information is the basis for population-based public announcements that are the first line of triage management, along with social distancing measures (e.g., sheltering-in-place, closing schools, canceling mass gatherings, and isolating cases), to ensure safety and control disease transmission. Community-based programs primarily would consist of phone-based hotlines and face-to-face encounters in infection-free (“cold zone”) triage and information centers, outside hospitals, ambulatory care facilities, clinics, or vaccination and prophylactic medication distribution centers within a community. The first level of communication would include repeating and disseminating the exact message via television, radio, or the Internet by the Department of Health Public Affairs personnel. This reinforcement and clarification of critical information should lead to recognition of potentially dangerous behaviors, confidence to manage issues of safety and creation of a safe home environment, and embrace of schedules of media-based, health information updates. In addition, the public health infrastructure must respond to essential needs such as the provision of food, medication, and the care of co-morbid disease, and to communicate these arrangements effectively to the population.

The Canadian SARS experience suggests that a phone bank approach is appropriate for first-line triage contact during an epidemic. The Canadian government-run 1-800-Telehealth phone bank, which normally received 2,000 calls per day, received up to 20,000 calls per day during the outbreak, requiring additional staffing by nurses and public health personnel. By utilizing protocol-driven recorded and live assessments and advice, the system was able to separate callers into probable ‘infected versus uninfected’ categories and served to minimize duplication of efforts and mixing of triage category populations at the hospital level. Real-time, central data interpretation of information and population needs collated by the phone bank system contributed to the development of new protocols and improved advice and referral schemes.

Fear Scoring Using the Bio-event Fear and Resilience (FR) Checklist

The triage–management system must be alerted to identify persons with excessive fear, low resilience, and a lack of coping skills that may require further evaluation without increasing their risk of exposure. Victims suffering hypervigilant fear represent a key subgroup that may benefit from short- and long-term interventions. Normally, the diagnosis can be mitigated cognitively by effective information that is frequent, honest, and transparent. Even then, hypervigilant fear states may compel many to seek additional assistance, and if left untreated and untreated, may be extremely debilitating and lead to chronic problems with an increased risk for permanent damage to the locus coeruleus, stress response system, and cognitive function.

A rapid assessment tool, the Bio–event Fear and Resilience (FR) Checklist, can be administered either by phone or face-to-face by trained volunteers (Figure 1). Parts 1–3 checklist objectives are used to assist in the determination of whether the caller to a phone hotline or a citizen showing up at a Triage–Information Center is probably exposed/infected versus probably not exposed/infected. For the purpose of illustration, each question would be weighed similarly at the onset during all epidemics and pandemics, especially of a respiratory nature, and are arbitrarily given generic scores of 1. However, the score weight of each question would change and become more disease-specific as the case definition of the outbreak would change. Part 4 (fear and resilience: FR) emphasizes physiological symptoms with special emphasis on physiological signs that are the most common and best-researched predictors of adverse, post-disaster consequences among healthy individuals. The symptoms are: (1) racing heart; (2) sweaty palms; (3) tremulousness; and (4) shortness of breath (hyperventilation). Indeed, Shalev et al reported that trauma survivors with PTSD had higher heart rate levels at the emergency department and reported more intrusive symptoms, exaggerated startle, and peri-traumatic dissociation than did those with major depression.
### Bioevent Fear and Resilience (FR) Checklist

Part 1 assists in identifying those exposed and/or infectious. Part 4 aims to objectively quantify current acute fear severity and to estimate pre-morbidity resilience levels.

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<th>Part 4: Total Score</th>
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**Part 1—Bracha-Burkle Bio-Event Fear and Resilience (FR) Checklist. Parts 1–3 assist in identifying those exposed and/or infectious. Part 4 aims to objectively quantify current acute-fear severity and to estimate pre-morbidity resilience levels.**

**Note:** Each yes/no answer selected will add 1 to your total score. **Low score indicates higher fear.**

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**Total Score**

- If your total score is less than 15, you have an acute fear of bioevents.
- If your total score is between 15 and 20, you have a chronic fear of bioevents.
- If your total score is greater than 20, you have a pre-morbidity fear of bioevents.
Fear and resilience scoring can be performed in two minutes using a yes/no/maybe format, providing a fear severity score. Part 4 scores range from zero to a maximum of 50 (the higher the score the greater the risk). Emotional resilience questions (3 of 17) estimate a person’s resilience to emotional stress (protective factors); physical resilience utilizes the number of different prescription medications as a proxy of physical frailty; and economic resilience is based on fearfulness of lack of income in the coming 2–3 months. The authors posit that these two questions are more likely to be accurate predictors than immediate income loss, property loss, or employment status. During the SARS epidemic, the Canadian government assured the affected population they would provide for lost wages, thereby directly lessening the fear potential.

High scores (Figure 2) would alert volunteers to refer the individual to a healthcare provider backup system for further evaluation/referral, place emphasis on the cognitive process utilizing effective information and reassurance of safety, daily monitoring of fear and resilience-related negative behaviors and actions, and/or medications to mitigate noradrenergic over-reaction. According to the Cochrane Database of Systematic Reviews, treating hyper-vigilant fear with anxiolytic medications (benzodiazepines) and/or critical incident debriefing are contraindicated.29,30 In contrast, a series of recent landmark studies have demonstrated that the short-term use of the beta-blocker, propranolol, in order to reduce noradrenergic over-activation in the immediate aftermath of emotional trauma is likely to be beneficial and efficacious in preventing the development of subsequent PTSD.42,43,44 Interestingly, the alpha-blocker prazosin recently has been shown to have a major role in the treatment of PTSD-related nightmares and PTSD-related intrusive symptoms.45,46 Only further studies will determine if such interventions for fear will serve to prevent the development of PTSD, and of stress-triggered major depression.

FR Checklist and PTSD

The FR Checklist was not intended to (and should not be used for) diagnosing disaster victims suffering from PTSD. Instead it was designed as a practical tool for assessing the severity of acute fear that may represent a level of suffering that deserves additional immediate and possibly long-term attention, evaluation, monitoring, and intervention. In addition, the FR Checklist has no overlap with any of the existing checklists for PTSD. A diagnosis of PTSD requires that the individual fully meet DSM-IV Criteria (A, B, C, D, and E). Unfortunately the focus of all the existing checklists almost is exclusively on Criteria B, C, and D. This is true for both civilian and military PTSD checklists.47 There is a growing awareness in the field of PTSD biology that Criterion-A assessment has been greatly underestimated.18,44 The FR Checklist (Figure 1) supplements these by providing a structured assessment of PTSD Criterion-A.18,37,38 This process incorporates into the checklist, a new sub-criterion (A3) purposed for the DSM-V, which, for the first time, utilizes psychophysiological research that has demonstrated the importance of tachycardia in the emergency department setting as an immediate predictor of subsequent PTSD.42,43,44 It also is argued that research is warranted to examine the predictive value of hyperventilation, sweaty palms, cold sweat, trembling/shaking, and buckling knees in the hours and days following a traumatic event (ideally in the emergency department setting) as additional predictors of subsequent PTSD.37,38

FR Checklist and Surge Capacity Adjustment

Bio-event, triage-management decisions, based on a resource-constrained environment, will require surge capacity decisions. An unfortunate but real consequence of silent disasters is that healthcare providers and other essential workers may choose not to report for duty. Realistic disaster planning may incorporate from the start, the assumption that only 40–58% will report at the time of a bio-event.48 Timely risk communications, just-in-time training, and evidence-based assurances of personal protection may increase these numbers. However, hotline callers may be functioning without the benefit of a cadre of back-up healthcare professionals, necessitating that the severity score be matched with available resources. Incorporating contemporary psychometric theory, the FR checklist was designed specifically to have no obligatory cut off. The practical advantage of no obligatory cut off during large-scale bioevent disasters is that intervention levels would be raised or lowered depending on the availability of critical referral resources.

Resilience Scoring May Facilitate Rapid Expansion of ‘Cold Zone’ Volunteers

Coordinating a rapid expansion in the number of volunteers is expected to be another challenge for disaster planners. Large numbers of ‘cold zone’ volunteers are required to assist in controlling, informing, and educating the susceptible population, and maintaining vaccination and prophylactic medication distribution centers and short- and long-term counseling of victim families and survivors. Currently, there is no brief interview for identifying potential volunteers. Pre-screened individuals who are trained and have accepted the risks may be more capable (and more emotionally stable) than individuals who offer to volunteer.
scoring are the first steps in surge capacity triage management that must begin at the point of contact by healthcare providers and disaster managers alike. The FR checklist serves as a useful tool in assessing a state of fear in victims deserving of further evaluation, monitoring, and intervention. In large-scale bio-event disasters, the FR checklist has the potential of assisting in the targeting of limited surge capacity resources, identifying victims who would benefit most by the targeted resources, assisting in mitigating mass chaos, assess the effectiveness and applicability of risk communication and public announcements in limiting fear-based symptoms, and assist in identifying a potential volunteer force that exhibits levels of functional resiliency. Further research is needed to validate this process.

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**References**


41. Bracha HS, Burkle FM: Bioevent Fear and Resilience Checklist. The Asia-P acific Center for Biosecurity, Disaster & Conflict Research, Asia-Pacific Institute for Tropical Medicine and Infectious Disease, John A. Burns School of Medicine, University of Hawaii, 2006.


